# Evaluation of the IRIS 7 Boroughs project

# Final report

**May 2022**

## 1. Introduction

### 1.1. About IRIS

IRIS (Identification and Referral to Improve Safety) provides primary care practitioners with domestic violence and abuse (DVA) training, support and a referral service for women experiencing current or former DVA from a partner, ex-partner or adult family member. It is based on the understanding that primary care, as part of effective multi-agency working, has an important role to play in identifying women affected by domestic violence and abuse and facilitating their access to appropriate support. However, because primary care staff do not always have the knowledge and confidence to fulfil this role, domestic abuse frequently goes unidentified and opportunities to support women are lost. IRIS aims to address this with a model which combines training and consultancy for primary care staff, peer support via a clinical lead for DVA, and an easily accessible referral route to a named advocate educator (AE) in a local specialist service.

Through monitoring and evaluation IRISi have gathered robust evidence[1] demonstrating that IRIS is effective in improving the primary care response and increasing women's access to support. This not only contributes to the improvement of women's health and well-being (thereby reducing their use of primary care) but can also impact positively on the resilience and protectiveness of families.

**The 7 Boroughs programme** was funded by MOPAC's Violence Reduction unit to enable IRISi to implement IRIS in selected London boroughs from November 2019 to the end of March 2022. The programme was implemented in two phases with phase 1 boroughs (Tower Hamlets, Croydon and Barking & Dagenham) starting by March 2020 and phase 2 boroughs (Brent, Ealing, Hammersmith & Fulham and Westminster) launched in November 2020. In addition, Waltham Forest, whilst not funded as part of the 7B programme, has a

[1] See for example: Hinsliff-Smith, K. (2016) Identification and Referral to Improve Safety (IRIS) programme. National review 2013-2016.

local VRU and has been implementing an IRIS programme within a similar timeframe, so has been included in the evaluation.

## 1.2. The evaluation

DMSS Research was commissioned by IRISi as evaluation and learning partner to the 7B programme. This work has had two purposes: a) to assess the effectiveness of the implementation of IRIS across the 7B programme and b) to feedback lessons as it has progressed and encourage the sharing of learning across the programme. Work started with a theory of change workshop for IRISi managers and VRU representatives in August 2020. The resulting theory of change framework (appendix 1) sets out the overall goal of the 7B programme and the milestones it aimed to achieve after 6 months and at 2 years.

**Methods and sources of data for the evaluation**

The data collected to evidence progress has been mainly qualitative: involving interviews at regular intervals with the key partners delivering, or closely involved with, the programme, as well as primary care practitioners who have undertaken the training. We have also facilitated a series of 'action learning meetings' for Advocate Educators, the main purpose of which was to share learning across the programme in real time, but which has also provided valuable insights for the evaluation. Our work has not included direct feedback from patients or survivors (a survivor consultation was commissioned separately from AVA), so our assessment of impact on the women referred to IRIS has been based on indirect feedback from AEs including the case studies which have formed part of their quarterly monitoring.

The quantitative elements of the evaluation have been derived from quarterly monitoring reports and we have liaised closely with the IRISi Contracts and Programme Manager to verify data on training delivery and referrals.

The evaluation, as well as the programme itself, has been conducted entirely within the context of the COVID-19 pandemic which has meant that all our interviews and meetings have been carried out virtually. This has obviously had some effect on the nature of the data we've been able to collect but our assessment is that for the most part it has not been detrimental – indeed, we've found that GPs and other informants have generally welcomed the opportunity to respond via a short online or telephone interview and the attendance at AE meetings by Zoom has been very good. The only missing element is that that we have not had the opportunity to visit a sample of practices and have therefore missed out on some of the feedback you would normally get from reception and administrative staff as part of these visits.

In summary, the data for this report has been drawn from the following sources:

- Action learning meetings for Advocate Educators (AEs). Seven of these were held between September 2020 and January 2022.
- Interviews with AEs, their service managers, Clinical Leads, a sample of steering group members and IRISi regional managers (a total of 75 interviews involving 50 informants).
- Interviews (16) and email feedback (4) with clinicians (a total of 20).
- Reviews of quarterly monitoring data/ reports.
- Analysis of a sample of 35 client case studies.

## 1.3. Structure of this report

Throughout the evaluation we have produced an update of progress at the end of each quarter, and interim reports in April 2021 (focusing on year 1 of the programme) and September 2021 (focusing on feedback from clinicians).

This final report provides a synthesis of the main findings from the evaluation over the past two years as well as drawing on a final set of interviews with key informants (AEs, CLS, service managers, steering group members and clinicians) carried out between January and April 2022. We have structured the report around the following key questions:

- How successful was the implementation of IRIS across the participating boroughs?
- What impact has it had on the practice of clinicians in primary care?
- What difference has it made to women affected by DVA?
- What lessons are there from the 7B experience that may be relevant for similar initiatives?

# 2. How successful was the implementation of IRIS across the participating boroughs?

## 2.1. Contextual issues

Successful implementation of any programme is strongly influenced by the context in which it is being delivered. The implementation of the 7B programme took place during the COVID-19 pandemic and the impact of this has of course been massive, affecting every aspect of delivery for boroughs in both phases. However, there were also two key contextual differences between phase 1 and 2 boroughs. These were:

***The timing of the pandemic.*** Phase 1 boroughs were mostly getting set up just as the first lockdown came into force. Some Advocate Educators (AEs) were only just in post and other appointments to AE posts were then delayed due to lockdown restrictions. IRISi had to

rapidly adapt their delivery model (particularly of the training) and AEs and managers had to contend with a radically changed primary care context. Many IRIS teams/IRISi partners never met face to face during the first full year of the programme. Phase 2 boroughs started in Autumn 2020 by which time some new ways of working had become established, and AEs and CLs came into post knowing that they would be working differently. However, all the teams had to adapt to delivering IRIS under pandemic restrictions, rapidly followed by the need to accommodate the impact on primary care of the vaccination programme.

***The way the partnerships are structured.*** For phase 1 boroughs, IRISi contracted with four different delivery partners: nia in Barking & Dagenham, Solace Women's Aid in Tower Hamlets and two organisations in Croydon (Bromley & Croydon Women's Aid and the Family Justice Centre). Waltham Forest was funded separately but also had Solace as the delivery partner. By contrast, IRISi contracted with Advance as lead delivery partner for all four phase 2 boroughs (Westminster, Brent, Ealing and Hammersmith & Fulham) with Advance sub-contracting the Asian Women's Resource Centre to provide specialist BAME advocate educators.

In addition to these overall differences which are likely to have had an influence on the progress of phase 1 and 2 boroughs, there have also been some contextual differences between individual boroughs which we note in the next section.

## 2.2. The implementation of IRIS in each borough

**Phase 1 boroughs**

***Tower Hamlets***

**Context:** The delivery partner in Tower Hamlets has been Solace, a well-established specialist agency with experience of running IRIS in other boroughs. Tower Hamlets is a borough with a very diverse population, high levels of poverty and health inequalities, with DVA and harmful practices both significant concerns. IRIS was generally welcomed as having an important role to play but a key contextual issue which affected its implementation was the fact that an earlier IRIS programme had been in place, led by a different lead agency. The advantage of this was that many GP practices were familiar with IRIS and keen to refer to it, but the downside was reluctance among some GPS to undertake the training prior to making referrals because they felt they'd done it already. This resistance was undoubtedly amplified by the additional pressures of COVID.

