Liverpool Heart and Chest Hospital NHS
NHS Foundation Trust

Reference Number: FOI2021/021
From: Private Individual

Date: 22 January 2021

Subject: Trust policies and procedures around domestic violence

Q1 Do you provide access to an Independent Domestic Abuse Advisor?
a. If yes, do you provide access to an IDAA at every hospital site?

A1 No

Q2 Do you employ a domestic abuse specialist nurse?
a. If yes, do you employ a domestic abuse specialist nurse at every hospital site?

A2 No

Q3 Do you have a Domestic Abuse policy?
a. If yes, please provide a copy.

A3 Yes; Please see attached *Domestic-Abuse-v50*

Q4 Do you produce an annual safeguarding report on domestic abuse?

A4 Yes an annual Safeguarding report is provided to the Trust Board this would include Domestic abuse content.

Q5 Do you conduct internal audits to ensure compliance to the domestic abuse policy?

A5 No

Q6 Have you conducted training for staff on domestic abuse in the last 12 months. If no, in the last 24 months?

A6 Yes Level 3 Safeguarding Ambassador training includes Domestic Abuse.

Q7 How many domestic abuse, stalking and harassment (DASH) risk assessments were completed by the trust/health board in 2016, 2017, 2018, 2019 and 2020?

A7 None

Q8 How many domestic abuse, stalking and harassment (DASH) referrals were made by the trust/health board to a Multi-Agency Risk Assessment Conference in 2016, 2017, 2018, 2019 and 2020?

A8 None

Domestic Abuse Policy

Authors Name & Title: Joanne Shaw Head of Nursing Clinical Services and Safeguarding	
Scope: Trust Wide	**Classification: Clinical**
Replaces: Domestic Abuse Policy v4.0	
To be read in conjunction with the following documents: Safeguarding Adults Policy and Procedure, Safeguarding Children and Young Adults Policy, Admitting Children to Hospital Policy, Supporting Staff following Work Related Stressful or Traumatic Incidents, Recruitment and Selection Policy	
Document for public display? Yes	

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Has the document undergone Equality Analysis?	**Yes**
Has Endorsement been completed?	**Yes**

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Policy Statement

This Policy and guidelines are intended to support the pivotal role that staff can play in empowering others, through the provision of information, to make informed choices about their safety and that of their children. However professionals have a duty to be vigilant to the wider child protection agenda and to use appropriate referral mechanisms. **It is important to remember that domestic abuse can affect anyone-including staff.** (See Appendix 1 for guidance for staff).

This Policy focuses on females though it is important to remember that though it is less frequent, men too can be victims of domestic abuse. The majority of services are aimed at women but there are organisations which provide support. The Men's Advice Line provides a free phone number for men suffering domestic abuse (0808 801 0327), and the Mankind initiative (01823 334244). In the rest of this document we will be focusing on female victims of abuse.

Both men and women perpetrate and experience domestic violence and abuse, but it is more common for men to perpetrate violence and abuse against women. This is particularly true for severe and repeated violence and sexual assault.

Multi-agency partnership working at both an operational and strategic level is the most effective approach for addressing domestic violence and abuse. Training and on-going support from within an organisation are also needed for individual practitioners. Without training in identifying domestic violence and abuse and responding appropriately after disclosure, healthcare professionals may fail to recognise its contribution to a person's condition and to provide effective and safe support.

Abused women are:

- 15 times more likely to abuse alcohol
- 9 times more likely to abuse drugs
- 3 times more likely to be diagnosed with depression/psychosis
- 5 times more likely to attempt suicide

The objective of this policy is to ensure that all relevant staff are conversant with the operational mechanisms to deal with cases of domestic abuse.

1. Roles and Responsibilities

Named Leads with specific duties and responsibilities within the Trust are:

- The Executive Lead for Safeguarding is Mrs Susan Pemberton (Director of Nursing)
- The Head of Nursing for Safeguarding Vulnerable Adults is Mrs Joanne Shaw (
- The Head of Nursing for Safeguarding Children and Young Adults is Mrs Joanne Shaw (
- The Named Consultant for Safeguarding Adults and children is Dr Petra Jenkins
- The operational nurse is Miss Angela Mckenna
- The administration support is Mrs Terri Marshall

Chief Executive

The Chief Executive has a statutory responsibility; it is her responsibility to:

- identify a person at Executive level with responsibility for Safeguarding
- identify a Named Nurse and Doctor for Safeguarding Vulnerable Adults and Children matters

Executive Lead

The Director of Nursing is accountable to the Trust Board for ensuring compliance with this policy across the Trust.

The Head of Safeguarding Vulnerable Adults and Children

The Head of Nursing for Clinical services is responsible to the Director of Nursing for ensuring the policy is implemented, reviewed and evaluated.

