

# **Identification and Referral to Improve Safety (IRIS) programme**

[www.irisdomesticviolence.org.uk](http://www.irisdomesticviolence.org.uk)

## **National Review 2013 – 2016**



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## Executive Summary

Domestic violence and abuse (DVA) is recognised as a significant global public health issue (World Health Organisation (WHO) 2013). DVA is a serious, multifaceted societal issue with profound health and mental wellbeing consequences with the potential for longer term health care needs in supporting survivors. The Office for National Statistics (2015) crime survey for 2013-2014 estimates that at least 1.4 million women and 700,000 men aged between 16 and 59 experienced DVA in England and Wales equating to 8.5% of women and 4.5% of men reporting a DVA crime (ONS, 2015). Furthermore, new data reports that 85% of DVA victims sought help, on average five times from professionals, including healthcare professionals, in the year before they received effective help (Safe Lives 2015). The cost to public services of domestic abuse (uprated to 2013 prices) is £4.3 bn with the majority of costs attributed to the health service (£1.9 bn) (Walby 2004, 2009).

In 2011 the findings from a cluster randomised controlled trial (RCT); funded by the Health Foundation, for the Identification and Referral to Improve Safety (IRIS) programme was published in *The Lancet* (Feder *et al.*, 2011). The trial was based on two urban primary care Trusts; Bristol and Hackney in London with a total of 48 general practices involved in the study from 2007 - 2010. The IRIS intervention programme comprises of a structured approach to support and management of DVA by providing training to clinical and non-clinical staff located within GP surgeries, ongoing consultancy to the practice team, a prompt within the patient's medical records and a defined referral pathway to an advocate educator (AE) working locally. In November 2010 the IRIS National Steering group was formed. The current membership of this group comprises Donna Covey (Chair) – CEO, AVA, Professor Gene Feder – University of Bristol, Carol Metters – CEO, Next Link, Karen Ingala-Smith – CEO, nia, Val Lunn – CEO, WAIS, Dr. Roxane Agnew Davis – DVTraining Ltd. The IRIS DVA intervention model has received national recognition and strategic relevance in over seven key UK documents on domestic violence and abuse.

This independent review of the national IRIS intervention is based on national and local data that is widely available since the publication of the IRIS RCT study (Feder *et al.*, 2011). This report has been conducted independently of the national IRIS steering group but in consultation as part of the review process to compile this report for the Department of Health (DOH) 3 year funding criteria (2013 – 2016).

The review is solely based on the literature available at the time of submitting this report (June 2016) and includes the annual IRIS data reports (2013, 2014, 2015) published peer review articles (Feder *et al.*, 2011, Devine *et al.*, 2012), local IRIS service evaluations (5 independent reports) from commissioned IRIS sites and an evaluation of the IRIS train the trainers report.

## **Background to Domestic Violence and Abuse (DVA)**

DVA is recognised as a significant global public health issue (World Health Organisation (WHO) 2013). DVA is a serious, multifaceted societal issue with profound health and mental wellbeing consequences with the potential for longer term health care needs in supporting survivors. The Office for National Statistics (2015) crime survey for 2013-2014 estimates that at least 1.4 million women and 700,000 men aged between 16 and 59 experienced DVA in England and Wales equating to 8.5% of women and 4.5% of men reporting a DVA crime (ONS, 2015). By contrast the British crime survey 2001-2002 showed only 35% of DVA cases were reported to the police but by 2008-2009 this figure had increased to 47% (Walker et al., 2009). Whilst this indicates a rise in the number of DVA cases that are then investigated and recorded as a crime these figures do not include cases that go unrecorded or fail to get a prosecution nor does it record violent crime resulting from domestic incidents.

Furthermore, new data reports that 85% of DVA victims sought help, on average five times from professionals, including healthcare professionals, in the year before they received effective help (Safe Lives 2015). Coy & Kelly (2011) when conducting an evaluation of four independent DVA advocacy schemes reported that female victims of DVA will sustain, on average, 35 episodes of abuse before seeking any form of help including discussing DVA with healthcare professionals (Coy & Kelly 2011).

