Leicestershire Partnership
NHS Trust

Responding to Domestic Violence / Abuse Experienced by Clients - Policy

Describes roles and responsibilities of staff in responding to disclosures of Domestic Violence by clients, including risk assessment.

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Version Control and Summary of Changes

Version number	Date	Comments (description change and amendments)
Version 1 Draft 0	June 2010	A policy based on a template developed by the NHS Domestic Violence Group has been in place at LPT for a number of years, was adopted by the Eastern Leicester Primary Care Trust and Leicestershire County & Rutland Community Health Services but not ratified by Leicester City Community Health Services. Domestic Violence of Service Users Policy recognised as required by LCCHS. HR Policy for Domestic Violence against staff already in place
Version 1 Draft 1	July 2010	Policy developed to be congruent with template policy for Domestic Violence produced by Carole Devaney, NHS Leicester City
Version 1 Draft 2	August 2010	Policy amended following comments received from Clinical Governance meeting in July 2010
Version 1 Final	September 2010	Submitted to LCCHS Clinical Governance Committee for approval
Version 2 Draft 1	October 2011	Submitted to LPT Safeguarding Committee for approval
Version 2 Draft 2	November 2011	Policy amended and Title changed to 'Policy and Guidelines for Professionals who are Responding to Domestic Violence / Abuse Experienced by Clients.
Version 2 Draft 3	December 2011	Policy amended following Due Regard considerations
	November 2013	Policy reviewed and process for health staff to support the legal aid of victims added to document following changes to statutory requirements.
	February 2014	Policy reviewed and definition of domestic violence/abuse updated. Health Visitors' Multi Agency Risk Assessment Standard Operating Protocol added to document
Version 3	March 2014	Appendices amended to now include the DASH 2009 Risk Assessment Tool & Indicators of Risk removed
Version 4	April 2016	Updated with current legislation and guidance. Added appendices HV MARAC flowchart, FGM decision making flowchart and deducted DV paper record.
Version 5	July 2018	Updated in line with current legislation & guidance.
Version 6	June 2020	Change of Domestic Abuse practitioners Job title. Details updated for Safeguarding Team Advice Line. Updated with current legislation and guidance.
Version 6.1	September 2020	Mobile phone number of Senior Safeguarding Practitioner – Domestic Violence & Abuse updated

All LPT Policies can be provided in large print or Braille formats, if requested, and an interpreting service is available to individuals of different nationalities who require them.

Did you print this document yourself?
Please be advised that the Trust discourages the retention of hard copies of policies and can only guarantee that the policy on the Trust website is the most up-to-date version.

For further information contact:
LPT Safeguarding Team: ☎0116 2958977
LPTSafeguardingDuty@leics.nhs.uk

Equality Statement

Leicestershire Partnership NHS Trust (LPT) aims to design and implement policy documents that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others.

It takes into account the provisions of the Equality Act 2010 and advances equal opportunities for all.

This document has been assessed to ensure that no one receives less favourable treatment on the protected characteristics of their age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex (gender) or sexual orientation.

In carrying out its functions, LPT must have due regard to the different needs of different protected equality groups in their area. This applies to all the activities for which LPT is responsible, including policy development, review and implementation.

Due Regard

LPT must have due regard to the aims of eliminating discrimination and promoting equality when policies are being developed. Information about due regard can be found on the Equality page of e-Source and/or by contacting the LPT Equalities Team.

Definitions that Apply to this Policy

Domestic Violence / Abuse	Domestic violence / abuse is any incident or pattern of incidents of controlling coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass, but is not limited to the following types of abuse: psychological; physical; sexual; financial; emotional. (Home Office 2013) This includes Forced marriage, honour based violence and female genital mutilation.
Forced Marriage	A forced marriage is a marriage in which one or both spouses do not consent to the marriage but are coerced into it. Duress can include physical, psychological, financial, sexual and emotional pressure. In cases of vulnerable adults who lack the capacity to consent to marriage, coercion is not required for marriage to be forced. (HM Government: 2014)
Honour Based Violence, "Izzat" or honour crime	Embraces a variety of crimes of violence (mainly but not exclusively against women) including assault, imprisonment and murder, where the person is being punished by their family or their community for actually or allegedly, undermining what the family or community believes to be the correct code of behaviour.
Female Genital Mutilation	FGM involves procedures that include the partial or total removal of the external female genital organs for cultural or other non-therapeutic reasons. (HM Government: 2014)
MARAC	Multi Agency Risk Assessment Conference; who review high risk domestic violence cases, to manage risk to victims.
UAVA	United against Violence and Abuse (UAVA) provides specialist sexual abuse and domestic violence services across Leicester, Leicestershire and Rutland, for professionals and service users.
IDVA	Independent Domestic Violence Advisor Specialist working with high risk victims of domestic violence.

1. Purpose of the Policy

The purpose of this document is to:-

- Inform staff of best practice when responding to domestic violence
- Improve safety and improve health by recognising domestic violence is a serious crime which has an adverse impact upon the health of individuals, families and communities
- Increase awareness and understanding of domestic violence across LPT and its impact upon those experiencing it
- Ensure that all staff are clear within their roles in tackling and responding to issues surrounding domestic violence
- Support Government policy for the NHS in terms of domestic violence and to ensure implementation of a safe, consistent and quality approach to domestic violence across LPT

2. Summary and Key Points

2.1 This policy defines organisational and staff roles and responsibilities responding to Domestic Violence / Abuse experienced by clients. It provides guidance to staff on:-

- Managing disclosures and any safeguarding referrals (Appendix 1).
- How to ask questions around domestic violence sensitively (Appendix 2).
- Helping victims formulate safety plans (Appendix 3).
- Use of the DASH risk assessment tool (Appendix 4)..
- Confidentiality and information sharing, in relation to DV incidents (Appendix 5).
- Healthy Together Public Health Nursing MARAC Pathway outlining responsibility following MARAC (Appendix 6).
- Responding to Legal Aid support for victims, from health professionals (Appendix 7).
- FGM Decision making pathway and flowchart (Appendix 8).
- Important contact numbers for supporting victims domestic violence (Appendix 9).

2.2 This policy is not only relevant to health professionals working directly with service users, but also to all staff working in LPT. This is in recognition that everyone shares responsibility for safeguarding children and vulnerable adults irrespective of individual roles.
Appendix (10 & 11) identifies vulnerability factors of victims of domestic violence.

2.3 Domestic violence is an act which adversely affects the health and well-being of individuals, families and communities. LPT is committed to ensuring that victims of domestic violence receive a high standard of care irrespective of their age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex (gender) or sexual orientation or ability and equality underpins all its service provision.

2.4 Domestic abuse can be perpetuated through cultural beliefs manifesting itself via forced marriage, female genital mutilation and so called 'honour crimes'. In these instances, the perpetrator may have the support of the extended family. However, actions considered as domestic violence are crimes and are neither morally nor socially acceptable whichever form it takes

2.5 LPT endorses the Governments view that domestic violence is a fundamental breach of trust and human rights, and contravenes an individual's right to feel safe, both within their home and within a personal relationship.

2.6 LPT recognises the serious impact domestic violence has on children who live in a violent abusive household, and the short and long term damage to their physical and mental health. Within this context LPT recognises its responsibilities to safeguard and protect children.

2.7 LPT recognises domestic violence is not only an issue for service users, and that there is a need to address domestic violence issues for staff, male or female when they themselves may be current or past victims of domestic violence, or are perpetrators of domestic violence.

2.8 It is widely recognised that health services alone cannot effectively meet the needs of individuals experiencing domestic violence, however, LPT is committed to ensuring that domestic violence is recognised, and that the local community are provided with information and support to minimise risk. In support of this, LPT will work alongside community partners throughout Leicester, Leicestershire and Rutland, towards the reduction of domestic violence. By working together with partner agencies a consistent and co-ordinated response will be developed.

Key points covered by this document are:-

- Identification of domestic violence
- Risk assessment and responding to domestic violence
- Recording
- Referral as appropriate
- Training
- Recognising the links between safeguarding adults and children and domestic violence and the Think Family, whole family agenda
- Identification of risk and professional responsibilities in relation to Female Genital Mutilation.

3. Introduction

3.1 It is the right of individuals to live without fear or violence. Domestic violence is serious and dangerous behaviour which must be acknowledged and addressed appropriately by staff regardless of:-

- Disability
- Gender Reassignment
- Marriage and Civil partnership
- Pregnancy and Paternity
- Race
- Religion and Belief
- Sex
- Sexual Orientation

3.2 Domestic violence is a breach of human rights.

3.3 This document ensures that each member of staff is equipped to recognise and respond appropriately to domestic violence.

4. Duties within the Organisation

4.1 The Organisation (Leicestershire Partnership NHS Trust)

- Will have a policy which provides information and promotes awareness of domestic violence
- Will have a Senior Safeguarding Practitioner – Domestic Violence and Abuse.
- Recognises the need for support and supervision and will ensure that there is an appropriate person to provide this.

4.2 Divisional Director

- The Divisional Director is responsible for ensuring that staff are appropriately trained and resourced to carry out duties specified in the policy through delegation where identified.

4.3 Heads of Services

- Are responsible for ensuring that their staff are appropriately trained in line with the requirements of the policy.
- Are responsible for ensuring that there are appropriate resources provided within their service area to implement and adhere to the policy.

4.4 Service Managers

- Are responsible for ensuring that this policy is implemented in their area of responsibility.

4.5 Responsibilities of Managers

- To attend appropriate training to support recognition and response to domestic violence; which may also be a feature of child protection or safeguarding adult cases.
- Provide support and guidance to staff working with clients who are involved in domestic violence and ensure adequate and appropriate supervision in place.
- Have a responsibility to ensure the safety of staff (Lone Worker Policy 14/12/2017).
- Must have an understanding of the Risk Assessment process (Appendix 4) to be undertaken with clients.
- Must ensure that their staff attend appropriate training to support recognition and response to Domestic Violence.
- Must ensure systems are in place to allow retrieval of data and information where required, e.g. for Multi Agency Risk Assessment Conferences (MARACs).
- To have appropriate strategies in place to respond to the practical and emotional needs of staff.

