

Independent Domestic Violence Advisors (IDVAs) in Surrey Hospitals Evaluation

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EST 1892 **LSBU**

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Executive Summary

In March 2021, Surrey County Council (SCC) commissioned London South Bank University to conduct an evaluation of their pilot programme of hospital-based Independent Domestic Abuse Advisors (IDVAs). The pilot, a collaboration between SCC, local health commissioners, Domestic Abuse Outreach providers and NHS Accident and Emergency (A & E) Trusts, aimed to help Surrey hospitals better respond to Domestic Abuse (DA). As part of the pilot programme, hospital-based IDVAs were introduced for the first time as staff members across four Surrey health providers: Epsom Hospital, Royal Surrey Foundation NHS Trust, Surrey and Sussex Healthcare NHS Trust and Ashford and St Peter's Hospital. This report details the findings from the evaluation.

The purpose of the evaluation was to assess the impact of hospital-based IDVAs in Surrey with reference to five Key Performance Indicators (KPIs):

1. Trust staff are confident in identifying and safely enquiring with patients about DA and know how to seek support within the Trust with DA-related matters.
2. DA survivors supported by the IDVAs have access to the right information, services, and support, at the right time, in the right place, at the earliest opportunity, through clearly defined referral pathways.
3. IDVAs enhance the Trusts' Safeguarding response to DA.
4. DA survivors feel enabled to access IDVA and outreach support services. DA survivors are viewed as experts by experience and their feedback on the IDVA service informs the delivery of IDVA services.
5. IDVA data collection in the Trusts provides the Trusts and Commissioners with a better understanding of the level of DA need in Surrey.

Ethical approval was obtained from London South Bank University's ethics committee and SCC ethics to conduct the evaluation using a multi-methods approach. This involved interviewing survivors of domestic abuse who had experience of the Hospital IDVA (HIDVA) services. Focus groups were also offered to NHS staff and the IDVAs. The qualitative aspect of the data collection occurred in two phases, the first was after ethical approval was obtained and the second approximately 12 months later. Quantitative data was collected using a bespoke workbook which was created collaboratively between SCC and the evaluation team. The workbook collected pseudonymised data for survivors who had consented to data being used for research and evaluation. Part of the IDVA role included training for NHS staff and a questionnaire was devised and administered by SCC to capture the impact of this training on staff confidence and knowledge in relation to domestic abuse.

A Resource Use Survey was also developed in conjunction with the LSBU evaluation team, commissioners and HIDVAs. This survey was designed to measure the potential impact of the HIDVA service on DA survivors use of wider societal resources. In particular the survey sought to measure the impact of the HIDVA intervention and service model on resources associated with the criminal justice system (i.e Police call outs) , the health care system (i.e visits to Accident and Emergency) and social care and support more generally. The E-survey was made available to users of HIDVA services and respondents were asked to complete the survey for a period prior to their involvement with the HIDVA service and post their involvement with the service, to ascertain the impact of any changes to their receipt of wider services arising from the HIDVA support.

Engaging participants in the qualitative element of the evaluation proved challenging. Only nine staff and survivors participated in interviews/focus groups. Similarly, only 16 completed the Resource Use Survey available to users of HIDVA services. Data from the workbook and the training questionnaire was far more encouraging, but caution should be used about the generalisability of the data.

Results showed that the IDVAs understanding of their role sits closely with SCCs definition and that the IDVAs are contributing to the Trust in the ways expected. A total of 48 NHS Staff across the Trusts referred themselves to HIDVA services with the number almost doubling in the second year. This indicates that staff have trust and confidence in the services provided.

The training provided was also impactful with attendees reporting increased confidence in asking questions and managing disclosures around domestic abuse as well as increased understanding of domestic abuse issues.

The IDVAs are also adept and NHS staff confident in at identifying nonphysical abuse i.e. offences that do not leave visible marks. This is likely to have a positive impact on accurate assessments (including risk assessments) and the suitability of referrals to HIDVA services.

Disappointingly only 16 respondents completed the pre and post HIDVA Resource Use survey. This limits the ability to assess the impact of the HIDVA service model on wider societal resource use across health, social care and the criminal justice system and to be able to report on whether the HIDVA service model provides good value for money or if it is cost effective. However, though limited in terms of a response rate, the data may provide some encouraging early findings around reducing risk, increasing wellbeing, promoting access to health care (and professionals) and promoting economic independence for DA survivors.

Introduction

In March 2021, Surrey County Council (SCC) commissioned London South Bank University to conduct an evaluation of their pilot programme of hospital-based Independent Domestic Abuse Advisors (IDVAs). The pilot, a collaboration between SCC, local health commissioners, Domestic Abuse Outreach providers and NHS Accident and Emergency (A & E) Trusts, aimed to help Surrey hospitals better respond to domestic abuse. It formed part of the [Surrey Against Domestic Abuse Strategy 2018-2023](#) and as such reflected the vision contained therein that 'every adult and child experiencing domestic abuse be seen, safe and heard, and free from harm caused by perpetrator behaviour'.

Established in Britain in 2005 (Howarth and Robinson 2016), IDVAs are specialist professionals who work to address the safety of victim/survivors who experience abuse from intimate partners, ex-partners, or family members. They are typically victim/survivors first point of contact, and the intervention is designed to be delivered from the point of crisis and is focused on addressing immediate risks to safety and barriers to service utilization (Safelives 2014).

As part of the pilot programme, hospital-based IDVAs were introduced for the first time as staff members across four Surrey health providers: Epsom Hospital, Royal Surrey Foundation NHS Trust, Surrey and Sussex Healthcare NHS Trust and Ashford and St Peter's Hospital. The Surrey-based IDVAs were recruited to provide *'support and advice to victims of domestic violence (and abuse) within hospitals. Link individuals and families to longer-term community-based support. Provide hospital staff with expert training so that they have the confidence to ask about domestic abuse'* (Safelives no date).

The purpose of the evaluation was to assess the impact of hospital-based IDVAs in Surrey with reference to five Key Performance Indicators (KPIs):

1. Trust staff are confident in identifying and safely enquiring with patients about Domestic Abuse (DA) and know how to seek support within the Trust with DA-related matters.
2. DA survivors supported by the IDVAs have access to the right information, services and support, at the right time, in the right place, at the earliest opportunity, through clearly defined referral pathways.
3. IDVAs enhance the Trusts' Safeguarding response to DA.
4. DA survivors feel enabled to access IDVA and outreach support services. DA survivors are viewed as experts by experience and their feedback on the IDVA service informs the delivery of IDVA services.
5. IDVA data collection in the Trusts provides the Trusts and Commissioners with a better understanding of the level of DA need in Surrey.

This report is structured so that it begins with a detailed explanation of the methodology. The findings will then be considered against the five KPIs outlined above before reporting on the Resource Use Survey. This Resource Use Survey measured the potential economic and social impact of the HIDVA service on DA survivors. It includes data on the DA Survivors use of wider societal resources, (whether this be visits to their General Practitioner or Police Call outs or visits to Accident and Emergency), as well as data that reports DA Survivors current social support, living situation, access to employment and benefits and their overall

wellbeing and perception of risk. The report will then move to look at the limitations of the evaluation project before discussing the results and making recommendations based on the learning from this evaluation.

Methodology

A multi-methods approach was proposed which included qualitative and quantitative data collection. There were two phases to the data collection. The first began immediately after the launch of the project and ran from May 2021 until March 2022 (Phase 1). The second phase covered the period April 2022 until April 2023 (Phase 2). Identifying and recruiting participants for all aspects of the evaluation was the responsibility of SCC.

The proposal for the qualitative element in Phase 1 of the evaluation involved a focus group with IDVAs from across the four hospitals, a focus group with NHS staff who referred patients to the service and interviews with victim/survivors who had engaged with the HIDVA services. The intention was to repeat this qualitative element in Phase 2 alongside an additional Work Package (WP 7) that involved presenting the preliminary findings from Phase 1 and 2 to an Advisory Group consisting of victim/survivors of domestic abuse. The purpose here was to capture important insights from experts by experience and thus ensure that the findings from the evaluation echoed victim/survivors' lived experiences.

Ethical approval for the evaluation was obtained from London South Bank University's ethics committee.

Work Package 1: Interviews with survivors: Regrettably, the recruitment of suitable participants to act as interviewees proved challenging. Only six victim/survivors of domestic abuse who had used HIDVA services were identified and referred to the evaluation team. Each potential participant was initially contacted via email with information about the evaluation and a request to complete a consent form. If no response was obtained a second email was sent and if still no response this was typically followed up with either a text or a voice call to the mobile number provided. Of the six participants who were approached only three were interviewed, two did not respond to the correspondence and one interview did not progress to safeguarding concerns. This decision was made by the PI in collaboration with the referring HIDVA. It is important to bear in mind that such issues around securing interviewees is common in research involving survivors of domestic abuse as the trauma of being interviewed has the '*potential to bring up emotionally disturbing and painful memories for victims as participants*' (McGarry and Ali 2016 p 471).

Nevertheless, of the three survivors who engaged in the evaluation, two were interviewed by the evaluation team, and the third by the Manager of the Analysis and Evaluation Team at SCC. This was because the participant had English as a second language and the staff member spoke the survivor's mother tongue. In this instance, professional transcription was not possible, rather the interviewer made detailed notes immediately after the interview.