In earlier work by Ramsay et al., (2006) and Richardson et al., (2001) they report poor or inappropriate responses by healthcare professionals to patients who have experienced DVA (Richardson et al., 2001). In the systematic review conducted by Ramsay et al., (2006) they found that clinicians are often unaware of the referral pathways for DVA survivors or have not received any training around DVA. Whilst in some areas of the UK specialist DVA training is provided, particularly in acute and ED settings (Hinsliff-Smith & McGarry, 2016, McGarry 2016, Basu & Ratcliffe 2014) there is little evidence of work undertaken in primary care (Feder *et al.*, 2006). In economic terms the cost to public services of domestic abuse (uprated to 2013 prices) is reported to be £4.3 billion with the majority of costs attributed to the health service (£1.7 billion) which includes acute, community and primary care (Walby 2004, 2009).

In February 2014 the National Institute for Health and Care Excellence (NICE) published detailed guidance and it is explicit that all agencies, including healthcare providers, have a central role in the prevention and management of DVA. Front line healthcare professionals, including those working in primary healthcare should receive targeted education and continual professional development in order to support and manage DVA (NICE 2014). It is known that those who experience DVA report significant immediate

and longer-term health impacts which affect both physical and mental health status (McGarry et al. 2011). The detrimental effect on an individual's mental health either from experiencing DVA or witnessing DVA (i.e. as a child or family member) is becoming well documented in the literature (Trevillion *et al.*, 2012). It is only more recently considerations have been given to the magnitude and extent of DVA including post-traumatic stress disorder (PTSD), depression, anxiety (Coid *et al.*, 2003, Golding, 1999) and self-harm (Boyle *et al.*, 2006). In 2012 the UK Home Office published an extended definition of DVA to include psychological abuse, and coercive and controlling behaviours. This change in the definition indicates recognition of the extent of DVA including 'psychological, physical, sexual, financial, and emotional' and may result in a more comprehensive understanding of DVA including rates of prevalence in the UK and mental health conditions.

The current UK Home Office definition for DVA is:

*...Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass but is not limited to the following types of abuse: psychological, physical, sexual, financial, emotional [...] includes so called 'honour' based violence, female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group (Home Office, 2012). The aspect of controlling or coercive behaviour in intimate or familial relationships was further enhanced with The Serious Crime Act (2015) creating a new criminal offence (Home Office 2015).*

In 2014, after extensive consultation including the direct involvement of the IRIS national steering group, NICE produced guidelines for the support and management of DVA across all healthcare settings and support services (2014). NICE further expanded these guidelines with the issuing of the NICE Quality Standards for DVA (2016). The new quality standards aim to improve structure, process and outcomes of care for people affected by DVA. The quality statements should have the following impact for patients:

*People presenting to frontline staff with possible indicators of DVA are asked about their experiences in a private discussion: This may help them talk about DVA, know they are not alone, feel that they will be believed and that their experience is not unusual. They will be offered help and support. (DVA 2014 NICE guideline PH50, recommendation 6)*

*People experiencing DVA receive a response from level 1 or 2 trained staff : Are helped to talk about their experience by trained staff, to know they are not alone, that they can get help and support that their experience is not unusual and they will be believed.*

*People experiencing DVA are offered referral to a specialist support service: Such as*

*refuges this will mean they can get the help and support they need.*

*(DVA 2014 NICE guideline PH50, recommendation 6)*

*People who disclose that they are perpetrating DVA are offered a referral to specialist services: Are offered referral to specialist services that can help them to change their views and understand more about violence. These specialist services can make it easier for them to get the help and support they need to change their behaviour.*

*(DVA 2014 NICE guideline PH50, recommendation 4, 5, 6, 10 & 14)*

## **IRIS - Identification and Referral to Improve Safety Programme**

IRIS is a general practice based DVA programme to support staff working within General Practice (GP) surgeries. The IRIS programme includes all levels of clinical staff as well as administrative staff (for example reception staff, administrators). The core programme includes training and ongoing education, delivered with two sessions for clinical staff and one session for non-clinical staff, identified care pathways and an enhanced referral route to specialist DVA service for women. The IRIS programme also provides information and signposting for male victims and perpetrators. In addition, the original IRIS trial utilised the electronic patient medical records to record disclosures or concerns about DVA. Use of such a system is well recognised within other settings, i.e. Emergency and Accident (Basu & Ratcliffe, 2014). This proven system (Feder *et al.*, 2011) directly alerts those accessing the patient healthcare system to be aware of the patient history within their consultation.