4.6 Responsibilities of Clinical Supervisors

- To understand the dynamics of domestic violence and the potential impact on staff.
- To have appropriate strategies in place to respond to the practical and emotional needs of staff.
- To support staff with appropriate risk management of cases and have clinical oversight.

4.7 Senior Safeguarding Practitioner – Domestic Violence and Abuse

- To fully engage with the MARAC, multi-agency forums where cases of domestic violence are assessed as being high risk are discussed. Ensure that information sharing is supported to support effective risk management plans.
- To raise awareness and understanding of domestic violence and its complexities.
- To facilitate training to LPT staff in relation to domestic violence and risk assessment.
- To provide specialist advice and guidance to LPT staff in relation to domestic violence and the MARAC process.

4.8 Clinical Staff

- Should ensure that they attend Domestic Violence & Safeguarding Training that supports them to recognise domestic violence and its interface with safeguarding and ensure they are aware of referral systems, appropriate support options for victims. Recognise there can be additional barriers that prevent some individuals and members of certain communities from disclosing abuse.
- Must demonstrate a sensitive approach, which is supportive to the abused client. Use open questions; see examples (Appendix 2). Should ask any questions in as quiet, private and safe an environment as possible. They should see the abused client on their own. However, some individuals will require another person present (same gender if possible) either as an interpreter for language differences, sign language interpreters or as an advocate, particularly for people with learning disabilities. Ujala Service is the approved interpretation services used by LPT. Family members/friends/children must not be used in these roles.
- May need to negotiate with clients how domestic violence is recorded. **You must record disclosures of abuse even when individuals ask you not to, to avoid compromising your professional accountability.** The abuse is almost certain to have an impact on a person's physical and/or emotional health. Information must be documented on appropriate records and never on client held notes/notes on bed ends etc. Must discuss confidentiality with the client who is being abused to ensure that they understand the limits to confidentiality and where there is a need to disclose information e.g. if the case needs to be referred to a MARAC and/or there are child protection, safeguarding adult issues (Appendix 5).
- Must not collude with the perpetrator(s) of abuse by alerting them when domestic violence is disclosed by a client. Such actions are a breach of professional codes of conduct/practice and can increase the risk of serious harm to the victim and / or any children they may have.
- Must respect the wishes of clients who do not want to take further action at the time of disclosure but recognise when there are limits to confidentiality (Appendix 5).

- If staff members are unsure about how to respond to a Domestic Violence disclosure and the need to disclose information, staff must seek advice from their line manager, lead clinician or Senior Safeguarding Practitioner – Domestic Violence and Abuse or the Safeguarding Team. Staff can access safeguarding advice by emailing their request to LPTSafeguardingDuty@leics.nhs.uk
  For URGENT advice or support staff can call the Safeguarding Advice Line on ☎0116 295 8977 the line is open Monday to Friday 9:00am-4:30pm).
- It is crucial that an initial, appropriate response is made to leave space for clients to feel able to take action at a later date (i.e. believe, listen and reassure patient/client, document all injuries/record history in a secure place, provide information about support/options, develop crisis/safety plan if required).
- The victim of abuse will be given appropriate/timely information/advice about options, e.g. signposting to support services, police domestic violence officers and other agencies. Offer the victim of abuse assistance in developing a crisis plan/safety plan (Appendix 3).
- Undertake a domestic violence risk assessment with the victim (Appendix 4), if this indicates high levels of risk (score 14 or professional judgement), contact the Senior Safeguarding Practitioner – Domestic Violence and Abuse or Safeguarding Advice Line before making a referral to a MARAC should be made by contacting UAVA on the business line 0116 255 0004 stating they have a MARAC referral and need to speak to an IDVA.
- Have a responsibility to carry out a risk assessment to assess the level of risk to themselves and other staff and adhere to the Lone Worker Policy.
- Ensure that specific needs of the individual in relation to disability, gender reassignment, race, religion and belief, sex and sexual orientation are supported.

5. Health Visitor Responsibility Following a MARAC

5.1 Health Visitors should follow the MARAC care pathway as Appendix 6 within the current FYPC Health Visiting Standard Operating Guidance when working with families / clients who have been discussed at a MARAC.

6. Confidentiality and Information Sharing around Domestic Violence for all LPT Staff

These guidelines have been devised to support staff; looking with families or individuals in relationships where domestic violence has been identified.

6.1 All healthcare professional bodies have guidelines/codes of conduct that state the need for healthcare professionals to protect all confidential information concerning clients obtained in the course of their professional practice. Confidentiality is essential in enabling victims of domestic violence to disclose their experiences and their physical safety can depend on confidentiality being maintained. Where the client has not consented, information should only be shared with other NHS Trusts or agencies where required by order of a court or where there is justified disclosure in the wider public interest. This could include where high levels of violence increase risk of death or suicide, risk to others especially children, risk to staff or the general public.

6.2 The basic principle is that violence is unacceptable. It is the right of every individual to live without fear or violence.

6.3 Personal safety of staff is paramount. Staff must be supported and should not feel isolated or burdened.

7. Limits of Confidentiality

Staff must understand that in some situations there are limits to confidentiality. When an individual starts to disclose abuse, discuss with them what you may have to do to ensure that they are clear about the limits of confidentiality.

7.1 A child's interests are paramount and therefore confidentiality will not override the need to make a child protection referral. Parents/carers should be informed of the referral unless this will increase the risks to children and other individuals within the household (refer to Local Safeguarding Children Partnership Domestic Violence Practice Guidance).
http://llrscb.proceduresonline.com/chapters/contents.html

7.2 Fear of sharing information must not be allowed to stand in the way of the need to promote the welfare and protect the safety of children, which must always be the paramount concern. Staff must be aware of their responsibility to share safeguarding information in line with Working Together to Safeguard Children (2018). This statutory guidance can be found by accessing: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/779401/Working_Together_to_Safeguard-Children.pdf

7.3 Healthcare staff have a duty of care to adults who are in need of safeguarding (vulnerable adults) and are at risk and their safety must be a priority. Staff should refer to Multi-agency Policies and procedures for the Protection of Vulnerable Adults from Abuse and Safeguarding Adults Policy.

7.4 Where the victim of domestic violence is assessed to be high risk/ risk of serious harm or death, information must be shared through the MARAC process. The healthcare worker can seek advice and support from Specialist Nurse Domestic Violence or line manager.

7.5 In certain circumstances it may be necessary to contact the Police, security etc. immediately because of the danger presented by the perpetrator(s) to the victim, other family members especially children, staff and/or the general public.

Decisions must take place with the individual and an explanation of the reason for sharing information should be given and their consent should be obtained wherever possible. The decision to share information without consent must be recorded along with the reasons for sharing.

7.6 Where there is significant concern that the perpetrator may be a danger to other individuals in the community including other workers, the healthcare worker must inform their line manager.

8. Record Keeping

It is vital to ensure that concise record keeping and documentation is maintained in line with the Trust's record management and lifecycle policy in order that healthcare professionals can respond appropriately to domestic violence.

8.1 The records may be used in evidence particularly in cases where the perpetrator(s) of domestic violence is being charged with assault.

8.2 The records may be used to help the abused person to obtain an injunction or court order for protection.

8.3 The records may be used by family courts to assess risks for children and there are issues of granting access.

8.4 Despite the need for concise records to be kept, the healthcare worker must ensure that care is taken to maintain confidentiality in order to protect the abused person from further violence. Therefore records of domestic violence should be recorded securely where they will not be visible to the perpetrator e.g. client held notes, notes at hospital bed ends, alert notes on computer screen.

9. Responding to Applications from Victims of DV for Legal Aid Support

9.1 On the 1st April 2013, The Legal Aid, Sentencing and Punishment of Offenders Act 2013 came into force which introduced changes to the Legal Aid system.

9.2 Legal Aid will still be available for victims of domestic violence. However, victims will have to prove that they have been a victim of domestic violence.

9.3 As a health professional involved in a case you may receive a letter from the Applicant (victim) themselves or the Applicant's solicitor requesting information in support of their application for Legal Aid. This request must be in the form of the standard template letter (Appendix 7a).

9.4 On receipt of the standard template letter requesting information in support of a victim's application for Legal Aid (http://www.justice.gov.uk/legal-aid-for-private-family-matters) staff should then:

- Contact the Applicant's solicitor or Applicant themselves for confirmation that the letter you have received has been sent by them
- Complete the template response letter (Appendix 7b) with information relevant to your service or you as a practitioner
- Send a cover letter saying "**Please find enclosed completed template letter"** send the response to the address identified on the Applicant's letter
- Save a copy of the cover letter and response letter within the adult health record.

10. Domestic Violence Disclosure Scheme (Clare's Law)

10.1 Aim of this scheme is to give members of the public a formal mechanism to make enquiries about an individual who they are in a relationship or who is in a relationship with someone they know and there is a concern that the individual may have a history of abuse.

10.2 Health professionals can make an application through the DVDS about an individual who is in an intimate relationship with another person and where there is a concern that the individual may harm the other person.

10.3 To make an application to the DVDS contact the Safeguarding Team. Staff can access safeguarding advice by emailing their request to LPTSafeguardingDuty@leics.nhs.uk. For URGENT advice or support staff can call the Safeguarding Advice Line on ☎0116 295 8977,this line is open Monday to Friday, 9:00am-4:30pm. Staff are also able to contact the Senior Safeguarding Practitioner - Domestic Violence and Abuse (☎0116 295 8710 / 07920 478569) who will support them through the process.

11. Female Genital Mutilation

11.1 Female Genital Mutilation comprises all procedures involving partial or total removal of, or injury to, the female genitalia for non-medical reasons (HMG, 2014).