Named Doctors for Safeguarding Vulnerable Adults and Children

The Named Doctors act as a contact for Trust staff and have responsibility for ensuring training of medical staff within the Trust.

Safeguarding Action Group

The group is responsible for agreeing all relevant policies prior to ratification by the Quality Patient and Family Divisional Governance Committee and for monitoring compliance with these policies. The Safeguarding Group is responsible for reviewing external reports and for monitoring that recommendations from local and national guidance are considered and where appropriate implemented.

Human Resources

The Human Resources Department is responsible for ensuring that, when requested, appropriate support is offered to members of staff who are subject to domestic violence.

All Staff
This policy applies to all Trust staff, including temporary staff and those in training. All staff must:

- be familiar with and follow Trust policy and procedures for promoting and safeguarding the welfare of vulnerable adults and children/young people within the Trust and know who to contact within the organisation to express concern about welfare
- discuss their concerns and any differences of opinion with their Line Manager. If there are still concerns, these must then be reported to the Named Nurse or Doctor for Safeguarding
- record all concerns, discussions with the victim, decisions made and the reasons for those decisions in EPR
- all Trust staff are responsible for co-operating with the development and implementation of corporate policies as part of their normal duties and responsibilities

Temporary staff
Temporary or agency staff, contractors, students or others will be expected to comply with the requirements of all Trust policies applicable to their area of operation.

Social Services/Local Authority (Children's Services)
The Local Authority Children's Services Department has a statutory responsibility for the protection of vulnerable adults and children/young people.

2. Standards

It is important that all staff know who to contact for advice if they have any concerns about the welfare of a child including unborn babies. Support and advice can be sought from the following:

The trust safeguarding team via switchboard

Careline (24hr service)	Children: 0151 233 3700 Adults: 0151 233 3800

- Domestic Abuse Helplines (POLICE Contacts are given in Section 3 Policy)

www.worstkeptsecret.co.uk	**08000 283 398**
wecanhelp@liverpool.gov.uk	**08007 311 313**
www.womansaid.org.uk	**08082 000 247**
24 hour Liverpool Helpline	**0800 731 1313**
National Domestic Abuse Helpline	**0808 2000 247**

3. Policy

3.1 Recognising Abuse

Physical and Emotional Symptoms of Abuse
There are a number of indicators of domestic abuse and physical abuse, of which staff should be aware. None of these are proof that abuse has definitely occurred and they should be taken as such. Rather, they are signs that the staff should be mindful and consider whether their concerns require escalation.

A history of:
- high incidence of miscarriage and termination of pregnancies
- stillbirth
- prematurity
- intrauterine growth retardation/low birth weight
- preterm labours
- smoking, alcohol and drug abuse
- unplanned or unwanted pregnancy
- chest pain, panic attacks, palpitations

Common Injuries
- gynaecological problems such as frequent vaginal and urinary tract infections, dyspareunia and pelvic pain
- frequent visits to healthcare facilities with vague complaints or symptoms without evidence of physiological abnormality 'of an unknown clinical cause' i.e. recurring admissions usually for abdominal pain / reduced foetal movements / suspected urinary tract infection.
- unexplained bruises / lacerations, whiplash injuries consistent with shaking, areas of erythema consistent with slap injuries, burns / multiple injuries in various stages of healing
- injuries to areas hidden by clothing (note it is not easy to properly examine women from some ethnic backgrounds because of the complicated nature of their clothing or cultural shyness or embarrassment to expose areas of their body)
- injuries inconsistent with explanation
- recount of incident in a hesitant, embarrassed, evasive manner
- repeated accidental injuries (examine previous medical records)
- injuries that are of several different ages, especially to the head, neck, breasts, abdomen and genitals
- repeated or chronic injuries
- postnatally removal of perineal sutures
- chronic pain, or pain due to diffused trauma without physical evidence or with bruising where the explanation does not fit with the description of the injury
- physical symptoms related to stress, other anxiety disorders or depression – panic attacks, feelings of isolation, an inability to cope, suicide attempts or gestures of deliberate self-harm
- frequent use of prescribed tranquilisers or pain medications
- rape and sexual assault, injury to genitals or sexually transmitted diseases

Behavioural Signs of Abuse

- missed appointments and / or non-compliance with treatment regimes
- lack of independent transportation, access to finances and ability to communicate by telephone
- partner accompanies the woman, insists on staying close and answers all questions directed to her – may also undermine, mock or belittle her
- woman may appear frightened, ashamed, evasive, embarrassed or be reluctant to speak or disagree in front of her partner
- intense irrational jealousy or possessiveness expressed by partner or reported by the woman
- denial or minimisation of abuse by the woman (or her partner) with an exaggerated sense of personal responsibility for the relationship, including self-blame for her partner's abuse
- post traumatic shock syndrome, reactions e.g. numbness, denial, shaking, crying, anger. Long-term anxiety, self-blame, replay memories
- history of behaviour problems of the women's children

All staff should be aware of the recognised physical, emotional and behavioural indications of domestic abuse. If any signs are apparent, or suspected, staff should always alert their concerns to Social Services Department and the Named Nurse for Safeguarding Vulnerable Adults.

