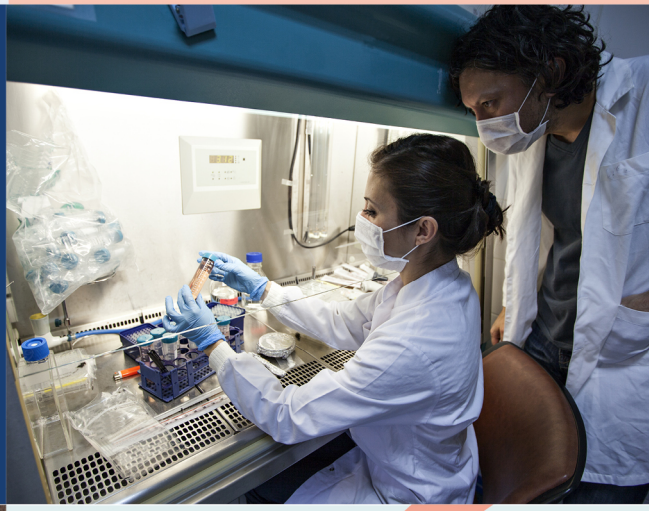
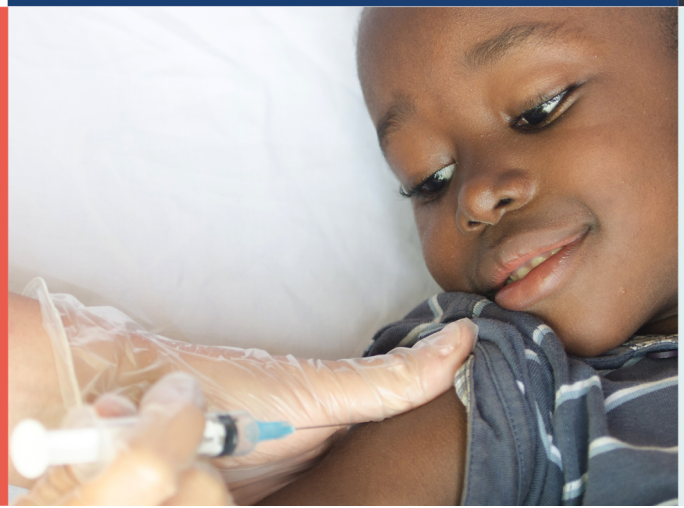
NIHR | Applied Research Collaboration Greater Manchester

An evaluation of the Hospital-based Independent Domestic Violence Advisor service in Wrightington, Wigan and Leigh NHS Foundation Trust

Final Report (September 2020)





Working in collaboration with:

Wrightington, Wigan and Leigh NHS Foundation Trust

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Preface

NHS England and Improvement provided funds to Wrightington, Wigan and Leigh NHS Foundation Trust (WWLFT) to evaluate a Hospital-based Independent Domestic Violence Advisor (HIDVA) service. WWLFT supplemented the evaluation funds and commissioned the National Institute for Health Research Applied Research Collaboration Greater Manchester (NIHR ARC-GM) to evaluate the service.

The evaluation aims to assess the processes, activity and outcomes associated with the WWLFT HIDVA service, providing a comprehensive assessment of the implementation and impact of the new service that will inform future decision making.

This report provides a brief background that describes the context for the evaluation, an overview of the evaluation approach taken, and presents findings of the evaluation related to qualitative assessments with a focus on the experiences of people involved with the HIDVA service; activity generated by the service; impacts on secondary care service use; quantitative assessments of impacts on MARAC activity and an assessments of costs and notional cost savings of the service.

We would like to acknowledge the help and support provided by Linda Salt (Head of Safeguarding), Bridget Cheyne (Domestic and Sexual Abuse Lead) and Angela Proctor (Senior Intelligence Analyst) at WWLFT.

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Background

- In England and Wales, 2.4 million people between the ages of 16-74 experienced domestic abuse in 2018/19 (5.7%), and over 20% have experienced domestic abuse at some point. Prevalence is greatest among women (7.5%) than men (3.8%). In addition to the psychological and physical impacts on health and wellbeing of victims, domestic abuse has wide social and economic impact.
- The financial cost of domestic abuse is estimated at £66 billion (£34,015 per victim) annually.
- Independent Domestic Violence Advisors (IDVAs) are specialist casework roles that act as a point of contact for victims at crisis point, assessing risks, options and safety plans for victims. IDVAs are placed in various sectors. Evidence suggests there may be benefits of placing IDVAs in a hospital setting (Hospital-based IDVAs, HIDVAs).
- Wrightington, Wigan and Leigh NHS Foundation Trust (WWLFT) commissioned a HIDVA service in 2018 in response to the locality experiencing higher than average rates of domestic violence. The service differs from typical HIDVAs due to the way the service is commissioned, with the HIDVA employed by the Trust rather than seconded to the Trust.
- NIHR ARC-GM worked in collaboration with WWLFT and NHS England and Improvement to conduct an independent evaluation of the HIDVA service. The study was a mixed-methods evaluation using qualitative and quantitative methods.

Qualitative process evaluation

- Eleven interviews were conducted with participants of varying levels of seniority, working across several areas of the trust.
- The HIDVA service was a new innovation at the Trust and was implemented within a context where levels of awareness, skills and confidence amongst

Trust staff relating to (undisclosed) domestic violence and abuse presenting at the Trust, and the ability to address this, were low.

- Considerable time and effort were invested in raising awareness of the HIDVA service and building relationships throughout the Trust. There was consensus this work was worthwhile and that good working relationships had been built. The HIDVAs had become known to staff in person across the Trust.
- The HIDVA roles were further embedded into the organisation by being employed directly by the Trust and located within the Safeguarding team.
- The HIDVAs drew on an extensive network of contacts beyond the hospital; this was key to carrying out the role successfully; they had also built effective working relationships with the local MARAC and community IDVA service.
- The HIDVAs were valued by staff in frontline and strategic roles. Having a role dedicated to domestic violence and abuse, able to provide an immediate response, was recognised as fulfilling a previously unmet need. The HIDVAs were positively perceived, with their knowledge, skills, approachable and reassuring manner appreciated. Having an identity as an independent advisor was important in encouraging patients to disclose abuse.
- The HIDVA service expanded skill mix within the Trust and altered work undertaken, in terms of case identification, referral and support. Awareness of and confidence amongst frontline staff, in dealing with domestic violence and abuse increased
- The HIDVA service contributed to the disclosure of cases of domestic violence and abuse amongst i) staff within the Trust, ii) long-term victims, and iii) cases that may often remain hidden in the community. Disclosures from staff had not occurred prior to implementation of the HIDVA service; these were an unanticipated consequence, which reinforced the need for the service within the Trust.
- During the first period of COVID-19 restrictions, The need for social distancing also enabled opportunities for disclosure at testing sites and on hospital wards.
- Future challenges for the service are capacity as awareness of the service increases, and with specialised support for sexual violence cases.

Referrals to the HIDVA service

- A total of 938 people were referred into the HIDVA service over the period 1st May 2018 to 31st March 2020. Source of referral was predominantly from WWLFT, with A&E in particular representing the highest number of referrals (58%), followed by midwifery services (10%), these are larger than the 3% of referrals made by hospitals to IDVA services in England and Wales.
- In year 1 (May 2018 to March 2019) 14% of referrals were male and in year 2 (April 2019 to March 2020) 13%; higher rates than those of IDVA services (4%) though lower than estimated prevalence shares in the general population (33% - 1.6 million women and 786,000 men).
- Victims referred to the HIDVA service are older than those seen in IDVA services nationally with the WWL HIDVA service having a greater proportion of victims aged 60 and over (15% compared to 3% in IDVA services nationally).
- The main outcome for victims referred to the HIDVA service was that of support provision by the HIDVA service (72%). 8% were referred to the local Multi-Agency Risk Assessment Conference (MARAC).

Referrals to the HIDVA service during the first COVID-19 restrictions period

- Referrals for the period when COVID-19 restrictions were first introduced and then eased, (April 2020 to August 2020 - hereafter referred to as the 'first COVID-19 restrictions period') declined, but with the easing of restrictions, referrals hit new peaks.
- The HIDVA service was particularly resilient to the first period of COVID-19 restrictions. The hospital setting looks to have provided a safe and secure opportunity for disclosure at a time where there was growing concern nationally of the impacts lockdown measures may have on the prevalence of domestic violence and abuse. Indeed, the service experienced new peaks in the volume of referrals, particularly as lockdown eased. This suggests the service may prove to be an important tool to address rises in domestic violence and abuse during lockdown periods.
- The first COVID-19 restrictions period impacted on referral outcomes: the proportion of outcomes that were MARAC referrals declined, and a smaller proportion of people referred to the HIDVA service declined support.

Comparisons of hospital activity prior- and post-HIDVA referral

- Comparisons of hospital activity prior- and post-referral to the HIDVA service suggest that prior to a referral, there are increases in A&E attendance, inpatient stays, and respective costs attributed to these services. Following a referral to the HIDVA service we found evidence that activity and costs declined but aside from emergency admissions, these were largely insignificant. It is important to note that these effects do not account for activity that may have occurred to these patients had they not been referred to the HIDVA service, in this respect the findings may be either an under- or over-estimate of the impacts of the service on hospital activity.

Cost implications of the HIDVA service

- In the first year the HIDVA service cost £39,897 in workforce costs (a single Band 6 HIDVA at FTE 1.0). In the second year workforce costs amounted to £77,058 (a Band 6 HIDVA and Band 7 HIDVA, both at 1.0 FTE). The total workforce costs over the evaluation period thus amounted to £116,955.
- It was not feasible, with current data, to accurately assess the impacts of the HIDVA service on costs and notional savings to the Trust. More research is necessary that covers a longer time period and greater volume of referrals.
- Preliminary findings suggest patients referred into the HIDVA service were estimated to have greater costs the year following referral (£112.53 per patient), though this was not statistically significant and may be inaccurate due to the limitations of the data available. Further, this assessment does not incorporate other impacts beyond secondary care activity (such as health and wellbeing).

Recommendations

General recommendations	
1	There is a need across NHS Trusts for greater awareness, improved identification of, and support (referral and case management) for, victims of domestic violence and abuse. These findings suggest that a HIDVA service is an appropriate and effective way of meeting this need. Other Trusts should consider setting up a HIDVA service.
2	Seek to recruit an experienced IDVA, with training (national qualification) and a background in community working. A network of relevant community organisations beyond the hospital and ability to make decisions rapidly in a crisis situation, are key to making appropriate, timely referrals.
3	Embed HIDVAs within the Trust, as permanent employees. Spread their involvement across as many relevant clinical areas as possible, rather than locating them in one department such as A&E.
4	Ensure that frontline staff are able to refer to the HIDVA service proactively – ensure they are trained in awareness of domestic violence indicators and promote the HIDVA service throughout the Trust so that staff refer to it.
5	Consider whether systems are in place to accommodate the issues raised (e.g. SARC), to enable maximum impact from the HIDVA's skills to be realised.
6	Review the current situation with domestic violence and abuse disclosures amongst staff at the Trust – are these frequently disclosed and supported within the Trust? If not, consider how staff disclosures will be supported and who will carry these cases, the HIDVA or other (e.g. community IDVAs).
7	Particular regard should be paid to the potential for HIDVA services to identify previously unmet need for domestic violence and abuse services when assessing the value of a HIDVA service. This unmet need was anecdotally evident for male patients and staff members within the Trust itself.
8	The service appears to be a valuable resource within which to identify and address an unmet need for domestic violence and abuse services in the locality and may help reduce inequalities in access to IDVA services, particularly for

	those aged 40+ and males. This should be considered when appraising the service.
9	Monitoring of referrals and support workload for the HIDVAs would help to understand whether further HIDVAs are required.
10	The service had 938 referrals in the first two years, 72% of these received support by the HIDVA service. As referrals grow so too will support needs. The stresses this may place on the HIDVAs should be monitored and where possible, solutions to reduce workload should be considered (such as dedicated administrative support).
11	The HIDVA service was particularly resilient to the first period of COVID-19 restrictions. The hospital setting looks to have provided a safe and secure opportunity for disclosure at a time where there was growing concern of the impacts lockdown measures may have on the prevalence of domestic violence and abuse. Indeed, the service experienced new peaks in the volume of referrals, particularly as lockdown eased. This suggests the service may prove to be an important tool to address rises in domestic violence and abuse during lockdown periods.
Future work	
12	The evaluation was limited in the ability to identify the causal impacts of the service on hospital activity. An assessment of the full sample of referrals would address any concerns of representativeness of the sample estimated in this study.
13	To ascertain the true economic impact of the service, further evaluation is needed that should consider the impacts of the service over a longer follow-up period, ideally using comparator areas to allow for a stronger design, and to consider impacts across a broader range of domains. For the service to be cost-effective, only small improvements in emotional and physical harms would be required. Future evaluations should examine impacts on these domains.

1 Background

1.1 Domestic violence and abuse

The term 'domestic violence and abuse' is used to mean any incident or pattern of incidents of controlling behaviour, coercive behaviour or threatening behaviour, violence or abuse between those aged 16 or over who are family members or who are, or have been, intimate partners. This includes psychological, physical, sexual, financial and emotional abuse. It also includes 'honour'-based violence and forced marriage (NICE 2016).

1.1.1 Domestic abuse prevalence in England and Wales

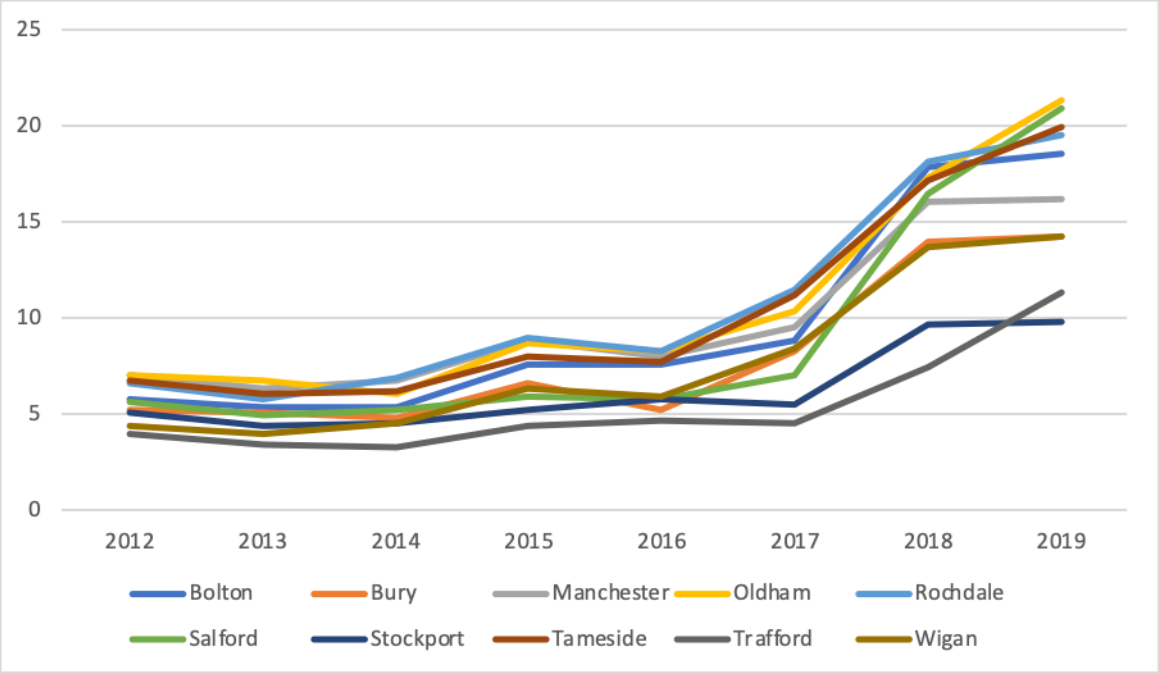
Approximately 2.4 million (5.7%) people aged 16 and over in England and Wales experienced domestic violence and abuse during the year ending March 2019 and over 20% have experienced domestic abuse at some point (ONS 2019a). Approximately 33% of those experiencing domestic abuse are male (1.6 million women and 786,000 men). In addition to the psychological and physical impacts on health and wellbeing of victims, domestic abuse has wide social and economic impact. Domestic abuse-related incidents and crimes recorded by the police amounted to over £1.3 million in 2018/19 (ONS 2019a) and have estimated costs in excess of £66 billion per year (£34,015 per victim) with the bulk of costs borne on victims (£47 billion) and costs to output in the economy of £14 billion and to the public sector via health (£2.3 billion) and policing services (£1.3 billion) and additional public services such as housing (Oliver et al. 2019).

An estimated 7.5% of women and 3.8% of men experienced domestic abuse in 2018-19 (ONS 2019b). Rates of domestic abuse were high amongst particular groups; in females aged 20-24 and males aged 16-19, those of mixed ethnicity, those separated or divorced, those unemployed or economically inactive, and for those in urban areas. Whilst females comprise 67% of those experiencing domestic abuse, they represent 75% of domestic abuse related crimes recorded by the police, and 74% of domestic homicides.

1.1.2 Domestic abuse in Greater Manchester

In Greater Manchester recorded domestic abuse crimes have risen since 2017 (Greater Manchester Police 2020) (Figure 1), similar increases are found nationally (ONS 2019a) and are in contrast to the relatively stable rates of domestic abuse prevalence in recent years, suggesting this is due to better reporting and/or recording of domestic abuse in the police data system. Manchester and Wigan have the greatest volume of domestic abuse cases in Greater Manchester, though this is partly reflecting the relatively larger population in the locality.

Figure 1: Recorded domestic abuse crime to Greater Manchester Police 2012-2019 (rates per 1,000 population)



Source: Recorded crimes: Greater Manchester Police (2020); Population estimates: ONS (2020a)

Note: Recorded offences from Greater Manchester Police's crime recording system with a 'domestic violence' marker (but includes all recorded crime with a domestic abuse element)

Estimates of domestic abuse prevalence are likely to be underestimates of the true scale of domestic abuse, particularly where these are based on recorded crime statistics or interventions in response of identified abuse.

1.2 Domestic violence and abuse services

Domestic violence and abuse was traditionally viewed as a criminal justice issue. A particular difficulty has been that domestic abuse has often remained a hidden crime, that has gone unreported to the police (SafeLives 2016). Previous research found that the response to domestic victims generally was often fragmented and identified a need for increased capacity, including more specialist support (Howarth et al. 2009).

In recent years, there has been increased government policy focus on tackling domestic violence and abuse. Core elements of government strategy were prevention, protection, justice and support and on achieving a quicker, safer response to domestic violence. To operationalise these strategic elements, various initiatives were proposed, including the provision of independent support and advice targeted specifically at victims of domestic abuse deemed to be at high risk of serious harm or homicide (Howarth et al, 2009).

1.2.1 The Independent Domestic Violence Advisor (IDVA) role

The proposal to develop experts in the provision of support to victims of domestic abuse was initially made in 2005 and since then, the role of Independent Domestic Violence Advisor (IDVA) has developed (Home Office 2005). In 2005, an accredited training course for IDVAs was established, which provided a formal qualification, framework for practice and service standards for practitioners.