Work Packages 2 and 3: Focus Groups (IDVAs & NHS Staff). Two focus groups were organised with the IDVAs. In Phase 1 all four named IDVAs participated in the focus group. In Phase 2, only two IDVAs responded to the email invitations. Given the limited numbers of participants across the project the evaluation team agreed to interview each of these participants separately to accommodate their availability. The focus group for NHS staff totalled two participants in Phase 1. Nobody attended the focus group scheduled for Phase

2. This means that nine participants (IDVAs, NHS staff and survivors) engaged in the qualitative analysis of this evaluation (i.e., WP 1, 2 & 3)

Work Package 4: Training. The IDVAs were also instrumental in training staff across all four NHS Trusts. SCC staff designed a questionnaire to evaluate impact and the IDVA trainers were responsible for distributing and collecting the questionnaires at the end of each training session. The questionnaires collected information about the staff who attended the training (e.g., the department in which they worked, their role within it etc.). Each participant was invited to rate their experiences of the training, and their understanding of the referral process, the IDVA role and its value to the Trusts. Attendees were also asked to grade their knowledge and confidence using a Lickert Scale of six indicators namely (i) *I am confident in defining domestic abuse*, (ii) *I am familiar with the concept of coercive control*, (iii) *I am aware of the reasons why survivors might choose not to disclose domestic abuse*, (iv) *I am aware of the impact domestic abuse causes to victims in terms of their health (physical, mental and sexual)*, (v) *I feel confident in asking patients questions about domestic abuse*. (vi) *I feel confident in managing patient disclosures about domestic abuse*. Attendees completed the questionnaire once at the end of the training session and at this time were required to assess their knowledge/confidence before and after the training. Open text boxes were also available to capture additional feedback from attendees.

Work Package 5: IDVA workbook. The IDVA workbook was devised collaboratively between staff at SCC and the evaluation team. The workbook collected pseudonymised data for survivors who had consented to data being used for research and evaluation. The purpose was to keep a detailed record of the victim/survivors who were referred to the service, including information that would be useful to SCC moving forward. The intention was that SCC would themselves have access to information that would be useful to them, but which was beyond the scope of this evaluation. Data included in the workbook that has been used in the evaluation includes demographic information, referrals made across departments and the relationship of the perpetrator to the victim/survivor.

The findings from analyses of data from Work Packages 1 to 5 above are presented under the relevant KPIs in the next section of the report.

Work Package 6: Resource Use Survey. A survey to evaluate the HIDVA services in Surrey was developed with London South Bank University evaluation team, commissioners in Surrey County Council and staff working in the HIDVA services. The main aims of the survey were to first collect data to help describe the impact of the IDVA service on different services and the patterns of resources used.

Secondly it was hoped the data returned as part of the survey would also help to make a case for the HIDVA services being cost-effective. Both these aims would entail collecting data on what types of services (whether health care, local authority or criminal justice) users of the HIDVA services had used or had access to, both prior to individuals entering the HIDVA services and since their involvement with the service.

Once the survey had been designed and approved users of the HIDVA services were approached by the IDVAs to see if they wanted to participate on a voluntary basis in the survey to evaluate the service, and specifically to help understand if the service offered good value for money. It was explained to potential participants that the evaluation would also look at the effectiveness of the service which included trying to understand the impact of the service on the level of risk to service users when comparing their current involvement in the IDVA service to a period before this support was being offered.

As the evaluation wanted to understand any impact of the IDVA service on how resources were being used, participants were advised that we would need to ask questions around the types of NHS care they may have received as well as any wider impact on society and on individuals and family life. For example, this could include asking questions about how many times participants went to hospital or saw a G.P. and whether they were economically active etc. It was explained to participants that this would involve questions that asked them to compare their current experiences in the IDVA programme with a period of time prior to their involvement in the IDVA programme.

Participants were advised that it would be a confidential survey and that the researchers conducting the evaluation would not access any personally identifiable information like addresses or names. Participants were also advised that they were free to proceed or withdraw at any stage.

The survey was launched on the 27th July 2021 and was closed to respondents on the 30th April 2023.

Analysis of this element of quantitative data are provided in the section entitled Resource Use Survey.

[Work Package 7: Advisory Group](#). Because of the difficulty recruiting suitable victim/survivors, it was not possible to proceed with this work package (see explanation above).

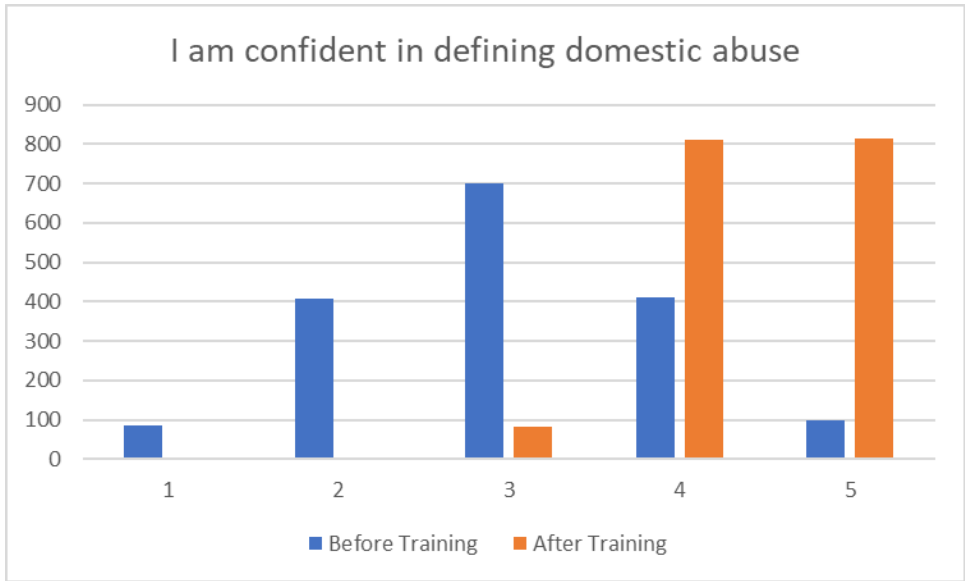
Findings

A total of 901 people who were referred to the HIDVA services between May 2021 and March 2023 consented to data being used for research and evaluation. The referrals were broadly even across the two phases with 452 (50.2%) referrals in year 1 and 448 (49.8%) in year 2. Training questionnaires were completed by 1,711 NHS staff members across all four Surrey health providers over the two-year evaluation period.

This section will address each of the identified Key Performance Indicators in turn before turning to an in-depth analysis of the results from the survey.

KPI 1: Trust staff are confident in identifying and safely enquiring with patients about DA and know how to seek support within the Trust with DA-related matters.

When asked to measure their confidence in defining domestic abuse, results showed a significant increase in confidence following the training with 1,623 (94.9%) stating they were either very confident or extremely confident. For this question, 1 represented not at all confident and 5 extremely confident.

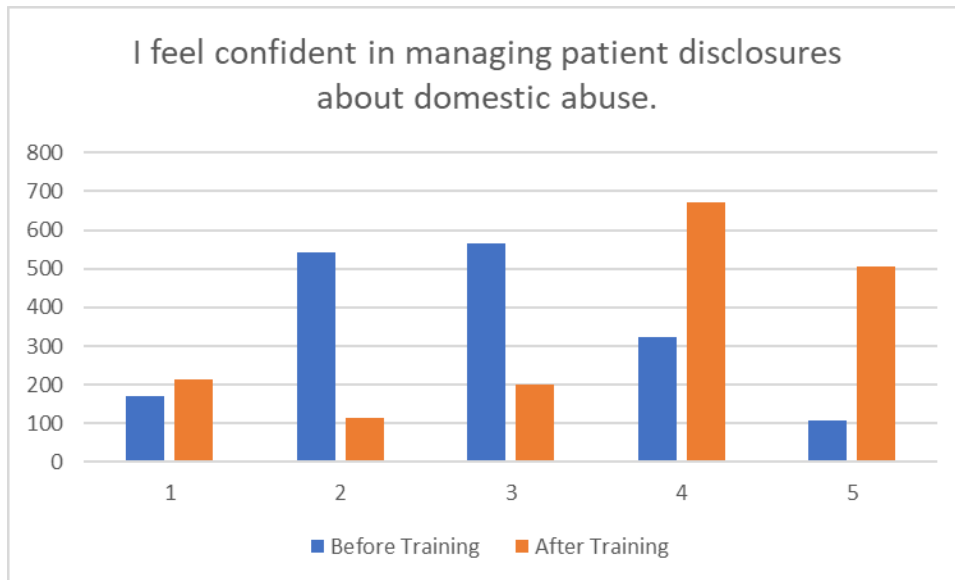


The training also led to a substantial increase in respondents' confidence to ask patients about domestic abuse. Prior to the training only 417 (24.4%) of attendees were very or extremely confident about asking patients questions about domestic abuse. This compares with 1,504 (87.9%) who were very or extremely confident when they had completed the training. In this scenario, scoring 1 on the Likert Scale = completely disagree and 5= completely agree.



Staff attendees at the training were asked about their confidence in managing patient disclosures of domestic abuse. This time the Likert Scale was reversed, and the question was rated such that 1 =completely agree and 5= completely disagree. The results show that 1,179 (87.9%) either disagreed or completely disagreed with the statement, suggesting that

staff confidence decreased as a result of the training. However, it is likely that these results are skewed because of the unexpected and unprecedented reversal of the Likert scale and that the 87.9% attendees either agreed or completely agreed with the statement *I feel confident in asking patients questions about domestic abuse.*



Analysing those who were referred to HIDVA services (i.e., data contained in the IDVA workbook), 48 (5.1%) of the people seeking support from IDVAs were staff. All but three were self-referrals. Eighteen of the referrals came in the Phase 1 of the evaluation, the remaining 30 in Phase 2. This almost doubling of the number of staff referred/self-referred in the second phase of the evaluation suggests increasing awareness and confidence on behalf of staff in the HIDVA services. As observed by one IDVA in the original (Phase 1) focus group.

we had staff disclosing domestic abuse or asking for information for people that they know, and they are dealing with domestic abuse, either in their family or their environment, like friends, neighbours,

IDVA Focus Group (Phase 1)

This noticeable increase in staff referrals is also encouraging because it suggests that staff have a level of trust in the services provided.