3.2 Supporting Disclosure

If domestic abuse is suspected and staff feel confident to do so they should explore the possibility of domestic abuse with the victim. The victim should always be alone when being asked about domestic abuse. If the member of staff does not feel confident to question the victim then they must immediately escalate their concerns to their Line Manager.

Staff should initially question the victim by asking indirect questions in an empathic manner (See Appendix 2). Staff should go on to ask direct open questions if the victim affirms there are problems, gives answers that do not seem plausible or is hesitant.

(Note: If the victim is hearing impaired or her 1st language is not English, staff must arrange for a skilled interpreter or advocacy worker to be present. **Family or friends must never be used to interpret**).

Staff should inform the victim that anything they choose to tell them will be confidential, but staff must also explain their limitations with confidentiality e.g. concerns over child protection issues.

If a victim makes a disclosure, they must be offered accurate information about support groups and agencies in and out of her area. Only give written information e.g. leaflets / contact cards / flyers if the victim feels it is safe for them to take these.

It is important that staff enquire about the safety of the victim before they leave.

If the victim does want immediate access to a refuge then offer the use of a phone if she wishes to enquire if there is a space or offer contact with an appropriate domestic abuse agency on her behalf.

3.3 Domestic Abuse Police Contact Numbers

IN AN EMERGENCY DIAL 999

Liverpool North Family Crime Investigation Unit	**0151 777 4587**
Liverpool South Family Crime Investigation Unit	**0151 777 5370**
Knowsley Domestic Abuse Unit	**0151 777 6387 / 9**
Sefton Domestic Abuse Police Unit	**0151 777 3087**
Wirral Police Domestic Abuse Unit	**0151 777 3087**

If the woman feels she cannot make her own way to the refuge in safety, or her partner is present and threatening, call the Police to accompany her from the premises to the refuge and control any disruptive partner.

If she does not wish to seek immediate refuge, discuss other safety options with her e.g. where to contact for further information, advice and support, discuss a safety plan if the situation at home becomes unsafe e.g. where she can go, how can she obtain money to escape etc.

It is up to the woman to decide an appropriate course of action. Each woman will use the information given in her own way. She may choose not to leave her abuser.

The staff must respect and accept the woman's decision, whatever that may be, unless there are child protection issues.

It should be remembered that staff may also be subjected to domestic abuse / abuse. A confidential counselling and support service is available for staff via the Human Resources Department. Staff can also be referred, or self-refer, into the Health Work and Wellbeing service for additional support if required.

3.4 Disclosure

If disclosure occurs, it is essential that referral pathways and safety needs are underlined and that attention is drawn to the safety information, all of which are contained in the Domestic Abuse Information Card.

Additional information about services in Merseyside and national telephone numbers can be found in the Directory of Domestic Abuse in Merseyside. Similar information is accessible through the **Freephone 24 hour Liverpool Helpline on 0800 731 1313.**

The free phone National Domestic abuse Helpline number is 0808 2000 247.

In the case of serious assault, consideration may have to be given to protection through hospitalisation or police involvement.

3.5 Children and Domestic Abuse

If children are living in the household, the involvement of Social Services must be sought. Professionals have a clear duty to safeguard children and do not have to seek parental permission for a referral.

3.6 Recording Domestic Abuse

The woman should be advised to document occurrence of domestic violence as, increasingly, a woman seeking help is likely to be asked to prove she is being abused and medical evidence can be the most useful to strengthen the case, especially in court.

Medical Documentation should be clear and accurate in EPR, including all physical and psychological symptoms.

Recording of domestic abuse should include any disclosure i.e. what the patient said, what was their composure – i.e. crying, frightened, a description of any injury / bruising and a body map, if possible, is essential. Polaroid photographs may be taken with consent to record physical injuries. The recording should comply with current professional guidelines and, as with safeguarding children, should include details of any given explanation and further observations by the professional which contribute to the information base, recorded in accordance with the level of expected competence at primary care level.

Note who is present when there is a history of an injury is being taken, i.e. husband or partner. Are there children in the household; were they present at the time of alleged assault / injury and / or present at history taking?

It is important to remember that records can be used to inform future planning for protection of an abused woman. She may not want to prosecute on this occasion but any recording forms part of the history of abuse and will mean that a prosecution can be brought more easily in the future.

Health professionals have a duty of care to record domestic abuse and permission need not be sought from the victim. Domestic incidents should be recorded in EPR.

3.7 Confidentiality

Extreme care should be taken to protect the safety of victims of violence and no information should be disclosed which might breach their safety i.e. a third party trying to use the whereabouts of children to trace a mother. This would apply even if the inquirer was a professional, partner or family member who worked in the system.