11.2 Female Genital Mutilation causes significant and lasting physical and emotional harm to women and girls. FGM is not a religious requirement. It is a cultural practice. Safeguarding women and girls is not racist, discriminatory, or disrespectful, but does need sensitivity and awareness in how actions are taken forward.

11.3 **From 31st October 2015 professionals have a duty to mandatory report FGM conducted on girls under 18 years of age.** If a disclosure is made by a child or young person that they have been subject to FGM or if an examination identifies that FGM has been performed, this should be reported to the police Child Abuse Investigation Unit via the 101 telephone number.

11.4 FGM procedure and risk assessment tools are available within the LSCB Safeguarding Children Procedures.
http://llrscb.proceduresonline.com/chapters/contents.html

11.5 For additional information see FGM decision making pathway and flowchart in Appendix 8.

12. Data Collection

12.1 LPT will monitor within the safeguarding children core data set; LPT membership at MARAC and numbers of high risk DV cases reviewed locally. Data on dependent children within high risk DV families is also collected.

13. Training Needs and Implementation Plan

13.1 This policy will be available on the LPT StaffNet intranet site within safeguarding quick link.

13.2 This policy will be disseminated through each divisional governance lead to all service areas; each division will ensure that staff have received and taken note of the content of this document.

13.3 There is a need for training identified within this policy. In accordance with the classification of training outlined in the Trust Learning and Development Strategy this training has been identified as role development training

The course directory e-source link below will identify: who the training applies to, delivery method, the update frequency, learning outcomes and a list of available dates to access the training.

A record of the event will be recorded on uLearn.

The governance group responsible for monitoring the training is the LPT Legislative Committee.

13.4 All staff will be given general domestic violence awareness training as part of their induction programme. Additional DV and risk assessment training is available please look on the uLearn. LPT Whole Family Safeguarding Training (staff require 3 year update) provides Domestic Violence Awareness training.

14. Monitoring Compliance and Effectiveness

14.1 This document will be reviewed on an annual basis by the Senior Safeguarding Practitioner – Domestic Violence and Abuse by collecting data by means of:

- A review of attendees' feedback at the domestic violence/risk assessment training

14.2 Domestic violence awareness is included within the annual trust wide safeguarding audit; which reports into the Safeguarding Committee and audit group. Audit will be carried out in accordance with the LPT Audit Programme and in response to specific information needs or queries.

Ref	Minimum Requirements	Evidence for Self-assessment	Process for Monitoring	Responsible Individual / Group	Frequency of monitoring
	All staff receive mandatory safeguarding induction and 3 yearly update training which includes basic Domestic Violence awareness.	Training records	Mandatory Training Flash Report	LPT Legislative Committee	Bi-Monthly
	Staff knowledge of Domestic Violence procedures and guidelines.	LPT safeguarding audit	Audit reports	LPT Legislative Committee FYPC/AMH & LD/CHS Safeguarding Operational Groups/Forums	Annually

15. Standards/Performance Indicators

The process for monitoring of compliance and effectiveness of this policy is documented in Section 14. It sets out the criteria, measurable, frequency, Lead Officer and Committee. The Policy Lead will lead the process and send reports to the relevant Committee.

TARGET/STANDARDS	KEY PERFORMANCE INDICATOR
All LPT staff to have an awareness of this Domestic Violence Policy and know how to access it.	All stakeholders can access this policy when necessary via LPT StaffNet.
Safeguarding within LPT including Domestic Violence has the right level of scrutiny and oversight, with overall responsibility held at board level or equivalent.	LPT Board, LPT Legislative Committee and Safeguarding Committees have on-going oversight of all safeguarding activity within LPT.
As part of their induction all staff receive safeguarding training that is relevant, and at a suitable level for their role which includes basic awareness of DV.	Training is updated at appropriate intervals to keep staff up to date with safeguarding processes and enables them to recognise Domestic Violence and report concerns.

16. References

HM Government (August 2018). Working Together to Safeguard Children. A Guide to Inter-agency Working to Safeguard and Promote the Welfare of Children,

NICE Domestic violence and abuse. Quality standard 116 (February 2016)

HM Government (2014), Multi Agency Practice Guidelines: Handling Cases of Forced Marriage

HM Government (2014) Multi Agency Practice Guidelines: Female Genital Mutilation.

Leicester Leicestershire and Rutland Local Safeguarding Children Partnership Practice Guidance, Children in specific circumstances Chapter 2.12 Domestic abuse (March 2015)

Home Office: Mandatory reporting of female genital mutilation-procedural information (2015)

DoH: Female Genital Mutilation risk and safeguarding. Guidance for professionals.
(March 2015)

Leicester Leicestershire and Rutland Local Safeguarding Children Partnership Practice Guidance, Children in specific circumstances Chapter 2.20 FGM (September 2015)

17. Associated Documents

Deprivation of Liberty Safeguards Policy

Domestic Violence Policy (For Managers) – (Published 17th March 2017)
http://www.leicspart.nhs.uk/Library/DomesticViolencePolicyForManagersexpMar20.pdf

Lone Worker (Published September 2019)
https://staffnet.leicspart.nhs.uk/wp-content/uploads/staff-directory/FinalLoneWorkerPolicyexpSep21v41.pdf

Mental Capacity Act Policy

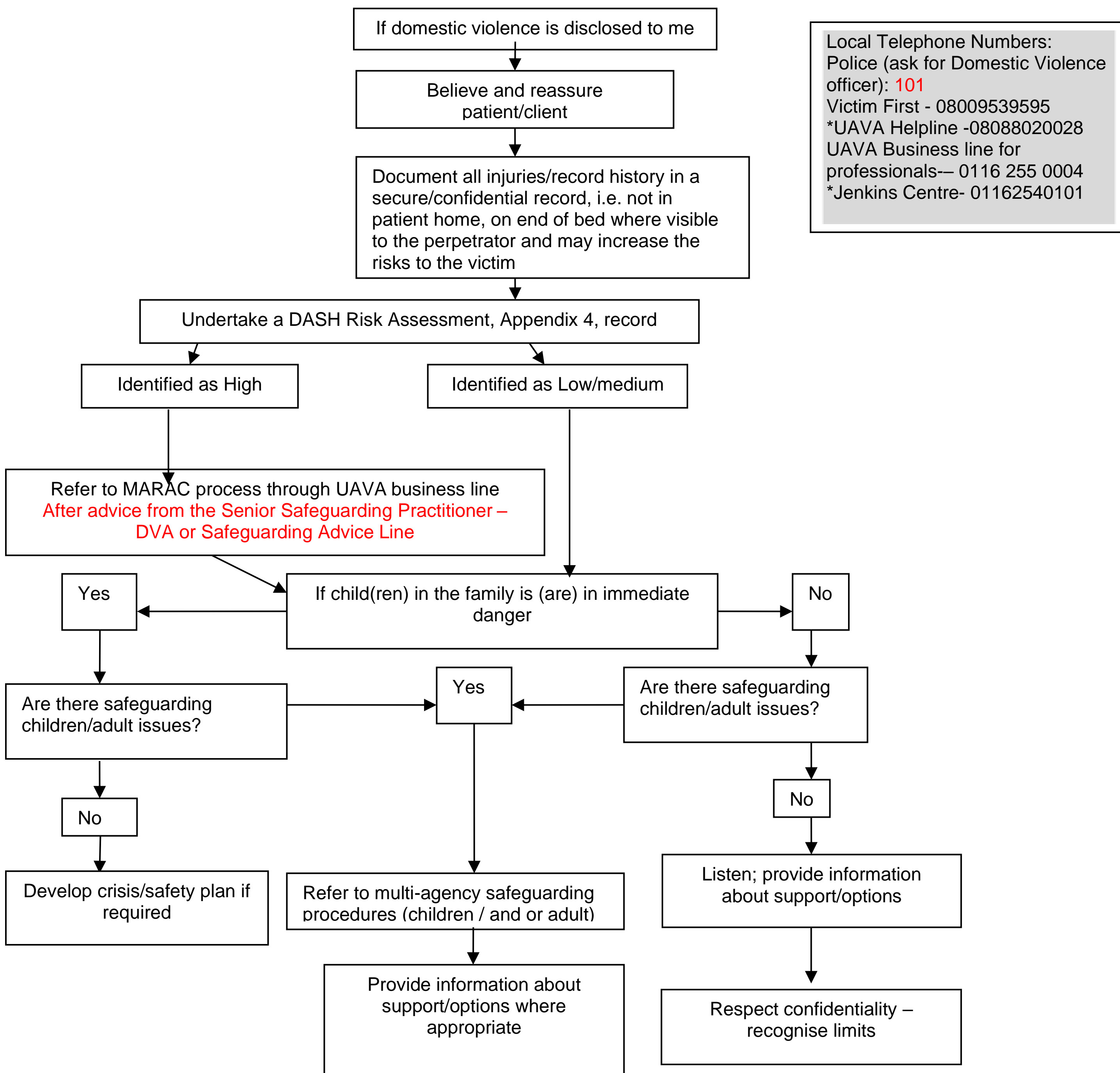
Safeguarding Adults Policy

Safeguarding Children Policy

Safeguarding Children Practice Guidance (Published 21st September 2017)
https://staffnet.leicspart.nhs.uk/wp-content/uploads/staff-directory/201707SafeguardingChildrenPracticeGuidancev21.pdf

Mandatory Reporting of FGM – procedural information. Home Office 2015
Updated 22nd January 2020