**Staffing:** Having Solace as the lead agency enabled the secondment of an experienced worker into the senior AE role. After a few months, Solace was also commissioned to run the borough's IDVA service which provided the further advantage of both IRIS and the IDVA teams being managed by the same manager. The first senior AE remained in post until September 2021 when she moved on. It took a while to replace her, and recruitment and retention of the second AE post has also been quite difficult – there have been two

postholders in this role with gaps in between. Two CLs were appointed from the start, both local GPs. One went on maternity leave after year 1, but a replacement was soon appointed.

**Practice engagement and training:** The IRIS team initially developed a flexible approach to practice training to take account of the additional COVID pressures on their capacity and to recognise that some had previously received IRIS training. Training was offered on a network level as well as via whole practices, and shorter refresher courses were offered to previously trained practices (although this was hampered by there being no reliable records of which practices/practitioners had received training). Throughout the programme, however, practices were encouraged to undertake the training according to the IRIS model (i.e. whole practices undertaking training together as far as possible with the majority of practitioners needing to be trained in a practice before they are able to refer to the AE) and in the last few months the IRIS team reverted to a strict model of only accepting referrals from trained practices. However, the implementation of training in Tower Hamlets remains partial and the withdrawal of the referral route from practices that were not fully trained has been poorly received by some clinicians.

**Referrals:** As noted above, the service in Tower Hamlets was opened to GP referrals early on and, with many practices being already familiar with what IRIS could offer, the team received a steady stream of referrals from the start. Twenty-five referrals were received in the first quarter (March to June 2020), increasing to 45 in quarter 2 (July to September '20) and 51 in quarter 3 (October-December '20). These referral levels continued so that by the end of the programme the total number had reached 365, by far the greatest number across the whole 7B programme. The AEs have commented that they have received referrals of women at quite high-risk and needed to refer several on to the MARAC. The fact that Solace also runs the IDVA service in the borough was noted to be a big advantage: cases assessed as higher risk could be transferred easily to an IDVA without the need for reassessment or delay.

**Partnership working:** Tower Hamlets has had a good level of engagement in the steering group by the local authority (e.g. the safeguarding lead) and the CCG. The CLs have been strongly committed to the programme throughout and there has been a good level of team working between them and the AEs. There has been a strong commitment to making the case for retaining IRIS in the borough and our interviewees have been keen to avoid a repetition of the gap in provision that occurred previously.

***Croydon***

**Context:** Croydon is a large borough with 48 GP practices. Arrangements for implementing IRIS in Croydon have been somewhat more complex because there were two delivery partners, the specialist third sector organisation, Bromley & Croydon Women's Aid (BCWA), and a local authority in-house service called FJC (formerly the Family Justice Centre), who

also run the IDVA service. Each organisation has employed one AE and they have divided between them the work of engaging practices and receiving referrals.

**Staffing**: BCWA recruited an AE who came into post in March 2020 and has remained throughout the programme. There was delay in recruitment to the FJC post with the AE not starting until September 2020. Croydon also had only one CL (a local GP) for most of year one, with a second (a designated safeguarding children nurse) not starting until January 2021.

**Practice engagement and training:** Delivery started slowly in Croydon with the first AE having trained just one practice by September 2020. She was not an experienced DVA worker, and her progress was impeded by COVID starting almost as soon as she arrived in post. From the arrival of the second AE, recruitment of practices increased significantly so that by February 2021, four practices were reported to be fully trained and 26 practices had training dates booked. The vaccination programme contributed to some stalling of progress along with the illness of the FJC AE later in 2021. However, by the end of the programme 24 practices had completed training, half of the target number.

**Referrals:** Again, referrals were slow to start in Croydon, with only three received by the end of December 2020. Numbers increased during 2021 and by the end of the programme AEs had received a total of 109 referrals.

**Partnership working:** The slightly more complicated arrangement in Croydon introduced a greater risk of miscommunication (perhaps particularly so in a COVID-19 context without face to face meetings) but despite this, the combined team worked out ways of working together.

The steering group has been very supportive in making the case for re-commissioning, arguing that the DHRs in the borough are evidence of the continued need for IRIS.

***Barking & Dagenham***

**Context**: The delivery partner in Barking & Dagenham is nia, a specialist organisation which provides some community-based services in the borough but not the IDVA service which is provided by Refuge.

**Staffing:** There was some initial delay in recruiting AEs with the first not starting until the end of September 2020 and the second in November. The first AE then left in July 2021 and the second has continued in post on her own. Fortunately, early implementation was enhanced by the recruitment of a very experienced CL who is also the GP Safeguarding Lead. This CL has remained linked to the programme throughout the whole period.

**Practice engagement and training:** The delay in AE recruitment was partially off-set by IRISi's regional manager stepping in to run initial courses with the CL whose extensive networks in the borough helped to promote the training. The initial approach to recruiting

practices to the training was according to the usual IRISi model i.e. the training was promoted to individual practices with the highlighted requirement of 75% attendance. However, the number of single-handed GP practices in the borough meant that some of the initial training courses combined staff across two or three practices and by the second round of recruitment individual practitioners were signing up across several practices. At this point the team opted to take a flexible approach to maximise the take up of training. The downside to this approach is that it resulted in individual practitioners opting into the training rather than attendance being co-ordinated through their practices, so that although a lot of training had been delivered by the end of year one, not many practices had been *fully* trained. From January 2021 the team decided to prioritise whole practice training, but they then ran into the issue of practices needing to prioritise the vaccination programme. By the end of year 2, ten practices were fully trained, 30% of the target number.

**Referrals:** Referrals were initially slow to come through. By the end of December 2020 just five referrals had been received although this started to increase during 2021 and a total of 94 referrals had been received by the end of the programme in March 2022.

**Partnership working:** The level of engagement in the local steering group has been good and includes attendance by the local authority (Community Safeguarding), Refuge and the CCG, although attendance from the CCG was affected by their representative being redeployed to the vaccination programme for three months. An early issue which emerged was the role of social prescribers in the borough and concerns that GPs would refer to them instead of IRIS, leading to potential confusion and delay. The manager of the service joined the steering group, and the IRIS pathway was opened to social prescribers who were included in the C1 and C2 training. AEs worked with social prescribers to triage DVA cases directly to IRIS and this has been a very positive element of partnership working in the borough.

The lead partner agency, nia, does not run the IDVA service (this contract is held by Refuge). Where the lead agency runs both IRIS and the IDVA service, they undoubtedly have an ease of cross-referrals between teams, and in the involvement in wider inter-agency networks. It is difficult to assess what difference this has made for nia in B&D but it is likely to have been a disadvantage.

In March 2021, Barking and Dagenham published a report from their local Commission on Domestic Abuse chaired by Polly Neate[2]. This Commission (which was the first in the UK) gathered local data and included the views of residents, survivors, staff and other key stakeholders. The report made several recommendations for both preventing DVA and

[2] https://modgov.lbbd.gov.uk/internet/documents/s143521/DA%20Commission%20-%20App%201.pdf

improving the response to survivors in the borough, including better training for all practitioners across all agencies. IRIS is cited in the report as a positive initiative.

***Waltham Forest***

**Context:** Waltham Forest was not funded under the 7B programme but from a one-off source identified by Public Health. Funding was also initially only for one year, but savings made by deferring the appointment of a second AE enabled extension across the 2 years. We were asked to include Waltham Forest as an 8th borough in the 7B programme partly because it was being implemented across a similar timescale and partly because Waltham Forest has a local VRU and there was interest in what difference this made to the progress of implementation. The lead delivery partner is Solace who are well established in the borough.

**Staffing:** The first AE appointed got the project established but left in November 2020 shortly after the arrival of a second AE who unfortunately also left after a few months– again shortly after the arrival of another AE. In June 2021 a senior AE was appointed so there have been 2 AEs in post since then. Hence Waltham Forest has had four different AEs over the two years with just one individual in post for most of the first 18 months. The CL has been consistent and supportive throughout. Unfortunately, she is not a Waltham Forest practitioner, and this has almost certainly been a drawback in terms of having local networks and influence with other GPs.