The core programme is delivered by Advocate Educators (henceforth AE) who work alongside third sector specialist organisations working closely with local GP surgeries, each programme has a clinical lead (usually a GP working at a practice from the clinical commissioning group (CCG) locally). The third sector organisations who are, in the most part, commissioned by the local CCG/s or Public Health teams are predominately specialist violence against women and girls (VAWG) organisations, for example Women's Aid or other specialist DVA services (for example in Bristol Next Link).

The IRIS programme and model of intervention model has received national recognition and strategic relevance in over seven key UK documents on domestic violence and abuse. These include:

- **Royal College of General Practitioners (RCGP).** The IRIS commissioning guidance is endorsed by the RCGP and the IRIS model is also highlighted in the RCGPs e-learning module on Violence Against Women and Children (VAWC).
- **Department of Health** taskforce report from the domestic violence subgroup, 'Responding to violence against women and children: The role of the NHS'. IRIS is cited as best practice within this report.
- **Department of Health** 'Commissioning services for women and children who experience violence or abuse – a guide for health commissioners'. IRIS is recommended in this report.

- **Home Office** published 'Domestic Homicide Reviews – Common Themes Identified as Lessons to be learned'. IRIS is cited as an example of action that can be taken locally to improve provision regarding training and awareness of domestic violence and abuse and appropriate follow up for cases and disclosures of such abuse.
- **National Institute for Care and Health Excellence (NICE)** guidance on 'Domestic violence and abuse: how health services, social care and the organisations they work with can respond effectively'. The IRIS model is described in recommendations 15 & 16 of the guidance on how to respond effectively to Domestic Violence and Abuse and NICE Quality standards have recently been published to support these.
- **Home Office** 'Modern Crime Prevention Strategy' 2016. The IRIS model is promoted in this strategy.
- **Government's VAWG strategy 2016-2020**. IRIS is recommended as an effective intervention which enables early identification and intervention for victims/survivors of domestic violence and abuse.

## Evidence Base

Local implementation of IRIS is based on the learning from the initial IRIS research in Bristol and Hackney <http://www.health.org.uk/publications/iris-case-study/>. Evidence of the effectiveness of this approach has been demonstrated in a randomized controlled trial (RCT) where the intervention proved to be cost effective and also have the potential to be a cost saving measure. For details of the trial and for further information about IRIS please refer to the IRIS website for details: <http://www.irisdomesticviolence.org.uk>

## Aims, objectives and Outcomes of the IRIS programme within the local CCG context

**Aim:** To improve the identification of and response to patients who are affected by domestic violence and abuse across general practices.

### Objectives:

- Increase knowledge of general practice staff about DVA and the help available for those patients affected
- Improve the confidence of general practice staff to ask questions about possible abuse in a safe way
- Make appropriate referrals resulting in improved patient care
- Improve the recording of DVA in the patients' medical notes
- Increase the number of patients referred from general practices for help with DVA
- Improve data collection and analysis of the number of disclosures and referrals
- Improve the safety of patients by reducing repeat victimisation

## Outcomes

To contribute towards

Domain 1 of the Public Health Outcomes Framework - Improving the wider determinants of health in relation to 'Domestic Abuse' and Domain 4 Healthcare public health and preventing premature mortality

## **Indicator - mortality from causes considered preventable**

Domain 1 of NHS Outcomes Framework – Preventing people dying prematurely  
CCG plans regarding Quality Innovation Productivity and Prevention

Delivery of the NHS Mandate through working in partnership so as to reduce violence, improve the way the NHS shares information about violence and support victims of crime

### **Summary findings:**

The completed IRIS review will comprise five themes:

- Overview of the national IRIS training programme 2013 - 2016
- IRIS referral data 2013 -2016
- SWOT analysis
- Challenges for the national IRIS model going forward
- Review limitations

### **Overview of national IRIS training programme 2013 – 2016**

The IRIS National Implementation Managers produce annual data reports (2013/2014/2015) which are widely distributed and will be made freely accessible on the IRIS web site [www.irisdomesticviolence.org.uk](http://www.irisdomesticviolence.org.uk). In addition, further documents were accessed and included in this review:

*Feder G. Agnew Davies A. Baird K. Dunne D. Eldridge S. Griffiths C. Gregory A. Howell A. Johnson M. Ramsay J. Rutterford C. Sharp D. (2011) Identification and Referral to Improve Safety (IRIS) of women experiencing domestic violence with a primary care training and support programme a cluster randomised controlled trial. Lancet 378:1788-95*