KP 2: DA survivors supported by the IDVAs have access to the right information, services and support, at the right time, in the right place, at the earliest opportunity, through clearly defined referral pathways.

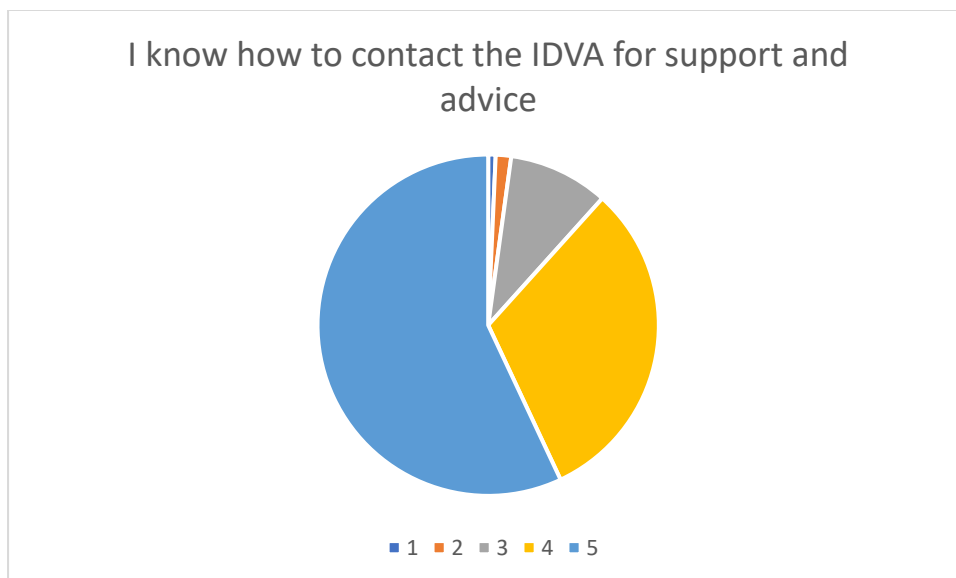
The IDVAs themselves were very clear about their role. Their understanding is consistent with the definition adopted by SCC's and described on earlier in this report.

My main duties are to be part of the general safeguarding for those 16 plus, that they can work with IDVAs. So, when we see a referral coming from the hospital stating that somebody has disclosed domestic abuse or has spoken with somebody from the hospital around DA and has consented to speak with an IDVA, I introduce myself. If the person is at the hospital I assess the patient, meaning I assess the risks first in order to see if the patient needs to be heard in MARAC [Multi-Agency Risk Assessment Conference]. if the patient doesn't need MARAC it will be referred to outreach services, I also assess what the situation is and what their needs are. For example, referrals to other services like counselling or legal guidance, and of course the completion of a safety plan including what to do in case of an emergency, if they want to leave the toxic environment, the perpetrator, no matter who the perpetrator is, it could be a parent, it could be an intimate partner, it could be a child if it's talking about elderly abuse.

IDVA interview (Phase 2)

When asked at the end of the training, if hospital staff understood the role of the IDVA in their hospital/Trust, 1, 458 (85% respondents) either agreed or completely agreed and no participants completely disagreed.

The question about whether staff who attended the training feel they know how to contact the IDVA to get support and advice, if necessary, showed that 1,507 (88%) respondents agreed or strongly agreed with this statement, whilst 37 (2.2%) disagreed or completely disagreed. The remaining 162 (9.5%) neither agreed nor disagreed. Here a score of 1 represents completely disagree and 5=completely agree.



When invited to grade the statement, “Given what I know after the training, I think the introduction of a IDVA in my trust is a good step towards improving our response to domestic abuse”, the majority (1,600; 93.5%) of respondents said they agreed or completely agreed.

This finding was echoed by a professional in the focus group during phase 1 of the data collection¹.

A massive impact, before it was very much a Cinderella service, you didn't speak about it, you didn't know about it, we don't have problems with domestic abuse, and now it's like actually the whole world's opening up, everyone seems to have an issue with domestic abuse, whether it's staff or patients, and actually they're getting access to a service that didn't exist.

Professional Focus Group (Phase 1)

All three of the survivors interviewed as part of the evaluation reported on their wholly positive experiences with the IDVAs.

I didn't have to do anything; I was in hospital, and they got in touch with me.

Participant 7 (Survivor)

It was extremely easy, which was surprising because I've lived here for only 3 years and was not aware of the help and support available... the girl in A&E asked me if I wanted to speak to [IDVA], I did, and she's been extremely helpful in helping me to access everything I needed.

Participant 6 (Survivor)

Very quick. Very good. Very supportive. Non-judgemental.... They have been brilliant, and they still are.

Participant 8 (Survivor)

In relation to the referral process, two attendees of the training made suggestions in the free text box. One attendee at the training proposed:

A flow chart as a quick reference of the referral process. Somewhere we can access while at work.

And another expressed an interest in the small cards:

¹ All of these questions were measured on a Likert scale where 1= completely disagree and 5= completely agree,

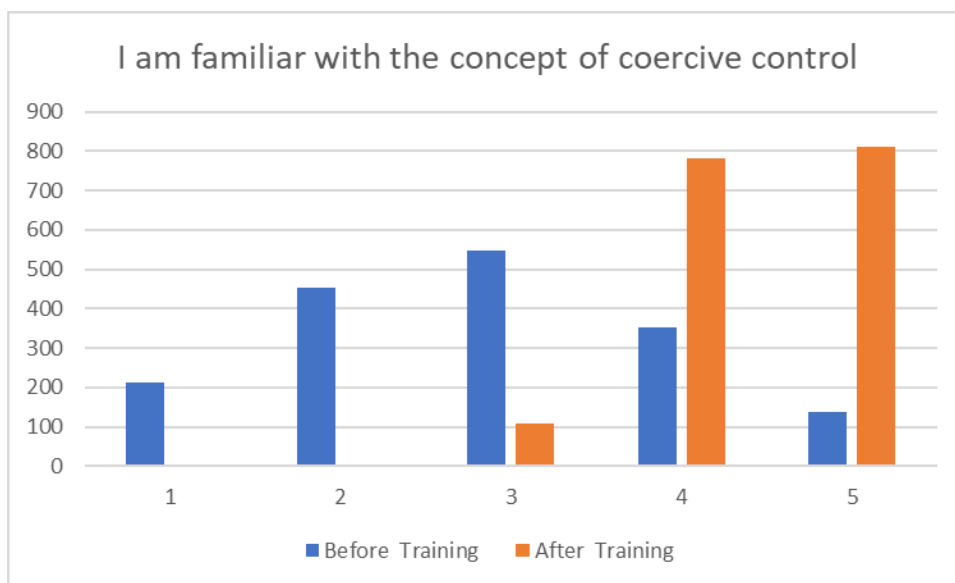
I would like some of the small cards that were offered to the teams regarding information of safeguarding and who to contact if required.

Further information relating to this can be found in section Resource Use Survey.

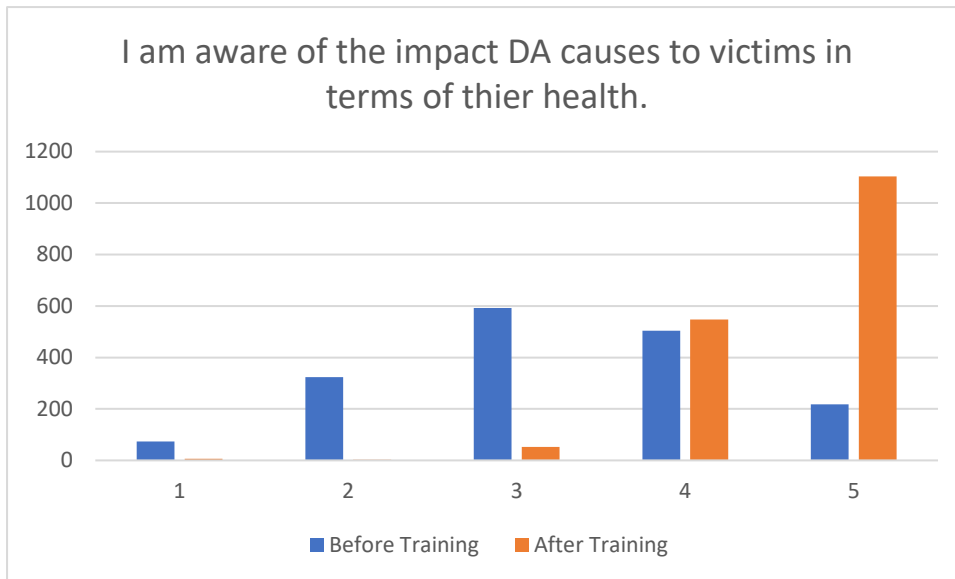
KPI 3: IDVAs enhance the Trusts' Safeguarding response to DA.

Coercive and controlling behaviours are notoriously difficult to identify, with Stark (2007, p14) identifying it as 'invisible in plain sight'. It is also recognised as an indicator of future violence and a risk indicator (Felson and Messner 2014). Identifying the presence and extent of coercive control can therefore be used to inform risk assessments and is a fundamental element of the Trust's safeguarding response to domestic abuse.