In the case of serious assault, it would be helpful to have the person's consent to share information with another agency but, as with safeguarding children and vulnerable adults, the welfare of the victim is paramount and if there was considered to be a serious risk to life or safety, then information may need to be disclosed with or without consent.

3.8 Staff Support

Where a member of staff is required to make a decision about the safety and disclosure of information this should be discussed with the Named Nurse for Safeguarding Vulnerable Adults who will be able to advise.

It is accepted that such situations can be difficult for staff to deal with and as such clinical supervision and de-briefing sessions can be arranged via the Named Nurse. Staff should contact the Named Nurse to discuss and make such arrangements.

It is also recognised that staff may be affected by the information and situation they have had to deal with or been involved in. Therefore, staff should be given the opportunity and be fully informed of the availability of the staff counselling service and the employee wellbeing service (0800282193). The details of these support services are available from Human Resources and Line Managers. Reference should also be made to the Support Staff following work related traumatic or stressful incidents which can be found on the Trust's intranet.

3.9 Important Points to Remember:

- always believe what the woman is telling you
- do not make judgements about what the woman is telling you
- discuss recording / documenting / photographing (where possible) of injuries and information. Discuss with the Police (with the woman's consent) safeguarding clothing or other evidence that may be required for forensic evidence
- respect the woman's choices, assuring her that she can contact you again should she need further support
- **be safe** – any member of staff has a right to withdraw from any situation where they feel their personal safety is in jeopardy. Postpone the discussion or request assistance from colleagues / manager / security / police as necessary
- complete a risk assessment for situations you are unsure of
- incident report all safeguarding issues
- do not direct or advise, give the options, let the woman decide
- child protection concerns take priority over patient confidentiality, refer to Trust's Safeguarding Children Policy
- staff must inform Named Nurse and Social Services Department

3.10 Points to Consider When Responding to Women Experiencing Domestic Abuse:

- the woman may have been experiencing violence and abuse over a long period of time. The violence and abuse may be a mixture of physical, sexual and emotional abuse
- the woman may have been limited in her movements
- the woman may have no access to money or be excluded from dealing with finances
- the woman will probably have done a whole range of different things already to try to stop or manage the violence and abuse
- you may be the first person she has spoken to or the 12th
- she may want to stop or escape the violence and abuse but she may also want to try and save the relationship
- it is likely that she will blame herself for the violence and abuse, be lacking confidence and be sensitive to your views
- she may be frightened of her perpetrator and possibly of you
- women are at most risk of life threatening or fatal violence and abuse when they try to attempt to leave, or have recently left their violent partner

3.11 Forced Marriage and Honour Based Crime

A forced marriage is where one or both people do not (or in cases of people with learning disabilities, cannot) consent to the marriage and pressure or abuse is used. It is an appalling and indefensible practice and is recognised in the UK as a form of

violence against women and men, domestic/child abuse and a serious abuse of human rights.

The pressure put on people to marry against their will can be physical (including threats, actual physical violence and sexual violence) or emotional and psychological (for example, when someone is made to feel like they're bringing shame on their family). Financial abuse (taking your wages or not giving you any money) can also be a factor.

3.12 Forced Marriage Unit

The Forced Marriage Unit [FMU] is a joint Foreign and Commonwealth Office and Home Office unit was which set up in January 2005 to lead on the Government's forced marriage policy, outreach and casework. It operates both inside the UK, where support is provided to any individual, and overseas, where consular assistance is provided to British nationals, including dual nationals.

The FMU operates a public helpline to provide advice and support to victims of forced marriage as well as to professionals dealing with cases. The assistance provided ranges from simple safety advice, through to aiding a victim to prevent their unwanted spouse moving to the UK ('reluctant sponsor' cases), and, in extreme circumstances, to rescues of victims held against their will overseas.

The FMU undertake an extensive outreach and training programme of around 100 events a year, targeting both professionals and potential victims. The FMU also carry out media campaigns, such as 2015's 'right to choose' campaign, where the FMU commissioned a short film to raise awareness amongst young people at risk of being forced into marriage, as well as potential perpetrators.

Contact

- Telephone **+44 (0) 20 7008 0151**
- Email: **fmu@fco.gov.uk**
- Email for outreach work: **fmuoutreach@fco.gov.uk**
- Facebook: **'Forced Marriage' page**
- Twitter: **@FMUnit**

3.13 Legislation on Forced Marriage

The Anti-Social Behaviour, Crime and Policing Act (2014) makes it a criminal offence to force someone to marry This includes:

- taking someone overseas to force them to marry (whether or not the forced marriage takes place)
- marrying someone who lacks the mental capacity to consent to the marriage (whether they're pressured to or not)
- breaching a Forced Marriage Protection Order is also a criminal offence
- civil remedy of obtaining a Forced Marriage Protection Order through the family courts will continue to exist alongside the new criminal offence, so victims can choose how they wish to be assisted
- details of the new law can be found on the legislation website

3.14 Multi-Agency Risk Assessment Conference

Domestic violence and abuse is a large scale national problem. This Policy is intended to assist those involved in information sharing between agencies about Domestic violence to make decisions. In particular Caldicott Guardians and those responsible for making decisions about the appropriateness of sharing information (including sensitive health information) about individuals involved in domestic violence.