**Practice engagement and training:** Although IRIS was set up in Waltham Forest early in 2020, training only got properly started in in July due to COVID and the need to revise the materials for on-line delivery. Despite this delay, and concerns that some of the initial momentum had been lost, Waltham Forest had achieved 3 fully trained practices by November 2020. Progress in early 2021 stalled due to lockdown 3, the illness and departure of the second AE and the pressures of the vaccination programme. By the end of March 2022 nine practices had been fully trained (out of a target number of 39).

**Referrals:** Practices were invited to make referrals from March/April 2020 so that the delay in training should not impede GP's access to the AE service, but once training got established, the referral pathway was restricted to those practices who had been trained. Between April and December 2020, the AEs received 20 referrals including some from social prescribers who were included in the training. During 2021 referrals gradually increased so that by the end of the programme 66 referrals had been received.

**Partnership working:** As noted, Waltham Forest is not formally part of the 7B programme but locally funded following longstanding concerns about GPs not making any referrals to the MARAC. This funding is from a one-off source, so partners were keen to be involved in the wider programme in order to capitalise on any evaluation and sources of evidence that

might help them make the case for sustaining IRIS. The steering group has had a good level of engagement from partner agencies.

There is a local VRU in the borough and there was some interest in learning about the difference this made to IRIS. Unfortunately, we have not been able to identify any discernible difference and the VRU does not seem to have been actively engaged with IRIS in the borough.

**Phase 2 boroughs**

The phase 2 boroughs got started towards the end of 2020 so have had around 16 months of implementation. As there is therefore less detail we're providing an overall picture of their implementation rather than reporting on them individually.

**Staffing:** IRISi commissioned the same delivery partner, Advance, for all four boroughs. Six full time AEs were employed by Advance: four who have been full-time in a single borough, and two working across two boroughs – half-time in each. In addition, Advance has worked in partnership with the Asian Women's Resource Centre who have employed two further AEs who each worked across two boroughs to provide specialist BAME support. This means that each borough has had a team of 3 AEs, one full-time in the borough and two half time. Most of the postholders have been experienced DVA workers. Oversight of the phase 2 IRIS programme has been with one Advance manager who has line managed the Advance AEs (although AWRC staff have had their own line manager). Retention of AEs has been a challenge over such a time-limited programme. By the end of 2021 two of the Advance AEs and both AWRC AEs had left, although coverage has been maintained across all four boroughs.

CLs were recruited for all four boroughs. In both Westminster and Hammersmith & Fulham the role has been held by individual local GPs. In Ealing, the role was shared between two GPs, and in Brent between a GP and a Safeguarding Lead nurse.

**Practice engagement and training:** Initial engagement of practices started well across the phase 2 boroughs in November/December 2020. In early 2021, all were reporting challenges in recruitment to training because of the vaccination programme. However, overall progress has been very good as shown in table 1.

**Referrals:** The progress of referrals was initially slow across all the phase 2 boroughs, but this gradually picked up during 2021 so that by the end of the programme in March 2022 Brent had received 56 referrals, both Ealing and Westminster 58, and Hammersmith & Fulham an impressive 98 referrals.

**Partnership working:** The management of IRIS by a single lead agency across the phase 2 boroughs has brought some advantages in terms of team working. The AEs have been appreciative of the varied skills of their colleagues and working in small teams of three may

have helped to reduce the isolation of postholders working from home. The pressures of working across two boroughs for some of the AEs was identified early on as an issue and attempts to manage this by allocating specific days to each borough only seemed to partially resolve this.

The partnership between Advance and AWRC seems to have worked well overall although the partnership arrangement meant that AWRC postholders had both an organisational line manager as well as being accountable to the Advance manager responsible for IRIS and it was noted that the supervision and management elements for AWRC was under-funded. The AWRC AEs also found themselves in great demand because a sizeable proportion of referrals required the input of a specialist BAME AE.

The engagement of steering groups in phase 2 boroughs seems to have been positive and supportive. There have been some glitches in local relationships. In one of the boroughs for example, a key player in the CCG seems to have been resistant to offering their support, reportedly due to difficulties in establishing a positive early relationship. This is likely to have impeded progress there, despite an exceptionally positive and committed AE. However, overall, the additional lead-in time for phase 2 gave IRISi the opportunity to get CCGs and other key players more engaged, with stronger co-ordination of involvement across all the north-west boroughs. On the other hand, there was less time for phase 2 boroughs to get IRIS established prior to having discussions about ongoing funding and our interviews with partner agencies suggest that these discussions would have benefitted from more time to get IRIS bedded in.

## 2.3 Numerical overview of implementation in phase 1 and 2 boroughs

The information in the tables below is drawn from the quarterly data submitted by IRIS teams in each area.

**Table 1: Training delivered by programme end**

| | **Phase 1** | | | **Phase 2** | | | | |
|---|---|---|---|---|---|---|---|---|
| | ***Tower Hamlets*** | ***Croydon*** | ***B&D*** | ***Brent*** | ***Ealing*** | ***H&F*** | ***Westminster*** | ***Total*** |
| ***No. practices targeted*** | 36 | 48 | 33 | 51 | 25 | 27 | 33 | 253 |
| ***No. fully trained*** | 15 | 24 | 10 | 15 | 18 | 22 | 14 | 118 |
| ***Per cent achieved*** | 42% | 50% | 30% | 29% | 72% | 81% | 42% | 47% |

Waltham Forest had 39 practices targeted for training of which 9 (23%) were fully trained by programme end.

| Table 2: Referrals received by programme end | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Phase 1** | | | **Phase 2** | | | | |
| ***Tower Hamlets*** | ***Croydon*** | ***B&D*** | ***Brent*** | ***Ealing*** | ***H&F*** | ***Westminster*** | ***Total*** |
| 365 | 109 | 94 | 56 | 58 | 98 | 58 | 838 |

Waltham Forest had received 66 referrals by programme end.

Of the 838 women referred to the 7B programme by the end of March 2022 (excluding Waltham Forest), 691 (82%) had received support from an AE. There were 95 cases referred on to the MARAC, 20 to adult social care and 69 to children's social care.

## 2.4. Demographic information on referrals

***Ethnicity***

| Table 3: Ethnicity of people referred to IRIS across the 7B programme | | |
|---|---|---|
| ***ONS Categories*** | | |
| White | British | 132 |
| | Irish | 6 |
| | Gypsy or Irish Traveller | 2 |
| | Eastern European | 18 |
| | Other White background | 42 |
| Mixed/Multi Ethnic Background | White & Black Caribbean | 8 |
| | White & Black African | 0 |
| | Other mixed/multiple | 9 |
| Asian/Asian British | Chinese | 2 |
| | Bangladeshi | 142 |
| | Indian | 35 |
| | Pakistani | 31 |
| | Other | 52 |
| Black/African/Caribbean/Black British | African | 35 |
| | Caribbean | 42 |
| | Other Black/African/Caribbean | 20 |
| Other Ethnic Group | Arab | 3 |
| | Any other Ethnic group | 30 |
| | Don't know | 224 |
| | Total | 838 |

As shown in table 3 above, 132 of the 838 referrals to the 7B programme (excluding Waltham Forest) were of White British individuals (15.8%) with a further 68 (8.1%) from other White backgrounds. 262 (31.2%) were Asian/Asian British, of whom 142 (16.9%) were of Bangladeshi origin. 97 (11.5%) were Black/African/Caribbean/Black British. Ethnicity was unknown for 224 referrals (26.7%).