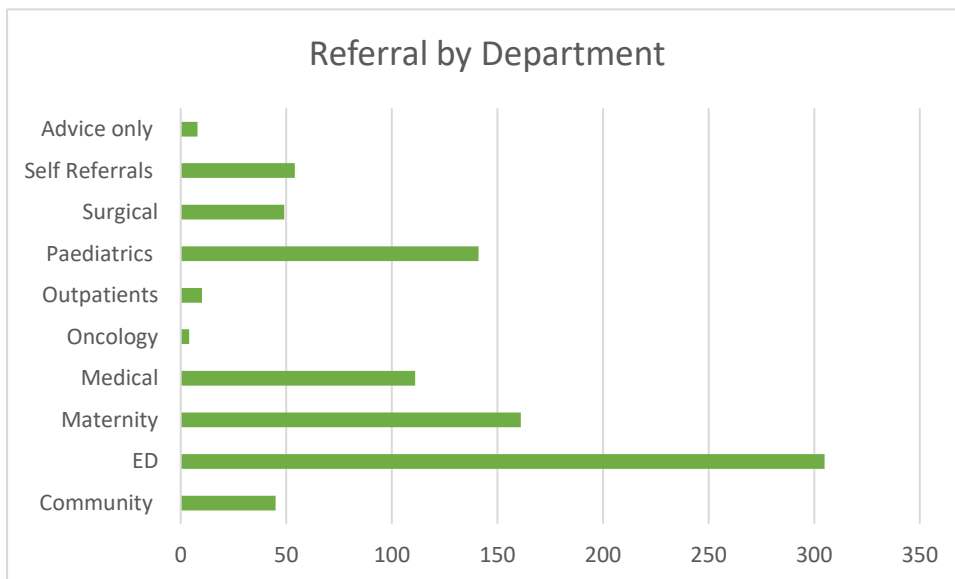
Attendees to the training course were asked about their familiarity with the concept of coercive control. The questionnaire saw a significant shift in staff insight into coercive control as a result of attending the training with 1,593 (93%) of staff feeling very or extremely confident about their familiarity with the concept after the training.



NHS staff were asked to grade their knowledge in relation to the following question '*I am aware of the impact domestic abuse causes to victims in terms of their health (physical, mental and sexual)*' results showed an overall increase. At the end of the training no staff were unaware or completely unaware and 1, 651 (96.5%) were either aware or completely aware.



Data from the workbook showed that referrals were being made across departments (see graph below) suggesting that the staff were confident in identifying and safely enquiring about domestic abuse and that they know how to seek support within the Trust (KPI 1).



Most referrals came from Emergency Departments, which may be as a result of a particularly violent episode which have resulted in injuries that required emergency treatment and subsequent admissions. However, research (Boethius and Akerström 2020) has shown that women often disclose their abuse in an unplanned way and in response to specific situations. These *'turning points'* (Ibid p187) and the fear of what might happen (Kelly 1998) may also have encouraged unplanned disclosures and also contribute to the frequency of referrals from these departments. Without the qualitative data it has not been possible to explore this notion further.

That the second most common referring departments are maternity wards is also in keeping with the literature as domestic abuse is associated with unplanned pregnancy, sexually

transmitted infection and miscarriage (Torress-Vitolas 2010). In this evaluation, 161 (17.9%) of referrals were from Maternity departments.

Perhaps surprisingly referrals from Paediatrics department are the third most common source of referrals, totalling 141 (15.6%). It may also be relevant that the total number of patients reporting to be pregnant was 157 (17.4%), approximately half of whom (50.2%) have children. Given that this evaluation engaged with only those aged 16 years and over (as defined by the Domestic Abuse Act 2021) it is feasible that the parents/carers of the children who attended the Paediatric departments were the people ultimately referred to HIDVA services.

Paediatric staff accounted for only 78 (4.6%) of the staff who attended the training. Whilst their engagement would undoubtedly have increased awareness of domestic abuse and thus increased the number of referrals it is unlikely that training alone accounts for the high percentage of referrals from this department. When combining the results from Maternity and Paediatrics departments, 302 (33.5%) of the referrals came from departments where victim/survivors are or soon will be parents. It may be therefore that their responsibilities as parents/mothers and their concern about the risk posed to their (unborn) children influenced their decision to disclose. Again, we have been unable to explore this further due to the limited qualitative data.

That said, the qualitative data available to the evaluation team was encouraging. One victim/survivor was unaware of the Trusts safeguarding responses, but she experienced a seamless service from admission to A&E and receiving IDVA support.

I am not sure what the Trust safeguarding response is. I know that when I spoke to people about my problems, they were there for me – the girl in A&E was, and she listened to me and supported me and got me in touch with [IDVA].

Participant 6 (Survivor)

NHS staff were also very positive about their relationships with the IDVAs and the efficient safeguarding responses available because of this service.

So we've had patients coming in post leaving a violent relationship, I've been spoken to [IDVA] about this patient who is coming into fracture clinic at this time, so we've sorted everything out to make sure that the patient is safe, moved through the system quickly and then brought back out again. So this patient had day surgery and all the rest of it and we made sure that security were aware and that all of the agencies were working together, because the perpetrator was actually named at that point, so it was very much working together and just creating something that works for the patient, and it's dynamic in that as well.

Professional Focus Group

During the second phase of data collection, one IDVA explained:

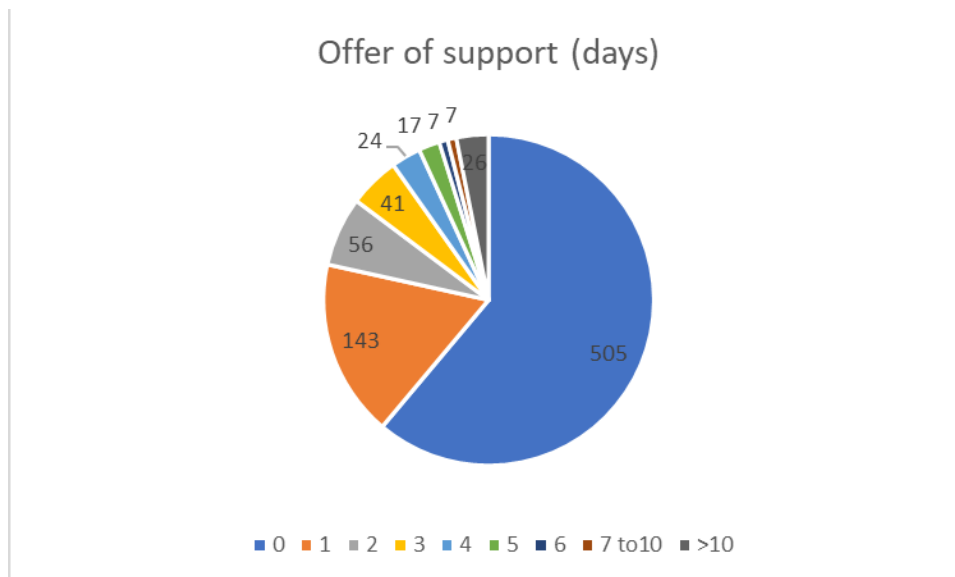
I think the trust are improving. I think, if you don't know a service is there, then you can't use it. So, I would say that, knowing now the service is here, the people that do know are using the service. So, I think I've already seen an increase in referrals, which tells me that, when you know it's there, they will use it..... without our role, we wouldn't be picking up any of these people.

IDVA interview (Phase 2)

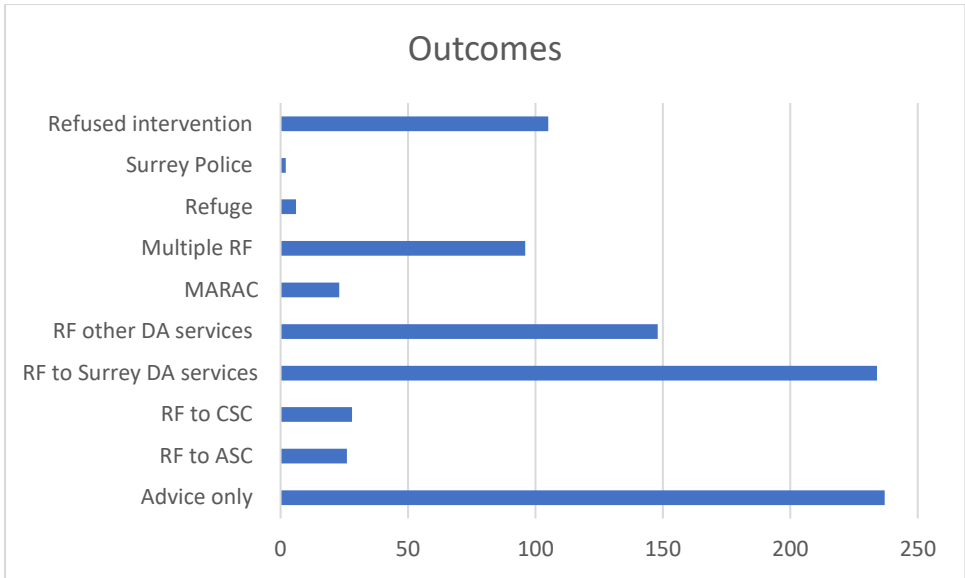
Further information relating to a change in risk score can be found in the Resource Use Survey section of the report.

KPI 4: Domestic abuse survivors feel enabled to access IDVA and outreach support services. Domestic Abuse survivors are viewed as experts by experience and their feedback on the IDVA service informs the delivery of IDVA services.