An IDVA is a specialist casework role focused on domestic violence, predominantly on high risk victims. IDVAs typically work at a crisis point for victims and assess risks, options and safety plans for victims (SafeLives 2014). It is estimated that there are over 1,000 IDVAs in England and Wales at a cost of £25 million (SafeLives 2018a; Oliver et al. 2019). IDVAs are based in various agencies including specialist domestic abuse services, police forces, housing associations, Local Authorities, courts and health care organisations (SafeLives 2018a).

1.2.2 Development of domestic violence and abuse services in healthcare settings

There is great potential for healthcare professionals to recognise and respond to domestic abuse. Health services are often the first point of contact for victims of domestic violence and abuse. There is the potential for staff in health settings to play a greater role in identifying domestic violence and abuse but barriers such as shame or embarrassment among victims, lack of time and lack of awareness amongst healthcare professionals, have often contributed to 'missed opportunities' for people to disclose abuse or to access support (NICE 2016). Research found that without a service to immediately refer onto, the effectiveness of health professionals asking about domestic abuse is likely to be limited (SafeLives 2016).

In the year before getting effective help, nearly a quarter (23%) of victims at high risk of serious harm or murder, and one in ten victims at medium risk, went to accident and emergency departments because of their injuries. In the most extreme cases, victims reported that they attended A&E 15 times. SafeLives has therefore made recommendations that there be more specialist domestic abuse services based in A&E (SafeLives 2016).

The Public Health Outcomes Framework contributed to developing practices to integrate domestic abuse services with healthcare, and there is a NICE Quality Standard for domestic violence and abuse (NICE 2016). This states that health and social care service managers and professionals should:

> "Ensure frontline staff in all services are trained to recognise the indicators of domestic violence and abuse and can ask relevant questions to help people disclose their past or current experiences of such violence or abuse. The enquiry should be made in private on a one-to-one basis in an environment where the person feels safe, and in a kind, sensitive manner."

1.3 Hospital-based Independent Domestic Violence Advisor (HIDVA) services

IDVAs based in hospital settings (Hospital-based Independent Domestic Violence Advisors, HIDVAs) have been identified as providing additional benefits due to the potential to be proactive in identifying victims who may have not yet reported abuse elsewhere (SafeLives 2016).

HIDVA services have been piloted and/or seconded in a variety of settings in England over the past 10 years. These have been largely focused in mental health (SafeLives 2018b), A&E and/or maternity units. The SafeLives Themis research project presents a comprehensive assessment of HIDVAs in place in four geographical areas in England (5 hospitals) (SafeLives 2016). Here HIDVAs were located in A&E and maternity units. More recently, the Pathfinder project engaged with 18 NHS Trusts and 9 CCGs across England to develop interventions across acute hospital Trusts, mental health Trusts and GP practices (Pathfinder 2020).

2 Evaluation Approach and Objectives

NHS England and Improvement provided funds to WWLFT to evaluate the HIDVA service. WWLFT supplemented the evaluation funds and has worked in collaboration with the National Institute for Health Research Applied Research Collaboration Greater Manchester (NIHR ARC-GM) to evaluate the service.

The evaluation aims to assess the processes, activity and outcomes associated with the WWLTH HIDVA service, providing a comprehensive assessment of the implementation and impact of the new service that will inform future decision making.

The specific objectives of the evaluation were:

1. To provide a description of the HIDVA service implemented, including changes made to the service over time.
2. To describe the processes associated with implementation of the HIDVA service, including the facilitators and challenges to its implementation, and how the latter have been addressed. To identify provider perspectives on what does and doesn't work with the HIDVA service and with regards to impacts on services elsewhere in the system (e.g. MARAC referrals).
3. To examine the activity associated with the HIDVA service, with a particular focus on service user demographics.
4. To explore any correlation between the introduction of the HIDVA service and referrals to MARAC:
    a. Overall referrals
    b. Referrals by sub-groups
5. To explore any correlation between use of the HIDVA service and impacts on hospital service use.
6. To examine the cost of providing the HIDVA service to WWLFT.

For clarity, data availability, data quality and the timeframes associated with this evaluation *do not* enable examination of the following: a complete WWLFT evaluation

of patient experience/satisfaction; the impact of the HIDVA service on activity in other public services; and the impact of the HIDVA service on service user health outcomes beyond health service use.

The qualitative evaluation of the HIDVA service relates to objectives 1 and 2 and form the basis of Chapters 3 and 4. The NIHR ARC-GM team carried out semi-structured interviews with relevant stakeholders. Participants were identified by key contacts within the WWLFT as being associated with the service and likely to have useful perspectives ('snowball' sampling). The interviews focused on the experiences of people involved with the HIDVA service. Key areas of questioning were: experiences of identifying and managing cases of domestic violence and abuse, experiences of the HIDVA service, and how the project fits within the wider health and social care system.

The quantitative evaluation of the HIDVA service relates to objectives 3 through 6 and are presented in Chapters 5 to 8. These assess data on referrals to the service (objective 3, Chapters 5 and 6), referrals to MARAC from the HIDVA service (objective 4, Chapters 5 and 6), assessment of how hospital activity of victims change prior- and post-HIDVA referral (objective 5, Chapter 7), and an assessment of the costs of providing the service (objective 6, Chapter 8).

The evaluation is particularly informative to the evidence base. Existing evaluations have been largely small scale, the Themis research by SafeLives (2016) for example, covered 692 hospital victims over five hospitals over a period of three years and though provided an extremely thorough and comparative assessment of HIDVA services in relation to community IDVAs, was limited in victim demographics reported and assessed a small number of victims (29) when assessing hospital service use pre- and post-HIDVA referral. The period of evaluation also enabled an early insight into the potential impacts that the first period of COVID-19 restrictions may have on domestic violence and abuse services.

3 Wrightington, Wigan and Leigh NHS Foundation Trust context and HIDVA service overview

This Chapter addresses the first study objective: to provide a description of the HIDVA service implemented, including changes made to the service over time.

The borough of Wigan has high incidence rates of domestic abuse with some estimates from Greater Manchester Police (GMP) showing domestic abuse rates 4 times the national average. Despite that, referrals from health professionals to the community IDVA service and local Multi-Agency Risk Assessment Conference (MARAC), based with Wigan Council and GMP, remain low. For that reason, Wrightington, Wigan and Leigh NHS Foundation Trust (WWLFT) together with Wigan Borough Council and GMP, conducted a pilot scheme for a HIDVA service. The main aim of that pilot was to develop a new hospital-based service and enhance collaborative working across the borough to improve support for victims, keep patients safe, reduce the prevalence of domestic abuse and reduce harm necessitating in presentation to hospital (WWLFT 2019 and 2020).

Following the pilot scheme, WWLTH introduced a HIDVA service on 1st May 2018. WWLFT includes three hospitals plus community services. In April 2019, Wigan Community Services transferred from Bridgewater Community Trust to become part of WWLFT. Table 1 provides a description of the HIDVA service provided in WWLFT including the rationale for the introduction of the service, and specific details to enable clarity of service components. The service is described using the Template for Intervention Description and Replication (TIDieR) checklist (Hoffman et al. 2014).

Table 1: TIDieR Checklist description of the WWLFT HIDVA service

Item number	TIDieR Checklist element
1	**BRIEF NAME** Wrightington, Wigan and Leigh Teaching Hospitals (WWLTH) Independent Domestic and Sexual Violence Advocate. For the purposes of this report the term HIDVA is used throughout. A secondary care based intervention, aimed at providing enhanced support for victims of domestic and/or sexual violence and abuse at one hospital trust.
2	**WHY (rationale, theory or goals)** A need to improve rates of identification of domestic violence and abuse was ascertained. Sexual abuse and assault is an area where local agencies reported a gap in service. There is no sexual assualt referral centre (SARC) in Wigan (just an outreach service) and frontline hospital staff have no forensic expertise. The WWLTH HIDVA service follows the safeguarding model 'Triage and Make safe' which was deemed to be suitable for the hospital environment. This involves the HIDVA taking on cases and working intensively with them in a short timeframe then referring them elsewhere. The goals of the service are to: • Increase WWLFT staff awareness of the indicators of domestic violence and abuse. • Increase identification of cases, through staff initiating sensitive routine enquiry of patients. • To ensure staff have sufficient professional curiosity to recognise suspected domestic abuse and the ability to have the structured conversation with them and to make referrals to adequate support.
3 and 4	**WHAT (process and materials)** <u>Staff training</u> The HIDVAs provide training on domestic violence and abuse to WWLFT staff. This is now part of the mandatory safeguarding training that all staff must attend. The focus is on increasing awareness of the indicators of abuse, how to ask relevant questions of patients and how to respond to disclosures. <u>Risk assessment, referral and case management</u> *Process:* Most cases are referred by WWLFT staff. Some people who are experiencing domestic violence and abuse disclose this to staff and are referred, but in most cases, staff notice an indicator(s) of abuse which leads to identification and referral. The majority of cases are identified by hospital staff, if the HIDVA is on site they will go straight to the patient if possible and complete the risk assessment. If it is outside the HIDVA service hours, or they are otherwise unavailable, the staff member identifying the case completes an initial risk assessment and sends this to the HIDVA service.

	Referrals are made via telephone - when a frontline member of staff has a patient with them and they call the HIDVA for immediate support. When the HIDVA is not available, staff make referrals, either through the hospital safeguarding system, via email or an incident reporting system (for staff based outside the hospital e.g. walk in centre) or on paper (preferred system for out of hours in A&E). The HIDVAs access the Hospital Information System (HIS) to collect information about the patient and their admission. A risk assessment is undertaken, with the patient, following this the patient either receives support from the HIDVA, is referred to a local agency(ies), is referred to the MARAC, or declines support. Most patients return to their own homes, but some are discharged straight to refuges for their safety. HIDVAs provide various support and liaise with a range of relevant agencies. Support includes signposting, to voluntary agencies and counselling services, helping complete paperwork such as housing applications, as well as more involved safety planning and measures such as installing mobile phone safety apps or arranging extra security at the victim's home. HIDVAs liaise with voluntary organisations, local authorities, MARACs and the police and provide support with legal processes, either arranging legal aid, contacting a solicitor, completing paperwork for victims if legal aid is not available, arranging safety measures at courts and attending court with victims. For cases referred to MARAC, the HIDVA prepares a Domestic Abuse, Stalking and Honour Based Violence (DASH) form and other relevant information and presents the case to the MARAC, most cases are then taken on by a community IDVA. Previously, the MARAC met weekly at the police station, in response to the COVID-19 restrictions, the MARAC currently meets each morning, on a virtual basis (usually conference telephone call) and one of the HIDVAs attends each day. The HIDVA retains cases which are members of staff at WWLFT. *Materials:* The DASH form is completed for all risk assessments. The service is publicised via posters displayed in the hospital, with tear-off strips with contact details on. The HIDVAs work to promote the service in person – they visit certain wards (A&E, minor and major admissions units) in person on a daily basis, to pick up cases that have come in over night/the weekend and to maintain contact with staff. They regularly visit other wards, such as maternity, to meet with patients and endeavour to walk in to other wards if they pass by, to maintain their presence and awareness of the service.
5	**WHO PROVIDED** The service is provided by two HIDVAs, both working full time, based within the hospital safeguarding team. Both HIDVAs completed formal IDVA training whilst working in the community and have several years of experience as community IDVAs, working in various voluntary organisations. One HIDVA is an experienced manager and a qualified Independent Sexual Violence Advisor (ISVA) and the other is currently undertaking an external training course to qualify as an ISVA.

	Referrals to the service are made by staff across the trust, with the majority being made by staff at the hospital sites.
6	**HOW** The staff training is provided in person by the HIDVAs, to groups of staff, in pre-arranged session, using presentations and videos. Ongoing support and developmental feedback is provided on an individual ad hoc basis, via the HIDVAs regularly feeding back the outcome of referrals to staff. The risk assessments are provided in person, by the HIDVAs. They also speak with patients over the telephone.
7	**WHERE** Case identification happens on Trust premises, during unscheduled attendances at A&E, the urgent care centre or walk in centre, on wards during inpatient stays and also in the community, for example, during a Health visitor appointment at the patient's home. Most risk assessments and follow up appointments take place on the Trust premises, in a private room. The HIDVAs also work outside the trust premises as necessary, for example attending court. Prior to the first period of COVID-19 restrictions, the MARAC took place at the police station, now it is held via teleconference.
8	**WHEN AND HOW MUCH** The service provides an immediate response, as soon as a patient discloses domestic violence or abuse. If the HIDVA is available they may receive a telephone call from a member of staff and go to the patient straight away. Usually, one risk assessment is completed for each patient, in some cases where the HIDVA is not available (e.g. outside the HIDVAs' working hours), the member of staff who is with the patient at the time undertakes an initial risk assessment and the HIDVA does another assessment when they see the patient. The HIDVA service is provided between 8am and 6pm Monday to Friday. When cases are identified outside these hours, the HIDVA picks up the case on their return to work. Disclosures of domestic violence and abuse happen during A&E attendances, during outpatient appointments and during stays on hospital wards. Following the risk assessment, support is provided to the patient as required – the aim of the service is to respond quickly and to provide mainly short term support; due to the range of presentations, the support provided varies in terms of length, intensity and nature of the support provided and can involve the HIDVA supporting patients over a long time period, for example supporting them during a court case. One HIDVA attends each MARAC, previously the MARAC was held once a week, currently it runs daily Monday to Friday. • In some cases the HIDVA's input ends soon after completion of the risk assessment – for patients who require brief input such as signposting to a relevant agency and for those who decline support.

	• Cases referred to the MARAC are represented by the HIDVA at the MARAC and then usually referred on to other agencies; in some cases, if ongoing support from the HIDVA is deemed necessary then they continue to provide this after referral to the MARAC. • The HIDVAs retain all cases who are staff members at WWLFT and support them as long as necessary. • Cases which do not meet the MARAC threshold but require ongoing support are also held by the HIDVAs. • Some victims decline support initially and contact the HIDVA weeks (sometimes months) after the consultation, when they feel ready to access support and/or when it is safe for them to do so; the HIDVAs emphasise to victims that the service is available to them later on, not just immediately.
9	**TAILORING** Referrals to the HIDVA service include complex cases, so it is important that support can be tailored to fit individual needs.
10	**MODIFICATIONS** The service initially operated with one full time HIDVA post, in 2019 this increased to two posts. In addition to domestic abuse, the service also received referrals for sexual assaults in a domestic abuse situation; this support has now been built into the service.

4 The Qualitative Process Evaluation

4.1 Aim, methods and final sample

This Chapter addresses the second study objective: to describe the processes associated with implementation of the HIDVA service, including the facilitators and challenges to its implementation, and how the latter have been addressed. To identify provider perspectives on what does and doesn't work with the HIDVA service and with regards to impacts on services elsewhere in the system (e.g. MARAC referrals).

A semi-structured interview schedule was used, with open-ended questions, designed to address the study objectives and to elicit other relevant perspectives on the HIDVA service. All interviews were conducted over the telephone, were audio recorded with informed consent and fully transcribed. We carried out a 'thematic analysis' of the data, which involves identifying themes in the data and then organising the data according to these themes. Identification of themes was informed by the study objectives and by the data. Analysis followed the principles of 'Framework', an approach to thematic analysis often used in policy-relevant research; analysis was also informed by Normalisation Process Theory, which focusses on how people understand and relate to new interventions in practice. We also focused on understanding the areas set out in objective 2: that is, the facilitators and challenges to providing the service, why and in what ways these helped or hindered and in the case of challenges, how or if these could be overcome. The interviews were conducted between June and August 2020, shortly after the introduction of the first COVID-19 restrictions; accordingly, we asked interviewees about the impact of COVID-19.

Eleven interviews were conducted with participants working in safeguarding, the walk in centre, unscheduled care, adult and child wards, drug and alcohol services, health visiting and Trust senior management. Table 2 below summarises the participants:

Table 2: Participants interviewed

Job role or area of practice	Number of participants
Safeguarding: nurse, Head of safeguarding	2
HIDVA	2
Nurse: including health visitor and nurse practitioner	3
Matron	2
Senior manager	2

4.2 Themes

The following sections present the themes identified through our analysis: raising awareness of a new role, engagement and relationships; roles and skill mix; information systems and processes; impacts and consequences of the HIDVA service; impact of COVID-19.

4.2.1 Raising awareness of a new role

The HIDVA service was implemented within a context where domestic violence and abuse in particular, and safeguarding more generally, had a relatively low profile within the Trust – both strategically and at the frontline. Although there was a general awareness of the high domestic violence rate in the locality and a need to tackle this, the role of the Trust seemed unclear, for example, there was no domestic violence policy and no clear referral pathway from the hospital to domestic violence services elsewhere. When the first business case was submitted to the Trust board, only half the resource requested was offered (one HIDVA rather than two) – the participant quoted below seems to suggest that senior executives were not used to addressing the problem of domestic violence and abuse and were perhaps unaware of the potential to help, what services were needed and what the uptake would be:

> *I think the board were aware…that Wigan was an outlier from a domestic violence perspective…so they knew there was a problem in Wigan. I think initially when the business case was presented for two IDVAs, they weren't sure about the scale of the problem and how that would manifest itself within a hospital…what the demand would be on that service…*(Senior manager)

Prior to the HIDVA service some of the failures to identify cases of domestic violence and abuse were due to a lack of staff awareness, and some were due to reluctance to act, even where staff had suspected there was a problem. The latter situation manifested as frontline staff avoiding initiating conversations about domestic abuse with patients, and not responding appropriately or taking action when disclosures were made. This avoidance seemed to be due to a lack of appropriate communication skills to talk with patients about domestic violence and abuse and to a lack of confidence in the support and referral systems in place once a disclosure was made:

> *It was very variable what happened and we've since had staff say that they didn't know what to do, so they would just change the subject, which is awful…for staff as well as victims that they know they've not done as well as they could have done…it didn't feel like there were any pathways in place for domestic abuse except to contact the police if it was a police matter…or if it was high risk and it was likely to go to MARAC some members of staff felt able to complete the risk assessment form for MARAC but most didn't.* (Safeguarding)

This lack of awareness about undisclosed domestic violence presenting at the Trust, and the potential to provide support, is further illustrated by the quote below, describing the situation at the point that the walk in centre was integrated into the Trust during the first year of operation:

> *I had some significant concerns around the way that domestic violence was picked up within the walk-in centre…because they weren't getting any referrals for the IDVA from that unit. So, when I explored why [they said] 'we don't get any domestic violence here, we don't…you know, we just don't need to refer…'.* (Matron)

The HIDVA role was a new innovation within the Trust, that began with the initial pilot; no HIDVA role had existed within the Trust before, therefore there was work to do to raise awareness of the service. Much work has been undertaken to highlight the presence of the HIDVA service throughout the Trust. Posters (with tear off contact strips) publicising the service are displayed on Trust premises. When the first HIDVA was appointed, she and the head of safeguarding spent time 'walking the floor' of the hospital, to meet staff on relevant wards and introduce the HIDVA in person. This approach has continued and now the HIDVAs visit the A&E department, minor and major admissions units daily and other wards as and when they get an opportunity. Maintaining regular in-person contact across the Trust was considered worthwhile, both to keep the service in the forefront of the minds of staff and to reach as many staff as possible. Unscheduled care areas (such as the urgent treatment centre) tend to have high staff turnover, so continuing to meet staff there, to reach new starters, was deemed particularly important. Since community services became part of the Trust the HIDVAs also regularly visit the walk in centre.

