Domestic abuse is a human rights, public health and criminal issue that has a devastating impact on victims, their families and friends, and the wider community. It occurs across all races, ethnicities, genders, religions, ages, socioeconomic groups and social classes – although women are more likely to be victims than men. In England, one in four women and one in six men experience domestic abuse, with 62% being directly harmed by the perpetrator. The prevalence of domestic abuse is much higher among people attending GP practices than the wider population so GPs are well placed to identify patients at risk and help them access support. Despite this, GPs are often unaware of high-risk cases among their patients or the existence of safety plans, and fail to share information that could help safeguard people at high risk of such abuse. This article describes a nurse-led domestic abuse service for general practice, which improves information sharing and increases GP engagement to give earlier and effective interventions for people at greatest risk of harm.

Key points
- One in four women and one in six men in England experience domestic abuse, which claims the lives of 100 women and 30 men each year.
- Of women in violent relationships, 80% are reported as seeking help from health staff – usually in general practice.
- GP information that could help safeguard people at high risk of domestic violence is often not shared.
- GPs are often unaware of high-risk cases among their patients or the existence of safety plans.
- A nurse-led domestic abuse service for general practice can improve GP engagement and information sharing to help safeguard patients at risk.

Development of a nurse-led domestic abuse service for general practice

Domestic abuse is a human rights, public health and criminal issue that has a devastating impact on victims, their families and friends, and the wider community. It occurs across all races, ethnicities, genders, religions, ages, socioeconomic groups and social classes – although women are more likely to be victims than men. In England, one in four women and one in six men experience domestic abuse, with severe domestic abuse claiming the lives of over 100 women (Department of Health, 2017); 130,000 children live in homes where there is high-risk domestic abuse and almost two-thirds of them are directly harmed by the perpetrator of the abuse (SafeLives, 2015a) (Box 1). Domestic abuse is estimated to cost the NHS £1.7bn a year and the annual cost to the UK economy is £18bn (Fiore, 2017).

There is evidence that the prevalence of domestic abuse is significantly higher among people attending GP practices than the wider population (Roberts et al, 2005). Around 80% of women in a violent relationship seek help at least once from healthcare staff, usually in general practice, and this may be their first or only contact with professionals who can help them (Department of Health, 2017).

GPs treat all common medical conditions and are the primary gatekeepers to specialist and diagnostic services (Greenfield et al, 2016). Most people consult a GP during the course of their lives, with 90% of all female patients consulting their GP over a five-year period (SafeLives, 2015b).

GPs are often unaware of high-risk cases among their patients or the existence of safety plans, and fail to share information that could help safeguard people at high risk of such abuse. This article describes a nurse-led domestic abuse service for general practice, which improves information sharing and increases GP engagement to give earlier and effective interventions for people at greatest risk of harm.

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Abstract
One in four women and one in six men experience domestic abuse, and 100 women and 30 men die as a result of domestic abuse in England each year. In addition, 140,000 children live in homes where there is high-risk domestic abuse, with 62% being directly harmed by the perpetrator. The prevalence of domestic abuse is much higher among people attending GP practices than the wider population so GPs are well placed to identify patients at risk and help them access support. Despite this, GPs are often unaware of high-risk cases among their patients or the existence of safety plans, and fail to share information that could help safeguard people at high risk of such abuse. This article describes a nurse-led domestic abuse service for general practice, which improves information sharing and increases GP engagement to give earlier and effective interventions for people at greatest risk of harm.

Citation

In this article...
- The role of GPs in helping safeguard vulnerable people from domestic abuse
- Improving safety planning for high-risk cases through better information sharing
- The benefits of a domestic abuse liaison nurse service in general practice
importantly, they hold patient information that could help keep people at high risk of domestic abuse safe; this information should be shared with other agencies as required.

Other staff in GP practices, particularly practice nurses, have a role in identifying people experiencing or at risk of domestic abuse. They have face-to-face contact with patients and often develop long-term therapeutic relationships, so they also are ideally placed to identify:
- Changes in patients’ demeanour or behaviour;
- Increased frequency of visits to the practice.

High-risk cases of domestic abuse are discussed at the Multi Agency Risk Assessment Conference (MARAC), an information-sharing and risk-management meeting attended by all key agencies, where safety plans are developed and agreed. Much work has been done to ensure GPs are attuned to patients who attend repeat consultations for health issues and injuries that may relate to domestic abuse (DH, 2017; Feder et al, 2011), but competing demands on their time mean they are often not present at MARACs, even though they may hold information vital to the development of safety plans.