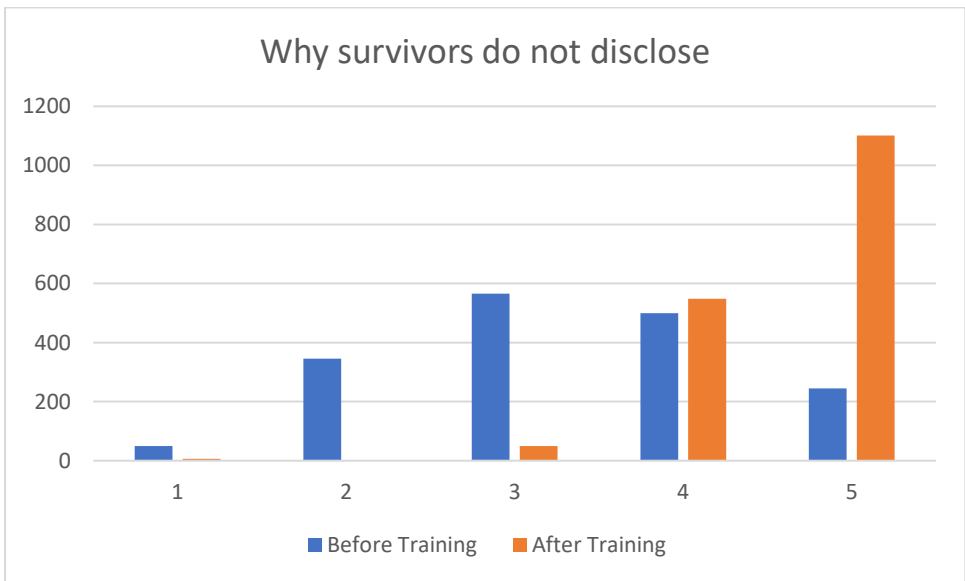
IDVAs were quick to respond to domestic abuse referrals with 505 (56%) of referrals responded to on the same day, a further 143 (15.8%) a day later, and 40 (4.4%) of patients waiting 7 days or more for IDVA contact.



Of the 901 referrals to HIDVA services, 563 (62.1%) were referred to other services for support/intervention. A breakdown of these services is provided in the chart below. 342 (37.8%) of those who had contact with the IDVAs either refused services or were given advice only, many of those who refused are recorded as being given advice in any event. Such good practice is important, because survivors of domestic abuse are abused on average 35 times before reporting their abuse to the police (Jaffe 1986). Providing advice is important as survivors of domestic abuse are empowered to access services at any time in the future when they are ready to do.



Attendees at the IDVA training sessions, were asked to grade themselves against the following statement *'I am aware of the reasons why survivors might choose not to disclose domestic abuse.'* In this question a score of 1 indicated completely disagree and 5= completely agree. By the end of the training 1,101 (64.3%) of attendees completely agreed with this statement and a further 548 (32%) agreed.



The confidence of training attendees in recognising survivors reluctance to disclose is very encouraging. Such understanding will likely prevent any stereotypical assumptions and the perpetuation of myths related to domestic abuse, e.g., if it was that bad, she would leave or women often lie about the abuse (Refuge no date). Staff awareness of this issue will also likely enable them to look behind the obvious, trust their knowledge from the training, make more accurate risk assessments and appropriate referrals to the HIDVA services.

The limited number of domestic abuse survivors interviewed for this evaluation means there is insufficient data to analyse domestic abuse survivors' thoughts and experiences of this KPI. Those who were interviewed indicated satisfaction with their access to support services, but these contributions are only a few in number and cannot be extended to understand the experiences of the 901 individuals who were referred to the service. That said one victim/survivor was especially grateful for the autonomy she was afforded by the IDVA.

She let me make my own decision and wasn't at all judgemental that I might want to go home.... She talked to me, she was very gentle, she was very kind, I got a phone number that I could ring her if I wanted to, and she rang me regularly to get updates until I was home and back on my own feet and said I'm okay now, but I have the phone number where I can get in touch with them if I need.....

Participant 7 (Survivor)

NHS staff also recognised the value of the IDVAs:

It was difficult before we had a HIDVA because there wasn't anyone you could refer onto, so it was like I am very aware that if I open this can of worms, I'm unsupported and I can't deal with this, especially if I'm triaging and I've got 15 patients to triage and I've only got two minutes a patient, I'm not going to be able to get this done, so having a HIDVA I've found is massively beneficial, which then makes me more confident to ask the question because then I can say actually I've got someone who can talk to you about it.

Professional Focus Group

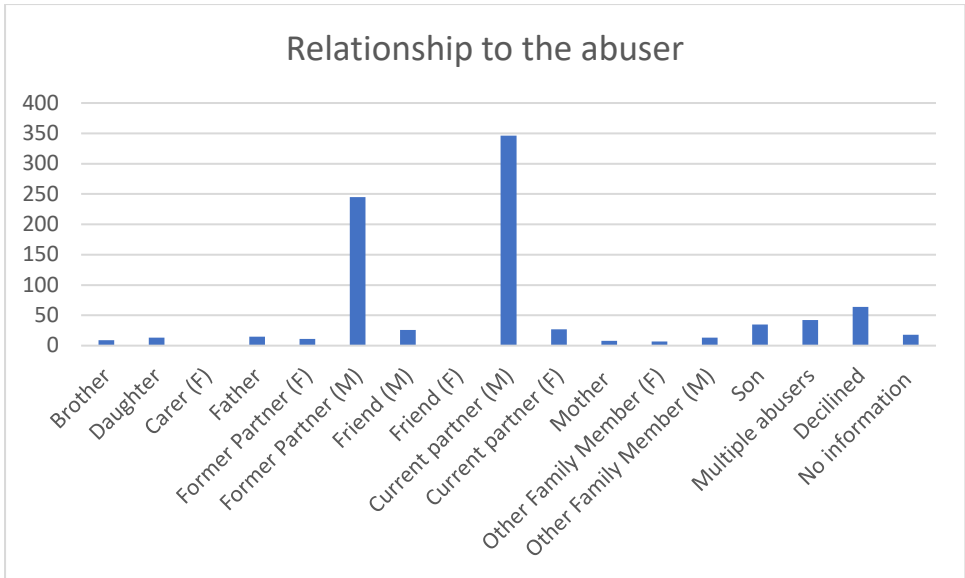
KPI 5: IDVA data collection in the Trusts provides the Trusts and Commissioners with a better understanding of the level of DA need in Surrey.

Of those referred to HIDVA services 54 (6.2%) were male, 822 (93.8%) were female and one referred patient identified as non-binary.

Nearly three-quarters (74.3%) of those referred were white, 9.93% Asian, 5.6% black; 1% mixed/multiple ethnic groups and remainder (8.2%) defined themselves as belonging to 'other' ethnic group. This is in contrast with the population of Surrey where 85.5% residents identified as white, 7.7% Asian, 1.7% black, 3.4% mixed/multiple, and 1.7% other (Office for National Statistics 2021 cited in Surrey County Council, no date). These figures suggest there is a slight difference in the proportion of Asian people referred to HIDVA services when compared to the population across Surrey.

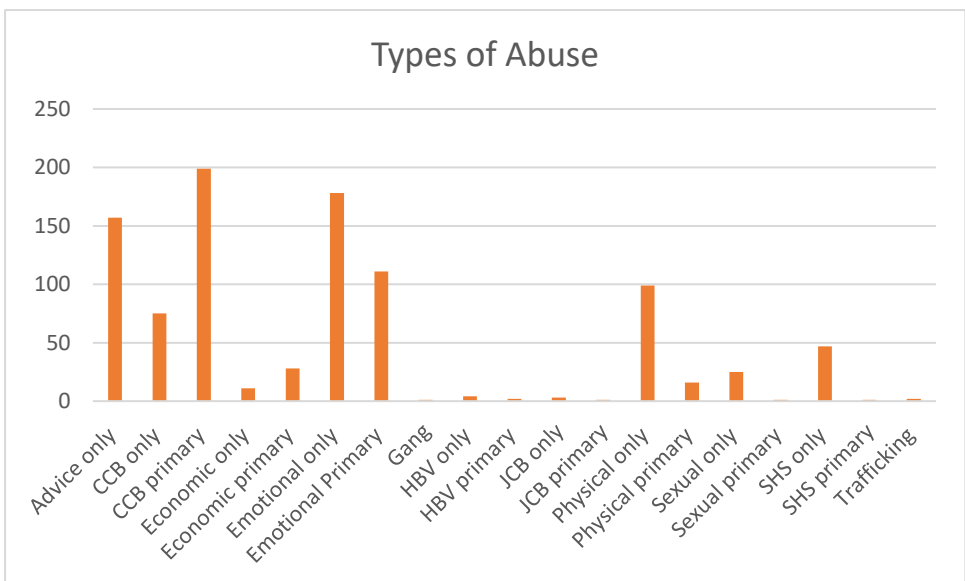
Of the 83 referrals identifying as Asian who disclosed their relationship to the abuser, 73 (88%) were abused by their current or former male partners. One female was abused by a former female partner. The remainder were abused by other family members, three of whom were female.

The relationship between the victim/survivor and the abuser(s) is shown below. 64 participants declined to disclose who their abuser was, and information was missing for a further 18.