This policy outlines the Trust's role as a contributing agency, to Multi Agency Risk Assessment Conference (MARAC), and provides guidance to those nominated to act on behalf of the Trust when involved in MARAC.

MARAC was established originally in Cardiff in 2003 and has been developed nationally with the safety of high risk victims of domestic abuse as its focus. Research has indicated that an effective MARAC process can reduce domestic abuse repeat victimisations by on average 63%.

In a MARAC local agencies meet to discuss the highest risk victims of domestic abuse in their area. Information about the risks faced by those victims, the actions needed to ensure safety, and the provisions available locally is shared and used to create a risk management plan involving all agencies

The MARAC process is guided by the Home office through CAADA (Co-ordinated Action Against Domestic Abuse) and the principles are defined in the MARAC Guide 2012. CAADA is now referred to as Safe Lives although some of the documentation may still have CAADA insignia it is still applicable.

The MARAC Process aims to:
(i) identify and refer victims at high risk of harm
(ii) share relevant information among those MARAC agencies involved in supporting the victim and their family
(iii) identify actions on behalf of the Trust to support and increase the victim's safety
(iv) confirm when actions are completed to the MARAC
(v) identify any risks from the perpetrator to the Trust and its Employees

The purpose of the Risk Identification Checklist is to give a consistent and simple tool for practitioners who work with adult victims of domestic abuse in order to help them identify those who are at high risk of harm and whose cases should be referred to the Trust's identified lead and to a MARAC meeting in order to manage their risk.

When cases of domestic abuse are high risk they may warrant a referral to the MARAC to ensure all agencies share information in order to reduce the risk of repeat incidence of abuse.

It should be noted that MARAC is not a legal entity in itself but a set of administrative arrangements with authority resting with each agency involved. The Trust recognises its responsibilities with regard to multi-agency working, the support and protection of victims, and its role in reducing serious harm. As such, the Trust embraces implicitly, its statutory duty to co-operate in respect of Multi Agency Risk Assessment Conference work.

The Trust's geographical footprint encompasses a vast Number of MARACs therefore the Trust lead should always be the first point of contact to see which MARAC needs to be contacted.

The Trust has an identified lead who is designated as a single point of contact for MARAC referrals. The broad aim of the representatives is to ensure that there is a quality and uniform approach to MARAC referrals.

The identified leads:

- acts as a source of advice to the MARAC process
- acts as a liaison worker between the MARAC and frontline/involved healthcare clinicians, facilitating referrals, supporting and advising staff in matters of domestic abuse
- agrees with the local MARAC information sharing protocol on what confidential information can be shared with teams providing care to MARAC victims where appropriate
- liaises appropriately with other health care professionals involved or potentially involved in Safeguarding processes
- acts as a "gatekeeper" to ensure that appropriate referrals are made from the Trust to the MARAC process

The MARAC referral form is completed, shared with the patient and consent is sought to share information at the MARAC meeting. A copy of the referral is placed in the medical notes EPR. Staff caring for the patient are notified of any risks identified and controls that should be put in place. The sharing of this information is on a need to know basis.

Third Party Information Requests

In the case of the Trust, a request is sent to the identified lead. Upon receipt of a request, the identified lead makes a search of health records, initially utilising the electronic record system. If this indicates that there has been contact then a more detailed search is undertaken.

When a clinical record is made available, the identified lead examines it, and if necessary liaises with involved clinicians. Where there are no health records, a nil return is made.

Where there has been contact of care and risks linked to a domestic abuse incident the identified lead will share the information at the MARAC meeting provided it is appropriate to do so and the victim has given consent or share where the risk is serious enough to warrant the sharing of information without consent.

Referrals to the MARAC Meeting

A key role of the identified lead is to act as a "gate keeper" to ensure that referrals to the MARAC are suitable. Any decision to refer a patient to MARAC will be taken by the Trust MARAC identified lead and the referrer.