*Devine A. Spencer A. Eldridge S. Norman R. Feder G. (2012). Cost-effectiveness of Identification and Referral to Improve Safety (IRIS), a domestic violence training and support programme for primary care: a modelling study based on a randomised controlled trial. BMJ Open 2:e001008. Doi:10.1136/bmjopen-2012-001008*

*Silburn & Silburn (2013) The Nottingham IRIS project*

*Granville (2014) Hearing voices of the IRIS service users*

*Taylor (2014) The IRIS Project: An evaluation of the Train the Trainers Induction Course*

*Downes (2015) IRIS Service South Gloucestershire – Review Report*

*Hinsliff-Smith (2015) Mansfield and Ashfield IRIS service evaluation report*

*Hinsliff-Smith (2016) Nottingham West service IRIS service evaluation report*

*T4T Evaluation (2016)*

*CLAHRC evaluation of five of the NE London IRIS sites (2016)*

*IRIS Strategic relevance document (2016)*

In total all these documents provide a useful and broad picture of the IRIS model nationally as well as the local context (South Gloucestershire, Manchester & Nottingham). The national IRIS reports provide an overall picture of the commissioned IRIS service across sites in England and Wales. The data contained within the annual reports is captured, as part of the commissioning, by the AEs who are employed locally and therefore the assumption is made that the data is robustly monitored at source.

In the original trial publication (Feder *et al.*, 2011) acknowledgment was made of the difficulties in implementing the IRIS intervention in resource poor settings and indeed in the UK the scarcity of resources; funding, advocacy services and therefore specialist staff. However, the documents show evidence of a growing number of commissioned IRIS programmes whereby as at 31<sup>st</sup> March 2016 33 IRIS sites were commissioned and running (31 in England and 2 in Wales). These 33 commissioned sites cover appropriately 462 general practices who have undertaken all or some aspects of the IRIS training. To be clear 350 practices have undertaken all aspects of the IRIS training (2 sessions per clinician and one for non-clinical staff) with a further 112 practices classed as partially IRIS trained at the end of 2015. The following map illustrates the range of areas covered in England and Wales.





It is also worthy of note that the rate of practices undertaking the IRIS programme shows no sign of slowing with data showing a 5 fold increase in take up of the IRIS programme since 2010 to 2015 (24 practices in the original trial to the current level of 462 practices).

The current 33 active IRIS sites cover a wide range of practices, both urban and rural although data was not provided on the number of patients covered across the 350 practices. This would provide useful data in terms of the reach of the IRIS programme as well as some economic data against the number of referred patients to the AE per practice. This review has not included the detailed profile of the IRIS trained staff from the 462 practices, both clinical and administrative, that has engaged in the IRIS programme although the local providers and the national steering group do have access to this detailed and comprehensive data. Likewise data is available for the capture of referrals per level of staff (i.e. GP, practice nurse, health care assistant, receptionist etc.). This type of data is valuable going forward for the national IRIS team in order to monitor the referral routes and how this might differ within primary care compared to the acute or other healthcare settings. Anecdotal evidence, obtained during this review, suggests that within primary care a culture exists whereby any DVA or safeguarding referral is only made in consultation with a GP or referred to a GP rather than practice staff acting directly. This is despite the IRIS training and the NICE quality standards (2016) strongly stating that that all healthcare staff have a responsibility to refer and offer support for DVA.

Furthermore, going forward referral data would enable targeted approaches by the commissioned advocacy services to actively target practices that are not referring or there is a slowing in referrals. Consideration needs to be given to the role of AEs and the clinical leads once practices are trained within the commissioned site. For example, in year 3 and 4 of the commissioned service emphasis should be placed on refresher training, further sessions offered for new or relocated staff to the site and a continual presence within the practices. A noted trend is that the IRIS programme is been commissioned on a short term basis, usually 12 – 24 months.

The latest evidence provided in the 2015 national report indicates that seven (Camden, Hackney, Lambeth, Manchester, Nottingham City, Portsmouth and Southampton) of the twenty three current sites are operating into year 3 and 4 where referral rates are growing in momentum (2015 national report page 19). For example, in Nottingham City accumulative to the end of year 2 saw a total of 100 referrals whereas by year 3 this had increased to a total of 196 patient referrals; 96 referrals in year 3 alone.