***Gender and Age***

As table 4 shows, 760 (91%) of referrals were female and 42 (5%) male. Gender was unknown in 32 (4%) of cases. Two individuals identified as transgender male to female and two as non-binary. Additional self-identification categories provided were transgender female to male, intersex, people with variations in sex characteristics, gender fluid, agender, bigender, polygender and other. No patients identified as any of these.

| **Table 4: Gender as identified by patient** | | |
|---|---|---|
| Female | 760 | 91% |
| Male | 42 | 5% |
| Transgender male to female | 2 | 0% |
| Non-binary | 2 | 0% |
| Don't know | 32 | 4% |
| TOTAL | 838 | 100% |

The majority of referrals were of people in the middle age groups with over a third (35%) of aged 26-35 and a further 31% aged 36-45.

| **Table 5: Age of people referred** | | | |
|---|---|---|---|
| **Age** | 16 – 25 | 74 | 9% |
| | 26 - 30 | 148 | 18% |
| | 31 – 35 | 143 | 17% |
| | 36 - 40 | 145 | 17% |
| | 41 – 45 | 121 | 14% |
| | 46 - 50 | 58 | 7% |
| | 51- 55 | 45 | 5% |
| | 56 - 60 | 28 | 3% |
| | 61- 65 | 16 | 2% |
| | 66 -70 | 6 | 1% |
| | 71+ | 17 | 2% |
| | Don't know | 37 | 4% |
| | TOTAL | 838 | 100% |

***Sexual orientation and disability***

The data on sexual orientation is incomplete with information unknown for 238 (28%) of referrals. 70% (589) were recorded as heterosexual with 8 as bisexual, 1 pan sexual, 1 lesbian and 1 gay.

Data on disability is also very patchy. 59% (492) were recorded as not having a disability. In 29% (242) the information was not known. 25 were recorded as having a disability, but type unknown, and 25 as having a physical disability, type unspecified. 9 were recorded as having a learning disability and 9 a mental health disability.

***Gaps in the data***

The gaps in demographic data can be partly attributed to the fact that AEs were only able to collect information from women who gave consent. These were women who engaged with the service. Some of these chose the option 'prefer not to say' and these were recorded as 'Don't know'. Data could not be recorded for women who were referred but declined support/were not possible to contact, or those who were immediately referred onto MARAC or other services.

## 3. What impact has IRIS had on the practice of clinicians in primary care?

In order to understand whether IRIS had impacted actual day-to-day practice in patient consultations we contacted clinicians between two and five months after they had completed their IRIS training. A total of 20 staff working in general practice in the 8 boroughs (15 GPs and 5 social prescribers) provided us with feedback on the training they had received, the impact it was having on their practice, and their views on the quality of the service received by the patients they had referred to IRIS.

We were extremely impressed with the response of GPs to our request for an interview in the context of the COVID pandemic. For example, in July 2021 we contacted 15 GPs by email, 11 responded immediately and we were able to arrange interviews with all but one. Given the pressures under which GPs are working – and the additional burden of the vaccination programme at the time of these interviews – this was a stunning response rate. In itself, this indicates the value of IRIS to our respondents. A second round of contact was made with practice staff, and additional interviews conducted, between January and March 2022.

## 3.1. What did practitioners think of the training?

All staff interviewed had attended C1 training and all but one had attended both C1 and C2 sessions. Almost all their feedback on content and delivery was extremely positive. Recall of the content was specific and included details of those aspects they had found particularly useful:

*We all agreed that the training was informative, organised, and presented with sensitivity. The content was pitched to our needs and the pace of the talks given were also just right.*

*The training was excellent. I found it a real eye opener. The model of teaching was good – it was very thorough but also so practical. For example, it gave us practical examples of what language to use with patients – how to approach the issue. It can be very awkward for GPs because we tend to know the whole family including the perpetrator. The training was very useful in explaining what to record on the notes and how to record – for example to ensure that a note is included on the children's records and the perpetrators but also how to record so that it is concealed from the perpetrator.*

*I'd had no training on DVA prior to IRIS. Even in adult safeguarding training although it gets mentioned it isn't covered in any depth. I enjoyed it actually and appreciated the virtual training which was more amenable to me – I could do it in the practice knowing that I was here if an emergency came up – much more convenient than having to go somewhere else.*

*Very good training – one of the better ones I've done especially doing remote delivery. It was well thought out and prepared, pitched very well to our needs and used very good and relevant case examples.*

*We particularly liked the scenarios and role plays which were helpful in giving insight into real life situations and the sort of things to look out for and the ways to respond. The role plays in C2 were particularly helpful. There was good participation despite it being on zoom.*

*We've now done both sessions and had amazing feedback from staff. Yesterday the second session was led by [AE] – beautifully paced delivery – understandable and empowering. So thorough and no 'ums' and 'ahs'. There were clear instructions about what people should do if they have a concern. People were chipping in and talking about their own cases – no long silences. Lots of examples used which resonated. Other safeguarding initiatives could really learn from this.*

*The training was excellent. It really helped us to think about how to pick up on issues of domestic abuse and how to ask about it especially in the context of phone consultations. …It's very difficult to find ways of talking about DV when you can't make eye contact or pick up on body language. And, as the training made very clear, you can't ask about DV unless you're certain that the patient is on their own which is very hard to be sure of by phone.*

The pace and structure of the sessions was thought to be appropriate:

> *The two sessions is a really big commitment but I wouldn't have shortened it – and the sessions didn't feel too long when we were in them.*

> *I liked the structure – 2 sessions felt right…an intro and then a follow up to consolidate the learning.*

The importance of refreshing and revitalizing knowledge about DVA was highlighted. One very experienced doctor commented on her own learning:

> *As I've been passionate about women's health for 25 years, I was really struck that I should know all this about domestic violence; but I didn't, and I really learned a few things: the Duluth Wheel for example.*

We only received two critical comments about the training, and both related to the pressures of undertaking it in the middle of a busy day. One GP also commented that there were some limitations to it being delivered by Zoom, but she still found it 'generally informative'.

Attendance in most informants' practices had been generally good – and a couple commented how much all their staff had got from the training – administrators as well as clinicians:

> *I had feedback from couple of reception staff who are also part of the local community. They were very positive [about the training] and said they feel they've learned a new skill.*

However, a couple discussed challenges they were encountering in getting colleagues to attend the training:

> *Only one of the male GPs in my practice attended the training. I'm afraid they think domestic abuse is not their responsibility. But also none of the practice nurses attended.*

Interviewees all thought that training administration staff was really important although it had not yet taken place in all practices:

> *Our admin are not trained yet but that will be really useful because they do so much 'triage' when they ask 'Can you tell me a bit about…?' and they see stuff going on in the waiting room that we don't see.*

Most GPs blamed the pandemic and the pressures people were under for delays in getting this training organized but one thought there was some resistance because:

*I think people think they know enough about domestic abuse these days because it's in the media much more, so it's harder to convince them they need training than it was a few years ago.*

One GP thought the main problem was that there was no 'protected time' allocated for the training:

*It's a big ask for GPs to do it in their own time and if this **had to be** a voluntary activity then making some Saturday mornings or evening slots might be a good idea. However, if this training was a priority for the government or for London (as funded by MOPAC suggests) it should be protected.*

## 3.2. Has the training made a difference to their practice?

Interviewees told us that the training had succeeded in increasing their awareness of the issue of domestic abuse; made them feel confident and comfortable talking to patients about abuse or about asking 'the question' and about what to do 'once the 'can of worms' had been opened'. It had also raised their consciousness about lower level risk and how this could escalate; about the barriers to disclosure that might be experienced by particular groups such as disabled, older, Black, Asian or traveller women and about abuse perpetrated by ex-partners or by other family members.