> *We're out and about all over the hospital. And we're being seen, so staff recognise us. When I walk onto a ward, staff say, '[name]'s here, that domestic abuse woman's here.' …So, you're at the forefront of them every day, so when someone comes in and discloses, they know, 'oh we'll phone Safeguarding and get [an IDVA] down'. And that is the key…You need to be as recognised in the hospital, like a doctor would be, because you need to be visual, you know? Even if it's just popping down and, how is everything, is there anybody I need to see? How are the staff?* (HIDVA)

Spreading awareness of the HIDVA service across the Trust was seen as important, in order to identify domestic violence and abuse cases in all areas. The success of the service relied on keeping staff engaged, so they were aware of the service and maintained an active role in staying alert to domestic violence and abuse and seeking support or referring to the HIDVA service as necessary. This was expressed as a contrast to a previous HIDVA service (elsewhere):

> *Then we placed an IDVA just in A&E. That doesn't work. You pick up quite a bit of stuff in A&E but at the same time your staff become quite deskilled because they just rely on the IDVA all the time to pick everything up. And it doesn't pick up domestic abuse everywhere else in the trust.* (Safeguarding)

Whilst there was consensus that awareness raising was very important, it was challenging. Visiting wards in person is time intensive and therefore challenging to fit into the HIDVAs' busy role. Similarly, providing the training to all staff was a challenge, partly due to the time required and also because of the personal sensitivity of the topic for some people. For staff who have themselves experienced domestic violence, engaging with or contributing to the service can be difficult. This had become apparent especially regarding attending the training:

> *in some areas, for example A&E, where we've had senior management say, 'you all need to do this', there have been a few individuals that have really tried to push back and not complete this training. And that makes you wonder why. You know, it's too close to home maybe for some reason…They have had some victims come forward who want to do the training but just physically cannot sit and listen to it.* (Safeguarding)

Summary

The HIDVA service was implemented in a context where domestic violence and abuse had historically had a low profile. Spreading awareness of the HIDVA service across the Trust was seen as important, in order to identify domestic violence and abuse cases in all areas. The HIDVAs were faced with the challenges of needing to raise awareness, about the problem of undisclosed domestic violence and abuse presenting at the trust. The HIDVA role was a new innovation, previously, suitable referral pathways and support had been lacking in the Trust and the HIDVAs worked to promote the service and make themselves known to staff. It was important to keep staff engaged, so they were aware of the service and maintained an active role in staying alert to domestic violence and abuse and seeking support or referring to the

HIDVA service as necessary. The sensitive nature of the problem made domestic violence and abuse difficult for some staff to address or engage with.

4.2.2 Engagement and building relationships

Neither HIDVA had worked in a hospital before and therefore had to get know a new working environment and culture. The initial 'culture shock' and becoming familiar with the hospital pathways and protocols, as well as the hierarchy, politics and personalities were mentioned by several interviewees. Unsurprisingly, good communication skills and common courtesy were seen as important in forming relationships. In addition, learning hospital conventions, such as making oneself known to whoever was in charge when arriving on a ward, were key.

The HIDVAs faced the challenges of forming relationships with existing staff. The HIDVAs and head of safeguarding described work that had been undertaken to embed the HIDVA role. This had been done at overall system, team/ward and individual level. The employment of the HIDVAs as permanent employees of the Trust, as members of the safeguarding team, was considered key to embedding the service. Interviewees drew contrasts with other/previous set ups where hospital IDVAs have been community IDVAs who have come to work in hospitals in temporary (usually seconded) roles. The permanent status of the HIDVA was felt to be significant. The HIDVAs are part of the safeguarding team and are co-located in the team office, this is advantageous, for building working relationships, but also as HIDVAs and safeguarding nurses hear about cases during conversations in the office, they are able to offer each other advice. The HIDVA role helps forge a link between the work of the safeguarding team and that of professionals working on the frontline with patients.

Many staff came into contact with the HIDVA service by attending the domestic violence training that the HIDVAs provide; this is run as part of the safeguarding training in the Trust. Details of the training are provided in Table 1. Processes such as the training sessions and staff being trained to complete DASH assessments, have helped the HIDVA service become embedded into Trust systems and processes.

In addition to the walkarounds to meet front line staff, the safeguarding team have engaged strategically throughout the Trust, for example, recruiting domestic violence 'champions' within teams, who take a lead on promoting the service within their team or area of practice. Line managers, the human resources department and the staff union are aware of the HIDVA service and signpost staff to it when they are concerned that a member of staff is experiencing domestic violence. The impact of the service has been presented to the senior management, which has contributed to the service gaining the support of the Trust executive:

> *The second year, I didn't actually have to ask for the funding, the funding just went into the budget…the executive directors…had requested an update on the IDVA service, so there was a six-month review … they were all a little shocked to receive in terms of the volume of referrals…They asked for a review coming up to 12 months and again when they saw the numbers of referrals…I think they personally were very shocked…I think the hard-hitting thing for some of the board wasn't just the impact on the people who live in the borough, but the percentage of referrals that were for staff members... nobody knows really what goes on behind closed doors... So when you hold that up to an organisation and say 'actually of these however many hundred referrals, X percent of them are staff', they start to think 'is this the tip of the iceberg?'...so I think every board member then felt a personal obligation, not only to the borough, but to our staff, to make sure we provided a service for them. And I think that's a really powerful message*…(Senior manager)

There was consensus that the work to get the HIDVA known to staff, in person, had been successful, that good relationships had been built and that these were worthwhile. For example, the HIDVAs felt that many staff now recognise them when they walk onto a ward. Having this presence and in person relationship was deemed to be very important to keeping staff engaged with the service and the contrast between this development and the previous situation, when the referral route was via an 'anonymous' person or system was clear:

> *When the IDVA came along…we had a face and a person to connect with…You can ring them and ask them…The minute that we pull away from that face to face is the minute that you will see staff will disconnect from that and they won't make the referrals the same...like out of sight out of mind... As a healthcare system we still actively promote…you must look out for safeguarding…you must refer but…you're more likely to ring for advice if you know who you're talking to and you've got that relationship rather than just ringing an anonymous person or going online…*(Matron)

In terms of engagement and relationships beyond the Trust, the HIDVA was a new attendee at the MARAC. The HIDVAs felt that attending the MARAC was an important part of their role, to represent the patient and 'be their voice'. The HIDVAs had experienced some initial resistance from the MARAC, for example, refusing to hear a case they had referred, but over time, more effective working relationships seemed to have been built and other MARAC attendees, such as the community IDVAs discuss cases with the HIDVAs between MARAC meetings.

In addition to the MARAC, the HIDVAs liaise with a wide range of organisations outside the Trust. These are listed in Table 1. Both HIDVAs had worked as IDVAs in the community and therefore had pre-existing working relationships with people in relevant organisations. HIDVA 01 in particular had an extensive network of contacts which she continued to draw on in the hospital role and both HIDVAs agreed this was key to the success of the HIDVA role in terms of being able to make referrals. The legal support, from the solicitor who the HIDVA had built a working relationship with in a previous role, was particularly key and unique to this service.

This was not built in at the start in any way – the first HIDVA brought her extensive, existing network of contacts. The second one found it challenging at first working without a familiar referral pathway. To some extent, close, effective working with the first HIDVA has helped build her knowledge and confidence. However, she still finds that she cannot always put in place what she wants to for patients and some of this is due to variation between areas in what services are available.

Summary

The hospital was a new working environment for the HIDVAs, therefore they had to work through some initial culture shock. Work to engage with staff at all levels, both frontline and strategic was important. The permanent status of the HIDVAs as Trust employees and location within the safeguarding team were felt to be significant in helping embed the service into the Trust team. The working relationship with the MARAC has developed. The HIDVAs liaise with a wide range of organisations outside the Trust. Both HIDVAs had worked as IDVAs in the community and therefore had pre-existing working relationships across an extensive network of contacts; this was considered key to the success of the HIDVA role.

4.2.3 Roles and skill mix

Both HIDVAs came to the role with a large amount of experience of working in community settings, but neither had worked in a hospital before. There was agreement that transferring between sectors presented challenges – as well as forming relationships with existing staff, there were challenges in adjusting to working in an acute medical environment, perhaps particularly for HIDVAs who do not have a healthcare background:

> *They did, both of them, individually found it very different. I think they found it very hard in the first month at the hospital environment….they're not used to seeing things that they might see … think they have to develop a fairly strong stomach because they'll be talking to people with drips in and, you know, quite raw injuries. Maybe in the community by the time they see people they've been patched up a bit…those that have been in hospital for such a long time we were quite entrenched in it…*(Safeguarding)

Having a dedicated role focused on domestic violence and abuse, has changed the skill mix in the Trust and altered the actual work undertaken, in terms of case

identification, referral and support. Due to the HIDVAs being located on Trust premises, they are able to respond immediately to calls from frontline staff and see victims in person. They spend time with victims initially undertaking the DASH assessment and continuing to work with some, covering a range of activities and liaison as described in Table 1. The amount of time and intensity of the support provided seems to lend itself to a dedicated role and goes beyond what frontline staff or safeguarding staff have the skills or time to do. The aim of working with cases for a relatively short time seems to allow the HIDVAs to stay available to respond immediately, as opposed to dedicating more time to long term case work. This was an important way in which the HIDVA was seen to function differently from a community-based IDVA.

The personal and professional attributes of the HIDVA themselves were also important. The HIDVAs' knowledge, experience, dedication and interpersonal skills were mentioned by interviewees, both frontline staff who had experience of referring into and liaising directly with the service and those in more managerial positions. The HIDVAs were described as knowledgeable and approachable, by frontline staff, who found their presence and skills reassuring. The HIDVAs were flexible and creative in their approach, finding different locations to meet with victims to create privacy so that they could speak openly. Often perpetrators were in attendance at the Trust premises with victims and the HIDVAs had to find ways to ensure they could speak with victims alone.

The recruitment strategy focused on appointing a HIDVA who held the IDVA qualification (a national qualification which is not always held by some working as community IDVAs), with experience and understanding of the remit of the role in terms of their personal and professional responsibilities, in order to be able to act quickly to keep victims safe. The HIDVAs thought that their own experience of working in the community, particularly knowing what services were available, were key to being able to function successfully in the role.

> *having the background of the community work, before I came into a hospital, that was like the foundation for me, so that I knew what was*

available outside. So, when I came in I could offer different things to people, that if you didn't work in the community, you wouldn't know what's available. It's just simple things like, you know, the housing. So, we would put things in place, it's [organisation] so if the property's not safe, you get additional locks, you get window alarms, things like that. You wouldn't know all them things if you hadn't worked in the community. (IDVA)

A senior manager felt that it was key for HIDVAs to be qualified, and beneficial for them to be experienced, to be able to work in a 'professional' way – to understand the remit and limits of their own practice and to have the 'professional confidence' to act quickly when necessary – in order to be able to manage the potential risks associated with the role.

In addition to being able to dedicate time to focus on cases of domestic violence and their skills and expertise, it was felt that patients perceived HIDVAs as having an identity that was different to other frontline staff and responded well to this:

they're just so great at being able to… because they're not the police, they're not a nurse…they're very well trained in being able to get victims perhaps to open up and feel more safe and secure. I mean, frontline staff are good, but you can imagine the amount of competing priorities we have…[the IDVA will say to patients] 'we're not nurses and we're not doctors…we're here to support you and you alone. And this is what I can do and we want to make sure you're safe'…(Safeguarding)

As outlined in section 4.2.1, staff skills in identifying and responding to cases of domestic violence and abuse were often lacking, before implementation of the HIDVA service. There was consensus that the HIDVAs had had a positive impact on this, through a combination of the training sessions they ran and also their presence as a source of support. Frontline staff and the HIDVAs themselves described increased awareness amongst staff, about domestic violence and abuse, derived from the training sessions:

> *Sometimes it's a bit of a shock…you can see as if the penny's dropped. And quite often they'll say at the end of the training, 'I think I've had a lot of people come through and I haven't recognised that it was abuse'. But then moving forward they do recognise it.* (HIDVA)

As well as increased awareness of the relevance of physical injuries, awareness of difference types of abuse and of more subtle signs were mentioned repeatedly. Paying attention to instinct or 'gut feeling' that there might be a problem and acting on this was also singled out. This was described by the nurse in Case Study 01 and also in the quote below:

> *I had a doctor on [an admissions unit] who rang me, and he said, 'something's not sitting right [name]'. And he said, 'it's 'cause I attended that training, that's made me stop and think of something you've said'.* (HIDVA)

In addition to the training and walkarounds, mentioned above, the HIDVAs provided feedback opportunistically, checking in with staff to update them on the outcome of cases. Informal, ad hoc feedback provided in this way seemed to an effective way for staff to gain insight into the impact their referrals had. The HIDVAs also checked patient records to identify previous attendances or admissions and sometimes spoke to the staff at the relevant department, to make them aware of the case and educate them about how the case could potentially have been identified at an earlier attendance or admission.

Staffing was the main resource required to run the service. The HIDVAs and other interviewees all agreed the service was constantly busy. Currently the administrative work for the service is undertaken within the Safeguarding team; dedicated administrative support was mentioned as an additional resource that would be beneficial.

As outlined in Table 1, both HIDVAs are now also qualified IDSVAs. The service receives referrals for sexual violence cases. A key challenge here is that the cases

tend to need long term support and this is an issue for the HIDVA due to the service being designed not to hold cases in the long term. However, there is a lack of support available in the community locally – there is no community IDSVA and only an outreach Sexual Assault Referral Centre (SARC), with the main SARC being located in Central Manchester.

Summary

The HIDVAs faced the challenge of transferring to a new sector of practice. The skills, knowledge and attributes of the HIDVAs, were key to the successful running of the service, in particular, strong interpersonal skills, professional experience and confidence. Having a dedicated role, being able to provide an immediate response and the HIDVA's identity as an independent 'advisor' were important. The awareness of domestic violence and abuse, skills and confidence of the other staff in the Trust have developed since the HIDVAs have been in place.

4.2.4 Information systems and technology

Several different record systems are relevant to the HIDVA service – as outlined in Table 1. There are different systems in place in different parts of the Trust; the hospital sites have the Hospital Information System (HIS) whilst the walk in centre has System One. Staff cannot access systems in different parts of the Trust. The 'mixed' system, with referrals being received in different ways, seemed to function effectively. The HIDVAs felt it was important for them to retain their own system of notes, that they control access to, due to the nature of the service and in the interests of confidentiality. Although the HIS has the functionality for 'flags' to be put on records, it is not feasible to use these to highlight, for example, that a patient is a victim or perpetrator of domestic violence or abuse. Issues such as these mean that staff have to find 'workarounds' such as emailing referrals in, or checking the HIS records for notes about domestic abuse. The HIDVAs act as a link between different areas of the Trust, as for example in Case Study 01 where they provide a link between different parts of the Trust that do not have access to different records – but that can be very important.

4.2.5 Impact of the service

Several case studies were discussed that highlighted the impact of the service across a range of groups:

- Staff disclosures of abuse. A key consequence of the implementation of the HIDVA service has been disclosures of domestic abuse amongst members of Trust staff. This was mentioned numerous times throughout the interviews and had not been anticipated, by the HIDVAs or existing staff in the Trust. Staff had made disclosures to the HIDVAs themselves, either after attending the training, or via other colleagues – see Case Study 6 below.
- Cases are being picked up after abuse has been occurring over the long term – Case Studies 4 and 5 below.
- Identification of cases that would be unlikely to be picked up in the community – as staff see on wards what is usually behind closed doors at home – as in Case Studies 4 and 5 below.

4.2.6 Impact of COVID-19

The COVID-19 pandemic and related societal restrictions have impacted on the service in several ways:

- When the national lockdown was imposed in March 2020, there was a drop in referrals, followed by an increase.
- Within the trust, HIDVAs could not visit A&E, wards or other departments, or meet victims in person. A workaround was for the patient to sit with a frontline member of staff in a private room and speak to the HIDVA via the telephone, for the risk assessment. HIDVAs are now able to visit hospital wards; there are some non-COVID wards and the HIDVAs use PPE.
- Having few visitors on wards made it easier for patients to disclose abuse to staff, due to being alone with them. Some members of Trust staff also made disclosures at COVID testing centres, when they were attending to be tested, as they had to attend alone, it seemed to present an opportunity to disclose.
- There were plans for changes to the way the MARAC meetings were held, before the pandemic, however, the lockdown seemed to have quickened the process of the MARAC being held more frequently and virtually.

4.3 Case Studies

Case Study 1

Increased ability of frontline staff to identify cases

…since the domestic violence team have been working with us more closely.. it has made us more alert. And we specifically ask now at triage and at treatment, if there's any history of domestic violence or abuse. And we've become a bit more mindful as to the sort of injuries they come in with, and the stories behind that…I had…a presentation of a young girl who had said that she'd [had an accident at home]…and that seemed okay. But I'd… had training [provided by the HIDVAs] … it made me ask questions, and the HIDVAs actually happened to be on the unit at that time. So they had their laptop, and had access to their HIS system, and when they looked on their HIS system, this young lady had actually presented at A&E the day before with the same…an assault injury…of the same injury she'd come to me with…that got referred to social services...Whereas without that amalgamation of the systems…my gut was telling me something wasn't quite right, but she wasn't going to disclose anything to me, and she was adamant in the story… But then…the [HIDVAs]… came and sat with this lady, and then she made a disclosure to them then.

Case Study 2

Outpatient clinic – disclosure of long term abuse – the ability of Trust staff to respond effectively has improved

…we had a lady that came in to one of our clinics and she came in and she went into clinic, her husband had brought her in the car… an elderly lady in her late 60s, and said to staff, 'I can't go back home with him, I don't want to go back, I can't go back in the car, he's abusing me'. ... So the staff are straightaway on the phone, rang the IDVA…so we had to then look at a safety plan … She was petrified of going back in the car … so we got her a taxi and…It's about that safety plan and putting things in place…it was onsite so [HIDVA] could go down straightaway and see the lady, so we brought her into A&E… you can imagine if that was another hospital

where there was no hospital IDVAs. Then the only thing you perhaps could have done at the time was either ring the police… the police perhaps wouldn't do too much in those scenarios. We'd obviously refer it …or try and get a family member on board, but I think her sister was far away and she couldn't go to her sister's.