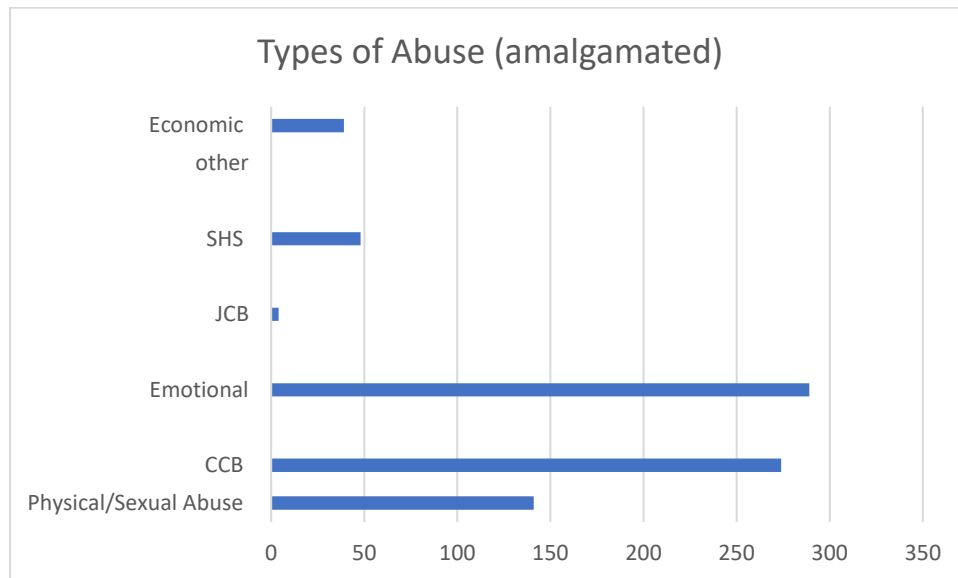
Where information was available about their relationship to their abuser(s) 42 (5.14%) had multiple abusers, typically different family members. Of those who reported only one perpetrator the most common were current or former male partners who constituted 591 (72.3%) of abusers.

The types of abuse experiences by those referred to IDVAs is summarised in the chart below. When only one type of abuse is reported that abuse is noted as 'only' (e.g., 'CCB only' means that Coercive and Controlling Behaviour was the only abuse reported. When more than one type of abuse is recognised, the identified abuse is noted as 'primary' (indicating that there are secondary, tertiary etc. forms of abuse, e.g., CCB primary means that more than one abuse has been identified but Coercive and Controlling Behaviour is the most problematic).



Note: SHS=Surveillance/Harassment and Stalking; HBV= so called 'Honour' Based Violence; CCB= Coercive and Controlling Behaviour and JCB=Jealous Controlling Behaviour.

People referred to these services experience a wide range of abuse that were readily identified by the IDVA. The most common form of identified abuse is Emotional Abuse accounting for 35.9% of the recorded abuse, closely followed by Coercive and Controlling behaviour at 21.6% of the recorded abuse. When the 'only and 'primary' forms of abuse are amalgamated, the majority of people referred (81.3%) experience 'non-contact' abuse that leaves no physical mark. Physical/sexual abuse accounts for 17.5%.



Deeper analysis showed that four referrals were because of so called 'Honour' Based Violence, all four were women, two of Asian descent, one white and one other. One referral (white female aged 21-30) was referred to HIDVA services because of gang related violence.

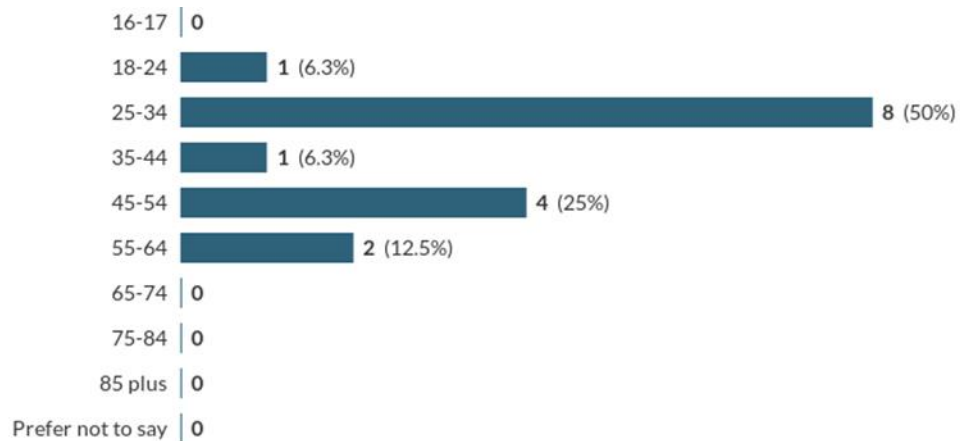
Resource Use Survey

In total 16 respondents completed the survey.

All respondents identified as female.

Age of respondents

As the chart below shows half of the respondents reported that they were between the ages of 25 and 34 years of age and another 44% of the respondents stated that they were between the ages of 35 and 64. A small proportion (6%) of respondents reported that they were between the ages of 18 and 24. There were no responses from anyone under the age of 18 or over the age of 64.

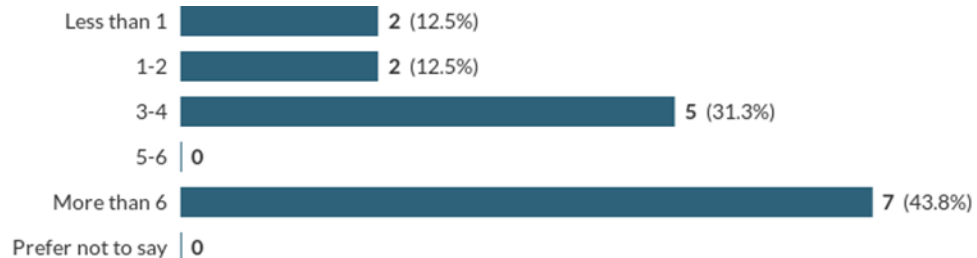


Number of years experiencing domestic abuse.

Participants were asked how many years they had suffered domestic abuse.

This is visually demonstrated in the bar chart below. The mean number of years was 3.5 years. Almost 44% of respondents had suffered domestic violence in excess of more than 6 years.

Survey Question. *How many years approximately had you suffered domestic abuse before being referred to the IDVA?*



Risk scores pre and post IDVA support

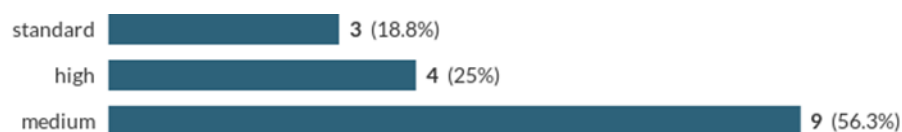
Risk scores were calculated using the CAADA-DASH Risk Identification Checklist. This tool is used by IDVAs and other non-police agencies for identification of risks associated when domestic abuse, 'Honour' Based Violence and/or stalking are disclosed.

The IDVAs keyworkers provided CAADA-DASH risk scores for individual participants for both the period prior to their involvement with the IDVA service and for a period during which they were actively participating in the IDVA service support scheme.

(These were scored within the service from 0-24 where 24 would be the highest risk score possible).

As can be seen from the graphics below the risk scores suggest a reduction in risk using the CAADA DASH scoring instrument when comparing the pre IDVA involvement stage with the IDVA support intervention.

Survey Question. What was the survivor's risk level at the beginning of the intervention?



Survey Question. What is the survivor's risk level now?



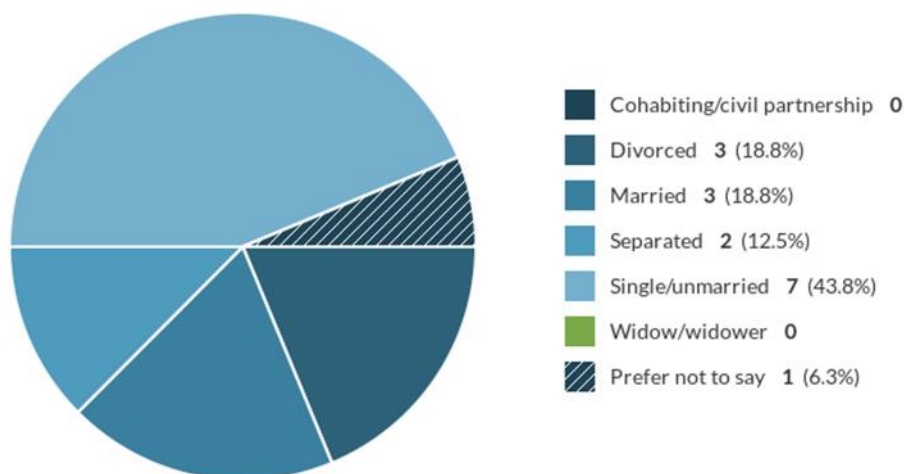
More precisely at baseline an average score of 8.13 was noted. At follow up this average score was reduced to 6.44 – showing a 1.69 point reduction in risk level on average using the CAADA DASH risk tool.

Household situation of respondents

The number of children on average remained at 1 for both the baseline and for follow-up.