*The training has absolutely made us more aware of the problem of domestic abuse. It has helped us to identify this, to know how to document this and, most importantly, it has given us an avenue to refer.*

One GP who said that it had definitely altered her practice as she was now 'actively seeking the issue out' explained what had changed:

*What's made the difference is that I'm confident of how to respond to a disclosure and confident of what will happen if I refer. Also the added confidence from having someone to consult – by phone or a quick email. I have made a number of referrals in the last 2 months including where I wouldn't have done so in the past – and wouldn't even have known I could for example in cases where the abuse was historic but still impacting on mental health. A specific example is one woman I referred who is no longer in a relationship but is still receiving threats from her ex partner.*

This was echoed in a number of other interviews:

*I ask more. 100% more. It's now a normal question to start with an easy opener: 'How are things at home?' I'm now unafraid to ask: 'Do you feel safe?', especially at post-natal checks and with Mums with young children, and I don't just stick to the 'mummy' questions.*

A couple of interviewees described some absolutely immediate impacts on their clinical practice:

> *I've done the first part of the training – the initial 2 hours. I hadn't heard of IRIS before but the timing couldn't have been better because in the same week I got a patient who disclosed DV – quite unusually she just came out with it. If it had been the week before I'd probably have handled it quite differently – I wouldn't have been so sure what to do, whether to make a police referral or go to adult safeguarding or whatever, but as I'd just had the training I could ring up Iris and talk it through and refer straight on to the AE. Which was great for me but also for the patient because I've had positive feedback from her about the support she's received. The training made me more comfortable about talking to the patient about DV and more confident about what to do.*

One GP who had recently attended the training told us:

> *This morning I've just done a case review about a pregnant patient who has been presenting a number of cues which might signal possible DA – yesterday's training made me think about it. She's been talking about how busy and stressed her husband is- almost as if she's making excuses for his verbal aggression and it made me decide to just check in with her….*

Another described seeing a woman with an eye injury:

> *She said her two year old had hit her in the eye…it seemed plausible and there was nothing in her notes to suggest anything else might be going on, but because I'd just done the training I didn't take it at face value. It turned out that she'd just had a miscarriage…and her husband got angry… It's so easy to miss it, especially in the pandemic context when you've so much going on.*

And one interviewee gave an illustration of how the training had made her reframe a particular issue:

> *I referred someone who'd told me she'd punched her partner – not for 'anger management' but about her past abuse. I wouldn't have made that referral before the training from IRIS but it can prevent revictimization. We should be a preventative service but often we are just firefighting.*

A number of interviewees commented on the fact that the training was so important because 'these were not issues covered in medical school', and a GP from a training practice described the value of the IRIS training for newly qualified doctors:

> *The training has definitely given clinicians more confidence in identifying possible abuse and asking about it. For example, after session 1 my registrar obtained a*

*disclosure from a woman – a textbook case – she hadn't intended to disclose but was very grateful that she had and that she'd been referred to IRIS for support.*

Having seen the value of the IRIS training he planned to lead another in-house session just to consolidate the learning and keep the topic on the agenda, and the practice was intending to use it as a formal part of young doctors' induction from now on.

The training had clearly caused even highly experienced practitioners to reassess and alter their own practice:

*I feel although some of it was stuff I already knew there were some new skills in there as well. It's made me aware of patients experiencing DV that we've probably missed previously and it made me think about unusual presentations e.g. gynaecological issues….I've looked back at my own practice and I can see that I've missed a lot. I've not realized how common it is. Asian women get missed even more because of the language barriers and they are less able to navigate [seeking help] for themselves.*

It had also led to helpful conversations between colleagues:

*My practice has personal lists but I spoke to a woman who wasn't my patient and during the call her husband took the phone off her. I just wondered, and afterwards I went back and looked at her notes. I saw he always accompanied her to appointments. So I spoke to her own GP – my colleague – and said that he needed to see her on her own.*

*I loiter around corridors before I go home to see what the current issues and concerns are, and this has now become part of normal conversation – it's discussed and open and part of the ordinary.*

## 3.3. What has been the experience of making a referral?

The success of the IRIS model depends on trained staff going on to make appropriate referrals. Each of the GPs we interviewed had referred patients and most had also consulted their AE about possible referrals or contacted them for advice:

*We're very positive about IRIS as a practice. We had the initial training in February and the follow up in May. Since then at least three of us have made referrals – I've made three myself and I know our safeguarding lead has made them.*

In each case interviewees reported that they were very satisfied with how referrals had been handled. AEs were reported to be responsive, prompt and to have provided both excellent support to the patient and feedback to the referring GP:

*I have emailed [the advocate educator] quite regularly when I have a query about a referral or an urgent referral. …I find it extremely helpful to know exactly who my*

*referral is being sent to. I find [the AE] very accommodating; she responds to my queries within 24 hours. It is an excellent service.*

*I've had feedback from the AE in each case i.e. when there has been an outcome and information on what support is being provided. Also when the AE has been struggling to make contact with the client we've discussed whether an extra nudge from me as her GP would be appropriate.*

*I have already made a referral to IRIS and found them very responsive. Even though the AE I emailed the referral to was away, it was picked up by a colleague promptly and they've provided me with feedback on what they've done.*

*[The AE] is proactive and interactive and the feedback is quick. IRIS is excellent – we really need to keep it in the borough.*

One practice had made a few referrals shortly after completing the training that had not met the referral criteria. However, the GP we interviewed commented that although she had initially been disappointed that some were not eligible: "*I believe this was helpful for the team and the patients as they were guided on what other support could help."*

In every interview the direct referral route to a known worker was praised. One GP told us that the most important things for her were a) knowing who to contact and it being a personalized service: 'not an agency but a person' and b) that IRIS is about actually getting support for a patient not just about reporting (as in safeguarding referrals).

*I value the ability to phone up IRIS – they actively encourage you to do that which again is unusual – so you can talk through any concerns you have e.g. whether a children's safeguarding referral should be made. It feels very personal and reassuring for health care professionals.*

The fact that they had 'met' the AE in training meant clinicians felt confident that they were referring to someone with the right specialist knowledge and skill.

*Having someone with expertise so close to home is so helpful. There was an FGM issue and I consulted [AE] and she immediately came back with a whole load of resources.*

GPs emphasised how quick and easy it was to make a referral and contrasted that with referrals to other services of various kinds:

*Having a simple route for referral to the AEs makes a real difference. I've got their referral pathway on my screen now and its very straightforward; contrast that with the usual safeguarding pathway which looks like a plumbing diagram with lots of arrows and boxes. I feel that other agencies such as children's services could really*

*learn from this. My registrar reported that the whole referral process was smooth – they barely had to break step. User friendly processes are so important.*

*IRIS provide a really good response to referrals – they follow up if can't get in touch with someone to ask if anything else can be done. And give feedback (often you refer to an agency and never hear anything ever again so that's exceptional).*

*I've been so impressed at the way the IRIS advocate worked to contact, chase a particular client and persuade her to engage. It was different to other agencies you referred to in that regard.*

In addition to general comments, interviewees frequently provided specific examples of the nature and types of concerns about which IRIS had been able to provide support and advice. One GP described the range of referrals she had made in the last 6 months:

*Since training I've consulted [the AE] by email on whether a number of referrals were appropriate and actually referred 4 patients – all have been provided with support. One case has now closed and I had feedback from [the AE]. That surprised me. I didn't expect that and it was really nice and useful. The others have been for a wide range of issues: a patient who had just moved to [the borough] to escape abuse and was very isolated and too afraid to leave the house; another involved in a court case with her ex-partner needing support around that and one woman who had just disclosed historical abuse and was considering possible reporting.*