Case Study 3

Disclosure by male victim – the ability of Trust staff to identify cases and question patients effectively has improved

…all the males who have disclosed I know that they've been asked and they haven't disclosed to any other agency…We all know there're lots of reasons why men don't disclose… that's societal and the way that they're viewed, and things like that. And then also that there're less places for them to go. And we don't know is the answer… So, for some reason they don't feel they can tell the police or anywhere else. We don't know whether it's the fact that they're here being, you know, helped, usually physically or maybe they've come and they've self-harmed and actually they're at such a low ebb that somebody actually asking the right question actually…sort of gives them permission to say, 'yeah, this has happened to me'…Some of the injuries have not been that regular… the presentations have not been really very obvious domestic abuse. It's more as the staff are starting to talk to them a little bit more… One man came, for example, with [a minor injury] … [he provided a story about how it had happened] but didn't really want to do whatever he was doing, and…he was told by our staff what an IDVA was and did he want to speak to one. And he said, 'yes, I do'. So, they arranged for the IDVA…to go and meet him at fracture clinic and he was…so frightened because his perpetrator had come to [the] clinic with him.…[she managed to speak with the patient alone and] she was able to have a very sort of safe and frank conversation. And she ended up supporting him for quite a long time and he disclosed…he was under all sorts of pressure…and he was at wits end. whatever [the perpetrator] said to do he was doing it even if he didn't want to do it. Quite a sad case really. It affected him at work and everything. But it was interesting that he'd got…that had happened to him for years and he hadn't told anyone.

Case Study 4

Disclosure at point of discharge from ward

…we're getting a lot of disclosures when it's time for people to be discharged home. So people are saying, 'I don't want to go home, I'm too frightened'. So, they might have been in here for nothing to do with domestic abuse, they might have been in here [on the] stroke ward, so it might be that people have come in with other illnesses, and then said, 'I don't want to go home, I don't want to go home'. And then they say, 'cause there's domestic abuse. So we go down then. So, you know, they could have come in for, I don't know, a hysterectomy or anything, and they end up disclosing.

Case Study 5

Identification of a case of financial abuse that would unlikely be picked up in the community

…because in the community… behind closed doors, you know, they may never have the opportunity to speak to somebody. Whereas in here, they have got the opportunity. It's a safe place for somebody to tell us. But also, staff are witnessing that abuse on the ward by family members, whereas you wouldn't witness that in somebody's home. I think that has gone up and that's surprised me. I'm not saying, I always believed it was there, but it's about how can you capture that somebody's being abused? You might know, you know, but unless the police are called, when you work in the community, you'd never find that out. Where here, like I say, 'cause the staff are doing their training and what to look for, they're picking up on that straightaway…So we've had like a patient that had no clothing, he had no toiletries, no nothing. And it all turned out that a family member was in full control of that money…we went down and took a bag full of stuff for [the patient]. And that's when it all came out, like, why have you not got anything, where's your stuff? But the staff had identified that…a family member held that card, and they hadn't brought anything for [the patient].

Case Study 6

Disclosure by member of Trust staff

…and it's been recognised by some staff, of staff that they're working with. Like the most recent one I was involved in was…where [a staff member put her hand up…and just said, 'I need help'. And [IDVA] she came in to see her… sit with her and help her through the whole process. So it's not just patients, it's staff as well are actually recognising that there is help there and they can access it as well.

I: Okay. And was that, disclosures from staff, is that something you'd ever seen prior to the IDVAs being in?

R: No, I've never seen that before…the whole team were supporting this girl, the whole team on the ward. She didn't disclose it to anybody senior, she just disclosed it to one of them, her colleagues, while they were [working on a ward]...And then it got escalated up. And the trust were really supportive and they arranged accommodation…The whole team kind of rallied round and put some money together for her, and toiletries and clothes and stuff to help to look after her till it was sorted out…I've never seen that before with a member of staff.

4.4 Summary

The HIDVA service was implemented in a context where domestic violence and abuse historically had a low profile. Prior to implementation of the HIDVA service, suitable referral pathways and support had been lacking in the Trust. This is an issue that goes beyond WWLFT; barriers to healthcare staff playing a greater role in identifying domestic violence and abuse have been recognised and guidance such as the NICE quality standard (NICE 2016) have been developed to address these. The HIDVA service aimed to follow the principles in this guidance, to improve the response to domestic abuse in a healthcare setting.

The HIDVA role was a new innovation within the Trust, until the pilot that preceded it there had been no focused domestic violence and abuse support available. The

service design was informed by knowledge and experience of previous HIDVA services; these have tended to focus on a specific areas of practice or department (SafeLives 2016 and 2018b, Pathfinder 2020) within a Trust. The WWL service design took a different approach - raising awareness of the HIDVA service across the Trust was seen as important, in order to identify domestic violence and abuse cases in all areas. The HIDVAs worked to promote the service and make themselves known to staff. It was important to keep staff engaged and taking an active role in staying alert to domestic violence and abuse and seeking support or referring to the HIDVA service as necessary. In addition, previous HIDVA services have tended to be piloted or seconded, whereas at WWL the permanent status of the HIDVAs as trust employees and location within the safeguarding team were felt to be significant in helping embed the service into the Trust team.

The HIDVAs faced the challenge of transferring to a new sector of practice; the hospital was a new working environment for them and they had to work through some initial culture shock as they settled into their roles. Work to engage with staff at all levels, both frontline and strategic was important. The HIDVAs liaise with a wide range of organisations outside the Trust. Both HIDVAs had worked as IDVAs in the community and therefore had pre-existing working relationships across an extensive network of contacts; this was considered key to the success of the HIDVA role, indeed, it seems that it would be difficult to successfully run an equivalent service without these networks and relationships in place.

The skills, knowledge and attributes of the HIDVAs were key to the successful running of the service, in particular, strong interpersonal skills, professional experience and confidence. The awareness of domestic violence and abuse, skills and confidence of the other staff in the trust have developed since the HIDVAs have been in place. Having a dedicated role, being able to provide an immediate response and the HIDVAs' identity as an independent 'advisor' were important and seem to allow the fulfillment of the service aims of providing a timely response and achieving disclosures.

Various information systems are used in different areas of the Trust; staff cannot access systems outside their area. A 'mixed' system, with referrals being received in different ways, seemed to function effectively, albeit with some workarounds. The HIDVAs felt it was important for them to retain their own system of notes, that they control access to, due to the nature of the service and in the interests of confidentiality.

4.4 Recommendations

- There is a need across NHS Trusts for greater awareness, improved identification of, and support (referral and case management) for, victims of domestic violence and abuse. These findings suggest that a HIDVA service is an appropriate and effective way of meeting this need. Other Trusts should consider setting up a HIDVA service.
- Seek to recruit an experienced IDVA, with training (national qualification) and a background in community working. A network of relevant community organisations beyond the hospital and ability to make decisions rapidly in a crisis situation, are key to making appropriate, timely referrals.
- Embed HIDVAs within the Trust, as permanent employees. Spread their involvement across as many relevant clinical areas as possible, rather than locating them in one department such as A&E.
- Ensure that frontline staff are able to refer to the HIDVA service proactively – ensure they are trained in awareness of domestic violence indicators and promote the HIDVA service throughout the Trust so that staff refer to it.
- Consider whether systems are in place to accommodate the issues raised (e.g. SARC), to enable maximum impact from the HIDVA's skills to be realised.
- Review the current situation with domestic violence and abuse disclosures amongst staff at the Trust – are these frequently disclosed and supported within the Trust? If not, consider how staff disclosures will be supported and who will carry these cases, the HIDVA or other (e.g. community IDVAs).
- Particular regard should be paid to the potential for HIDVA services to identify previously unmet need for domestic violence and abuse services when assessing the value of a HIDVA service. This unmet need was anecdotally evident for male patients and staff members within the Trust itself.

5 Referrals to the HIDVA service

This Chapter addresses the third and fourth study objectives: to examine the activity associated with the HIDVA service, with a particular focus on service user demographics; and to explore any correlation between the introduction of the HIDVA service and referrals to MARAC.

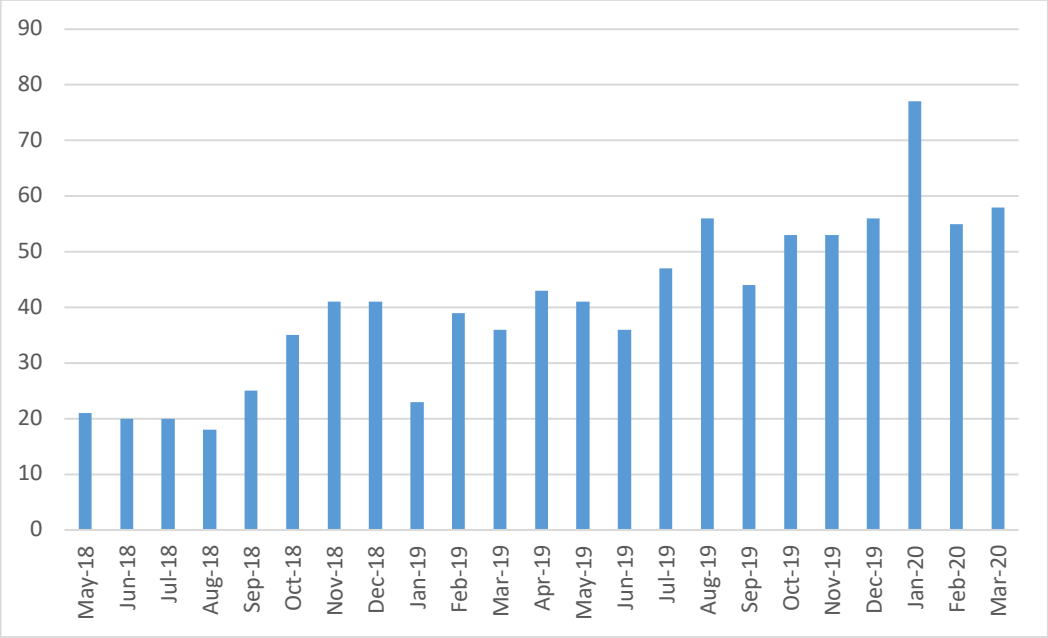
WWLFT provided details on the volume of referrals to the HIDVA service, source of referral and demographics related to gender and age of the victim. Where possible, comparisons are made to SafeLives' assessment of 3,672 cases recorded across 22 IDVA services in England and Wales for the period April 2018 to March 2019 (SafeLives 2019). This comparison was made to identify whether the HIDVA service may be identifying a different type of victim than community IDVA services. However, caution is needed because the populations covered by the SafeLives dataset may differ from those in Wrightington, Wigan and Leigh. Unfortunately, due to the nature of the data, SafeLives are unable to provide details of the 22 IDVA services to enable comparisons of demographics between Wrightington, Wigan and Leigh and the 22 areas.

A total of 938 people had been referred into the HIDVA service over the period 1st May 2018 to 30th April 2020 (319 in 2018/19 and 619 in 2019/20).

5.1 Source of referral

Data on source of referral were available for both years of HIDVA activity. Referrals have increased over the period (Figure 2).

Figure 2: Referrals into the HIDVA service 1st May 2018 to 31st March 2020

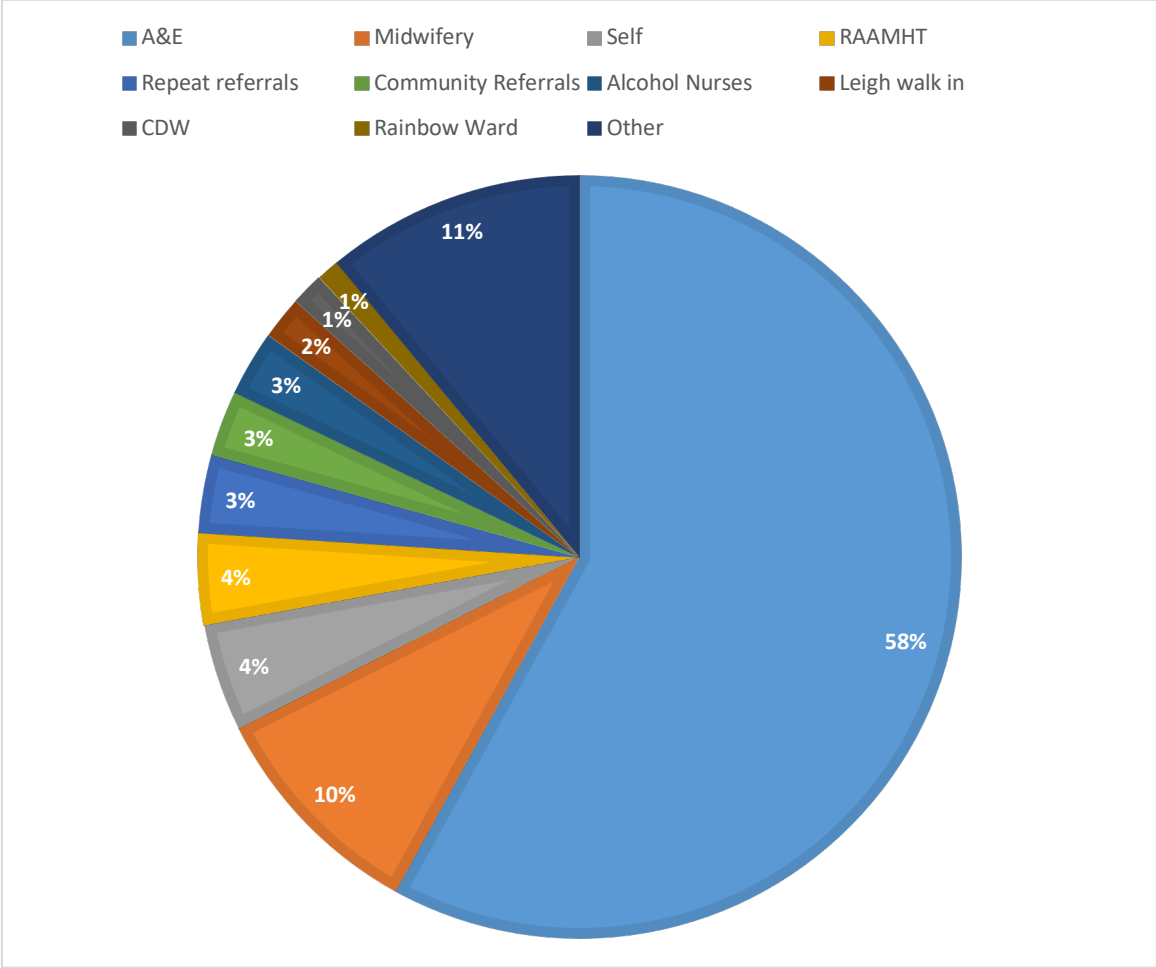


Referrals were predominantly from the Trust with 58% (544) coming from the Emergency Department, 10% (90) from midwifery, and 5% (43) from self-referring patients at the Trust. Source of referrals are presented in Figure 3 and included referrals from outside the Trust (for example, community referrals (3%)). Referral sources vary from those observed in IDVA services where only 3% of referrals are made by hospital (SafeLives 2019). These differences are likely to reflect the location of the service and the proactive approach of case finding in the HIDVA service.

Repeat referrals to the service (3%) represent a smaller proportion of repeat referrals seen in IDVA services (15%) (SafeLives 2019). This is likely to be due to the HIDVA service being relatively new compared to IDVAs. The predominant referral route for IDVA referrals were via the police service (34%), these account for only 0.2% of referrals in the HIDVA service.

Sexual assault referrals were seen from January 2019 with a total of 63 up to and including March 2020.

Figure 3: Referral source 1st May 2018 to 31st March 2020



RAAMHT: Rapid All Age Mental Health Team
CDW: Clinical Decisions Ward
Rainbow Ward: Children's inpatient ward

5.2 Demographics of victims

Anonymised data on victim demographics for referrals over the periods 1st May 2018 to 30th April 2019 and 1st May 2019 to 31st March 2020 were provided to the NIHR ARC-GM team, these were compared to demographics of IDVA referrals from cases recorded across 22 IDVA services in England and Wales for the period April 2018 to March 2019 (Table 3) (SafeLives 2019).

Table 3: Demographics of referrals

Victim demographics	Year 1 1st May 2018 – 31st March 2019 (n=319)		Year 2 1st April 2019 – 31st March 2020 (n=619)*		IDVA referrals^ (n=3,556)	
Gender						
Male	49	13.54%	78	12.60%	130	3.66%
Female	270	86.46%	541	87.40%	3381	95.08%
Age*						
Under 16	0	0.00%	1	0.18%	13	0.87%
16-19	24	7.52%	34	6.19%	202	5.68%
20-39	191	59.87%	293	53.37%	2415	67.91%
40-59	56	17.55%	140	25.50%	800	22.50%
60+	48	15.05%	81	14.75%	108	3.04%
LGBT	-		7	1.13%	78	2.19%
Learning Disability	-		12	1.94%	40	1.12%
BAME	-		7	1.13%	574	16.14%

*Notes: ^Safe Lives (2019); *Age bands provided for 549 referrals in Year 2; age bands for SafeLives IDVA demographics differ slightly (Under 18, 18-20, 21-40, 41-60, 61+)*
- Not provided in data by WWL NHS Foundation Trust

Males comprised 14% and 13% of referrals in years 1 and 2 respectively (14% over both periods), this is a smaller relative share than the 33% share for males in prevalence estimates presented by the Crime Survey for England and Wales (ONS 2020b) but higher than the 4% share observed in Greater Manchester MARAC referral data for 2017/18 (ONS 2019c). The percentage male is also greater than the 4% share of IDVA referrals (SafeLives 2019).

HIDVA referrals were predominantly in victims aged between 20-39 (60% in year 1 and 53% in year 2), this age group comprises of a larger proportion of referrals in IDVA services (68%). Comparing the shares of referrals where the victim was aged 40+ suggests the HIDVA service is identifying a relatively older victim, particularly for those aged 60+ which account for 15% of HIDVA referrals in year 1 and 15% in year 2 and 3.04% of IDVA referrals. Similar findings have been observed in the Pathfinder project where 54% were aged 21-40, and 12% 61+ (Pathfinder 2020). Whilst the Pathfinder project also includes mental health Trust and GP practice referrals, there appears to be a consistent picture that IDVA services co-located in a health setting appear to identify older victims of domestic violence.

The proportion of referrals that were lesbian, gay, bisexual, or transgender (LGBT) or having a learning disability was low in both HIDVA and IDVA referrals. The proportion of referrals that were BAME is lower in the HIDVA service (1%) than the IDVA service (16%) and Pathfinder project (36%). In both years of the service 5% of referrals were NHS staff.

The HIDVA service appears to be identifying an unmet need of domestic abuse services for male victims and victims aged 40+. However, IDVA services appear to have a relatively greater share of referrals of BAME. Caution is advised with these figures as differences may reflect demographic differences between the Wrightington, Wigan and Leigh locality, the IDVA services sampled in the SafeLives case notes assessment, and the Pathfinder project sites. For example, the Wrightington, Wigan and Leigh locality has a 2.8% non-white demographic compared to 14.1% in England and Wales and the higher BAME rate in the Pathfinder project may be due to the London Pathfinder sites (who made up 79% of BAME clients). [1] However, Wrightington, Wigan and Leigh does have a similar rates of males (49.89% versus 49.43%) and average age (42.1 versus 40.2) to that in England and Wales (ONS 2020a).