The MARAC identified lead discusses the case with the referring clinician and determines the relevance of the referral based on the CAADA-DASH Risk Identification Checklist and either:

- is satisfied that the referral is of such seriousness that it meets the criteria as a potential MARAC referral; or
- is concerned that the victim may not meet the MARAC Referral criteria but there is sufficient disquiet about the danger posed by the perpetrator of the abuse that it warrants further discussion with the Trusts Named Director for Safeguarding and Caldicott Guardian (if appropriate); or is satisfied that the patient concerned does not meet the criteria for referral and that he/she should be offered advice, support and signposting to domestic abuse support agencies

Supervision and Deputy Arrangements

In all cases the MARAC representative must offer support and advice to the person/s making the referral. Supervision to the MARAC representation will be via their line manager The MARAC representative must ensure deputy arrangements are in place for periods of annual leave.

Caldicott Principles

The MARAC process to be correctly implemented must comply with all Caldicott Principles:

1. Formally justify the purpose – It can be justified both in terms of individuals' best interest & interests of society

2. Identifiable information only when absolutely necessary – It will normally be necessary to use identifiable rather than anonymised information

3. Only the minimum required should be used – use proportional disclosure based on risk

4. Need to know access – MARAC "needs to know" even if some individual agencies don't, confidentiality maintained by representatives personally signing specific confidentiality agreement

5. All must understand their responsibilities – Statement read out at start of each MARAC reminding participants of their ethical, legal and cultural responsibilities. Caldicott Guardians as gatekeepers to the individual's information should ensure that their organisation is effectively engaged with the MARAC process.

6. Comply with and understand the law- Caldicott Guardians should understand and authorise MARAC information sharing and delegate authority to ensure all disclosures are "Caldicott Compliant".

The confidentiality of an individual's information is not absolute, a fact that is recognised by the Courts and by professional regulators. It is expected that organisations share information in child protection and similar cases. It is not ethically justified if we hold information that we know could prevent serious harm to others and yet knowingly decide not to share it.

Any information in relation to MARAC provided to practitioners, is done so in confidence. Consent to share information should be obtained from the victim. However if the victim refuses to give consent the information can still be shared in high risk cases, under the crime and disorder act, in order to prevent serious harm to the victim.

When a victim of domestic abuse lacks capacity to consent to a MARAC referral, a professional should always make the referral in their best interest.
The alleged perpetrator are not asked for their consent or informed about the MARAC referral as to do so might jeopardise the victims safety.

4. Policy Implementation Plan

4.1 Training Requirements

Safeguarding Vulnerable Adults and Children awareness training will be delivered to staff groups as identified in the Trust's Training Needs Analysis [TNA] as part of their

corporate induction and thereafter at mandatory training. Please refer to the Trust's TNA.

The Trust will provide Level 2 and 3 training in child protection for those specific staff groups as outlined in the Trust's TNA.

4.2 Implementation Responsibilities

The Director of Nursing is responsible for monitoring the implementation of this policy.

The Head of Nursing and safeguarding is responsible for ensuring that this document is reviewed and if required, revised in the light of legislative, guidance or organisational change. Once the document is revised it will be re-issued to departments and wards and posted on the intranet.

Ward Managers and Departmental Heads should ensure full implementation within their area.

4.3 Implementation Plan

- policy updates to be included in QPFEC
- policy to be appropriately archived and up to date policy on intranet
- policy to be made available to public via the intranet
- implement training programme as under Section 4.1 (Training Requirements)

5. Monitoring and Review

- The Learning and Development Department will produce quarterly and annual training reports indicating the level of Safeguarding training undertaken by staff.
- An annual audit will be undertaken on behalf of the Safeguarding Group to ensure compliance and to identify number of referrals made regarding domestic violence. This will be reported in the Annual Trust Board report.
- Reported cases will be reviewed by the Safeguarding Group to ensure compliance with the policy; these will be reported in the Annual Trust Board report.
- Any updates to this policy will be reviewed and agreed by the Safeguarding Group and ratified by the Quarterly Patient and Family Divisional Governance Committee
- The quality measures in Nice 2016 guidance will serve as the quality statements aim to improve the structure, process and outcomes of care in areas identified as needing quality improvement.
- Expected levels of achievement for quality measures are NICE 2016. Quality standards are intended to drive up the quality of care, and so achievement levels of 100% should be aspired to (or 0% if the quality statement states that something should not be done). However, NICE recognises that this may not always be appropriate in practice, taking account of safety, choice and professional judgement, and therefore desired levels of achievement should be defined locally.
- NICE's quality standard service improvement template helps providers to make an initial assessment of their service compared with a selection of quality statements. It includes assessing current practice, recording an action plan and monitoring quality improvement.

6. Appendices

APPENDIX 1

Guidance for Managers in Dealing with Staff who are Experiencing Domestic Abuse

It is the Trust's policy that every employee who is experiencing domestic abuse has the right to raise the issues with their employer, in the knowledge that the matter will be treated effectively, sympathetically and confidentially.