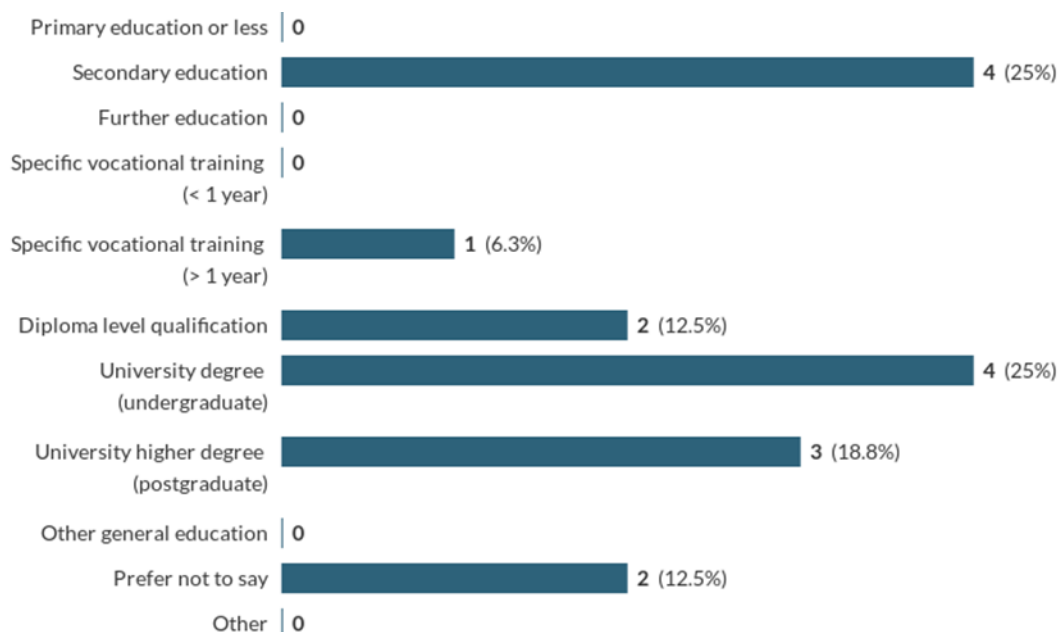
Respondents were asked how their weekly employment and how it had changed comparing the 12 months before being referred to the IDVA and then after. On average respondents reported working on average 36.1 hours a week prior to being referred to the IDVA service, compared with 28.7 hours after. Three respondents reported at follow up that this was 'not applicable' and reported that they were on maternity leave.

Respondents to the survey were asked to provide information that best described their situation relationships wise. As can be seen from the Pie Chart visual graphic below the largest group at just under 44 % described themselves as single or unmarried with married and divorced categories equally totalling 18.8%.



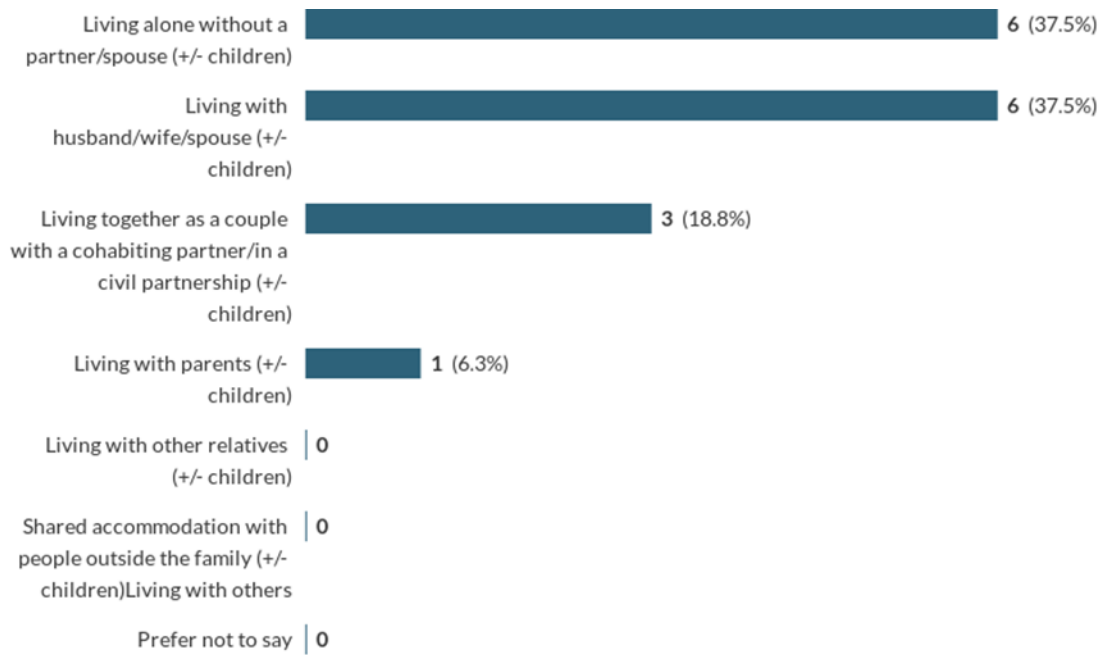
Out of the 16 respondents 12 or 75% identified as White: English/Welsh/Scottish/Northern Ireland/British, 1 as Caribbean (6.3%), 1 as White/Asian (6.3%), 1 as other mixed or multiple ethnic backgrounds (6.3%) and 1 just as 'Other' and then described themselves as 'Spanish Filipino' (6.3%).

In excess of 60% of respondents reported having an education that was beyond secondary education schooling and is represented in the bar graph data below.

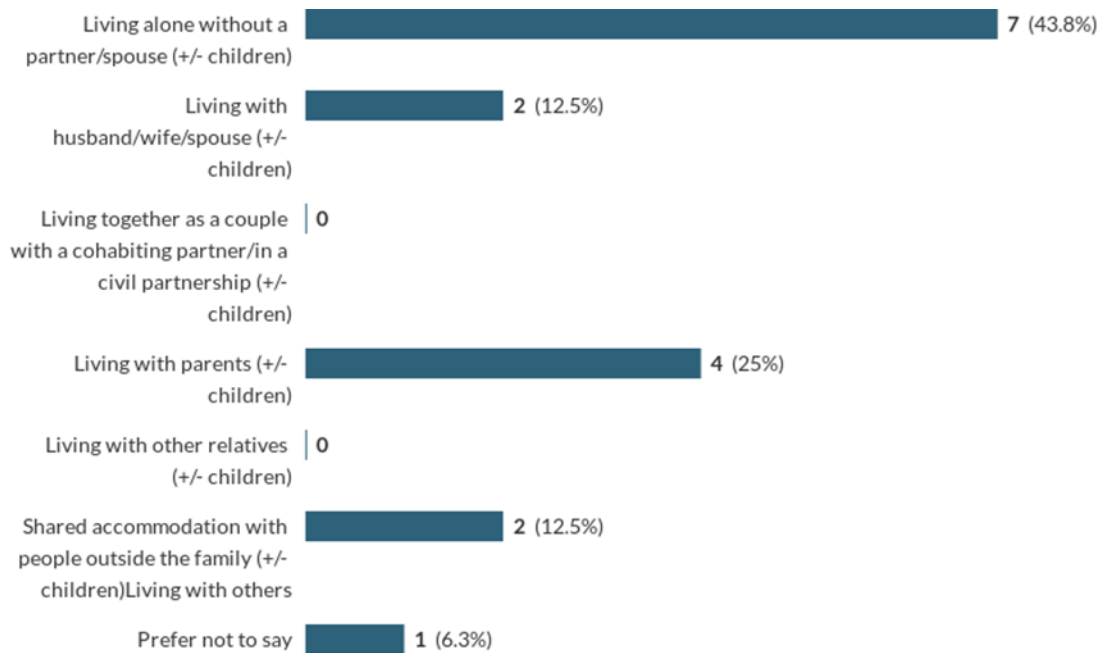


When participants were asked what was their usual/normal living situation that most closely described their situation they reported a change pre and post especially in relation to living alone and living with partner. [This is demonstrated in the pre and post graphics below.](#)

Survey Question. *What was your usual/normal living situation that most closely described your situation in the 12 months before being referred to the IDVA?*



Survey Question. *What is your living situation now?*



Stays in hospital

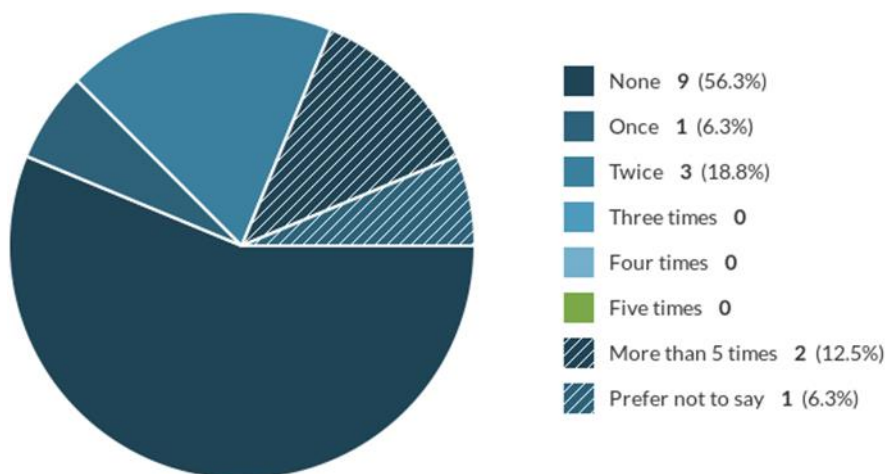
No respondents reported staying overnight in a hospital setting due to domestic abuse in the 12 months before being referred to the HIDVA services. One respondent reported at follow up a 3 night stay in hospital as a result of domestic abuse.

Contact with the police in relation to domestic abuse

To understand the potential impact of the HIDVA services on the criminal justice system, participants were asked to report contact with the police prior to their involvement with the IDVA service and as well as since being referred to the IDVA service. The responses depicted in the graphic below show over half had not contacted the police though >30% had needed to contact the police in excess of 2 occasions.

This remained constant at both time points being measured.

Survey Question. *How many times have you (or someone on your behalf) contacted the police in the 12 months about a domestic abuse-related issue before you were referred to the IDVA?*



Employment status

There was one small change in terms of one person less describing themselves as unemployed when respondents were asked to report their experiences post involvement with the IDVA service.

There was also a reduction in the number of days absent from work due to illness (days of <5) of 12.5% from 50% down to 37.5% when comparing post involvement with pre deployment of the IDVA support services.