5.3 Referral outcomes

Data on the outcomes of referrals were provided for 565 referrals in year 2 (May to March 2020, Table 4). The vast majority of referrals (72%) resulted in support given. 9% were not able to establish contact and 6% declined support. 8% were referred to the local MARAC (representing high risk cases). The HIDVA service appears to have limited impact in expanding workloads in community IDVAs (0.35%) and Adult and Child Social Care (1.06%).

[1] England and Wales rates of non-white ethnicity sourced from Census data, available at: https://www.nomisweb.co.uk/census/2011/ks201uk

Table 4: Outcomes of referrals made between 1st May 2019 to 31st March 2020

Outcome	Volume	Share of referrals (%)
Support	405	71.68%
Unable to establish contact	48	8.50%
MARAC referrals	46	8.14%
Declined support	35	6.19%
Referral to refuge	9	1.59%
Application for civil orders	7	1.24%
Adult Social Care referral	6	1.06%
Referral out of area	5	0.88%
Child Social Care referral	2	0.35%
Support from community IDVA	2	0.35%
Total	**607**	

5.4 Summary

The volume of referrals into the HIDVA service has increased over the two years the service has been in place. This may partly be explained by the introduction of a second HIDVA in 2019/20. In addition, the qualitative analysis (Chapter 4) explains that since implementation of the HIDVA service, awareness of domestic violence and abuse has increased amongst Trust staff and their ability to identify and refer cases has improved. The increase over time may reflect the bedding in of the service and increases due to these improvements, over time.

It has been suggested previously that HIDVA services may increase the disclosure of domestic violence and abuse because: victims are presenting at a crisis point where abuse may be more difficult to conceal; in hospital victims are seeking care; access is possible to those who may not have sought support elsewhere; and disclosure may be more likely due to the confidential and caring environment (SafeLives 2016). The findings of the referrals assessment lends some support to this argument. The HIDVA service largely deals with referrals from within the local hospital whilst only 3% of IDVA referrals nationally are from hospitals (SafeLives 2019).

There appears to be a demand for the service and demographics of victims look to be different to those in IDVA services suggesting a HIDVA service is identifying an unmet need for domestic violence and abuse services. The hospital setting may be helping

to identify this need. The qualitative findings in Chapter 4 suggest that staff were identifying male victims who had suffered abuse over a long time.

The majority of HIDVA referrals result in HIDVA support being given to the victim (71.68%). 3% of referrals are repeat referrals, this is lower than the 15% seen in IDVA services nationwide, further research could explore whether this is due to relatively better outcomes in the service.

5.5 Recommendations

- The service appears to be a valuable resource within which to identify and address an unmet need for domestic violence and abuse services in the locality and may help reduce inequalities in access to IDVA services, particularly for those aged 40+ and males. This should be considered when appraising the service.
- Monitoring of referrals and support workload for the HIDVAs would help to understand whether further HIDVAs are required.
- The service had 938 referrals in the first two years, 72% of these received support by the HIDVA service. As referrals grow so too will support needs. The stresses this may place on the HIDVAs should be monitored and where possible, solutions to reduce workload should be considered (such as dedicated administrative support).

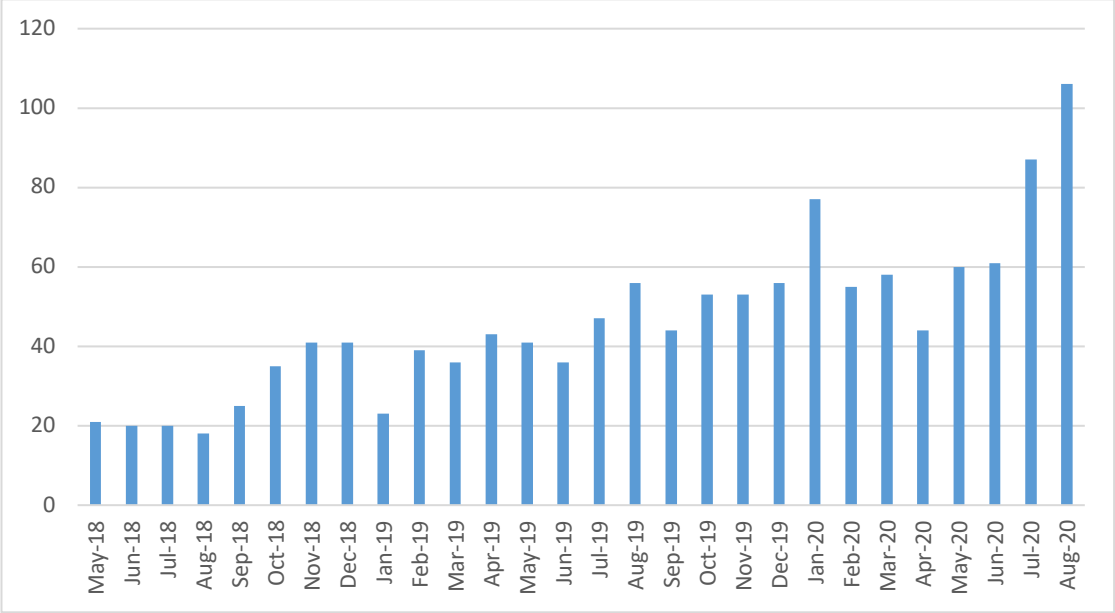
6 Referrals to the HIDVA service over the COVID-19 period

The evaluation of the HIDVA service overlapped with the first period of COVID-19 restrictions. Referrals over the period 1st April to 31st August 2020 were provided to the evaluation team, these are reported separately to the main evaluation period with the aim of providing an insight into how referrals into the HIDVA service changed over the period.

6.1 Source of referral

A total of 358 people had been referred into the HIDVA service over the period 1st April 2020 to 31st August 2021 (Figure 4). The period of lockdown appears to have only slightly impacted on referrals with a decline in April but recovery to pre-lockdown volumes seen in February 2020. Referrals have increased to new peaks during the easing of lockdown. The HIDVA service therefore appears to be particularly resilient to the first period of COVID restrictions at a time where there was growing concern of the impacts lockdown measures may have on the prevalence of domestic violence and abuse.

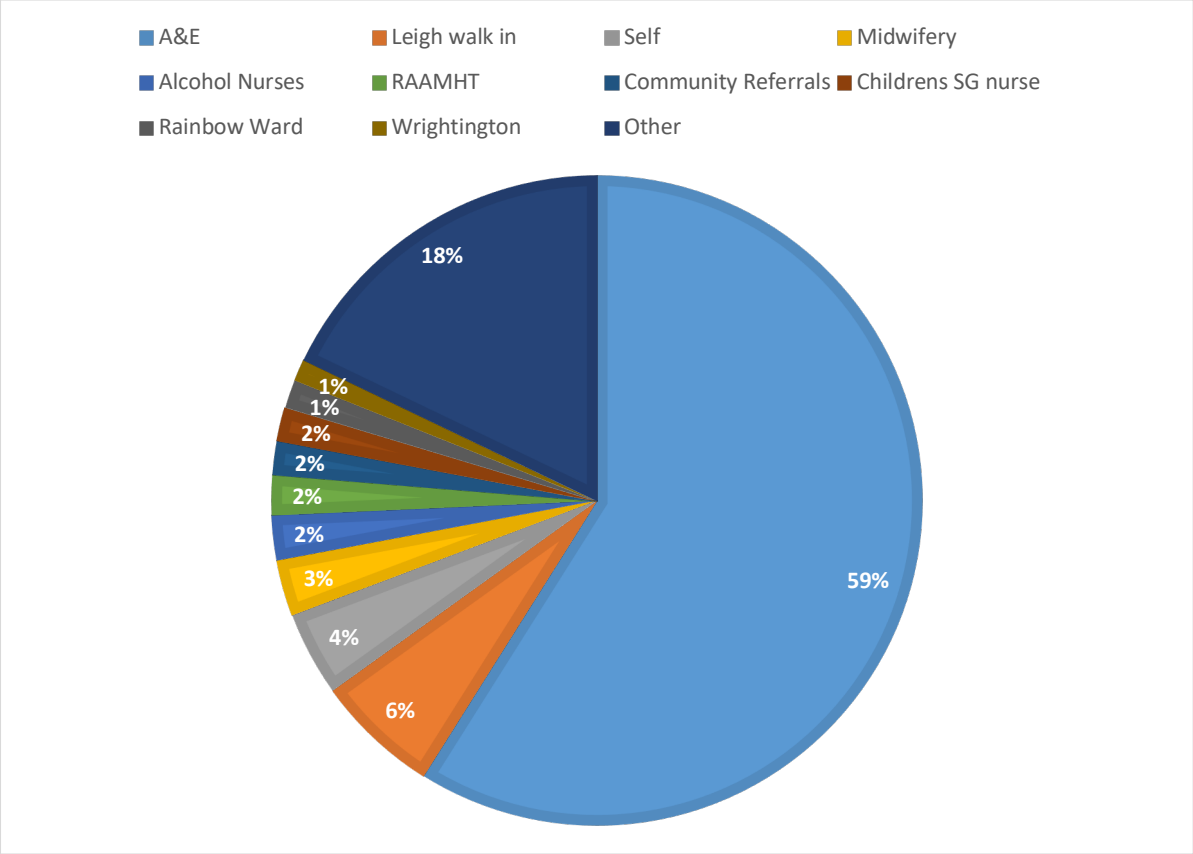
Figure 4: Referrals into the HIDVA service 1st May 2018 to 31st August 2020



The source of referrals were broadly in line with year 2 of the service with A&E accounting for 59% (58% in year 2), and similar rates of self-referrals (4% in both periods) (Figure 5). There was a higher percentage of referrals coming from Leigh walk-in centre (6% compared to 2% in year 2), and a lower percentage from midwifery (3% compared to 10% in year 2).

Sexual assault referrals amounted to a total of 29 up to and including August 2020.

Figure 5: Referral source 1st May 2018 to 30th April 2020



RAAMHT: Rapid All Age Mental Health Team
Rainbow Ward: Children's inpatient ward

6.2 Demographics of victims

There was limited evidence of a change in the gender composition of referrals in the first COVID-19 period compared to either years 1 or 2 of the HIDVA service (Table 5). The first COVID-19 period had a relatively older referral demographic than previous years.

Table 5: Demographics of referrals

Victim demographics	Year 1 1st May 2018 – 31st March 2019 (n=319)		Year 2 1st April 2019 – 31st March 2020 (n=619)*		COVID-19 1st April 2020 – 31st August 2020 (n=358)	
Gender						
Male	49	13.54%	78	12.60%	47	13.13%
Female	270	86.46%	541	87.40%	311	86.87%
Age*						
Under 16	0	0.00%	1	0.18%	0	0.00%
16-19	24	7.52%	34	6.19%	27	7.54%
20-39	191	59.87%	293	53.37%	177	49.44%
40-59	56	17.55%	140	25.50%	95	26.54%
60+	48	15.05%	81	14.75%	59	16.48%
LGBT	-		7	1.13%	5	1.40%
Learning Disability	-		12	1.94%	1	0.28%
BAME	-		7	1.13%	3	0.84%

*Notes: *Age bands provided for 549 referrals in Year 2*
- Not provided in data by WWL NHS Foundation Trust

6.3 Referral outcomes

Referral outcomes differ in comparison to year 2, in particular, MARAC referrals have declined (5% compared to 8% in year 2), and there are a smaller proportion declining support (1% compared to 6% in year 2) (Table 6).

Table 6: Outcomes of referrals between 1st April 2020 to 31st August 2020

Outcome	Volume	Share of referrals (%)	Volume year 2	Year 2 share of referrals (%)
Support	261	75.87%	405	71.68%
Unable to establish contact	37	10.76%	48	8.50%
MARAC referrals	18	5.23%	46	8.14%
Referral to refuge	8	2.33%	9	1.59%
Referral out of area	6	1.74%	5	0.88%
Support from Community IDVA	5	1.45%	2	0.35%
Declined support	5	1.45%	35	6.19%
Adult Social Care referral	3	0.87%	6	1.06%
Child Social Care referral	1	0.29%	2	0.35%
Application for civil orders	0	0.00%	7	1.24%
Total	**394**		**607**	

6.4 Summary

The HIDVA service was particularly resilient to the first period of COVID-19 restrictions. The hospital setting looks to have provided a safe and secure opportunity for disclosure at a time where there was growing concern of the impacts lockdown measures may have on the prevalence of domestic violence and abuse. Indeed, the service experienced new peaks in the volume of referrals, particularly as lockdown eased.

The source of referrals are different in the first COVID-19 period, here, referrals from midwifery represented a smaller proportion of referrals while the proportion of referrals from Leigh walk-in centre increased. Whilst the gender composition of referrals were similar to year 2 there was some evidence that referrals were of older ages which may indicate lockdown has resulted in a worsening of domestic abuse for these age groups relative to younger age groups.

The first COVID-19 period impacted on referral outcomes. The proportion of outcomes that were MARAC referrals declined. There were a smaller proportion of outcomes declining support in the first COVID-19 period.

6.5 Recommendations

- The HIDVA service was particularly resilient to the first period of COVID-19 restrictions. The hospital setting looks to have provided a safe and secure opportunity for disclosure at a time where there was growing concern of the impacts lockdown measures may have on the prevalence of domestic violence and abuse. Indeed, the service experienced new peaks in the volume of referrals, particularly as lockdown eased. This suggests the service may prove to be an important tool to address rises in domestic violence and abuse during lockdown periods.

7 Hospital activity prior- and post-HIDVA referral

This Chapter addresses the fifth study objective: to explore the correlation between the use of the HIDVA service and impacts on hospital service use.

The HIDVA service provided a list of patients referred into the service to WWLFT Business Intelligence (BI) team, the BI team matched these patients to activity in the Trust and extracted all A&E and admissions activity for these patients for periods of 1 year prior to referral and the period post-referral to March 2020. The evaluation team received an anonymised version of this data that contained year of birth, age, dates of activity and related ICD-10 or HRG codes.

Activity data were aggregated by calendar quarter. Quarters prior- and post-referral were then determined based on the quarter of referral. Table 7 provides an illustrative example. Here the victim is referred into the HIDVA service in January 2019. Defining the referral quarter as point 0 the quarters prior- and post-referral can be determined. Since referrals dates vary over the sample some victims have fewer quarters post-referral. For example, those referred from 1st April 2019 have a maximum of 3 quarters post referral.

Table 7: Example of calendar quarter and prior- and post-referral quarter

Referral date	Calendar quarter	Quarter prior- and post-referral
	January-March 2018	-4
	April-June 2018	-3
	July-September 2018	-2
	October-December 2018	-1
January 2019	January-March 2019	0
	April-June 2019	1
	July-September 2019	2
	October-December 2019	3
	January-March 2020	4

Data for 379 victims were provided by the BI team. This represents a sample of all HIDVA referrals. The difference here is due to i) an inability to identify those referred from outside the hospital and ii) the matching process where a unique patient based on demographics and referral source and date could not be identified. The matching process was particularly limited for year 1 referrals (2018/19) due to the data being recorded in the HIDVA service at that time, which limited the ability to match patients to hospital records.

After grouping the data into quarters relative to referral into the HIDVA service, there are relatively fewer observations on patients in the post-referral period (Table 8). This reflects the fact that more patients had their first contact with the service during 2019.

A total of 292 females and 49 males had data on A&E attendances, and a total of 252 females and 37 males had data on inpatient admissions. There were many more females than males in the hospital activity data (e.g. 292 (85.63%) to 49 (14.37%) in the A&E data). This is in line with the gender ratios seen in Chapter 5 for HIDVA referrals and helps provide some reassurance that the sample may not be biased against any particular gender. The average age at referral was 38.31 for females and 46.87 for males.

Table 8: Quarters of data relative to first HIDVA contact by sex

Quarter relative to HIDVA contact	A&E data		Inpatient data	
	Females	**Males**	**Females**	**Males**
-4	292	49	252	37
-3	292	49	252	37
-2	292	49	252	37
-1	292	49	252	37
0	292	49	252	37
1	259	42	220	33
2	207	35	181	30
3	151	27	131	20
4	101	19	91	14
5	53	11	45	8
Total	2,231	379	1,928	290

Comparisons of prior- and post-referral A&E and admissions activity and costs of activity were compared were compared.[2]

Estimated changes are presented as incident rate ratios (IRRs), which show the relative difference in activity compared to the referral quarter. Here, an IRR of 1 suggests no difference in secondary care activity, an IRR >1 would suggest an increased level of secondary care activity relative to referral quarter, and an IRR<1 would suggest a lower level of secondary care activity relative to referral quarter.

A limitation of the approach taken is that we do not have a counterfactual group to compare against. A counterfactual group is helpful because this would give an indication of how activity may have changed in the absence of the HIDVA service. For example, we may find A&E activity reduces following referral to the HIDVA service. However, it could be that A&E attendance would have declined for victims in the absence of the HIDVA service meaning the reduction seen is not a true reflection of the impact of the HIDVA service. This would overestimate the impact of the HIDVA service. Alternatively, it could be that A&E attendance would rise in the absence of the HIDVA service meaning the reduction seen is an underestimate of the impact of the HIDVA service.

In the absence of a counterfactual group we present a range of scenarios based on: i) an assumption that activity continues in line with any trend observed in the prior-referral period; ii) an assumption of a 'levelling off' of activity at the level observed in the quarter of referral; and iii) an assumption that activity declines post-referral.

[2] The changes are estimated via regression models using negative binomial regression; this approach is appropriate for the analysis of count health care data, which exhibit pronounced overdispersion (with a small number of individuals accounting for a relatively high share of activity). We adjusted for year of birth, gender and calendar quarter in the analyses to ensure changes in secondary care activity are not reflective of the impacts of ageing, gender, and trends in secondary care activity over time that is unrelated to the HIDVA service.

7.1 A&E attendances

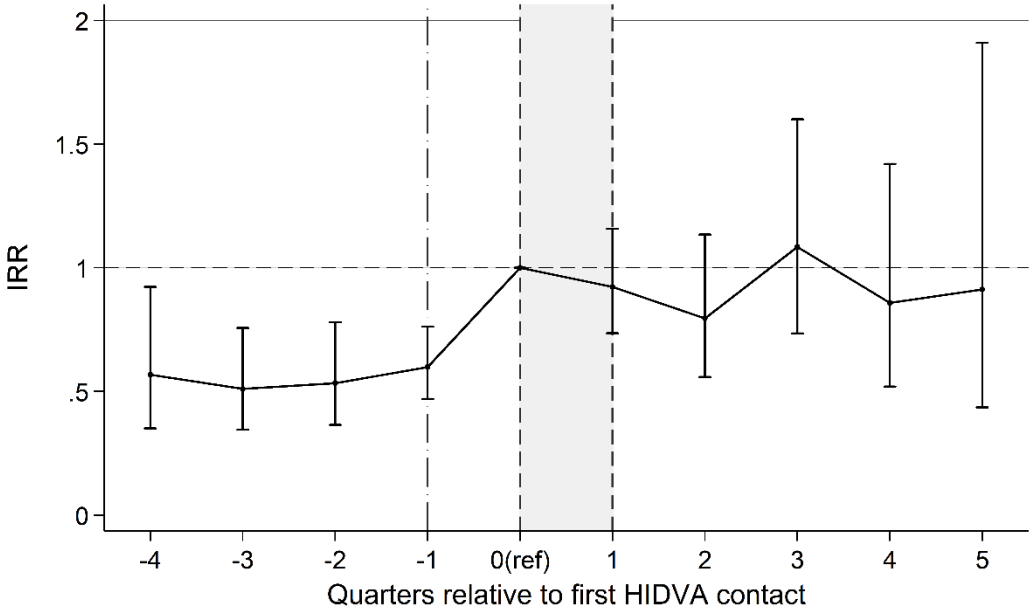
Attendances were rising in the quarters prior to HIDVA referral, and decrease very slightly after contact with service (Figure 6).[3] The decline post-referral is not statistically significant meaning we cannot be confident that the decline is an accurate reflection of the impacts of a HIDVA referral.