Other GPs detailed the range of information and support their AE had provided with specific cases:

*I had a case just after the training and called [AE]. I used her as a sounding board because it was a delicate situation and I wasn't sure if this was just an unhappy marriage or controlling abuse. You are in a funny position as a GP unless there is a very clear safeguarding risk but I knew I didn't want to just prescribe anti-depressants.*

*The best thing was we met in 3 way meetings at the surgery and I learnt so much! [The AE] talked to the patient about preparing a 'go' bag just in case she wanted to leave in a hurry and placing a list of where things were at the Surgery (like her passport) so she could access it without going home. And I set up monthly follow up appointments with her and was very aware of not texting/calling inappropriately as the training had alerted me to that.*

*[The patient's] husband came to see me as a patient and when I realized that I talked to [AE] and transferred him to a partner. [AE] said it was common for perpetrators to do this and try to present their different account of things. I also learned about*

*'hidden' notes being possible so they wouldn't expose someone if they accessed their medical records.*

All interviewees spoke extremely highly of the IRIS referral process, and described how the persistence or flexibility of the IRIS AE had been crucial in engaging and supporting clients:

*Without IRIS there's no other one-stop shop – so sometimes we'd just encourage patient to seek help for themselves and sometimes they don't…or maybe I'd refer to VSS [Victim Support]. With IRIS they will handle that onward referral and that makes us confident they'll get to the right place. For example, there's a woman who has been complaining to us about her husband for years but who would never go anywhere else for help under her own steam.*

*The most important thing about IRIS is that contact is so quick after a referral has been made. It means I can say to a patient that they will be contacted that same week and be confident it will happen and assure patient of that. That's unheard of in any other referral context.*

*The IRIS workers are excellent – they're like no other service we refer to be honest. They're unbelievably responsive and get back to us straightaway. They also email us most weeks to see if there's anything they can do to help. Recently we contacted them about a patient affected by FGM to ask who we could get support from – and they immediately said they could take that as a referral themselves.*

*I've made referrals since and had some good experiences. I've liaised with and attended a professionals meeting with [IRIS AE] over a woman abused by her son. She is now being supported by SOLACE, she's had an IDVA and MARAC referral and there has been very good liaison to get her housing sorted.*

*I've found it particularly helpful that the IRIS workers will offer support around historic abuse because that does get disclosed to social prescribers as part of their work – they've more time than GPs to listen to clients and it does come up. Helping people deal with previous trauma is so important.*

*We've had feedback from patients which has been very positive – for example a woman who appreciated the flexibility of support when the worker was willing to meet her face to face at the practice.*

*They really do everything to make it easier for patients – checking out which number to ring them on and arranging to see them at the surgery.*

*IRIS gives you a known person on the end of a phone and with something as important as this that's great. It's a very different experience to ringing social services and sitting on the phone for hours waiting for an answer!*

## 3.4. Is there anything about IRIS that could be improved?

There was a mixture of suggestions as to the best way to organise and deliver training. Most respondents valued the convenience of virtual provision, but while some felt that shorter one hour 'lunchtime' sessions were best, others would have preferred protected time to be allocated to enable longer in-depth workshop sessions.

*It has been a bit of struggle to fit it in and in the end we did the first lot of training in 2 one hour sessions so we could do it over lunch breaks. That worked well for us. Training between clinics isn't ideal – you are trying to eat lunch and do admin and listen! I'd prefer a proper 3 hour block of study leave. A lot happens in the week between sessions.*

A few GPs commented that it would be helpful if the IRIS referral pathway could be set up on/integrated with their existing computerized referral systems. Others said they would find a visual aide on referral useful:

*I think it would be helpful to have a few posters: 1 sided print out as aide-memoire as to who would qualify to be referred/ a flow chart that is easily able to be followed.*

A couple of GPs said they would value more joint working with AEs particularly on more complex or long-term cases:

*Perhaps in the future we may be able to have ad hoc meetings to discuss shared patients on our books and the progress being made.*

Some tentative suggestions were made in relation to the IRIS 'whole practice' model. A couple of locum GPs who had been trained didn't realise they wouldn't be able to refer to IRIS if they moved to a non-IRIS practice. They were disappointed that the IRIS model meant they wouldn't be able to 'take IRIS with them' even within the same borough. Some questioned whether this made sense in the London context where the workforce is particularly mobile.

# 4. What difference has it made to women and girls affected by DVA?

## 4.1. Case studies of referrals

As part of the routine monitoring of the 7 boroughs project AEs have produced two case studies for each of the boroughs each quarter. We analysed a sample of 35 of these case studies in order to explore the range of referrals received, the issues in women's lives, the interventions provided by IRIS AEs and the outcomes reported.

**Limitations of the case study data**

This data has a number of limitations as the sample is inevitably partial and 'biased' in various respects. In order to provide the necessary content it is likely that the cases selected by AEs are ones where a woman engaged well with the service, shared information about her situation/experience and received support over a period of time. They may be a-typical of all referrals received in these respects. In addition, it is likely that AEs selected those cases they considered most interesting: in some instances because they exemplified some experience or concern which had arisen frequently, or in others, because they 'stood out' as unusual.

A further limitation is that although guidance on case study reporting is provided by IRISi, it is not always followed, and the information included in case studies is often incomplete and inconsistent across the sample. It is therefore not possible to compare the case study sample with the pattern of overall referrals received by IRIS AEs and assess their representativeness.

**Profile of the case study sample**

The majority of women for whom information on age was provided were aged between 30 and 60 with an average age of 44.

| **Age range** | **No of women** |
|---|---|
| Under 20 | 1 |
| 20-29 | 3 |
| 30-39 | 5 |
| 40-49 | 7 |
| 50-59 | 4 |
| 60-69 | 1 |
| 70+ | 3 |
| *Information on age was provided in 24 case studies* | |

The case studies included women from a wide range of ethnic groups. One-third of those for whom information was provided were Asian British and a further third were White British/European.

| **Ethnicity identified** | **No of women** |
|---|---|
| White British | 6 |
| White Irish | 1 |
| Asian British/Indian/Bangladeshi | 8 |
| Black British/Afro-Caribbean | 4 |
| Black-White mixed heritage | 1 |
| Eastern European | 3 |
| Other European | 1 |
| *Information on ethnicity was provided in 24 case studies* | |

In the majority of case studies there were children currently resident with their mother, although in a quarter there were no children in the household.

| No of children in household | No of women |
|---|---|
| 0 | 7 |
| 1 | 6 |
| 2 | 8 |
| 3 | 4 |
| 4 | 0 |
| 5 | 2 |
| *Information on resident children was provided in 27 case studies* | |

All case studies included information on the identity of the alleged perpetrator(s). In two-thirds of cases the perpetrator was an ex-husband/partner/boyfriend. More than one perpetrator was identified in 8 case studies.

| Perpetrators identified | No of women |
|---|---|
| Current male partners | 12 |
| Ex-male partners | 23 |
| Father | 2 |
| Brother | 3 |
| Son | 2 |
| Other family members | 3 |
| *Information on perpetrators was provided in 35 case studies* | |

## 4.2. Thematic analysis of the case study sample

Notwithstanding the limitations outlined above, the case study sample provides a fascinating insight into the extent of domestic abuse experienced and its impact on the lives of women referred; the complex issues and multiple disadvantages faced by many of them; the range of interventions provided by AEs and the good outcomes this frequently facilitated.