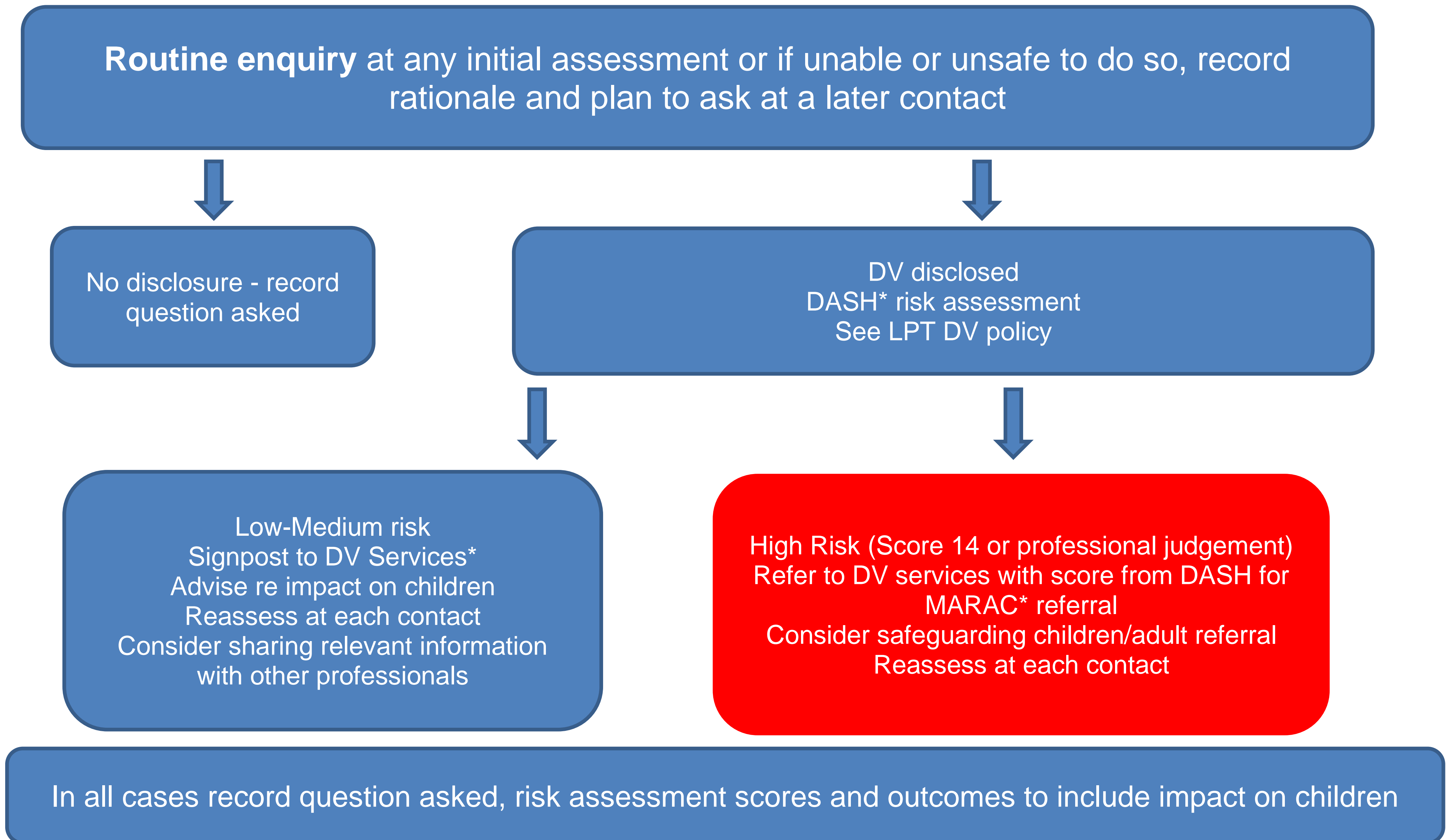
Appendix 1- Responding to Disclosure of Domestic Violence



*United against violence and abuse (UAVA)
*Jenkins Centre-Perpetrator programme (City only)

Seek support for self if required

FLOWCHART FOR DOMESTIC VIOLENCE (DV) PROCESS



Definition of Domestic Violence and Abuse

"Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass, but is not limited to, the following types of abuse: Psychological, Physical, Sexual, Financial, Emotional" (Home Office 2013)

Definition also covers Forced Marriage and Honour Based Violence.

Practitioners are reminded that DV covers all ages, cultures and social status. If the victim is an adult in need of safeguarding or a Looked after child the social worker **must** be informed.

Key to Flowchart

*DASH** (Domestic Abuse Stalking Harassment and Honour Based Violence) risk assessment. (Appendix 5 in Responding to Domestic Violence/Abuse Experienced by Clients – LPT 2020).
*MARAC** – Multi-agency Risk Assessment Conference
*DV Services**

Victim

- UAVA (United Against Violence and Abuse) LLR
  Helpline 0808 802 0028
  Business Line for Professionals 0116 2550004

Perpetrator

- Jenkins Centre 0116 254 0101

If unsure seek guidance / advice

Appendix 2

Guidance on Asking the Questions

After the issue has initially been raised, you may find the following questions useful when dealing with victims of domestic violence. The questions refer to 'male' partners, but could be asked where the suspected perpetrator is female. Furthermore, they can be tailored to ask about violence by other family members, or between individuals and their carers, or between same sex couples. This is a prompt, not a checklist. You can adapt the questions in a way that feels more natural to you and ask them in any appropriate order. If you have any concerns about how to respond to a disclosure you must discuss the issues with your line manager, lead clinician or other relevant professional regarding the need to share information. These questions will assist you to undertake a risk assessment (Appendix 5).

Client focused questions:

- Do you get support at home?
- I noticed a number of bruises/cuts/scratches/burn marks, how did they happen?
- Do you ever/did you ever feel frightened/intimidated by your partner?
- Does/did you partner ever treat you badly, such as shout at you, constantly call you names, put you down, push you around or threaten you?
- Have you ever been in a relationship where you have been hit, punched, hurt in any way? Is that happening now?
- Many patients/clients tell me that their partners are cruel, sometimes emotionally and sometimes physically hurting them – is that happening to you?
- How are decisions reached?
- We all have rows at home occasionally. What happens when you and your partner fight or disagree?

Has your partner ever:

- Thrown things?
- Destroyed things you care about?
- Threatened or abused your children?
- Forced sex on you/made you have sex in a way you are unhappy with?
- Withheld sex/rejected you sexually in a punishing way?
- Used your personal fears to 'torture' you?
- Stalked you?
- Does your partner get jealous of seeing friends, talking to other people, going out? If so, how does he then act?
- Does your partner/you mention your partner used/uses drugs/alcohol. How did/does he behave when this happens?
- Your partner seems very concerned and anxious – that can mean he feels guilty. Was he responsible for your injuries?

Questions about the household:

Be aware that there may be children or adults in need of safeguarding in the household or there may be animals at risk from the perpetrator. You will need to refer to the appropriate polices for adults or children in need of safeguarding. Concerns about animals should be reported to the RSPCA or the police.

- What do/did your children do when (any of the above) happens/happened?
- How do/did your children feel when (any of the above) happens/happened?
- Is there anyone else in the household who might be worried about what is happening?

Appendix 3

Safety Planning/Crisis Plan

Developing a plan can help all clients that about what is happening to them, to feel more in control of their life and may assist them to take action now or at a later date. You must still make a referral to the MARAC process if the client is at high risk (Score 14+ on DASH risk assessment). The plan can be adapted for individuals without children.

Remind client:

You do not have control over your partner's violence. However, you can think about how to respond and how best to get yourself/your child(ren) /others to safety.

Talk through this plan with someone you can trust. Fill it out and keep it in a safe place where no-one can find it. Review and update your safety plan regularly.

If you want to stay:

Our priority is that you are as safe as you can be. The most important thing is to remember that you won't be able to stop the perpetrator(s) violence, only he/she/they can do that. However, there are some things you can do to increase your own and your children's safety while staying with him/her/them.

- I will have important telephone numbers accessible for myself and my children
- I will teach my children how to call 999
- I can tell ________________________________ and _______________

about the possibility of violence and ask them to phone the police if they hear the noise of a violent attack coming from my house

- If I suspect an attack is coming on or an argument is brewing, I can try to move to a lower risk room (try to avoid the kitchen, bathroom, garage, or rooms with no outside door)
- If I am afraid for my safety and the safety of my children and need to leave home I can go to a refuge or ______________________________
- Rehearse an escape plan with my children so they can get out quickly and safely

Increasing my safety if I decide to leave:

You should plan ahead for your safety. It is a very stressful time – both emotionally and practically, you'll have a lot to deal with. Sometimes when abusers find out individuals are planning to leave, the violence can get worse.

- I will inform ____ and ____ that my partner no longer lives with me and to call the police if he/she is seen near the house or the children. If my ex or other people do not have permission to see the children I will tell child-minders, school, etc. that only ____ has permission to pick them up.
- I can tell ____ at work about the situation and ask ______________________________ to screen my calls
- I can avoid shops, banks and __________________________________ that I used to use when we lived together
- I can get an order from the Court and keep copies handy. I will give a copy to ____
- If I move I will keep my address confidential and get an ex-directory number
- I can leave extra money, clothes, house and car keys and copies of documents with ____

To feel more safe and independent I can try to:

- ✓ Keep change for phone calls with me and memorise/carry emergency numbers
- ✓ Keep my mobile charged
- ✓ Open my own savings account
- ✓ Try to save money for taxi, bus or train fares if necessary
- ✓ Rehearse an escape plan with my children so they can get out quickly and safely
- ✓ Keep the keys, any medication, the crisis fund of money and a set of clothes for myself/children packed a bag that I can quickly get and take with me. Do not forget personal photographs, mementoes, children's special toys, benefit/rent/bank books, passport etc.
- ✓ Make plans for pets

If your client is ready to leave:

Do they have somewhere to go?

Help them contact UAVA (United against violence and abuse) or Police Domestic Abuse Officer

Discuss options such as refuge accommodation or bed and breakfast, staying with family and friends

Check they have personal support and enough cash

Check whether or not they need immediate police protection and/or legal advice

Prioritise the safety of the victim and that of any children or adults in need of safeguarding and consider referral to children's social care.

Appendix 4

Domestic Abuse, Stalking and Harassment and Honour Based Violence (DASH, 2009) Risk Identification and Assessment and Management Model

Risk identification and assessment is not a predictive process and there is no existing accurate procedure to calculate or foresee which cases will result in homicide or further assault and harm.