Compared to the quarter of referral to the HIDVA service, attendances were: 0.568 times the level at four quarters before HIDVA contact (IRR=0.568, 95% CI [0.350; 0.922]); 0.511 times the level three quarters before (IRR=0.511, 95% CI [0.345; 0.757]); 0.533 times the level two quarters before (IRR=0.533, 95% CI [0.365; 0.779]); and 0.598 times that level in the quarter before HIDVA contact (IRR=0.598, 95% CI [0.470; 0.762]) (Table A1).

Figure 7 provides the rate of attendances (predicted values of attendance) rather than the IRR. These are plotted separately for males and females. These predictions are consistent with the findings above. The general pattern is similar for males and females, but males have a higher level of attendance at each quarter. Figure 7 also provides smoothed predictions to aid in interpretation.

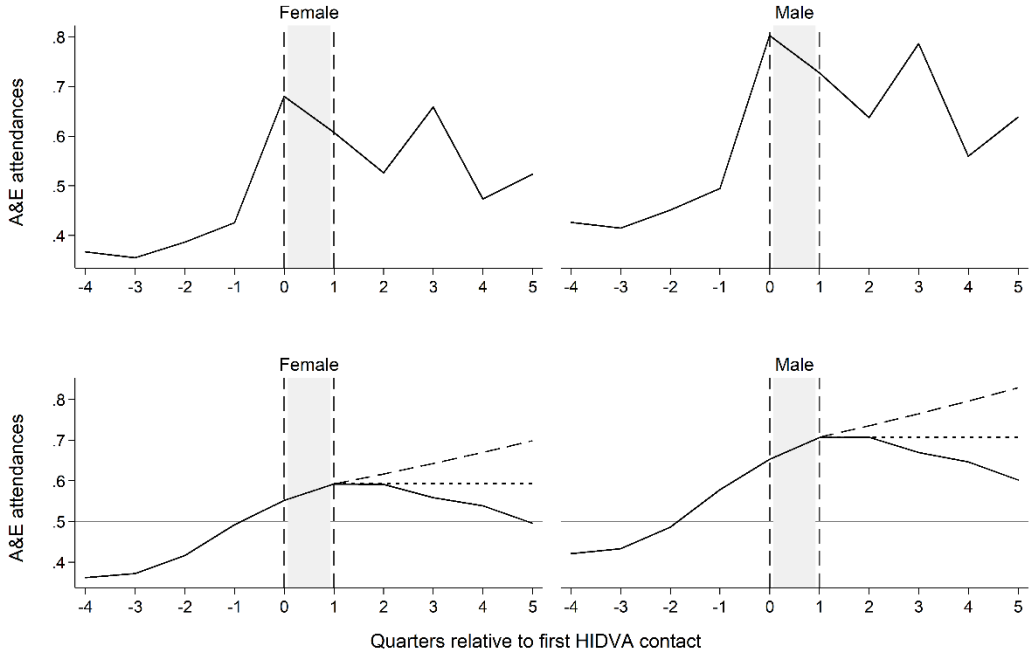
[3] A full set of estimates from the regression analyses are provided in the appendix (Table A1)

Figure 6: Estimates and 95% CIs – time relative to first contact with HIDVA service



Model estimated using negative binomial regression; errors clustered on individual;
model includes event time and (chronological) quarter indicators; and birth year/sex
First HIDVA contact occurs in quarter indicated by grey shading; IRR=1 in quarter=0 (reference)

Figure 7: Predicted values of quarterly A&E attendances relative to HIDVA contact



Notes: First HIDVA contact in the quarter from 0 to 1 (shaded grey); upper figures plot unsmoothed predicted values from regression model; lower figures plot smoothed (i.e. moving average) predicted values of attendances per quarter after controlling for age, sex and quarter using lowess function (locally weighted smoothing); dashed line plots scenario of continuation of pre-trend; dotted line plots scenario of 'levelling off'

7.2 Hospital inpatients (All admissions)

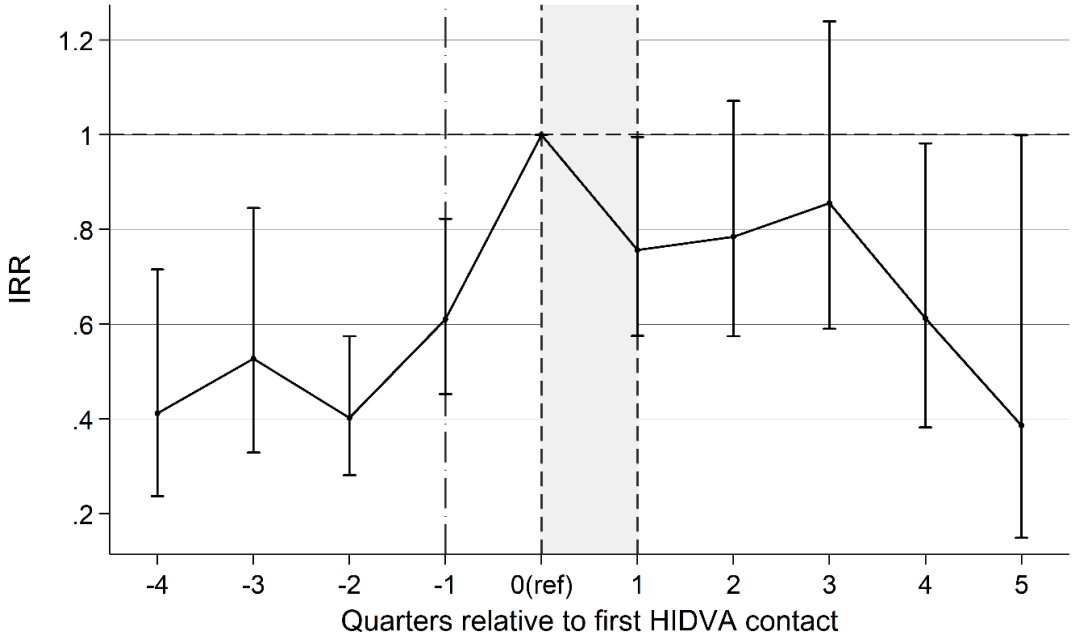
Hospital admissions were rising in the year prior to referral to the HIDVA service, and decrease after contact with the service (Figure 8).[4] The decrease in admissions post referral is not statistically significant for every quarter post referral.

Compared to the quarter of contact with the HIDVA service, admissions were:
Lower (but increasing) in the quarters prior to HIDVA contact – for example 0.412 the level of referral activity four quarters prior (IRR=0.412; 95% CI [0.237; 0.716]), and then 0.610 the level in the quarter prior (IRR=0.610; 95% CI [0.575; 0.995]) (Table A2). Admissions then decrease in the post HIDVA period compared to quarter of HIDVA contact: for example to 0.612 the reference level four quarters later (IRR=0.612; 95% CI [0.382; 0.982]).

Figure 9 shows the estimated volumes of admissions per quarter, plotted separately for males and females. These predictions are consistent with the findings above: attendances decrease after contact with the service – to a level that is lower comparing one year after with a year before contact with the service. Similar to attendances, the profile across these indicators of relative time is similar for males and females - but males have a higher level of admissions.

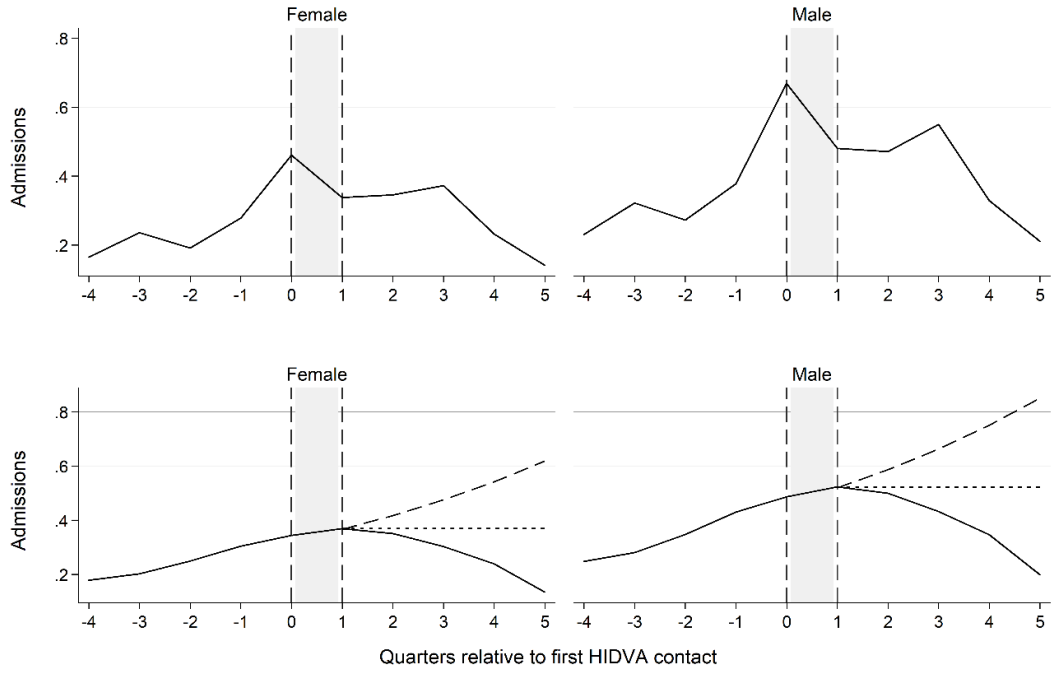
[4] A full set of estimates from the regression analyses are provided in the appendix (Table A2)

Figure 8: Estimates and 95% CIs – time relative to first contact with HIDVA service



Model estimated using negative binomial regression; errors clustered on individual;
model includes event time and (chronological) quarter indicators; and birth year/sex
First HIDVA contact occurs in quarter indicated by grey shading; IRR=1 in quarter=0 (reference)

Figure 9: Predicted values of quarterly admissions relative to HIDVA contact



Notes: First HIDVA contact in the quarter from 0 to 1 (shaded grey); upper figures plot unsmoothed predicted values from regression model; lower figures plot smoothed (i.e. moving average) predicted values of attendances per quarter after controlling for age, sex and quarter using lowess function (locally weighted smoothing); dashed line plots scenario of continuation of pre-trend; dotted line plots scenario of 'levelling off'

7.3 Hospital inpatients (Emergency admissions)

Emergency admissions were rising in the year prior to referral to the HIDVA service, and decrease after contact with the service (Figure 10).[5] The decreases in emergency admissions post referral are statistically significant for most of the quarters post referral.

Compared to the quarter of contact with the service, emergency admissions were lower in the year previous (but increasing): for example, emergency admissions were 0.363 times the reference level four quarters prior (IRR=0.363; 95% CI [0.209; 0.631]); and 0.550 times the reference level one quarter prior (IRR=0.550; 95% CI [0.397; 0.763]) (Table A3). These admissions fall in the year after contact with the service: to 0.581 times the reference level three quarters after (IRR=0.581; 95% CI [0.350; 0.996]); and 0.335 times the reference level four quarters after (IRR=0.335; 95% CI [0.128; 0.878]).

[5] A full set of estimates from the regression analyses are provided in the appendix (Table A3)

Figure 10: Estimates and 95% CIs – time relative to first contact with HIDVA service

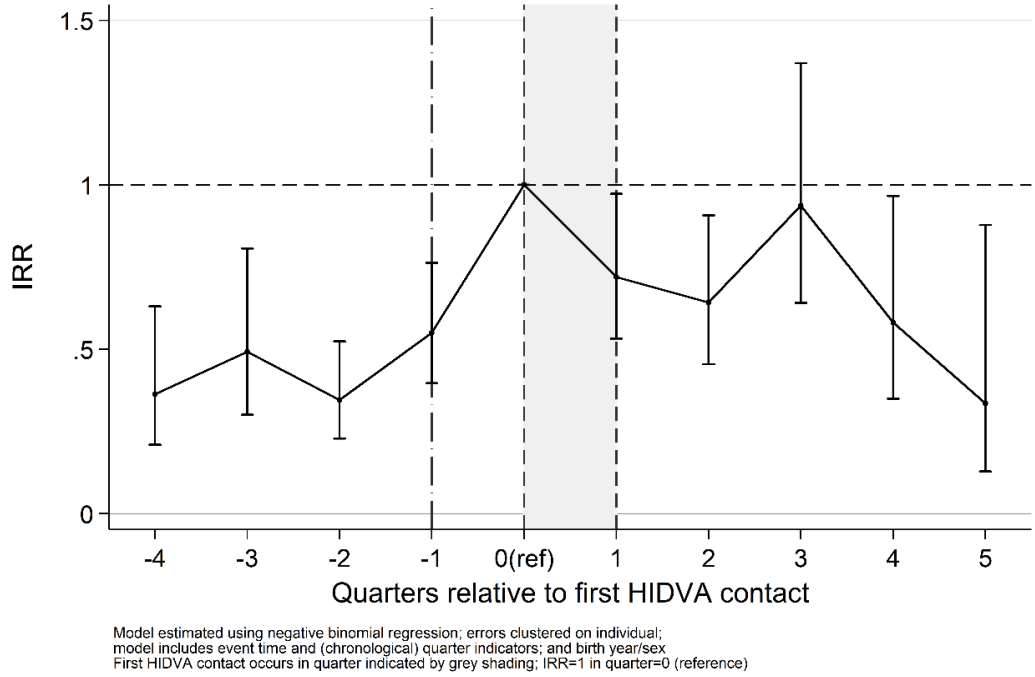
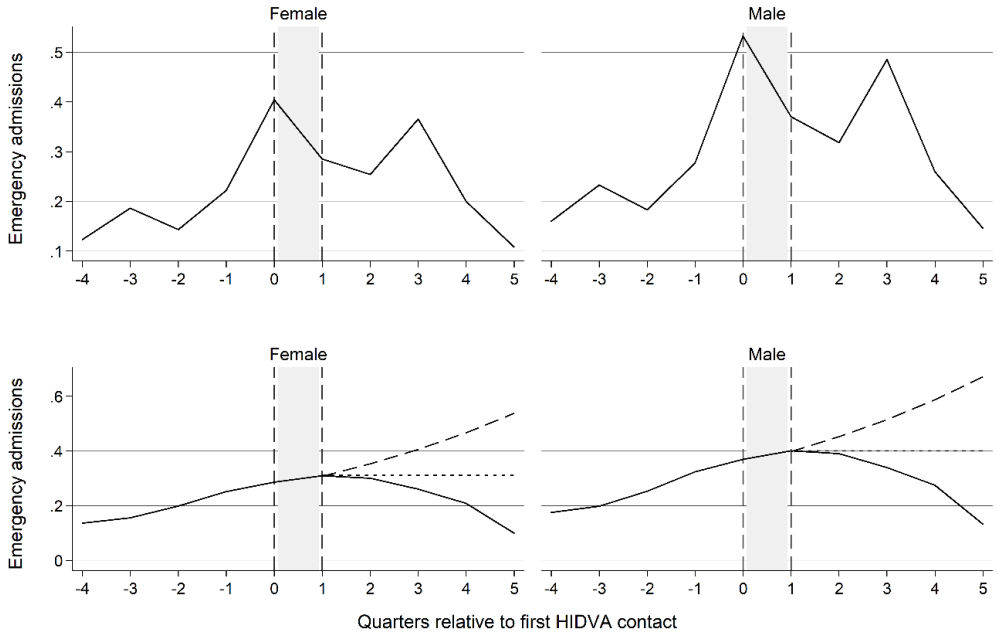


Figure 11: Predicted values of quarterly emergency admissions relative to HIDVA contact



Notes: First HIDVA contact in the quarter from 0 to 1 (shaded grey); upper figures plot unsmoothed predicted values from regression model; lower figures plot smoothed (i.e. moving average) predicted values of attendances per quarter after controlling for age, sex and quarter using lowess function (locally weighted smoothing); dashed line plots scenario of continuation of pre-trend; dotted line plots scenario of 'levelling off'

7.4 Hospital inpatients (Hospital bed days)

Bed days per quarter follow a similar pattern to those seen for all admissions: rising prior to referral to the HIDVA service, and falling the year after – albeit to a level higher than one year before (Figure 12).[6] The decreases post referral are not statistically significant for all but one quarter post referral.

Compared with the quarter of HIDVA contact, quarterly bed days are lower but increasing in the year prior: for example they are 0.185 times the reference level four quarters prior (IRR=0.185; 95% CI [0.088; 0.390]); and then 0.452 times the level one quarter prior (IRR=0.452; 95% CI [0.258; 0.794]) (Table A4). They fall after contact with the service to 0.549 times the reference level three quarters post (IRR=0.549; 95% CI [0.306; 0.986]).