### The extent and impact of domestic abuse

The case studies describe domestic abuse that includes physical violence, coercive control, emotional and psychological manipulation, death threats and financial abuse. In many cases women had suffered abuse over a long period - in one instance during 42 years of marriage - and their mental health had suffered. Anxiety, depression and chronic health issues had led

women to seek medical help and their abuse had been disclosed in the course of a consultation with their GP.

> *He used to threaten to hurt me and my family members if I tried to leave. Then he'd cry and apologise to me. He would threaten to attempt suicide and use emotional tactics to control me. I was not allowed to go out, and if I brought friends or family round, he would make them feel uneasy. At one point, he made me feel like I was going insane; I never wanted to get out of bed because he made me feel so small and insignificant... He made me believe it all.*

For some women in the sample abuse by their husbands had been compounded by abuse from other members of his family. In three cases women who had previously left their abuser experienced considerable pressure from family members to return particularly 'for the children'.

> *Now in her 60s, she can no longer use work and children to distract herself. She always thought with age things would get better but since the beginning of the pandemic, she has been at home alone with her husband and this has made things worse. When her daughters were younger she went twice to a women's refuge, but both times was persuaded to return to the perpetrator by her family, mainly her mother, who believed that if she left or divorced this would bring shame upon the family and make it difficult for her daughters to get married to someone from their community when they grew up.*

Such long-term abuse suffered by women now in their 50s and 60s was described in a number of case studies. However, the situation most frequently described was one of current abuse and control mainly being experienced by slightly younger women post their separation from a partner. In three cases women were still being threatened and harassed from prison by abusers who were serving sentences for domestic abuse. Others had court orders in place that were failing to protect them from stalking, manipulation and blackmail. One woman never left her flat for fear of being found by her ex-husband. The ongoing impact on women's mental health was considerable and a safe and secure life for their children and themselves often seemed almost impossible to achieve.

> *Since her ex had discovered where she lives she has been stalked in person as well as online. He drives around her home and sends her nasty voice messages. He recently turned up asking to see the children and stole money and door keys.*

Abuse had frequently escalated during Covid lockdowns and mothers were concerned that the impact on their children had consequently increased:

> *Five years after separating the perpetrator still tries to control her and the children's life despite a court order being in place. He regularly turns up to the house without consent and the children are fearful about seeing their father although he often lures them with*

*gifts. Her son has severe anxiety that stems from a young age after witnessing the assaults. Since the lockdown the perpetrator has been ringing up and emotionally abusing her and putting her down for her parenting.*

**Complex issues and multiple disadvantages**

In many of the cases studies women were experiencing domestic abuse in combination with other severe disadvantages. Poverty, as well as economic abuse by a perpetrator, was frequently part of the picture. Some women had 'no recourse to public funds', while others had neither jobs nor benefits in their own right or did not know what they were entitled to. Disability and serious health issues featured frequently – including the support a child with a disability such as autism required. Fear of homelessness, the possibility of children's services involvement and insecure immigration status represented considerable barriers to some women leaving abusive relationships.

*In the process of divorcing her husband but he has threatened her and her children with homelessness, and he has not made any payments toward the mortgage or towards child support since they separated.*
*She has three children under the age of 9; one has a disability and additional vulnerabilities, and T is the fulltime carer. She had accessed a refuge in the past but the epileptic seizures of her special needs child had increased and she was therefore afraid of being homeless or of going into unsuitable accommodation.*

*Married in Bangladesh aged 16 to a much older man: her husband had paid a dowry to her family, who were extremely poor, and she was extremely concerned that this would have to be repaid if she left the marriage. She had no relatives or friends in the UK and had been pressured and physically abused by her husband and members of his extended family. Her movements were monitored and the only place she could go independently was to her local Children's Centre.*

A couple of women faced the additional complexity of their abusers being gang affiliated. Others had experienced multiple forms of abuse across their lives or intergenerational abuse from fathers, brothers, and even from sons who had previously witnessed domestic violence:

*Her son is now 18 – she left an abusive marriage 6 years ago – but he has learned behaviours from his father. He witnessed verbal, physical and emotional abuse and has been coming home drunk once or twice a week for some time now and has been verbally abusive, using his male privilege. She feels it is ruining her life and that of her young daughter – but she is also conflicted about what to do because he too is vulnerable.*

For some women with long histories of abuse, poor mental health was not just a consequence of abuse but also formed an additional barrier to escaping their current situation. In common with women with a disability or chronic illness they were often dependent on their abusive partners for 'care'.

An additional complexity that emerged from some case studies was that of perpetrators portraying *themselves* as being the victims of domestic abuse - sometimes telling friends and family or sharing their account on social media and in one instance, where a woman had threatened to disclose domestic abuse, the perpetrator had reported her to the police for abusing him.

**The range of interventions provided**

It is clear from the case studies that AEs provide a very wide range of support: legal, practical and emotional. This often included:

- Safety planning around separation and co-habitation
- Safety planning around child contact arrangements
- Safety planning around mental health
- Civil remedies advice
- Housing advice
- Financial advocacy

In many cases support with on-line access to services, form filling and translation was often necessary as well as undertaking extensive consciousness raising around abuse, women's rights and empowerment.

- *We are supporting her with a housing transfer and with support for the upcoming fact finding hearing .*
- *We have requested for her address to be flagged and are liaising with the Police to get an update regarding the reports she had made.*
- *We have liaised with the school so that there is support in place for her child.*
- *We have also been looking into specialist counselling as P now feels that she is ready to address the trauma and abuse she had endured for many years.*
- *We are considering the possibility of a referral for a Domestic Violence Economic Abuse Advocate to help her with her debts and finances.*

Case studies frequently included information on which aspect of the support or intervention had been most appreciated by women. In many cases it was the combination of emotional and practical support that seemed to be key:

*The amount of support, compassion and understanding is truly invaluable and immeasurable. Not only has [AE] been checking up on us during these difficult times, helping with advice, kind words and facilitating fast progress of our case, but she has gone above and beyond most other professionals by donating food and dishes to us in the time of need.*

*My experience with the service, especially you, so amazing. I've never been supported like this before. I really appreciate you. You came out to support me - the love is so overwhelming. I did not expect that.*

## 4.3. Outcomes facilitated

A wide range of positive outcomes were reported to have resulted from IRIS interventions. These included 'hard' outcomes such as prosecutions and convictions of perpetrators; obtaining Restraining Orders; women returning to work and education; children back in school or college; families being re-housed and benefits being accessed:

- *R was successful in accessing safe temporary accommodation for herself and her two children.*
- *R was successful in her immigration application and now has access to public funds.*
- *R was able to maintain her employment and temporarily reduce her hours, following the AE supporting letter.*

- *N obtained a grant to support her Children's wellbeing and educational needs.*
- *N has completed all the relevant forms needed to obtain the Individual Assistance Programme Covid Winter Grant.*
- *N received appropriate onwards referrals from her GP to address ongoing health conditions.*
- *N has arranged to start college again once the children return to school.*
- *N successfully found a Council House swap in a different borough.*

Other 'softer' outcomes frequently included feeling safer and better able to cope and make decisions. Most fundamentally, awareness, knowledge and confidence were the 'foundational' outcomes that had been facilitated for women across the case studies. Such outcomes were frequently reported by both AEs and women themselves:

*Advice from a solicitor about non-molestation orders and child contact arrangements have meant she reports feeling more confident about taking legal action in the future if she needs to. She has also explained to the perpetrator and asked him to support her in keeping to the arranged child contact agreement. She is starting to feel more confident in addressing her needs.*

*I really appreciate you being willing to listen and to talk to me about everything and thank you for making me feel confident that I can do this. You've been patient even when I haven't been moving forward when I should be.*

It is difficult to over emphasise the power that such increases in awareness, knowledge and confidence can have in altering the course of women's lives:

*If you had not told me about the destitution domestic violence concession and my rights as a victim of abuse on a spousal visa, I would have remained with him for the next 10 years.*

## 5. What can be learned from the 7B experience?

As is evident from the report so far, the most important lesson from the 7B experience is that a well implemented IRIS programme can be immensely successful in reaching clinicians, supporting them to change their practice and ultimately improve outcomes for women affected by domestic violence and abuse.