A known issue within primary care is the high level of movement within CCG areas of clinical staff, including the use of locum staff. This is an aspect that needs close monitoring by the local and national IRIS team if they are to ensure the continued rates

of patient referrals and management of DVA within primary care settings, particularly when so far commissioning of the IRIS programme is usually for an initial period of 12 – 24 months. Of the 33 IRIS commissioned sites all but one have received extended funding although it is noted that this is often on a rolling programme and very often confirmed within 4 – 12 weeks of the funding expiring. This short term funding presents many challenges for the IRIS programme not least the uncertainty this creates for staff working within the programme and more widely the women that are receiving support.

### **IRIS referral data 2013 -2016**

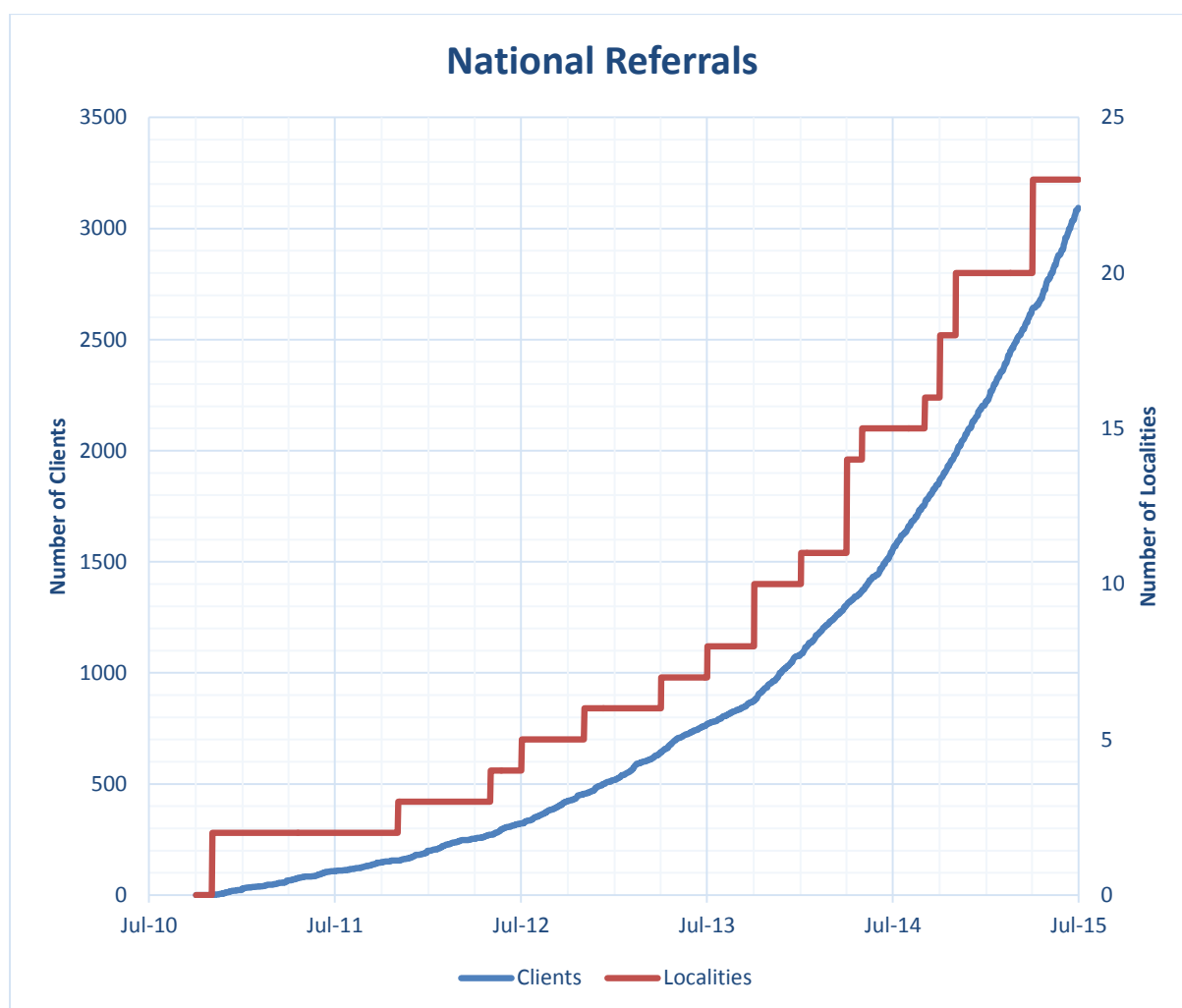
In conducting this review there was clear evidence of the effective tracking and monitoring of patients who were referred to the AEs across the 33 active IRIS areas.