Information sharing is a contentious issue and the lack of appropriate multi-agency/professional information sharing is a recurrent theme in serious case and domestic homicide reviews (Department of Education, 2016). National guidance says information sharing must comply with Caldicott Principles, which allow information on an adult to be shared with Caldicott Principles; this includes sending data from the GP to the MARAC where there is domestic abuse was co-ordinated with the MARAC in line with Caldicott Principles; this includes liaising with other health professionals, such as health visitors and accident and emergency (A&E) staff;
- Case management – analysing and synthesising health information from a range of sources that could help identify and minimise risk to the victim and any dependent children, and feeding it into the multi-agency risk assessment and development of safety plans;
- Information sharing – ensuring all information is shared with the MARAC in a timely manner;
- Representation advocacy – representing GPs’ views at the MARAC, asking questions on their behalf and explaining medical terminology to non-health colleagues;
- Advocacy – ensuring victims have their voices heard at the MARAC from a health perspective;
- Feedback – ensuring GPs know the outcome of the MARAC for patients registered at their practice and the actions they need to take;
- Partnership working – developing robust networks with colleagues from statutory sector local authority domestic abuse services and non-statutory sector services, such as the women’s charities Women’s Aid (womensaid.org.uk) and nia (niaendingviolence.org.uk);

Training – working closely with nia, which delivers the IRISi (irisi.org) training programme on responding to domestic violence for general practices; this includes training about the MARAC liaison nurse to raise GP awareness of the role and how to contact the nurse;

Identifying learning – participating in significant case review (SCR) meetings for domestic homicide cases that were ‘near miss’ domestic abuse cases that could have resulted in homicide or where safety plans were not sufficiently robust to protect victims and dependants from risk of further abuse; this is done to identify how the MARAC and affiliated agencies can standardise and improve practice and service delivery.

The MARAC liaison nurse attended two SCR meetings in 2018–19; actions for the GP were identified at one of these. Learning was shared directly with the practice in writing and a one-off training session for GPs on safeguarding children in families where there is domestic abuse was co-delivered by the Named GP for safeguarding children.

Working with GPs

The general practice notification and feedback pathway is summarised in Fig 1. A service protocol was also drawn up showing GPs what the MARAC liaison ser-
Clinical Practice

**Innovation**

**Fig 1. General practice notification and feedback pathway**

Information is received by the MARAC liaison nurse from the local authority MARAC coordinator for the cases to be discussed

A request is sent by secure email to the patient’s GP asking for relevant information from the patient records to be returned by secure email within 4-5 working days

Relevant information from the GP is presented at the MARAC by the liaison nurse

A safety plan is agreed by partner agencies at the MARAC

Actions for GPs and the outcome of the MARAC are shared with the GP

**ACTIONS FOR THE GP**

- Provide feedback on actions when completed
- Place an alert on patient records
- Complete a service evaluation form

**MARAC = Multi Agency Risk Assessment Conference.**

GPs’ feedback has been crucial throughout to ensure the nurse-led service responds to their needs and maintains best practice. There is evidence that the MARAC liaison nurse role has improved GP engagement in domestic abuse issues and allows them to make a meaningful contribution to the MARAC, as illustrated by the following comments collected from GPs in the clinical audit:

“It is very helpful to have a MARAC liaison service as it improves communication and greatly improves the sharing of important information.”

“Absolutely the service should continue – participation from primary care in the MARAC process is fundamental.”

During the pilot, when the liaison nurse primarily focused on victims and their dependants, the percentage of GPs sharing relevant health information with the MARAC averaged 32%. This often included useful information on victims’ mental health, substance misuse, learning needs and long-term health conditions that affected their vulnerability, as well as GPs’ views relating to child/adult protection concerns, level of risk, and victims’ interaction and engagement with the GP. After introducing the service protocol and improving the feedback process, the percentage of GPs sharing relevant information with the MARAC increased to 93-95%.

Another positive outcome of this improved GP engagement is that local independent domestic violence advisers (IDVAs) now use the relationship GPs have with their patients to offer joint appointments in the practice setting with patients’ consent; this improves GPs’ understanding and awareness of available safety plans and services. The presence of the liaison nurse at the MARAC as the GPs’ representative means

Sharing information about perpetrators allows GPs to make enquiries and explore domestic abuse issues sensitively with patients who are experiencing or at risk of abuse, and signpost them to appropriate specialist services. As violence by perpetrators is not always limited to intimate partners, children and the wider family, such information can also be used to help safeguard professionals, allowing GPs to assess the risk of lone working should a perpetrator present for a consultation.

**Working with victims and perpetrators**

The primary focus of the MARAC liaison nurse role is to collate information about victims and their dependants (aged <18 years). However, information is now also shared about perpetrators; this has been well received by core members of the MARAC and GPs, particularly when the perpetrator is registered with the practice. SCRs and domestic homicide reviews have shown that perpetrators in the home (usually male) are often ‘invisible’ to services, meaning professionals may be unaware of their behaviours and the impact on victims, their children and extended family (National Society for the Prevention of Cruelty to Children, 2015).