However, effective implementation is key and there are some useful lessons about the process of this which are relevant for IRISi and similar future initiatives.

It has first to be acknowledged that the context of the 7B implementation has been very particular. All the teams and their partner agencies have experienced greater challenges due to COVID-19. Phase 1 boroughs were arguably hit the hardest, with lockdown 1 arriving just as they were getting started, but phase 2 boroughs also had to adapt to a continually changing context in primary care: including the pressures of the vaccination programme, the impact of staff shortages and numerous competing priorities.

Implementing a new IRIS programme is always going to be challenging but there is no doubt that the pandemic made it harder in several respects including:

- **Recruiting practices** to the training when they were under so much additional pressure. The AE and CL teams have had to be additionally persistent and creative in using all possible channels of communication, working on getting the messaging right to emphasise the value of the training, capitalising on any pre-existing networks, and making repeated contact with practices without appearing to be 'harassing' them.
- **Delivering the training entirely on-line.** This required some different training skills compared to face to face delivery and some rapid adaptation of the materials by IRISi. Engaging people in on-line training can be more difficult (with participants having the option of keeping their cameras off etc) and it can be harder to keep

participants' attention for longer sessions. It also makes the quality and readability of the slides even more important.

- **Maintaining relationships with practices beyond the training.** Mostly it has not been possible for AEs to maintain ongoing relationships with primary care practitioners by being visible in practices, so they have had to compensate for the more restricted personal contact by communicating in other ways e.g. by producing newsletters.
- **Coping with staff isolation** and the additional challenges to team working when staff do not have face to face contact. COVID restrictions have undoubtedly impacted on team communication and relationships (e.g. between AEs and CLs and between AEs and their organisational colleagues).

However, not all the 'side effects' of COVID have been negative. AEs have also noted that, for the most part, on-line training delivery has been very successful (particularly once the training materials were fully revised and updated in 2021) and for many clinicians the ability to access the training virtually has been positively welcomed. AEs have appreciated the time saved by not having to travel for training and enabling them to fit more into their working day. They have also commented that the women referred to them for support have mostly been happy with virtual contact and although, as COVID restrictions have changed, some support has again been provided face to face, on the whole the demand for this has been minimal.

An obvious factor which always affects the implementation of an initiative is the **recruitment and retention of staff**. COVID factors have had an impact on this too, for example by contributing to initial delays in recruiting AEs in some phase 1 boroughs. Over the course of the programme there has inevitably been some turnover with staff leaving for other posts and as noted in section 2 of this report, some boroughs have experienced significant gaps in AE coverage and the loss of valuable experience. Recruiting staff to short term contracts is challenging under any circumstances, and in some instances, recruiting AEs with the ideal mix of experience and skills has been difficult with a couple coming into post with little or no direct experience in the DVA field. This has relied on them having transferable skills in related areas and learning fast 'on the job'. COVID-19 has had an impact here too, with new staff having fewer opportunities for the informal learning from colleagues which is normally such an important part of starting a new role. Some service managers in phase 1 boroughs noted that this had meant them spending more time in supporting staff.

**Support to AEs** is always important and it's been even more so in a COVID context. Feedback from AEs indicates that they have generally felt well supported by their host agency, although one of our observations is that this has probably been easier in settings where, in addition to their line manager, the AE has also been able to access support from colleagues in a similar role. The AEs in phase 2 boroughs certainly seem to have appreciated

the benefits of being able to work more as a team due to the same lead agency operating across all three boroughs.

**Roles and relationships**: As well as it being important for AEs to have supportive relationships within their lead agencies, another key factor which can enhance or impede the process of implementation is the quality of relationships across the team and within the borough. **The clinical lead** can play a vital role in engaging practices and providing the clinical expertise and professional networks which are so important for the credibility of IRIS. Where it works well, the AE and CL work as a team with the CL acting as a door-opener, advisor and trouble-shooter. How the CL fulfils their role will inevitably vary depending on their own background and experience and the extent to which they are known in the borough. Experienced, local and well-networked CLs certainly have an advantage, but to derive most benefit from their role, some time and attention is needed to develop a mutual understanding between AEs and CLs of their roles, how to work most effectively as a team and how to make the best of their respective strengths. Clarity about the CL role, and particularly their ongoing contribution once the initial delivery of training is complete, is important.

Establishing good relationships with people in key roles in the borough is also important. VAWG leads in the local authority and safeguarding leads in the CCG can play a particularly vital role in advocating for IRIS and smoothing the process of implementation. Where these relationships are not established, or worse, where they go wrong, such key individuals can seriously undermine progress. The role of steering groups can be very useful here. Overall, the steering groups for the 7B boroughs seem to have been productive but there has been variation across groups and across individual members in respect of their involvement – some have been very proactive, others have attended meetings but not taken an active role beyond that. Steering groups can also be a helpful means of **communicating about the IRIS model** across the borough/CCG. A few of our interviews with external stakeholders suggested that the model is not always universally understood or appreciated. For example, a few interviewees commented that they didn't entirely understand the differences between IRIS and the IDVA service or why an additional service was needed. There was not always a sense of 'ownership' of the IRIS initiative in their area: our interviewees were generally appreciative of having been 'given' IRIS but it was not necessarily integral to their borough's DVA strategy or commissioning plans.

A further important lesson from the implementation of the 7B programme is that **quality matters.** The feedback from GPs in particular highlights the value they placed on the quality of the training and of the response they received when they referred to an AE, frequently comparing their experience of IRIS very favourably to other services they had used. From a clinician's point of view one of the most important selling points for IRIS was the fact that it offers a single, clear **pathway of referral to a named worker**. Maintaining this quality of

service and 'selling' its benefits to key decision makers needs to be a major component of IRISi's ongoing strategy.

Several of our interviewees commented that a key value of the IRIS 7B programme is that it has taken **serious account of diversity.** The fact that the programme deliberately fostered expertise on diversity was commented on. As one interviewee noted:

> *There is a lot of nervousness about diversity in the health care sector so it's important to have specialist workers both to refer to and to raise the cultural confidence of clinicians - it's a vital input. If IRIS can reach women who do not access support elsewhere then they are playing an important role in challenging institutional exclusion.*

Of course, without a great deal of comparative data, it is difficult to evidence the extent to which IRIS has reached minoritized women who do not access other support. However, a key element of the theory underlying IRIS is that primary care can play a vital role in reaching women who do not present to other services and our interviews with informants suggests that this is indeed the case. Several of the service managers commented that the referrals that came to them via IRIS were mostly of women who were not known to their service previously. For example, AWRC noted that despite working in Brent for 40 years, there were women who came to them via IRIS who they did not think would have been identified otherwise.

Finally, several interviewees reiterated the importance of having a service available to primary care which is both **specialist in DVA and pitched at women at lower/medium risk**. One clinician put this very eloquently:

> *DVA is a specialist area and needs specialist input. We wouldn't ever question the need for specialists for cancer or major diseases and I think DVA should be seen in the same way. And also, like cancer, we need interventions to prevent DVA and its escalation. It's so important to have support for women at lower/medium risk – without IRIS where would women get that support?*