The DASH (2009) Risk Checklist was created by Laura Richards, BSc, MSc, FRSA on behalf of ACPO and in partnership with CAADA.

It has also been endorsed by:

PLEASE DO NOT CHANGE THIS RISK IDENTIFICATION AND ASSESSMENT MODEL

If you do have comments or suggestions please send them to:

Laura Richards, BSc, MSc, FRSA
Criminal Behavioural Psychologist
(E): laura@laurarichards.co.uk
(W): www.laurarichards.co.uk
(W): www.dashriskchecklist.co.uk

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Risk Identification for Trained Front Line Practitioners (Please refer to the DASH (2009) Practice Guidance on Risk Identification in full)

A number of high risk factors have been identified as being associated with serous violence and murder through researching many cases. Any professional using the DASH (2009) must be trained in it's use. This is crucial to understanding what the high risk factors are and how they apply in each situation, and what needs to be done to keep the victim safe.

This form should be completed for ALL cases of domestic abuse by front line staff. Initial risk identification must be undertaken by asking ALL the questions on this checklist, as well as searching appropriate databases, such as the intelligence databases. First response staff and their supervisor should identify risk factors, who is at risk and decide what level of intervention is required.

Details of children resident at the address must be provided. Consider the nature of the information and what it means in terms of public protection - preservation of life, reduction and prevention of harm to victim and others.

Please ensure that when you ask these questions the victim is comfortable and understands why you are asking them – it is about their safety and protection. Particular sensitivity and attention is required when asking about whether the victim has been assaulted, physically and/or sexually by the perpetrator. The vulnerability of victims cannot be overstated. This could be further compounded by issues such as traditional gender roles, literacy, language and/or immigration or refugee status. Please take into consideration the victim's perception of risk.

Please ensure you ask the victim about the abuser's behaviour when stalking and honour based violence are present. Do not just tick the box 'yes'. You must identify what is happening. There are specific risk factors that relate to these areas as well. Assessment of risk is complex and NOT related to the number of risks appearing alone. Rather, the risk posed to the victim or others in a particular situation will be dependent upon what they are and how they apply in that context. Refer to the full DASH (2009) Practice Guidance on Risk Identification.

Record what steps you have taken to ensure the immediate safety of the victim(s) and any children. Ask yourself 'Am I satisfied that I have done all I can?' Everything you do must be recorded.

The risk identification process must remain dynamic. Events and circumstances may undergo rapid and frequent change. Where this is the case, the assessment must be kept under review. Risk identification is based on structured professional judgement. This model is most effective when undertaken by professionals who have been fully trained in its use. High risk cases may well require a multi-agency response and should be referred to the relevant risk management panel i.e. the Multi-Agency Risk Assessment Conference (MARAC) or Multi-Agency Public Protection Panel (MAPPP). MARACs are for the most serious and high risk cases.

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CURRENT SITUATION THE CONTEXT AND DETAIL OF WHAT IS HAPPENING IS VERY IMPORTANT. THE QUESTIONS HIGHLIGHTED IN BOLD ARE HIGH RISK FACTORS. TICK THE RELEVANT BOX AND ADD COMMENT WHERE NECESSARY TO EXPAND.	YES ☑	NO ☑
1. Has the current incident resulted in injury? (please state what and whether this is the first injury)	☐	☐
2. Are you very frightened? Comment:	☐	☐
3. What are you afraid of? Is it further injury or violence? (Please give an indication of what you think (name of abuser(s)..... might do and to whom) Kill: Self ☐ Children ☐ Other (please specify) ☐ Further injury and violence: Self ☐ Children ☐ Other (please specify) ☐ Other (please clarify): Self ☐ Children ☐ Other (please specify) ☐	☐	☐
4. Do you feel isolated from family/ friends i.e. does (name of abuser(s).....) try to stop you from seeing friends/family/Dr or others?	☐	☐
5. Are you feeling depressed or having suicidal thoughts?	☐	☐
6. Have you separated or tried to separate from (name of abuser(s)....) within the past year?	☐	☐
7. Is there conflict over child contact? (please state what)	☐	☐
8. Does (.....) constantly text, call, contact, follow, stalk or harass you? (Please expand to identify what and whether you believe that this is done deliberately to intimidate you? Consider the context and behaviour of what is being done. Ask 11 additional stalking questions")	☐	☐
CHILDREN/DEPENDENTS (If no children/dependants, please go to the next section)	YES	NO
9. Are you currently pregnant or have you recently had a baby in the past 18 months?	☐	☐
10. Are there any children, step-children that aren't (.....) in the household? Or are there other dependants in the household (i.e. older relative)?	☐	☐
11. Has (.....) ever hurt the children/dependants?	☐	☐
12. Has (.....) ever threatened to hurt or kill the children/dependants?	☐	☐
DOMESTIC VIOLENCE HISTORY	YES	NO
13. Is the abuse happening more often?	☐	☐
14. Is the abuse getting worse?	☐	☐
15. Does (.......) try to control everything you do and/or are they excessively jealous? (In terms of relationships, who you see, being 'policed at home", telling you what to wear for example. Consider honour based violence and stalking and specify the behaviour)	☐	☐
16. Has (.....) ever used weapons or objects to hurt you?	☐	☐
17. Has (.....) ever threatened to kill you or someone else and you believed them?	☐	☐

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18. Has (.....) ever attempted to strangle/choke/suffocate/drown you?	☐	☐
19. Does (....) do or say things of a sexual nature that makes you feel bad or that physically hurt you or someone else? (Please specify who and what)	☐	☐
20. Is there any other person that has threatened you or that you are afraid of? (If yes, consider extended family if honour based violence. Please specify who. Ask 10 additional HBV questions*)	☐	☐
21. Do you know if (.....) has hurt anyone else ? (children/siblings/elderly relative/stranger, for example. Consider HBV. Please specify who and what) Children ☐ Another family member ☐ Someone from a previous relationship ☐ Other (please specify) ☐	☐	☐
22. Has (.....) ever mistreated an animal or the family pet?	☐	☐
ABUSER(S)	YES	NO
23. Are there any financial issues? For example, are you dependent on (.....) for money/have they recently lost their job/other financial issues?	☐	☐
24. Has (.....) had problems in the past year with drugs (prescription or other), alcohol or mental health leading to problems in leading a normal life? (Please specify what) Drugs ☐ Alcohol ☐ Mental Health ☐	☐	☐
25. Has (.....) ever threatened or attempted suicide?	☐	☐
26. Has (.....) ever breached bail/an injunction and/or any agreement for when they can see you and/or the children? (Please specify what) Bail conditions ☐ Non Molestation/Occupation Order ☐ Child Contact arrangements ☐ Forced Marriage Protection Order ☐ Other ☐	☐	☐
27. Do you know if (........) has ever been in trouble with the police or has a criminal history? (If yes, please specify) DV ☐ Sexual violence ☐ Other violence ☐ Other ☐	☐	☐
Other relevant information (from victim or officer) which may alter risk levels. Describe: (consider for example victim's vulnerability - disability, mental health, alcohol/substance misuse and/or the abuser's occupation/interests-does this give unique access to weapons i.e. ex-military, police, pest control) or is there serial offending?		
Is there anything else you would like to add to this?		

In **all** cases an initial risk classification is required:

RISK TO VICTIM:		
STANDARD ☐	MEDIUM ☐	HIGH ☐

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DASH (2009) Additional Stalking and Harassment Risk Questions

Q8. Does (......) constantly text, call, contact, follow, stalk or harass you?* (Please expand to identify what and whether you believe that this is done deliberately to intimidate you? Consider the context and behaviour of what is being done)

PRACTICE POINTS: If the victim answers 'yes' to this question then you must ask the following as they are risk factors for future violence:

- ✓ Is the victim very frightened?
  ....
- ✓ Is there previous domestic abuse and harassment history?
  ....
- ✓ Has (insert name of the abuser....) vandalised or destroyed property?
  ....
- ✓ Has (insert name of the abuser....) turned up unannounced more than three times a week?
  ....
- ✓ Is (insert name of the abuser....) following the victim or loitering near the victim?
  ....
- ✓ Has (insert name of the abuser....) threatened physical or sexual violence?
  ....
- ✓ Has (insert name of the abuser....) been harassing any third party since the harassment began (i.e. family, children, friends, neighbours, colleagues)?
  ....
- ✓ Has (insert name of the abuser....) acted violently to anyone else during the stalking incident?
  ....
- ✓ Has (insert name of the abuser....) engaged others to help (wittingly or unwittingly)?
  ....
- ✓ Is (insert name of the abuser....) been abusing alcohol/drugs?
  ....
- ✓ Has (insert name of the abuser....) been violent in past? (Physical and psychological. Intelligence or reported)
  ....

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DASH (2009) Additional HBV Risk Questions

Q20. Is there any other person who has threatened you or who you are afraid of?* (If yes, please specify who and why. Consider extended family if HBV)

Practice Point: If the victim is subject to HBV and answers 'yes' to this question, ask the following questions:

- ✓ Truanting – if under 18 years old is the victim truanting?

  ....

- ✓ Self-harm – is there evidence of self-harm?

  ....

- ✓ House arrest and being 'policed at home' – is the victim being kept at home or their behaviour activity being policed(describe the behaviours)?

  ....

- ✓ Fear of being forced into an engagement/marriage – is the victim worried that they will be forced to marry against their will?

  ....

- ✓ Pressure to go abroad – is the victim fearful of being taken abroad?

  ....

- ✓ Isolation – is the victim very isolated?

  ....

- ✓ A pre-marital relationship or extra marital affairs – is the victim believed to be in a relationship that is not approved of?

  ....

- ✓ Attempts to separate or divorce (child contact issues) –is the victim attempting to leave the relationship?

  ....

- ✓ Threats that they will never see the children again – are there threats that the child(ren) will be taken away?

  ....