To be clear the number of referred patients only takes into account those patients who agreed or requested to be referred to the named AE for support. In cases where there is a recognised high risk or safeguarding issue the IRIS model is very clearly defined for referrals. For any staff in the practice they are able to contact their AE for specialist advice and for the AE to assess and refer high risk cases to MARAC. Whilst this is not a 24/7 service from the AE and is not intended to replace the normal safeguarding and crisis procedures in place within any general practice it does provide the specialist input and guidance to assess the level of risk.

In terms of referral data this is obtained nationally from an established database accessed by all the AEs and advocacy services. In order to ensure consistency of recording data, advocacy services receive training on the IRIS programme including the training materials and data handling. This includes the pre and post questionnaire data which is collected at the beginning and end of each training session (two sessions for clinicians and one session for practice admin staff). The IRIS training programme for AEs is delivered by the National Implementation Manager and in 2014 the train the trainer programme was evaluated (see Taylor 2014 An Evaluation of the Train the Trainers Induction Course). Overall the feedback was very positive with recommendations implemented. In addition to delivery of the IRIS training, each AE attends the initial IRIS training with twice yearly updates which are held around the UK.

Graph 1 below shows the number of referrals nationally over time (blue line) and the increase in localities commissioning IRIS over time (red line).

**Graph 1 National IRIS patient referrals against trained localities**



A concern for any DVA intervention and advocacy service is capturing those patients who decide not to disclose DVA to a healthcare professional during a consultation but the patient later acts upon advice received, this can often be many months or even years afterwards. The nature and scope of contact with advocacy services is often difficult to capture often resulting in the true extent of support through the IRIS programme to go unrecognised.

The IRIS programme is designed to allow practice staff to record any concerns or advice provided on the patient’s electronic medical records by way of a prompt for future consultations. Initially this was through a newly developed pop-up template called HARKS. The system has faced some difficulties and many practices are not accessing or utilising the HARK system instead opting to code patients under the current myriad of codes provided nationally for system 1.

In addition to staff recording any DVA concerns on the patient records they have access to health promotion materials provided by the specialist advocacy services, usually

posters and “bra” cards. This is in addition to the IRIS intervention materials such as posters and practice based leaflets. Within the DVA literature these are known issues particularly when trying to capture the true extent and prevalence of DVA. This further emphasizes the complexities of providing and supporting survivors and families of DVA within any healthcare setting including primary care (Richardson *et al.*, 2002, Hegarty, 2006) and the acute setting (Hinsliff-Smith & McGarry 2016).

The IRIS national data sets provide extensive and comprehensive demographic data about the 3093 patient referrals received by the AEs working across the 33 trained IRIS sites since 2010 and up to 30<sup>th</sup> June 2015. This not only includes useful data around age, gender, and ethnicity but a unique data set for the types of abuse experienced by those referred as well as the relationship to the perpetrator. This data is of national significance to the DVA community and those involved in providing support and advocacy services and should be made available in the national arena.

### **SWOT analysis**

The analysis of the strengths, weaknesses, opportunities and threats of the national IRIS programme follows the review only of the available documents as described earlier in the report. In addition, discussions with third sector specialist advocacy services were undertaken as well as CCG commissioners, two IRIS clinical leads, a public health consultant and four AEs. Each bullet point included in the SWOT have been described earlier in the report and aims to provide a succinct overview of the aspects that the IRIS national steering need to consider going forward. This SWOT should be viewed as a useful tool to aid the process of securing future funding and the impact of the IRIS intervention locally and nationally.