**Box 2. Case study**

Sheila Mason*, whose case was discussed at the MARAC, had two children aged under five years old and a chaotic life as a result of escalating domestic abuse. She had type 1 diabetes and her blood-sugar levels were uncontrolled, requiring frequent trips to A&E due to hypoglycaemic episodes. She had also missed her appointments with the diabetic specialist nurse at the practice.

Ms Mason had recently moved home, taking her children with her. As she no longer lived with the perpetrator, MARAC professionals felt domestic abuse concerns had reduced and planned to close the case. The liaison nurse highlighted the severity of Ms Mason’s diabetes, and the potentially negative consequences of it not being well controlled, which ensured planning by all agencies prioritised her health needs.

**MARAC = Multi Agency Risk Assessment Conference.**

The patient’s name has been changed.
there is a health professional who can answer questions from non-health professionals and act as the patient’s advocate by highlighting health needs that increase the person’s vulnerability, either in terms of continuing in an abusive relationship or their ability to make appropriate life choices. This is illustrated in the case study (Box 2).

**Partnership working**

The liaison nurse has built positive working relationships with statutory and non-statutory domestic abuse IDVA services. This allows her to contact victims to:
- Help them register with a local GP if they do not have one
- Help them access health services more appropriately
- Reduce the pressure on A&E and out-of-hours services.

**Performance monitoring**

A set of key performance indicators has been developed with commissioners (Table 1). The liaison nurse has also completed two clinical audits of the service. The first assessed its quality and value from the perspective of GPs and core MARAC partner agencies; the overwhelming consensus was the service was valuable and should continue. Suggested improvements included providing consistent feedback to GPs about their patients regardless of the outcome of the MARAC (for example, no GP actions identified, case removed from the agenda) and this has now become standard process.

The second audit measured the impact of decisions made at the MARAC on improving health outcomes for victims and health services following the introduction of the liaison nurse role. A&E attendances for 10 victims in 2016-17 were assessed pre- and post-MARAC; after cases were referred to the MARAC, total A&E attendances dropped from 34 to five, and reasons for attending A&E also changed. Before cases were referred to the MARAC, reasons for A&E attendance were mostly assaults, injuries or gynaecological/sexual health problems. After referral to the MARAC patients’ main reasons were long-term conditions and mental health problems.

These findings resonate with evidence from Co-ordinated Action Against Domestic Abuse (2010), which showed that for every £1 spent on MARACs, a minimum of £6 is saved on direct costs to agencies such as the police and health services. The development of effective multiagency safety plans for victims and their children prevents them from needing support from criminal justice, health and child protection services. Evidence from this project suggests employing a MARAC liaison nurse helps raise GP awareness of patients at risk, enabling early health intervention work to support these patients and minimise their risk of attending A&E in crisis.

**Improving information for GPs**

Audit and routine feedback were requested from GPs after an interaction with the service via an online questionnaire. They showed that some doctors were still not clear on the role of the MARAC, how it functions and, crucially, how its liaison service differs from IRIS.

A service leaflet was produced explaining the function of the MARAC, and the roles and responsibilities of the MARAC liaison service; hard copies were distributed to all GP practices and key partners. An electronic copy was also placed on City and Hackney CCG’s intranet. Information request forms sent to each GP practice now contain a link to a short video produced by SafeLives (Bit.ly YTsafeLives), which explains what the MARAC is and how information is shared.

**Future areas for development**

The first audit highlighted the need for improvement in the flagging and tagging of patients’ records to ensure the correct alerts were added. Currently, the MARAC liaison nurse adds the alert to the electronic patient record or RiO system. Each GP practice now contains a link to a short video produced by SafeLives (Bit.ly YTsafeLives), which explains what the MARAC is and how information is shared.

There is also an opportunity for trainee GPs to shadow the liaison nurse as part of their continuing professional development.

**Conclusion**

A nurse-led domestic abuse service for general practice increases GP engagement to give earlier interventions for people at the highest risk of harm. Most importantly, it ensures that valuable patient information, often only held by GPs, is made available in a timely manner to help safety planning for high-risk cases. The service has been well received by GPs and has been refined and developed in response to GP feedback, with further improvements planned for this next financial year.

**Table 1. Key performance indicators for MARAC liaison nurse role**

<table>
<thead>
<tr>
<th>Key performance indicator</th>
<th>Target</th>
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<tbody>
<tr>
<td>Number of cases discussed at the MARAC in which information is provided by the GP</td>
<td>85%</td>
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<tr>
<td>Number of cases discussed at the MARAC with an alert on the GP record</td>
<td>85%</td>
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<tr>
<td>Unregistered victims supported to register with a local GP</td>
<td>85%</td>
</tr>
<tr>
<td>GPs’ understanding of the MARAC process</td>
<td>Confirmed through GP feedback questionnaire</td>
</tr>
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</table>

**References**


Fiore V (2017) GPs to Get Access to New Domestic Violence Referral Option. pulsedaily.co.uk, 27 November.


SafeLives (2015b) Getting it right first time. Bit.ly/EvidenceAbuse