- ✓ Threats to hurt/kill – are there threats to hurt or kill the vitcim?

  ....

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MARAC REFERRAL	
Do you believe that there are reasonable grounds for referring this case to MARAC?	**Yes / No**
If yes, have you made a referral?	**Yes/No**

CONSENT	
If the case is high risk and you are referring it to the MARAC, please explain to the victim what the MARAC is and that it is there to help them, giving them options and choices to keep them and their children safe.	
Has the victim given verbal consent to share information with partner agencies?	**Yes/No**
Officer's signature..	**Date:**...................

Risk Assessment Categorisation
This is *based* on the Offender Assessment System (OASys) developed by the Prison and Probation Services definitions of what constitutes standard, medium, high risk. Please use your professional judgement to categorise the risk level:

Standard	Current evidence does not indicate likelihood of causing serious harm.
Medium	There are identifiable indicators of risk of serious harm. The offender has the potential to cause serious harm but is unlikely to do so unless there is a change in circumstances, for example, failure to take medication, loss of accommodation, relationship breakdown, drug or alcohol misuse.
High	There are identifiable indicators of risk of serious harm. The potential event could happen at any time and the impact would be serious. Risk of serious harm (Home Office 2002 and OASys 2006): 'A risk which is life threatening and/or traumatic, and from which recovery, whether physical or psychological, can be expected to be difficult or impossible'.

Risk Management Framework
Use the **RARA** model when compiling safety plans for victims. What are you planning to do?

Remove the risk:	By arresting the suspect and obtaining a remand in custody.
Avoid the risk:	By re-housing victim/significant witnesses or placement in refuge/shelter in location unknown to suspect.
Reduce the risk:	By joint intervention/victim safety planning, target hardening, enforcing breaches of bail conditions, use of protective legislation and referring high risk cases to Multi-Agency Risk Assessment Conference (MARAC).
Accept the risk:	By continued reference to the Risk Assessment Model, continual multi-agency intervention planning, support and consent of the victim and offender targeting within Pro-active Assessment and Tasking Pro forma (PATP), or Risk Management Panel (such as Multi-Agency Risk Assessment Conference (MARAC) or Multi-agency Public Protection Panel (MAPPP).

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Appendix 5

Confidentiality and Information Sharing around Domestic Violence

1. **Guidelines for Staff**

These guidelines have been devised to support staff; looking with families or individuals in relationships where domestic violence has been identified.

1.1 All healthcare professional bodies have guidelines/codes of conduct that state the need for healthcare professionals to protect all confidential information concerning clients obtained in the course of their professional practice. Confidentiality is essential in enabling victims of domestic violence to disclose their experiences and **their physical safety can depend on confidentiality being maintained.** Where the client has not consented, information should only be shared with other NHS Trusts or agencies where required by order of a court *or* where there is justified disclosure in the wider public interest. This could include where high levels of violence increase risk of death or suicide, risk to others especially children, risk to staff or the general public.

1.2 **The basic principle is that violence is unacceptable. It is the right of every individual to live without fear or violence.**

1.3 **Personal safety of staff is paramount. Staff must be supported and should not feel isolated or burdened.**

1.4 Staff should inform their line manager about cases of domestic violence to ensure they receive appropriate support.

2. **Limits of Confidentiality**

Staff must understand that in some situation there are limits to confidentiality. When an individual starts to disclose abuse, discuss with them what you may have to do to ensure that they are clear about the limits of confidentiality.

2.1 A child's interests are paramount and therefore confidentiality will not override the need to make a child protection referral. Parents/carers should be information of the referral unless this will increase the risks to children and other individuals within the household (refer to Local Safeguarding Children Partnership Domestic Violence Practice Guidance Trust's Protocol for Practice and multi-agency referral form) located at https://llrscb.proceduresonline.com/contents.html

2.2 Healthcare staff have a duty of care to adults who are in need of safeguarding (vulnerable adults) and are at risk and their safety must be a priority. Staff must discuss any suspected abuse with the Safeguarding Adults Lead (refer to Multi-agency Policies and procedures for the Protection of Vulnerable Adults from Abuse and Safeguarding Adults Policy).

2.3 Where the victim of domestic violence is believed to be at risk of serious harm the decision to pass on information to other parties/agencies through the MARAC process must be discussed. The healthcare worker must take advice urgently from the Senior Safeguarding Practitioner – Domestic Violence and Abuse or Safeguarding Advice Line or their line manager. In certain circumstances it may be necessary to contact the police, security etc. immediately because of the danger presented by the perpetrator(s) to the victim, other family members especially children, staff and/or the general public.

Decisions must take place with the individual and an explanation of the reason for sharing information should be given and their consent should be obtained wherever possible. The decision to share information without consent must be recorded along with the reasons for sharing.

2.4 Where there is significant concern that the perpetrator may be a danger to other individuals in the community including other workers, the healthcare worker must inform their line manager.

3. Record Keeping

It is vital to ensure that concise record keeping and documentation is maintained in line with the Trust's record management and lifecycle policy in order that healthcare professionals can respond appropriately to domestic violence.

3.1 The records may be used in evidence particularly in cases where the perpetrator(s) of domestic violence is being charged with assault.

3.2 The records may be used to help the abused person to obtain an injunction or court order for protection.

3.3 The records may be used by family courts to assess risks for children and there are issues of granting access.

3.4 Despite the need for concise records to be kept, the healthcare worker must ensure that care is taken to maintain confidentiality in order to protect the abused person from further violence. Therefore records of domestic violence should be held separately from records which may be held or seen by the perpetrator, e.g. client held notes, notes at hospital bed ends, notes on computer screen.

Appendix 6

Healthy Together Public Health Nursing

MARAC Pathway

Specialist Nurse Domestic Violence / Named Nurse Safeguarding Children shares infromation from the MARAC with the LPT practitioner (within 10 working days of the MARAC) and advises them of any action(s) agreed at the MARAC that is/are for them to complete.

On receipt of the MARAC information and/or any agreed actions the LPT practitioner will review the child's / children's SystmOne record and assesses whether that child/children requires a universal plus package of care.

If no universal plus care offer is indicated, the child/children will continue to receive a universal package of care.

Practitioner to consisder using the discharge tool/pathway.

Practitioner to consider the child's/children's safety, the risk to LPT staff/partner agency staff and the public throughout the process. Any completed risk assessments to be recorded within the record.

Appendix 7a

Request to health professional for medical evidence of injuries/condition consistent with domestic violence

---

This example letter has been designed by the Ministry of Justice to be used to request evidence of injuries/condition consistent with domestic violence from a doctor (including GP), nurse, midwife, practitioner psychologist or health visitor.

Information required is highlighted and instructions are italicised. ***Please delete any unnecessary text and instructions (including this introduction) before sending.***

[Name of health professional]
[Address of surgery/hospital]

[Your Address]

[Your E-mail (if applicable)]
[Your Contact telephone number]

Dear [insert name of doctor, nurse, practitioner psychologist, health visitor or midwife],

Request for evidence of domestic violence for access to legal aid

I would like your help so I can get Legal Aid.

I would like to request written confirmation that I was examined by you in the last 24 months with injuries or a condition that were consistent with those of a victim of domestic violence. In the event of your being absent, I would be grateful if a medical colleague[1] with access to my medical records could do so.

This is needed as evidence of domestic violence in order that I can access legal aid for a family dispute in accordance with the Legal Aid, Sentencing & Punishment of Offenders Act 2012. Without evidence I will be unable to get legal aid to pursue my family case. **I would therefore be grateful if this could be treated as a matter of urgency.**

There is an example letter for this which is available on www.justice.gov.uk/legal-aid-for-private-family-matters which can be pasted onto the practice/hospital letterhead.

I will then take your letter to a family lawyer so they can assist me with my dispute.

The legal aid legislation defines domestic violence as “any incident, or pattern of incidents, of controlling, coercive or threatening behaviour, violence or abuse (whether psychological, physical, sexual, financial or emotional) between individuals who are associated with each other.” This follows the cross-Government definition.

The Ministry of Justice and the Legal Aid Agency recognise that the great majority of physical injuries and many non-physical conditions could be caused by domestic violence.

I can confirm that the [injuries/condition] that I presented to you with on [insert date when you were examined by the health professional if known] were caused by domestic violence.

[Delete following paragraph if not sending this letter to a GP]

I would be grateful if you could let me know when the letter is ready to collect from the surgery. The best way to contact me is [Enter details on best way to be contacted]

Yours [faithfully/sincerely],

[Add your name here]

---

[1] In order to meet the requirements to access legal aid, this will need to be a doctor, nurse, health visitor, midwife or practitioner psychologist.

Appendix 7b

Leicestershire Partnership NHS Trust

A University Teaching Trust

www.leicspt.nhs.uk

[Addressee name]
[Address]

[Your Address]
[Your E-mail (if applicable)]
[Your Contact telephone number]
[GMC/NMC] Registration Number: [GMC/NMC Registration Number]

Dear [Insert name of addressee],

Name of applicant: [Name of applicant]

I understand that [APPLICANT'S NAME] ('the Applicant') wishes to access legal aid for a family dispute as a victim of domestic violence. For this reason I have been asked to provide a letter in accordance with regulation 33 of the Civil Legal Aid (Procedure) Regulations 2012.

Accordingly I can confirm that the Applicant presented [himself/herself] to me on the [DATE WHEN CONSULTATION OCCURRED] (being within 24 months prior to the Applicant's intended application for legal aid). I was satisfied that the [injuries [and/or] condition] that the Applicant presented me with were consistent with domestic violence and I have no reason to believe that the injuries or condition were not caused by domestic violence.

I understand that the Ministry of Justice and the Legal Aid Agency recognise that the great majority of physical injuries and many non-physical conditions could be caused by domestic violence.

I understand that this evidence is only required for a decision on whether or not to grant legal aid – it is not designed to prove domestic violence in the context of a criminal or civil court case.

The applicant has confirmed that the [injuries/condition] that [he/she] presented to me with on [date of consultation] were caused by domestic violence.