**Strengths:**

- IRIS model uses established networks of DVA referral pathways
- Programme links to NICE (2014) guidelines & NICE (2016) quality standards
- National capture of referral rates for commissioned areas
- Evidence of patient outcomes
- Comprehensive evidence of the nature and type of DVA
- Steering group membership
- IRIS covers urban and rural practices
- IRIS referrals cover both genders
- Extensive DVA data set for England
- Proven DVA model
- Programme is comprehensive offering three elements: training, patient markers, referral pathways
- Regular updates for regional AEs
- Robust demographic referral data

**Weaknesses:**

- CCGs are not commissioning IRIS routinely
- CCG commissioning is often short term (12 - 24 months)
- Uncertainty about future funding for the IRIS model without DOH funding
- Lack of cohesive plan to engage more CCGs and re-commissioning of IRIS
- Limited effective dissemination of IRIS impact to front line staff (in surgeries)
- Lack of planning for +3/4 year commissioned IRIS service
- The current model of funding for AEs (this is based on practice numbers, not patients)
- Time commitment by practices to undertake the IRIS training
- No robust data on practice staff and their role within practices (those that undertake the IRIS training)
- Challenges faced by the national managers
- Lack of web site updates and relevance to the public or healthcare professionals

**Opportunities:**

- Proven model of DVA referral/support could be extended to other settings (i.e. ED, community nursing)
- IRIS model could be tailored to deliver specialist training to medical schools and pre-reg training (nurses, midwives)
- Raised public awareness of DVA
- Media interest in DVA
- NICE guidelines and Quality Standard (2016)
- Government acknowledgment and commitment by other public sectors (i.e. Police) to DVA
- To expand and cover more urban/rural practices, some big cities covered
- To include the voice of survivors and those who have experienced IRIS AE support
- To develop IRIS materials for refresher training
- A large data set of DVA prevalence and type of DVA from primary care settings

**Threats:**

- Lack of sustainable funding for current IRIS model
- Reduction in advocacy services in England and therefore lack of specialist staff
- DVA becomes subsumed under safeguarding so no need for IRIS model
- Advocacy services (locally and nationally) are not able to cope with the influx of referrals
- IRIS refresher training and 'mop up' sessions for practices is not funded
- Limited evidence of public engagement locally or nationally to attract new funding
- Limited evidence of service evaluations in the commissioned CCG areas

## **Challenges for the national IRIS model going forward?**

These are listed in no particular order and reflect the independent findings from the review of documents and discussions held with those involved in the IRIS programme.

**Continued funding** –The IRIS programme was initially funded by the DOH for a period of 3 years with funding finishing in spring 2016. The National Steering group is considering the longer term funding requirements and how this may shape the IRIS programme going forward. Due consideration will need to be given to the operational aspects of the IRIS programme from a national perspective but also the leadership and direction of the IRIS programme which has received national recognition. Tied to the national funding picture, are the continual pressures faced by local CCGs often the commissioners for many healthcare services, including the IRIS programme. Short term funding appears to be an accepted norm for many third sector organisations and these often include the specialist DVA advocacy services.

**Wider reach of IRIS intervention programme** – Whilst this aspect is presented in the SWOT as an opportunity, the national steering group will need to consider how best to diversify the successful, highly recognised and proven DVA model outside of general practice. The recent NICE quality standards (2016) places the IRIS programme in an excellent position and conduit for meeting many aspects of the NICE (2016) quality standards across a vast array of healthcare settings. The national steering group therefore needs to carefully consider its position going forward and how it may meet the challenges of a diversification of the IRIS programme.

**Going forward** - The IRIS programme is embedded into 450 general practices the task for the national steering group is to consider the timescales and realistic expectations for the next 3 – 5 years within general practice. Do the national steering group have a clear vision for the next 3 - 5 years with strategic goals and aspirations?

### **Limitations**

This independent review is solely based on the materials provided by the IRIS national steering along with other independent commissioned service evaluations and user engagement reports.

### **Declaration**

The author is not employed by the national steering group other than in her capacity to complete and compile this document. The author has previously conducted and produced two local IRIS service evaluation reports for CCG commissioners which were included as relevant documents in this review.

## **Acknowledgement**

I am grateful to the National Implementation Managers in particular Lizzie Birch, Medina Johnson and Annie Howell for providing all the written materials required for this review.

I would like to thank those that willingly shared their experiences of the IRIS programme locally including staff working on the IRIS programme within WAIS Nottingham. As part of the review I was able to reflect upon two CCG commissioned services and incorporate the practical elements of delivering a DVA intervention.



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