Impact on Work

Domestic abuse will have an impact on performance at work and therefore has a different effect on the quality of service provision. Such abuse may be identified by areas such as:

- lateness
- health and safety
- job prospects
- physical and emotional exhaustion
- absenteeism
- work performance
- behavioural change

In addition to the details of possible signs of abuse mentioned earlier in this document, other indicators may include the following:

- low self-esteem
- withdrawn or quiet due to feelings of isolation
- unusual number of calls from home and strong reaction to these calls
- comes to work late, needs to leave early
- secretive about home life
- partner may attempt to limit their work or social contacts
- partner may ridicule them in public
- partner exerts unusual amount of control over their life

Guidelines for Support

- all requests for assistance and support must be treated seriously and sympathetically and you should establish if the employee is happy talking to you or if they would prefer to speak to someone else
- ensure that you speak to the employee somewhere that is private, you cannot be overheard and cannot be interrupted
- reassure the employee that confidentiality will be maintained
- listen and do not pressurise to take action
- give a positive message that domestic abuse is a serious crime and every individual has the right to live a life free from abuse in any form
- ask the employee what they want to do, if anything, and respect their decision
- ask the employee if they want to report it to the Police and/or need to see a GP/Occupational Health Nurse for medical attention. This, of course, must be their choice
- give information (not advice) about support services available including local refuges and/or help lines

- be prepared to offer the same standard of support, on all occasions, no matter how many times the same employee approaches you. Remaining in an abusive relationship is part of the nature of the domestic abuse

Management Responsibilities

- to provide a confidential and sympathetic response to staff who may be suffering through domestic abuse
- allow flexibility to facilitate visits to solicitors and other agencies
- consider an advance of salary if financial difficulties are being experienced
- consider requests to change working hours
- ensure that security measures have been considered for staff who work alone
- ensure that no personal details of the individual are divulged including work place details
- ensure that confidential counselling / Health, Work and Wellbeing Services are made available to employees suffering domestic abuse
- managers should refer staff who are subject to allegations of abuse to appropriate confidential support/counselling if requested. In addition if there is a conflict between the post held and the criminal allegation against them, the disciplinary procedure should be invoked
- establish how the employee suffering domestic abuse wishes to be contacted; contacting them at home may not be appropriate
- consider the effect of domestic abuse on any children cared for by the employee and inform social services and other appropriate agencies

Responsibilities of Employees

- to ensure they inform the Line Managers if they are involved in a domestic situation which impacts on their work
- employees who know of colleagues who are suffering from domestic abuse should acknowledge a duty of care and provide practical advice or support for them. however, unnecessary intrusion should be recognised and respected
- to keep matters concerning colleagues confidential - abusive partners use numerous methods of tracking their partner's whereabouts.

APPENDIX 2

It is easier for a woman to answer 'yes' or 'no' to questions. (Indirect) Often requests for help are veiled. Their answers must be heard and enlarged upon (Direct).

Examples of Indirect Questions

- is everything alright at home?
- do you have good support at home?
- do you have a happy supportive relationship with your partner?
- I am worried about you, has someone hurt you, was it …….?
- do you feel controlled by your partner?
- are you frightened by your partner?

Examples of Direct Questions

- how are things at home?
- I noticed some bruises/burns/scratches/cuts/marks: how did this happen?
- your partner seems very anxious/frightened/angry. Is this because they were responsible for your injuries and perhaps feel guilty about it?
- are you ok? you seem very anxious / frightened; how can I help you?
- does your partner treat you badly? Such as shouting at you, insulting or undermining you, hitting you or threatening to hit you?
- sometimes people tell us their partner is cruel to them emotionally and sometimes physically, is this happening to you?
- we all have arguments at home sometimes, however it is unacceptable to be threatened or hit or abused in any way by our partners. Do you feel any of these things are happening to you?
- you have mentioned your partner uses drugs/alcohol, how do they behave towards you when they are under the influence of these substances?
- does your partner ever threaten your children?
- do you sometimes worry about the safety of your children because of your partner's behaviour toward you?

APPENDIX 3

Child Protection Issues

Changes in the definition of “Significant harm” now include children witnessing or overhearing harm to others (this will include domestic abuse of one parent by another) and support the need for a preventative approach when considering the protection of children living in an environment where they witness domestic abuse.

At least 750,000 children a year witness domestic abuse. Nearly three quarters of children on the ‘at risk’ register live in households where domestic abuse occurs (DOH 2000).

Men who are abusive to their female partners are also likely to be abusive to their children. The overlap between men’s abuse towards women and the physical abuse of children is estimated in the range of 30-66% (Edleson 1999).