Financial support

For participants involved in the IDVA service there was an increase in the number of individuals receiving child benefit and universal credit in comparison to the 12 months before being referred to the IDVA. For example the receipt of Universal credit increased from 5 individuals (31.3%) pre IDVA to 9 individuals (56.3%) during the period of receiving IDVA support. For child benefit this rose from 2 individuals to 4 or 12.5 % to 25% of respondents.

Professional support

Professional support offered to participants in the evaluation (detailed in the tables below) show a change in the pattern of professionals support being accessed. For example, respondents cited an increase in psychology and social work support once the IDVA service was underway relative to the period prior to IDVA support.

Prior to IDVA support Count		Once referred to IDVA Count	
Psychologist	0	Psychologist	2
Social worker	2	Social worker	5
General practitioner	4	General practitioner	4
Individual counsellor or therapist	7	Individual counsellor or therapist	7
Substance misuse worker or advisor	0	Substance misuse worker or advisor	0
Other	0	Other	2
None of the above	6	None of the above	3
Prefer not to say	3	Prefer not to say	2

	Pre IDVA	Once referred
Mean rank	5	4.04
Variance	4.18	4.36
Standard Deviation	2.04	2.09
Lower Quartile	3.25	2
Upper Quartile	7	6

In extra data provided by respondents (reflected above under 'other') two participants described in more detail the extra support they received. One participant described extra support for Obsessional Compulsive Disorder and another received Cognitive Behavioural Therapy. In both cases these extra support services were offered once the respondents had been referred to IDVA services.

Self-reported subjective wellbeing

When respondents were asked to score their overall health and wellbeing, prior to their referral to the IDVA, (a score of '0' would be the worst score whilst a score of '100' would be the best possible score), on average respondents scored 35 out of 100. The same question was asked in terms of how respondents felt post referral to the IDVA service and on average respondents gave a score of 68 out of 100.

Limitations

The small number of participants who engaged in the qualitative element of this evaluation is a significant limitation. It has prevented an in-depth exploration and analysis of their experiences and thus hindered a solid understanding of what works, what doesn't and what

might change to bring about more positive experiences and better ways to meet the needs of survivors. This lack of engagement also prevented the final stage of the evaluation, namely the creation of an Advisory Group consisting of survivors, and which aimed to serve as a quality assurance measure to confirm that the findings accurately reflected their lived experiences. It has not been possible to fully address Key Performance Indicator 4, regarding survivor experiences of the service.

It is important to bear in mind the context and timing of the evaluation. Data collection began in July 2021 following a global lockdown due to the Covid-19 pandemic. It was at a time when the UK was still negotiating different ways to manage the spread of the Covid-19 and shortly before the phased reopening of schools and non-essential shops in England (Institute for Government 2021).

The launch of this evaluation and much of its period of data collection therefore coincided with a time when there were rapid changes in healthcare and when NHS staff were under extraordinary strain (Majeed et al 2020). Most had been through a period when 'non-essential' services were paused, staff were re-deployed to new and unfamiliar roles with limited access to support. NHS staff were also repeatedly faced with difficult dilemmas such as prioritisation of care and managing their emotional responses to their perceived failures because of this (Liberati et al 2021).

As the evaluation progressed, the pressures continued on the 'broken' NHS (Darlow 2023) and the latter half of the data collection period corresponded with nurses, junior doctors and other NHS staff engaging in industrial action.

One of the questions in the training evaluation has the opposite measure on the Likert scale to other comparable questions. It is likely that this resulted in confusion for the attendees and that it explains the lack of confidence staff have in this area when all other areas saw a significant increase.

Lastly the economic data reported here from the cost effectiveness and resource use survey is limited by the low response rate of just 16 participants. This reduces opportunities to assess the impact of the IDVA service model on wider societal resources, whether this be access to health care, social care or the criminal justice system.

The limited data may provide some encouraging findings around reducing risk, increasing wellbeing, promoting access to health care (and professionals) and promoting economic independence. However there is currently insufficient information to support an argument one way or the other as to the cost effectiveness of the service model,

Discussion

It is disappointing that so few participants were recruited to engage in the qualitative elements of the research as this reduced the rich sources of in-depth analysis that is typically afforded to this method of data collection. It also reduced/removed the ability to triangulate the data and explore themes that arose from the quantitative data analysis. As a result, it is difficult to address some of the KPIs as defined in the original bid as this was dependant on victim/survivor input. Recommendations are also difficult to identify. The findings that have been presented are also not generalisable for this reason.

That the IDVAs understanding of their role so closely sits with SCCs definition is encouraging as it suggests they are promoting their work in line with the Trusts' needs. This clear understanding and explanation of the role may also have encouraged confidence in the staff who referred to these services as well as the patients who had contact with the IDVAs.

This is supported by the proportion of staff who were seen by IDVAs throughout the research. This is particularly encouraging given that all but three of the staff self-referred and that the rate of self/referral almost doubled in the second year. This should be viewed within a context that historically there is a reluctance by NHS staff to disclose their abuse and engage in services because they feel there is a minimal level of support from and confidence in employer's response (McGregor et al 2015). NHS staff also felt that healthcare sector culture silences issues such as domestic abuse and if/when disclosed there is concern about a lack of confidentiality which would result in them being judged by colleagues as unable or unsuitable for the role (McGregor et al 2015). Without the qualitative data it is impossible to comment on whether this increase is influenced by a realisation of staff (through attending the training) that they are/have been in abusive relationships.

The quantitative data from the IDVA workbook also indicates that IDVAs are contributing to the Trust in the way expected (see page 3). IDVAs trained over 900 NHS staff, offered support and advice to 26.3% of people referred to them and linked a further 62.1% with external agencies. Data relating to the expert training showed clear positive indications of staff increased confidence around many aspects of domestic abuse.

The training provided was also impactful with attendees reporting increased confidence in asking questions and managing disclosures around domestic abuse as well as increased understanding of domestic abuse issues.

The IDVA are adept at identifying nonphysical abuse i.e., offences that do not leave visible marks. As mentioned above coercive control is recognised as difficult to identify (Stark 2008). In addition, NHS staff are confident in understanding the reasons why domestic abuse survivors may not disclose their abuse and, further to their training, are less likely to dismiss their 'feeling' that abuse may be happening in that household. Such knowledge is likely to have a positive impact on accurate assessments and suitable referrals to services. It should therefore be reassuring to the commissioners and the Trusts that staff are aware of and able to identify the hidden nature of abuse, which is often an indicator of risk.

Some of the descriptive data obtained as part of the economic resource use survey, whilst limited, may still provide useful insights for the purposes of future local policy and service development. For example, the data returned may inform services on how best to evaluate these types of services in the future. This could include learning what data needs to be collected, how it should be collected and by whom along with considering some financial incentives for participants to complete surveys or participate in other evaluation methods.

The added value flowing from the IDVA data collection comes across very clearly in this evaluation. Detailed information is collected about each individual engaging with or referred to the HIDVA service. This data, routinely analysed and shared with the Trusts and Commissioners in a timely and easily accessible manner, should support a better understanding of the level of DA need in Surrey. Feedback from individual IDVAs on useability of the workbook should be considered. One suggestion for an improvement to facilitate more detailed analysis is to allow for the different forms of abuse to be entered individually on the workbook.

The number of referrals recorded across the span of the evaluation is clearly an indication in of itself of the success of the IDVA pilot. However, it is important to also consider these

numbers from the perspective of an IDVAs individual workload and implement support where referrals supersede the capacity of the individuals IDVAs.

Recommendations

As outlined above it has been difficult to make recommendations based on this evaluation because of the limited qualitative data available to the evaluation team and the inability to triangulate data.

With this in mind, the first recommendation must consider ways to address this limitation in future evaluations. Whilst it is acknowledged that survivors of abuse are often reluctant to engage in research because of the trauma endured (McGarry and Ali 2016), that the details of only six (less than 1%) of the 901 people referred to HIDVA services were shared with the evaluation team for interview indicates barriers to participation. Similarly, only 16 (1.8%) of victim/survivors completed the survey despite SCC offering an additional £30 incentive. It is suggested that stakeholders engage with those responsible for referring participants in an open and honest conversation so that if any reservations or barriers exist to referring survivors of domestic abuse in the evaluation process, these can be addressed.

Data from the training suggests that there is an increased awareness and confidence in staff to identify and raise the issue of domestic abuse. The high number of referrals from a wide range of hospital departments is encouraging and suggests that IDVAs are empowering staff to identify and refer potential victims/survivors and that HIDVA services are filling a gap in provision to domestic abuse survivors.

Broadly speaking, the referral process seems to be well understood, though the Trusts may wish to consider further ways publicise the services. Populating the hospital wards with posters of the referral process and how to access HIDVA services is one idea. This might be most useful displayed visually as a flow chart and if available in communal areas may encourage victim/survivors to actively seek help. Similarly, provide 'small cards' to hospital staff across all wards. These could be made available on reception desks and visible to both staff and patients. If not already existing, a central email address may be helpful to avoid the need to update the cards to reflect staff changes.

This evaluation evidenced the clear benefits of the training IDVAs delivered to NHS staff. Such training should continue, subject to available resources. Similarly, the data collection template IDVAs use to capture information about survivors appears to be functioning well and offers clear potential as a valuable tool to support the understanding domestic abuse need in Surrey. It should continue to be used, albeit with the option for further consultation with IDVAs on its useability. Referrals levels should also be monitored with a view to assessing IDVAs individual workloads. This will allow for solutions to be considered where demand for HIDVA services outstrips individual IDVA capacity.

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