[6] A full set of estimates from the regression analyses are provided in the appendix (Table A4)

Figure 12: Estimates and 95% CIs – time relative to first contact with HIDVA service

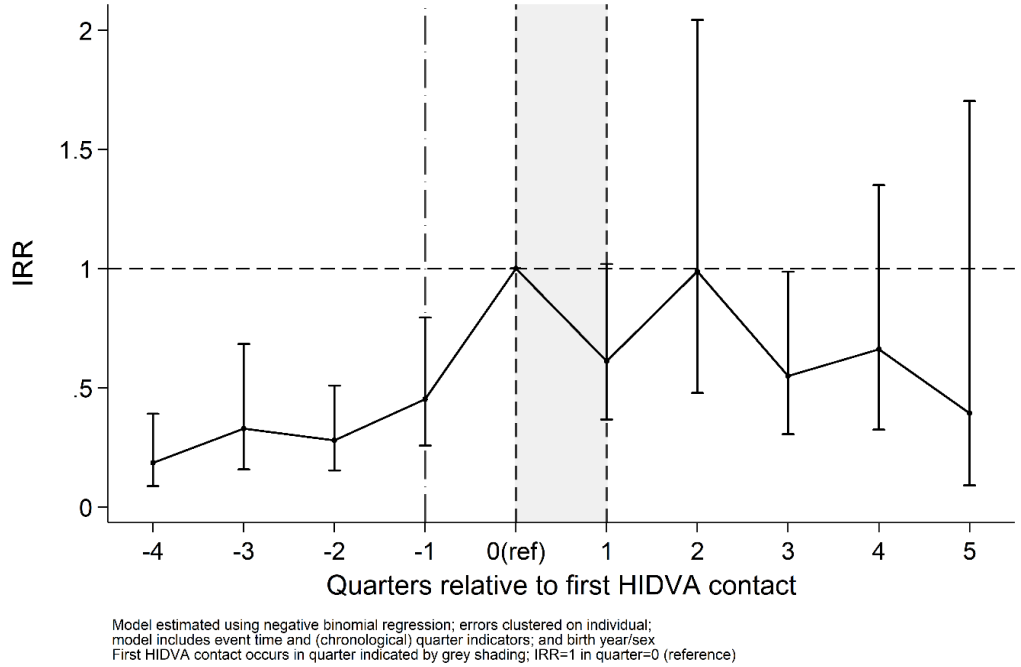
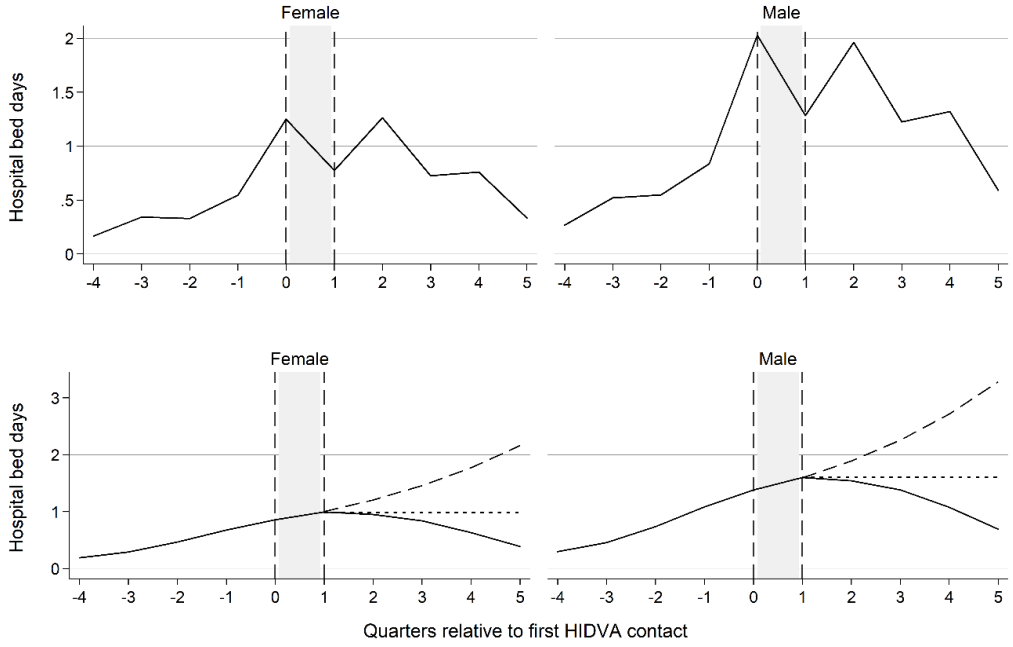


Figure 13: Predicted values of quarterly bed days relative to HIDVA contact



Notes: First HIDVA contact in the quarter from 0 to 1 (shaded grey); upper figures plot unsmoothed predicted values from regression model; lower figures plot smoothed (i.e. moving average) predicted values of attendances per quarter after controlling for age, sex and quarter using lowess function (locally weighted smoothing); dashed line plots scenario of continuation of pre-trend; dotted line plots scenario of 'levelling off'

7.5 Total costs of hospital activity

Quarterly hospital costs per patient were calculated by multiplying each type of activity (elective admissions, daycase admissions, non-elective short and long stays, A&E attendances, and arrivals to A&E via ambulance) with unit costs. Unit costs of hospital activity were taken from the 2018-19 NHS Reference Costs (Table 9).

Table 9: Unit Costs applied to hospital activity

Activity Type	Unit Cost (£)
Elective Inpatients	4,078
Non Elective Inpatients	3,293
Non-Elective Short Stay	589
Day Case	752
Accident & Emergency	166
Ambulance	108

Source: NHS England and Improvement (2020)

Total costs per quarter reflect a combination of the patterns on the other indicators of activity: rising in the quarter prior to referral to the HIDVA service, and falling the year after – albeit to a level higher than one year before (Figure 14).

Compared with the quarter of HIDVA contact, total costs are lower but increasing in the year prior to referral: for example they are 0.359 times the level at referral four quarters prior (IRR=0.359; 95% CI [0.216; 0.596]); and then 0.573 times the level one quarter prior (IRR=0.573; 95% CI [0.407; 0.806]) (Table A5). Whilst the estimates suggest a lower level of overall costs in the year after contact with the service, these estimates are not statistically significant (Table A5).

Figure 14: Estimates and 95% CIs – time relative to first contact with HIDVA service

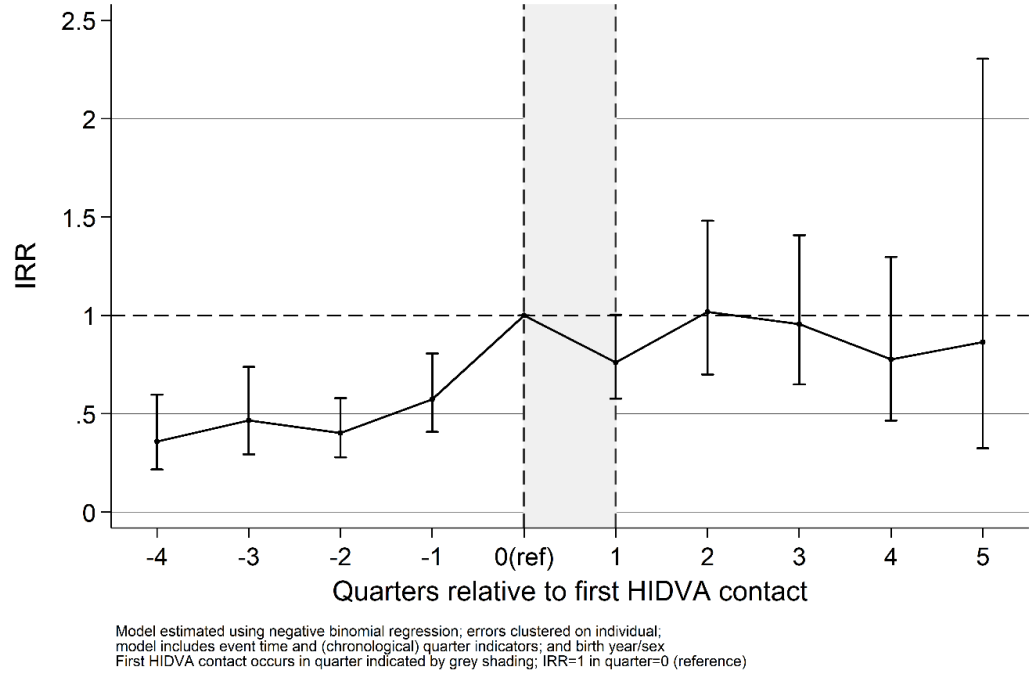
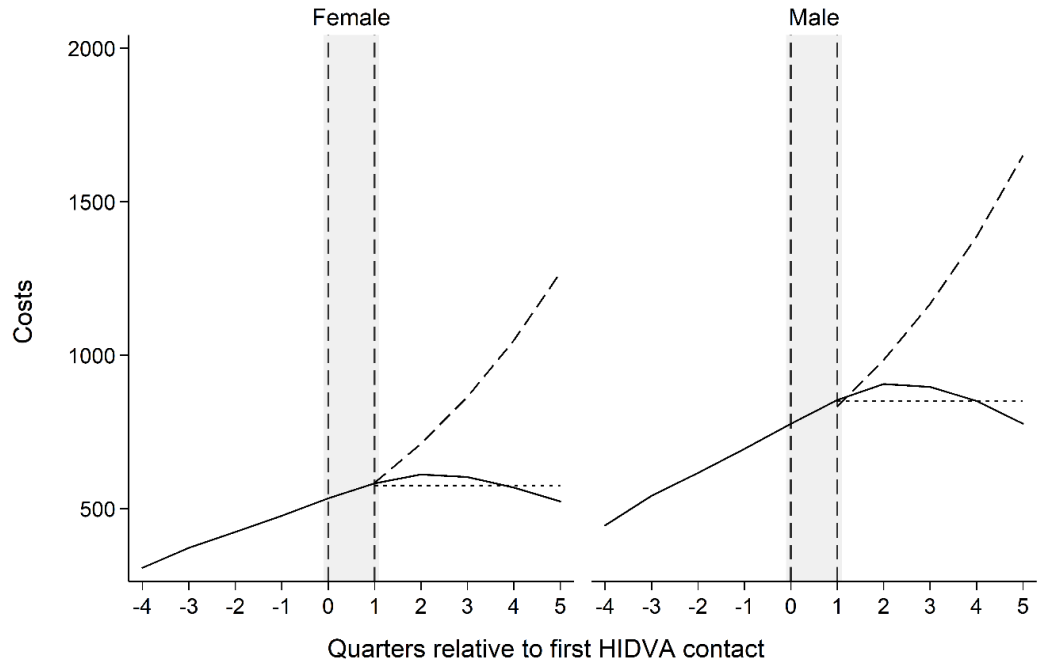


Figure 15: Predicted values of quarterly total hospital costs relative to HIDVA contact



Notes: First HIDVA contact in the quarter from 0 to 1 (shaded grey); figures plot smoothed (i.e. moving average) predicted values of attendances per quarter after controlling for age, sex and quarter using lowess function (locally weighted smoothing); dashed line plots scenario of continuation of pre-trend; dotted line plots scenario of 'levelling off'

7.6 Limitations

Only a subset of patients were included in the hospital activity data constructed for the evaluation and it is unknown whether these patients are more widely representative of this population referred to the HIDVA service beyond the gender distribution. The relatively small sample size also limits the capacity of the evaluation to detect statistically significant differences in the indicators considered. This problem is more pronounced for the quarters after referral to the HIDVA service – there are relatively small numbers of patients who have data on activity one year after referral.

The methods used enables assessments of changes in activity over the periods prior- and post-referral to the HIDVA service. We separate the effects of age, sex, and calendar time to ensure the estimated patterns do not reflect these factors. However, the approach is not comparative – and the lack of data on an appropriate comparison group or area in which the HIDVA service was not introduced limits the capacity of the evaluation to make inferences about the causal effect of the scheme.

All activity was analysed for the study population, and this includes activity unrelated to domestic abuse. It is not possible to clearly ascertain which subset of activity from the data provided could be identified as being attributable to domestic violence.

7.7 Summary

Comparisons of hospital activity prior- and post-referral to the HIDVA service suggest that prior to a referral, there are increases in A&E attendance, inpatient stays, and respective costs attributed to these services. Following a referral to the HIDVA service we found evidence that activity and costs declined but aside from emergency admissions, these were largely insignificant. It is important to note that these effects do not account for activity that may have occurred to these patients had they not been referred to the HIDVA service, in this respect the findings may be either an under- or over-estimate of the impacts of the service on hospital activity.

The findings contrast with the reduction in inpatient activity found in Halliwell et al (2019) and SafeLives (2016) (who adopted a similar before-after comparison), but is in line with these study findings of insignificant impacts on A&E attendances. There are a number of differences between the analyses here and those in SafeLives (2016) and Halliwell et al (2019). First, the sample in this study is much larger (379 compared to 29). Second, the geography is different. Third, the estimation approach differs (here we estimate negative binomial models to account for the count nature of the data and over-dispersion of activity).

7.8 Recommendations

- The evaluation was limited in the ability to identify the causal impacts of the service on hospital activity. An assessment of the full sample of referrals would address any concerns of representativeness of the sample estimated in this study.

8 Costs and cost implications of the HIDVA service

This Chapter addresses the sixth study objective: to examine the cost of providing the HIDVA service to WWLFT.

8.1 Costs of delivering the HIDVA service

The evaluation team were provided with the financial expenditure related to the staff costs of operating the HIDVA service to WWLFT. The costs for the first two years of the service amounted to £116,955 (Table 10). Costs increased in the second year of the service due to the recruitment of a second IDVA to the service and change in Band for the initial IDVA.

Table 10: Operating costs of the WWL HIDVA service

Year	Band 6 IDVA1	Band 6 IDVA2	Band 7 IDVA1	Total
1	1.0 WTE: £39,897	-	-	£39,897
2	-	1.0 WTE: £31,121	1.0 WTE: £45,937	£77,058
Overall				£116,955

Costs do not incorporate the administrative pressures put on Safeguarding

Beyond staff costs, the financial impacts both in terms of service delivery within the Trust and across the health and care sector in the locality were not captured. In this respect, the costs identified may represent an underestimate of the costs the service places on the Trust (which may include, for example, administrative, training and estate costs) and wider health and care economy (which may include, for example, increases in activity at MARAC hearings and social services impacts).

8.2 Consequences of the WWL HIDVA service

The ability to estimate consequences of the HIDVA service were limited to describing the costs of victims' hospital activity before and after contact with the HIDVA service (without a comparison group, Chapter 7). These consequences only describe the cost impact for those having contact with the HIDVA service, without making comparison to what would have happened in the absence of this contact.

The cost analysis in Chapter 7 was replicated but with cost comparisons relating to a year pre- and post-referral to the HIDVA service (rather than quarters). There was no significant change in costs in the year after contact with the service compared with the year leading up to contact (IRR= 1.245; 95% CI [0.975; 1.589]). The equivalent estimate and confidence interval in terms of the value of costs is £112.53 per patient annually (95% CI [-£18.78; £243.84]). In another evaluation of HIDVA services, Cry for Health, £2,050 per client per year was estimated to be saved to the health sector and a rise of £282 to social services, giving savings on the health and social services sectors of £1,768 (Table 11) (SafeLives (2016); Halliwell et al (2019)). However, the estimated cost impacts in this study are potentially biased as the estimates are based on a sample of only 29 survivors accessing a HIDVA service, and assumes effects felt in the 6 months post referral are replicated in months 7-12.

Table 11: Cry for Health estimates of the cost-consequences of HIDVA engagement

Service	Net financial impacts (per annum)
Health sector	
Hospital service use	-£2,184
Ambulance use	-£200
Local surgery use	+£64
Mental health service use	+£196
Drug/alcohol service use	+£74
Total	-£2,050
Social services	+£282
Total	-£1,768

Source: SafeLives (2016); Halliwell et al (2019)

8.3 Limitations

There are limitations associated with the evaluation of costs in this report. The limitations relate to the approach taken to estimate changes in hospital activity, and in terms of the scope of any evidence on hospital costs alone in the context of evaluating the cost consequences of the WWL HIDVA service.

8.3.1 Limitations of the evaluation approach

The evaluation approach has several limitations, most notably, the absence of a comparison group in which costs in the absence of the HIDVA service could be observed. With the data available it was not possible to examine whether costs would have continued to rise in line with the observed trend in the year prior to HIDVA referral, as extrapolated in Figure 15 – or whether they might follow some other trajectory. In addition to this, only one year of data after HIDVA referral was available. The cost consequences of health and care interventions are often delivered and observed over a much longer time horizon and require a longer follow-up to determine impacts on the health and care system and patients. Finally, the evaluation of hospital activity was based on a subsample of patients who we observe for a full year after contact with service – limiting the power of the analyses to obtain precise estimates.

8.3.2 Limitations of scope

Limitations of scope refers to being able to capture the range of cost consequences across both the range of government agencies affected and the valuation of health and wellbeing benefits associated with the HIDVA service. The costs assessment in this report covers only a subset of the costs described by Oliver et al. (2019) (Table 12). Health sector costs comprise around 3.5% of relevant costs, there are much larger financial impacts concerning physical and emotional harm, and lost output (over 92% of the relevant economic impacts).

Table 12: Unit costs of domestic abuse in England and Wales for 2016/17

Costs in anticipation	Costs as a consequence				Costs in response				Total
	Physical/emotional harm	Lost output	Health services	Victim services	Police costs	Criminal legal	Civil legal	Other	
£5	£24,300	£7,245	£1,200	£370	£645	£170	£70	£5	£34,015
0.01%	71.44%	21.30%	3.53%	1.09%	1.90%	0.50%	0.21%	0.01%	*% of total*

Source: Oliver et al. (2019)
Costs that will occur during the average length of abuse for a victim, which is estimated to be three years (SafeLives 2018).

8.4 Summary

Over the period 2018/19 to 2019/20 the HIDVA service cost £116,955 (workforce costs). The costs do not incorporate the resources for administrative support, or training across the Trust; nor do the costs include the impacts the service may place on agencies outside of the hospital.

Patients referred into the HIDVA service were estimated to have greater costs the year following referral (£112.53 per patient), though this was not statistically significant (95% CI [-£18.78; £243.84]). These findings should be treated with caution since the approach is limited in the same aspects as that of Chapter 7, namely due to i) the lack of a comparator group, and ii) the analyses are based on a subset of referrals. In addition, the assessment of costs implications does not incorporate other impacts beyond secondary care activity (such as health and wellbeing). Given health services represent a very small proportion of the costs of domestic violence, the findings here should not be interpreted as implying the HIDVA service is not cost-effective – further analysis is needed to understand the impacts beyond the hospital setting, most notably, on victims health and wellbeing.

The approach taken to estimate the impacts on secondary care costs advances the evidence base in two ways, first, the assessment is based on a larger sample, second, impacts are assessed over a longer time period (1 year rather than 6 months).

8.5 Recommendations

- To ascertain the true economic impact of the service, further evaluation is needed that should consider the impacts of the service over a longer follow-up period, ideally using comparator areas to allow for a stronger design, and to consider impacts across a broader range of domains. For the service to be cost-effective, only small improvements in emotional and physical harms would be required. Future evaluations should examine impacts on these domains.

9 Summary

The HIDVA service was introduced to increase identification of cases of domestic violence and abuse presenting at the Trust. This was to be achieved by increasing staff awareness of domestic violence and abuse indicators and providing the means to make referrals to adequate support.

The HIDVA service appears to have successfully met the aim of increasing identification of cases of domestic violence and abuse in the locality. 938 referrals have been made into the service in the first two years, referrals have grown with workforce capacity and appear to be facilitated by successfully embedding the service within the Trust Safeguading team, raising staff awareness throughout the Trust and providing an appropriate referral pathway. Referrals look to be identifying cases that would be seldom heard in the community, most notably from staff themselves, males and those aged 60+. Referrals are almost exclusively from within the hospital which is in stark contrast to IDVA services nationally where only 3% of referrals there are from hospitals.

The HIDVA service was particularly resilient to the first period of COVID restrictions. The hospital setting provided a safe and secure opportunity for disclosure at a time where there was growing concern of the impacts lockdown measures may have on the prevalence of domestic violence and abuse. Indeed, the service reached new peaks in the volume of referrals, particularly as lockdown eased.