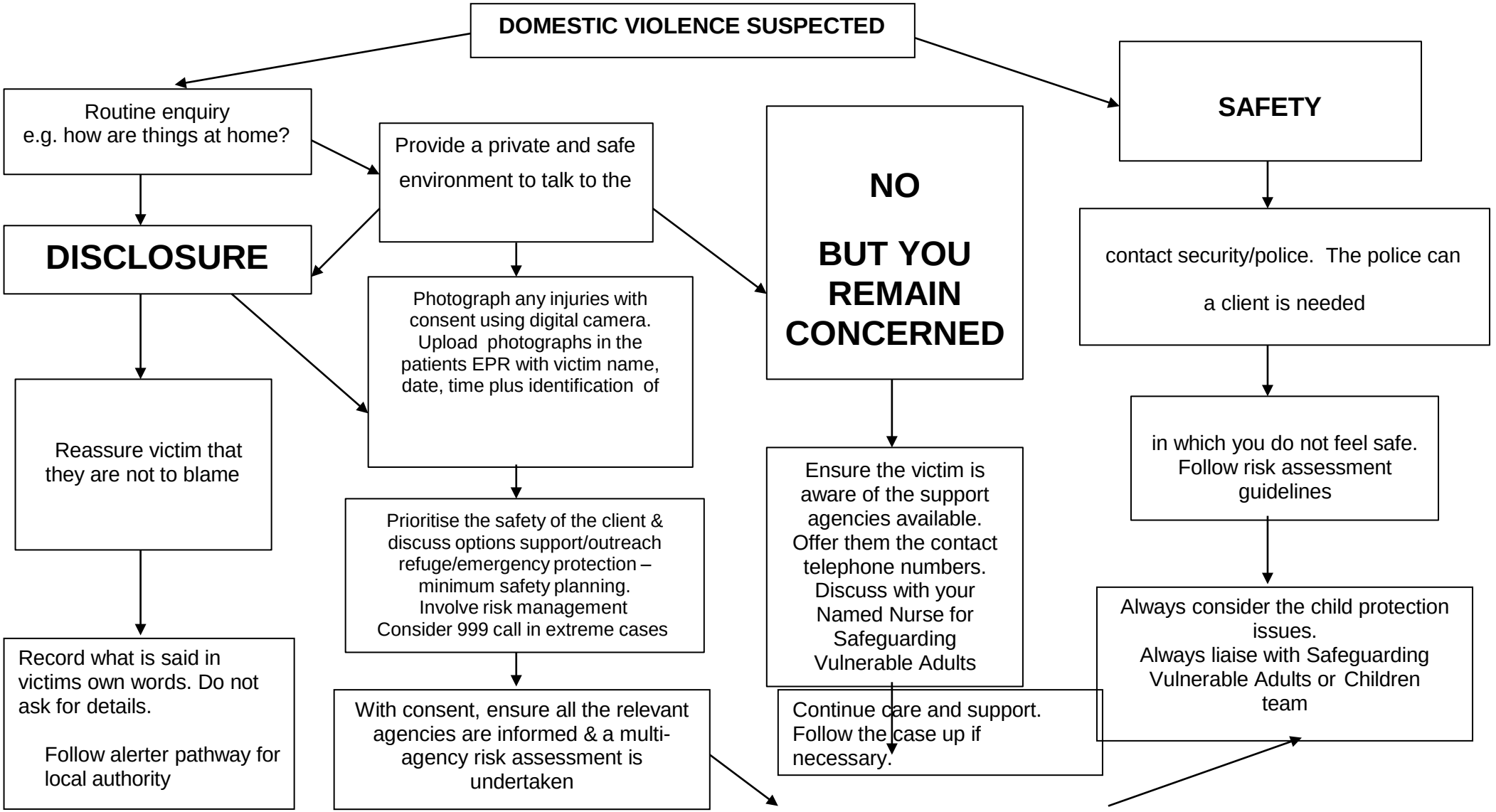
In 90% of domestic abuse incidents, children are in the same or next room. The government estimates a third of children in a violent home know what is happening with this figure increasing to half where violence is repeated. Around 50 children a year experience the killing of their mother by their father and in the last 4 years in the UK 25 children have been killed on contact visits with their father who had previously abused their mother (Sanders and Barron 2004).

Children may be seen as triggers or justification for violence, particularly in pregnancy when violence may commence or increase with deliberate attempts to hurt the unborn baby. Abuse can occur within the family because the perpetrator feels that the recipient of the abuse is giving too much attention to the baby or children. The perpetrator may threaten to harm or abduct children.

Children may take on a caring role for the victim of violence or may try to use themselves as a human shield. Domestic abuse can seriously interfere with parenting abilities. **Please refer to the Trust’s Safeguarding Children Policy for further guidance**.

APPENDIX 4

DOMESTIC ABUSE FLOWCHART



7. Endorsed By:-

Name of Lead Clinician/ Manager or Committee Chair	Position of Endorser or Name of Endorsing Committee	Date
Joanne Shaw	Chair – safeguarding committee	25th march 2015
Martin Walshaw	Medical lead – safeguarding	25th march 2015

Section Number	Version Number	Date of Change	Description of Amendment	Description of Deletion	Description of Addition	Reason

8. Record of Changes