Yours faithfully

[Sign]
[Name of Medical signatory]
[Title of signatory]

Chair: Cathy Ellis Chief Executive: Angela Hillery
To view our privacy notice please visit:
www.leicspart.nhs.uk/_Aboutus-Whatwedowithyourinformationprivacynotice.aspx
Leicestershire Partnership NHS Trust is a smoke-free Trust

NHS organisations are now using 100 per cent recycled paper as part of our sustainability commitment

Appendix 8

NHS Leicestershire Partnership NHS Trust

Female Genital Mutilation (FGM) Decision Making Guidance and Pathways

What is Female Genital Mutilation (FGM)?

FGM comprises all procedures involving partial or total removal of, or injury to, the female genitalia for non-medical reasons.

Multi-agency Practice Guidelines: Female Genital Mutilation (HMG, 2014)

Female Genital Mutilation causes significant and lasting physical and emotional harm to women and girls. FGM is **not** a religious requirement. It is a cultural practice. Safeguarding women and girls is not racist, discriminatory, or disrespectful, but does need sensitivity and awareness in how actions are taken forward.

The Law and FGM

Under the Female Genital Mutilation Act (2003) it became a criminal offence to perform FGM in the UK. It is also illegal to have the procedure performed abroad on a UK citizen.

The Serious Crime Act (2015) amended the original legislation to introduce a new **mandatory reporting duty.** This duty came into force from 31st October 2015 and is not retrospective.

The mandatory reporting duty **only** applies when disclosure or identification occurs relating to a child or young person under the age of 18.

Complying with the duty does not breach any confidentiality requirement or other restriction on disclosure.

How does the mandatory reporting duty apply to LPT practitioners?

The mandatory reporting duty requires the reporting of '**known**' cases of FGM in under 18s to the Police. It applies to regulated health and social care professionals, and teachers; and includes all practitioners regulated by the General Medical Council, Health and Care Professional Council and the Nursing and Midwifery Council.

The duty is a personal duty which requires the individual professional to make a report; the responsibility cannot be transferred.

The law defines 'known cases' as, "those where either a girl informs the person that an act of FGM – however described - has been carried out on her, or where the person observes physical signs on a girl appearing to show that an act of FGM has been carried out".

Asking the questions

Do you come from a community that practices cutting (FGM)?

Have you or any member of your family been cut?

Do you or any member of your family plan to have your daughters cut?

Female Genital Mutilation, A handbook for professionals working in health, education, social care and the police

Dr Sharon Raymond (2015)

Communication

The *Multi-agency Practice Guidelines: Female Genital Mutilation* (HMG, 2014) stress the importance of identifying girls and women at risk and of sharing that information as part of our safeguarding obligations.

If FGM is 'known' ie. disclosed or observed in a young person under 18 this must be reported to the Police.

If a child is identified as being at risk of FGM a risk assessment should be completed. If the assessment indicates **immediate** risk this must be reported to the Police and a referral made to Children's Social Care. If there is no immediate risk, but an overall high risk is identified this must be referred to Children's Social Care.

Risk of FGM should be shared with the Public Health Nurse (Health Visitor) and GP.

If you have suspicion of FGM but no disclosure or direct evidence, be curious and (if possible) provide an opportunity to speak to the girl/woman in private.

Investigations and enquiries are the responsibility of the Police and Social Care and are not the role of health professionals.

In the case of a pregnant woman refer to Children's Social Care for all expected female children or if gender is unknown.

Getting clear and accurate information is vital, but DO NOT use family members, children or members of the same community as interpreters. If an interpreter is needed use a professional resource such as Ujala or Language Line.

Informing the child and/or her family

In line with safeguarding best practice you should contact the girl and/or her parents/carers to explain the report/ referral and what it means.

Wherever possible you should have this discussion in advance or in parallel to the report/referral being made.

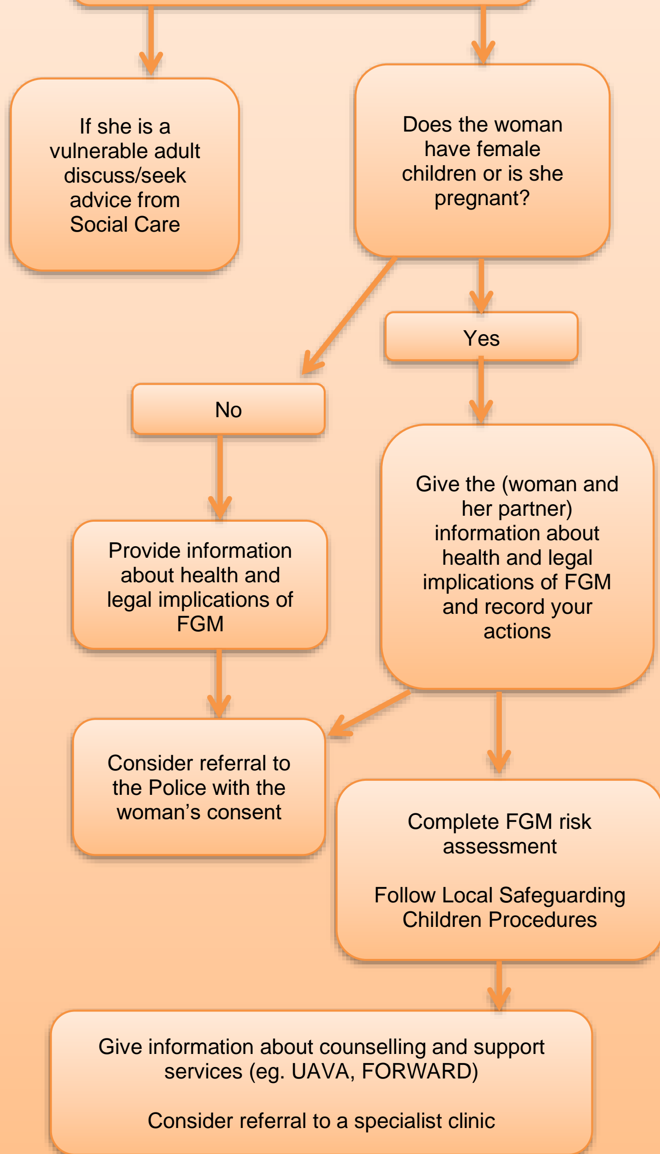
If you believe that telling the child and/or person with parental responsibility about the report/referral may result in a risk of serious harm to the girl or anyone else; or increase the risk of the family fleeing the country, you should not discuss it.

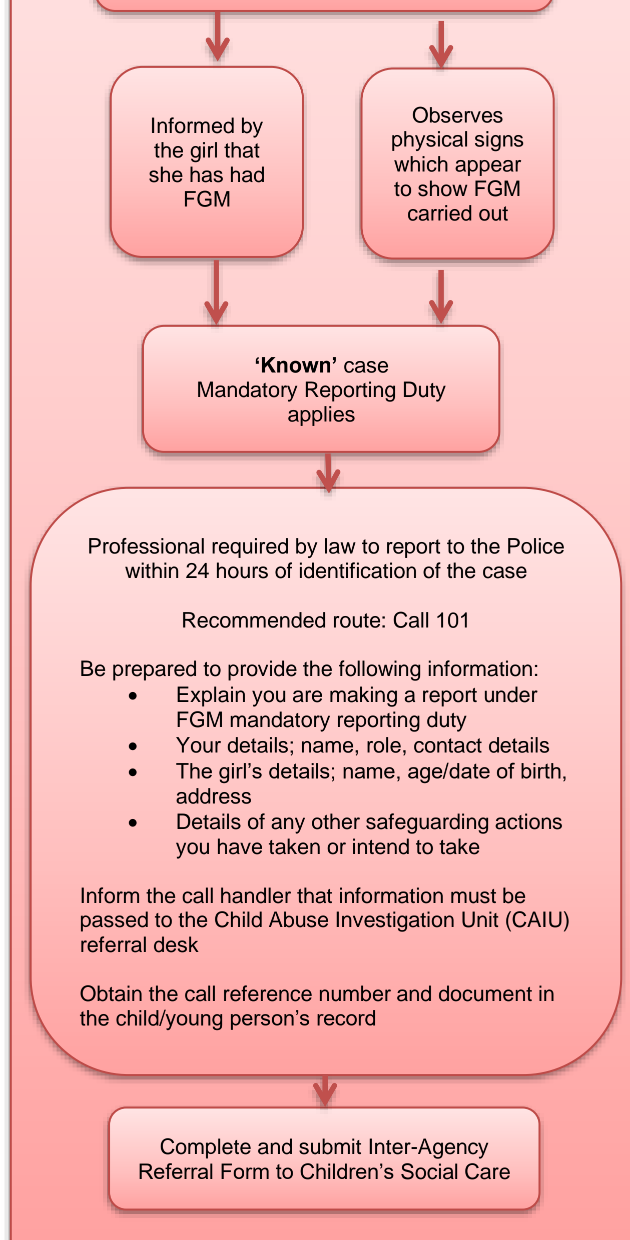
Record Keeping

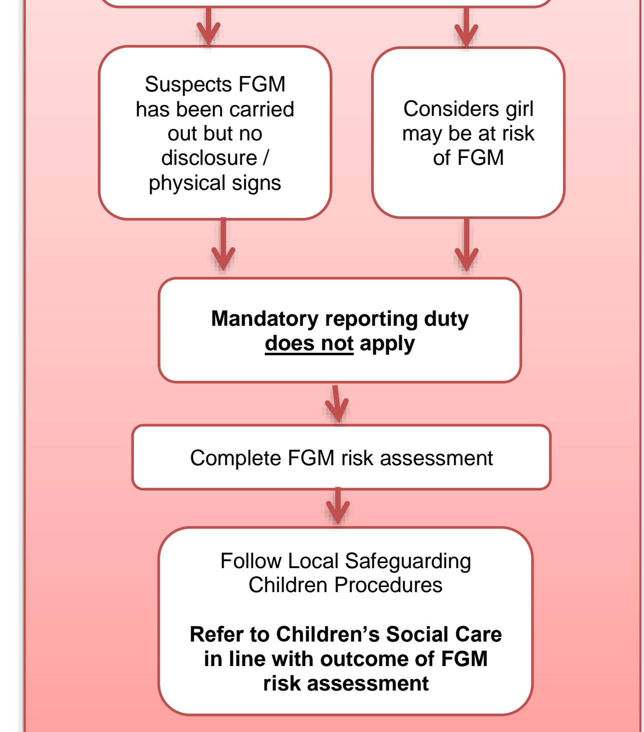
IN ALL cases the outcome of any discussion about FGM MUST be recorded in the Safeguarding Child Information Template of the SystmOne record. This includes an entry in the adult's record and in the records of all girls under 18 years.