The total workforce cost of the service amounted to £116,955 over the two years, this was for one Band 6 HIDVA in year 1 and a Band 6 and Band 7 HIDVA in year 2. With referrals at 938, the service would only need to have a small positive impact to result in a net benefit to the economy. The evaluation sought to estimate potential impacts of the service on hospital activity, this was problematic for a number of reasons. First, to understand the impacts of the service requires a counterfactual (knowledge of what would have happened in the absence of the service), however, no counterfactual group could be identified in the data because suspected domestic violence and abuse

cases are not recorded in hospital data. Second, larger volumes of referrals over a longer time period are required to improve the precision of the estimated effects. Third, the scope is limited, with impacts likely to extend beyond the hospital sector, most notably, on victims health and wellbeing. The estimated impacts on hospital service use and costs to the Trust presented in this report should therefore be viewed as preliminary with these limitations in mind. It is important to note that the same limitations can be made to other published studies in this area.

9.1 Recommendations

General recommendations	
1	There is a need across NHS Trusts for greater awareness, improved identification of, and support (referral and case management) for, victims of domestic violence and abuse. These findings suggest that a HIDVA service is an appropriate and effective way of meeting this need. Other Trusts should consider setting up a HIDVA service.
2	Seek to recruit an experienced IDVA, with training (national qualification) and a background in community working. A network of relevant community organisations beyond the hospital and ability to make decisions rapidly in a crisis situation, are key to making appropriate, timely referrals.
3	Embed HIDVAs within the Trust, as permanent employees. Spread their involvement across as many relevant clinical areas as possible, rather than locating them in one department such as A&E.
4	Ensure that frontline staff are able to refer to the HIDVA service proactively – ensure they are trained in awareness of domestic violence indicators and promote the HIDVA service throughout the Trust so that staff refer to it.
5	Consider whether systems are in place to accommodate the issues raised (e.g. SARC), to enable maximum impact from the HIDVA's skills to be realised.
6	Review the current situation with domestic violence and abuse disclosures amongst staff at the Trust – are these frequently disclosed and supported within the Trust? If not, consider how staff disclosures will be supported and who will carry these cases, the HIDVA or other (e.g. community IDVAs).

7	Particular regard should be paid to the potential for HIDVA services to identify previously unmet need for domestic violence and abuse services when assessing the value of a HIDVA service. This unmet need was anecdotally evident for male patients and staff members within the Trust itself.
8	The service appears to be a valuable resource within which to identify and address an unmet need for domestic violence and abuse services in the locality and may help reduce inequalities in access to IDVA services, particularly for those aged 40+ and males. This should be considered when appraising the service.
9	Monitoring of referrals and support workload for the HIDVAs would help to understand whether further HIDVAs are required.
10	The service had 938 referrals in the first two years, 72% of these received support by the HIDVA service. As referrals grow so too will support needs. The stresses this may place on the HIDVAs should be monitored and where possible, solutions to reduce workload should be considered (such as dedicated administrative support).
11	The HIDVA service was particularly resilient to the first period of COVID-19 restrictions. The hospital setting looks to have provided a safe and secure opportunity for disclosure at a time where there was growing concern of the impacts lockdown measures may have on the prevalence of domestic violence and abuse. Indeed, the service experienced new peaks in the volume of referrals, particularly as lockdown eased. This suggests the service may prove to be an important tool to address rises in domestic violence and abuse during lockdown periods.
Future work	
12	The evaluation was limited in the ability to identify the causal impacts of the service on hospital activity. An assessment of the full sample of referrals would address any concerns of representativeness of the sample estimated in this study.
13	To ascertain the true economic impact of the service, further evaluation is needed that should consider the impacts of the service over a longer follow-up period, ideally using comparator areas to allow for a stronger design, and to

	consider impacts across a broader range of domains. For the service to be cost-effective, only small improvements in emotional and physical harms would be required. Future evaluations should examine impacts on these domains.

10 References

Greater Manchester Police (2020) *Domestic Abuse and Rape, Sexual Assault.* Available at: https://www.gmp.police.uk/SysSiteAssets/media/downloads/greater-manchester/stats-and-data/da-and-sexual-assault/gmp-da-and-rape-sexual-assault-data-2018-19.pdf

Halliwell G, Dheensa S, Fenu E, Jones SK, Asato J, Jacob S, Feder G (2019) Cry for health: a quantitative evaluation of a hospital-based advocacy intervention for domestic violence and abuse. *BMC Health Services Research*, 19:718.

Hoffmann TC, Glasziou PP, Boutron I et al. (2014) Better reporting of interventions: template for intervention description and replication (TIDieR) checklist and guide. *BMJ*, 348.

Home Office (2005) *National Domestic Violence Delivery Plan.* London: Home Office

Howarth E, Stimpson L, Barran D, Robinson A (2009) *Safety in Numbers. A Multi-site Evaluation of Independent Domestic Violence Advisor Services.* Available at: https://safelives.org.uk/sites/default/files/resources/Safety_in_Numbers_full_report.pdf

NHS England and NHS Improvement (2020) *National Cost Collection, London: NHS England and NHS Improvement.* Available at: https://www.england.nhs.uk/wp-content/uploads/2020/08/1_-_NCC_Report_FINAL_002.pdf

NICE (2016) *Domestic violence and abuse. Quality Standard (QS 116). Published 29 February 2016.* Available at: https://www.nice.org.uk/guidance/qs116/resources/domestic-violence-and-abuse-pdf-75545301469381

Oliver R, Alexander B, Roe S, Wlansy M (2019) *The economic and social costs of domestic abuse.* Home Office Research Report 107.

ONS (2019a) *Domestic abuse prevalence and trends, England and Wales: year ending March 2019. Prevalence, long-term trends and types of domestic abuse experienced by adults, based on findings from the Crime Survey for England and Wales, and police recorded crime.* Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/domesticabuseprevalenceandtrendsenglandandwales/yearendingmarch2019

ONS (2019b) *Domestic abuse victim characteristics, England and Wales: year ending March 2019. Characteristics of victims of domestic abuse based on findings from the Crime Survey for England and Wales and police recorded crime.* Available at:https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/domesticabusevictimcharacteristicsenglandandwales/yearendingmarch2019

ONS (2019c) *Domestic abuse in England and Wales – Data Tool.* Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/datasets/domesticabuseinenglandandwalesdatatool

ONS (2020a) *Estimates of the population for the UK, England and Wales, Scotland and northern Ireland.* Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/populationestimatesforukenglandandwalesscotlandandnorthernireland

ONS (2020b) *Crime in England and Wales: year ending March 2020. Crime against households and adults, also including data on crime experienced by children, and crimes against businesses and society.* Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/bulletins/crimeinenglandandwales/yearendingmarch2020

Pathfinder (2020) *Enhancing the response to domestic abuse across health settings. Pathfinder Key Findings Report, June 2020.* Available at: https://safelives.org.uk/health-pathfinder

SafeLives (2014) *National Definition of IDVA work.* Available at: https://safelives.org.uk/sites/default/files/resources/National%20definition%20of%20IDVA%20work%20FINAL.pdf

SafeLives (2016) *A Cry for Health. Why we must invest in domestic abuse services in hospitals.* Available at: https://safelives.org.uk/sites/default/files/resources/SAFJ4993_Themis_report_WEBcorrect.pdf

SafeLives (2018a) *Barnet, Enfield and Haringey Mental Health NHS Trust: Mental Health Idva pilot evaluation 2018 (LINKS).* Available at: https://safelives.org.uk/sites/default/files/resources/BEH-MHT%20LINKS%20pilot%20evaluation.pdf

SafeLives (2018b) *SafeLive's 2017 survey of domestic abuse practitioners in England and Wales.* Available at: https://safelives.org.uk/sites/default/files/resources/National%20definition%20of%20IDVA%20work%20FINAL.pdf

SafeLives (2019) *Insights IDVA England and Wales dataset 2018-19. Adult independent domestic violence advisor (IDVA) services*. Available at: https://safelives.org.uk/sites/default/files/resources/Idva%20NDS%20201819.pdf

WWLFT (2019) *The WWL IDVA Service. The first 12 months.* (Not in the public domain).

WWLFT (2020) *Evaluation of WWLTH Hospital IDSVA Service. The Second Year.* (Not in the public domain).

10 Appendix

Table A1: Regression estimates (A&E attendances)

N= 2,610 observations on n=341 patients						
	IRR	**Robust SE**	**z**	**P>z**	**[95% CI]**	
Year of Birth	1.003	0.003	1.010	0.312	0.997	1.009
Male	1.201	0.190	1.160	0.247	0.881	1.639
Calendar time (quarters) [reference = Q1 2019]						
Q1 2017	0.772	0.612	-0.330	0.744	0.163	3.653
Q2 2017	<0.001	<0.001	-30.810	<0.001	<0.001	<0.001
Q3 2017	0.534	0.494	-0.680	0.498	0.087	3.279
Q4 2017	0.731	0.345	-0.660	0.507	0.290	1.844
Q1 2018	0.905	0.299	-0.300	0.762	0.474	1.729
Q2 2018	1.059	0.254	0.240	0.809	0.663	1.694
Q3 2018	1.098	0.201	0.510	0.610	0.767	1.571
Q4 2018	1.100	0.151	0.700	0.485	0.841	1.440
Q2 2019	1.301	0.231	1.480	0.138	0.919	1.841
Q3 2019	1.076	0.195	0.400	0.686	0.754	1.536
Q4 2019	0.803	0.186	-0.950	0.342	0.510	1.263
Q1 2020	0.857	0.256	-0.520	0.606	0.477	1.540
Event time (quarters) [reference = 0]						
-4	0.568	0.140	-2.290	0.022	0.350	0.922
-3	0.511	0.102	-3.350	0.001	0.345	0.757
-2	0.533	0.103	-3.250	0.001	0.365	0.779
-1	0.598	0.074	-4.170	0.000	0.470	0.762
1	0.923	0.107	-0.690	0.488	0.735	1.158
2	0.796	0.144	-1.260	0.206	0.558	1.134
3	1.084	0.215	0.410	0.684	0.735	1.600
4	0.859	0.220	-0.590	0.552	0.519	1.420
5	0.913	0.344	-0.240	0.808	0.436	1.910
/lnalpha	0.682	0.149			0.391	0.973
alpha	1.978	0.294			1.478	2.647

Model estimated using negative binomial regression; standard errors clustered on individual; alpha/lnalpha=dispersion parameters

Table A2: Regression estimates (all admissions)

N=2,218 observations on n=289 patients						
	IRR	**Robust SE**	**z**	**P>z**	**[95% CI]**	
Year of Birth	0.990	0.004	-2.730	0.006	0.983	0.997
Male	1.305	0.331	1.050	0.295	0.793	2.147
Calendar time (quarters) [reference = Q1 2019]						
Q1 2017	1.659	1.299	0.650	0.518	0.357	7.700
Q2 2017	<0.001	<0.001	-25.510	<0.001	<0.001	<0.001
Q3 2017	<0.001	<0.001	-32.880	<0.001	<0.001	<0.001
Q4 2017	0.435	0.209	-1.730	0.083	0.170	1.116
Q1 2018	0.685	0.288	-0.900	0.368	0.300	1.563
Q2 2018	1.203	0.335	0.660	0.506	0.698	2.075
Q3 2018	0.783	0.166	-1.150	0.249	0.517	1.187
Q4 2018	1.014	0.184	0.080	0.940	0.711	1.446
Q2 2019	0.915	0.156	-0.520	0.603	0.655	1.279
Q3 2019	1.195	0.210	1.010	0.310	0.847	1.686
Q4 2019	0.787	0.145	-1.300	0.193	0.548	1.129
Q1 2020	0.768	0.157	-1.290	0.196	0.515	1.146
Event time (quarters) [reference = 0]						
-4	0.412	0.116	-3.150	0.002	0.237	0.716
-3	0.527	0.127	-2.660	0.008	0.329	0.845
-2	0.402	0.073	-5.000	0.000	0.281	0.575
-1	0.610	0.093	-3.240	0.001	0.453	0.822
1	0.757	0.106	-1.990	0.046	0.575	0.995
2	0.785	0.125	-1.520	0.127	0.575	1.072
3	0.856	0.162	-0.820	0.410	0.590	1.240
4	0.612	0.147	-2.040	0.042	0.382	0.982
5	0.386	0.187	-1.960	0.050	0.149	0.999
/lnalpha	0.092	0.207			-0.313	0.498
alpha	1.097	0.227			0.731	1.646

Model estimated using negative binomial regression; standard errors clustered on individual; alpha/lnalpha=dispersion parameters

Table A3: Regression estimates (emergency admissions)

N=2,218 observations on n=289 patients						
	IRR	**Robust SE**	**z**	**P>z**	**[95% CI]**	
Year of Birth	0.993	0.003	-2.140	0.033	0.986	0.999
Male	1.221	0.243	1.000	0.317	0.826	1.804
Calendar time (quarters) [reference = Q1 2019]						
Q1 2017	2.327	1.877	1.050	0.295	0.479	11.304
Q2 2017	0.000	0.000	-24.670	0.000	0.000	0.000
Q3 2017	0.000	0.000	-31.840	0.000	0.000	0.000
Q4 2017	0.498	0.258	-1.350	0.178	0.180	1.373
Q1 2018	0.584	0.310	-1.010	0.311	0.207	1.651
Q2 2018	1.270	0.362	0.840	0.401	0.727	2.221
Q3 2018	0.873	0.207	-0.570	0.568	0.548	1.391
Q4 2018	1.098	0.234	0.440	0.661	0.723	1.667
Q2 2019	1.072	0.199	0.370	0.710	0.745	1.542
Q3 2019	1.274	0.229	1.340	0.179	0.895	1.813
Q4 2019	0.935	0.175	-0.360	0.720	0.648	1.349
Q1 2020	0.825	0.177	-0.900	0.370	0.542	1.256
Event time (quarters) [reference = 0]						
-4	0.363	0.102	-3.600	0.000	0.209	0.631
-3	0.492	0.124	-2.820	0.005	0.300	0.806
-2	0.346	0.073	-5.010	0.000	0.228	0.524
-1	0.550	0.092	-3.580	0.000	0.397	0.763
1	0.720	0.111	-2.140	0.032	0.532	0.973
2	0.642	0.113	-2.510	0.012	0.454	0.907
3	0.937	0.181	-0.340	0.737	0.641	1.370
4	0.581	0.151	-2.090	0.036	0.350	0.966
5	0.335	0.165	-2.230	0.026	0.128	0.878
/lnalpha	-0.015	0.239			-0.484	0.453
alpha	0.985	0.235			0.617	1.573

Model estimated using negative binomial regression; standard errors clustered on individual; alpha/lnalpha=dispersion parameters.

Table A4: Regression estimates (bed days)

N=2,218 observations on n=289 patients						
	IRR	**Robust SE**	**z**	**P>z**	**[95% CI]**	
Year of Birth	0.979	0.005	-4.570	0.000	0.970	0.988
Male	1.375	0.396	1.110	0.268	0.782	2.419
Calendar time (quarters) [reference = Q1 2019]						
Q1 2017	0.000	0.000	-25.700	0.000	0.000	0.000
Q2 2017	0.000	0.000	-26.260	0.000	0.000	0.000
Q3 2017	0.000	0.000	-35.870	0.000	0.000	0.000
Q4 2017	0.660	0.468	-0.590	0.557	0.164	2.649
Q1 2018	0.378	0.205	-1.790	0.073	0.131	1.095
Q2 2018	1.679	0.722	1.200	0.228	0.723	3.898
Q3 2018	0.801	0.267	-0.670	0.505	0.417	1.539
Q4 2018	1.228	0.430	0.590	0.558	0.618	2.437
Q2 2019	1.245	0.349	0.780	0.433	0.719	2.155
Q3 2019	1.670	0.482	1.780	0.076	0.949	2.941
Q4 2019	1.553	0.540	1.270	0.205	0.786	3.071
Q1 2020	0.860	0.288	-0.450	0.653	0.446	1.657
Event time (quarters) [reference = 0]						
-4	0.185	0.071	-4.430	0.000	0.088	0.390
-3	0.328	0.123	-2.970	0.003	0.158	0.684
-2	0.279	0.085	-4.170	0.000	0.153	0.509
-1	0.452	0.130	-2.760	0.006	0.258	0.794
1	0.611	0.159	-1.890	0.059	0.367	1.018
2	0.988	0.366	-0.030	0.974	0.478	2.043
3	0.549	0.164	-2.010	0.045	0.306	0.986
4	0.661	0.241	-1.140	0.256	0.324	1.350
5	0.393	0.294	-1.250	0.212	0.091	1.703
/lnalpha	2.495	0.076			2.347	2.644
alpha	12.124	0.919			10.450	14.067

Model estimated using negative binomial regression; standard errors clustered on individual; alpha/lnalpha=dispersion parameters.

Table A5: Regression estimates (total hospital costs)

N=2,218 observations on n=289 patients						
	IRR	**Robust SE**	**z**	**P>z**	**[95% CI]**	
Year of Birth	0.987	0.004	-3.280	0.001	0.979	0.995
Male	1.323	0.354	1.040	0.296	0.783	2.235
Calendar time (quarters) [reference = Q1 2019]						
Q1 2017	0.917	0.823	-0.100	0.923	0.158	5.328
Q2 2017	0.000	0.000	-36.810	0.000	0.000	0.000
Q3 2017	0.125	0.115	-2.260	0.024	0.021	0.757
Q4 2017	0.498	0.259	-1.340	0.180	0.180	1.379
Q1 2018	0.593	0.221	-1.400	0.160	0.286	1.230
Q2 2018	1.268	0.358	0.840	0.400	0.729	2.206
Q3 2018	0.794	0.173	-1.060	0.288	0.518	1.216
Q4 2018	0.974	0.209	-0.120	0.903	0.640	1.484
Q2 2019	1.114	0.210	0.570	0.566	0.770	1.611
Q3 2019	1.142	0.232	0.650	0.513	0.767	1.700
Q4 2019	0.820	0.177	-0.920	0.357	0.537	1.252
Q1 2020	0.737	0.180	-1.250	0.212	0.457	1.190
Event time (quarters) [reference = 0]						
-4	0.359	0.093	-3.950	0.000	0.216	0.597
-3	0.466	0.109	-3.250	0.001	0.294	0.738
-2	0.402	0.075	-4.880	0.000	0.279	0.579
-1	0.573	0.100	-3.200	0.001	0.407	0.806
1	0.761	0.107	-1.940	0.053	0.577	1.003
2	1.018	0.195	0.090	0.926	0.699	1.481
3	0.956	0.189	-0.230	0.819	0.649	1.407
4	0.776	0.203	-0.970	0.333	0.465	1.297
5	0.864	0.432	-0.290	0.770	0.324	2.304
/lnalpha	3.080	0.048			2.987	3.173
alpha	21.759	1.037			19.817	23.890

Model estimated using negative binomial regression; standard errors clustered on individual; alpha/lnalpha=dispersion parameters.

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