In the case of a child or young person under 18:

- SystmOne - complete the Safeguarding Children Information Template and ensure an alert note is visible in the journal.
- Other records e.g. RiO, paper records – ensure relevant entries are made to record the presence or risk of FGM and actions taken.
- Practitioners who do not have access to SystmOne must also contact the Safeguarding Advice Line for an entry to be made in the child's electronic record.
- Patient records left with parents/carers e.g. 'Red Books' should not include reference to FGM until a referral has been made to Children's Social Care.







USEFUL CONTACTS

Mandatory Reporting to Police – Call 101

Advice and Information:

CAIU (Police) Referral Desk ☎ 0116 248 5500
NSPCC FGM Helpline:☎ 0800 028 3550
Leicester City Duty and Advice Service: ☎ 0116 454 1004
First Response: ☎ 0116 305 0005
Rutland: ☎ 01572 722577
FORWARD:☎ 0208 960 4000
UAVA (United Against Violence and Abuse) LLR

- Helpline: ☎ 0808 802 0028
- Business Line for Professionals: ☎ 0116 255 0004

LPT Safeguarding Children, Young People & Adult Advice Line: ☎ 0116 295 8977

TAKING ADVICE SHOULD NOT DELAY TAKING ACTION TO SAFEGUARD A PERSON AT RISK

IN ALL cases the outcome of any discussion about FGM MUST be recorded in the Safeguarding Child Information section of the SystmOne record. This includes an entry in the adult's record and in the records of all girls under 18 years.

Appendix 9

Domestic Abuse Support Organisations (not exhaustive)

Every effort has been made to ensure appropriate advice and support is available to all protected characteristics /equality groups who are suffering or survivors of domestic abuse.

The following list includes web links to local and where applicable national support services and will be updated on a regular basis.

Local Services:

Organisation	Telephone Number	Website	Description of Service
Leicestershire Constabulary	999 in an emergency otherwise call 101	http://www.leics.police.uk/	Policing the areas of Leicester, Leicestershire and Rutland
UAVA – United against violence and abuse	Helpline – 0808 802 0028 Business line for professionals- 0116 255 0004	www.uava.org.uk	Provide refuge accommodation for women with or without children who are suffering from the effects of domestic abuse (Leicester, Leicestershire and Rutland) Domestic violence helpline and face to face support for DV victims living in Leicester, Leicestershire & Rutland
Juniper Lodge	0116 2733330	www.juniperlodge.org.uk	Rape and sexual assault response centre for adults (over 18 years of age)
Jasmine House – Leicester Rape Crisis	0116 2558852	www.jasminehouse.org.uk	Support and counselling for women (13 years and over) who have experienced rape or sexual assault recently or in the past.
Housing Advice North West Leicestershire District Council	01530 454545		Gives housing advice and support to victims of domestic violence who live in Leicestershire
Housing Options, Leicester City Council	0116 4541008		Access to city council hostels and independent refuges and hostels for victims of domestic violence who live in Leicester
Travelling Family Service	0116 2958759		Support to travelling families within Leicester, Leicestershire and Rutland.

General Support:

Organisation	Telephone Number	Website	Description of Service
National Centre for Domestic Violence	0800 970 2070	www.ncdv.org.uk	• 24 hour emergency service • Free legal advice • Injunctions within 24 hours • Completely confidential • Legal aid available
National Stalking Helpline	0808 802 0300	www.stalkinghelpline.org	Provides guidance and information
Revenge Porn Helpline	0345 6000 459	www.revengepornhelpline.org.uk	Free confidential advice and support.
Victim Support National telephone Support Line	0808 16 89 111	www.victimsupport.org.uk	Offers free and confidential help to victims of crime, their family, friends and anyone else affected. They give information, emotional support and practical help. The crime does not have to be reported to the police
Respect	0808 802 4040	www.respect.uk.net	Help and advice for perpetrators of domestic violence.
Jenkins Centre (City)	0116 254 0101	www.jenkinscentre.org	Provides interventions designed to help people stop using abusive behaviour towards an intimate partner or others (City).

Support for Children and Young People:

Organisation	Telephone Number	Website	Description of Service
NSPCC	808 8005000	www.nspcc.org.uk	Help for children experiencing abuse
NSPCC FGM Helpline	0800 028 3550		Offers advice and support to help protect UK children from FGM
Women's Aid		www.thehideout.org.uk	A website for children and young people to understand domestic violence (includes confidential chat rooms as well as advice, support and information)
Childline	0800 1111	www.childline.org.uk	

Support for Lesbian, Gay, Bi-Sexual and Transgender People:

Organisation	Telephone Number	Website	Description of Service
Broken Rainbow	0300 9995428	www.broken-rainbow.org.uk	The UK's only National Lesbian, Gay Bisexual and Transgender domestic violence helpline providing confidential support to all members of the LGBT communities.
Leicester Lesbian, Gay, Bi and Trans Centre	0116 254 7412	www.llgbc.com	Offers advice and support to LGBT people

Support for Men:

Organisation	Telephone Number	Website	Description of Service
Men's Advice Line - Talk it Over	0808 801 0327	http://mensadviceline.org.uk/mens_	Offers advice to men who are experiencing domestic violence
Man Kind	01823 334244	www.mankind.org.uk	Offers advice and support to male victims of domestic abuse.

Forced Marriage and Female Genital Mutilation:

Organisation	Telephone Number	Website	Description of Service
Forced Marriage Unit	020 7008 0151	www.fco.gov.uk/forced marriage	Offers advice and support to people who have been subject to or are concerned that they will be subject to forced marriage.
Foreign and Commonwealth Office (re female genital mutilation)	No number	www.fco.gov.uk/fgm	Support and advice for people concerned about or who have experienced female genital mutilation

Older People:

Organisation	Telephone Number	Website	Description of Service
Age UK Leicester Shire and Rutland	0116 2992233	www.ageuk.org.uk	Support and advice for older people.

Drug and Alcohol Services:

Organisation	Telephone Number	Website	Description of Service
Turning Point	020 7481 7600	www.turning-point.co.uk	Support for people with drug and alcohol concerns

Senior Safeguarding Practitioner – Domestic Violence & Abuse ☎Tel: 0116 295 8710

LPT Safeguarding Advice Line ☎Tel: 0116 295 8977

Police Domestic Abuse Officers ☎Tel: 0116 2222222

Social Care and Health via Duty Desk/Access Team Tel: 0116 252 7004 (City)
Tel: 0116 305 5500 (County)
Tel: 01572 758407 (Rutland)

Appendix 10

Domestic Abuse: Additional Vulnerability Factors (not exhaustive)

a) **Pregnancy**
In 30% of cases of domestic violence, the abuse first started during pregnancy (McWilliams and McKiernan, 1993). 30% who reported violence during pregnancy also reported that had at some time suffered a miscarriage as a result (Coid, 2000)
Domestic violence has been identified as a prime cause of miscarriage or still-birth (Mezey, 1997) and of maternal deaths during childbirth (Lewis and Drife 2001, 2005)
12% of the 378 women whose death was reported to the Confidential Enquiry on Maternal Deaths had voluntarily reported domestic violence to a healthcare professional during their pregnancy (Lewis and Drife, 2001). None had routinely been asked about domestic violence so this is almost certainly an underestimate.
During 2000 – 02, within the six weeks following birth, 11 new mothers were known to have been murdered by their male partners and 14% of all women who died during or immediately after pregnancy (43 women) had reported domestic violence to a health professional during the pregnancy (Lewis and Drife, 2005)

b) **Culture**; No culture endorses or condones Domestic Abuse. However, some minority communities can face particular barriers and pressures which can make it difficult to acknowledge or report incidents of abuse.

c) **Temporar**y Accommodation/Refuge; Many families live in temporary accommodation and may face chronic poverty, social isolation, discrimination and other problems associated with living in temporary accommodation or refuge. These families can become disengaged from, or cannot access health or social care, and other support systems.

d) **Disability;** Disabled women are twice as likely to experience domestic abuse as non-disabled women. They are also abused over a longer period of time and suffer more physical injury as a result of the violence. Women and children may be especially vulnerable in situations where the abuser is the primary carer. Women with learning disabilities will also have additional needs.

e) **Age;** Older women's experiences of domestic violence tend to be subsumed into the broader headline of elder abuse. Older women might feel the stigma of talking about domestic abuse more than younger women, and there are also many practical reasons why older women may find it harder to speak out e.g. the length of the relationship, lack of suitable refuge accommodation for elderly people, financial reasons or they may be disabled or caring for a disabled partner – who could also be abusive.

f) **Social Exclusion**; People on a low income and / or not being homeowners are more likely than those on a higher income and/ or homeowners to have experienced domestic abuse. This can include women with no recourse to public funds.

g) **Travelling Communities**; Members of these communities may be disengaged from services and face cultural barriers preventing disclosure of domestic abuse.

h) **Lesbian, Gay, Bisexual and Transgender people**; These groups are less likely to disclose abuse which may be due to stigma, shame, mistrust of authority, lack of specialist services or fear of sexuality being disclosed.

i) **Language/Literacy;** Women and children may face additional challenges if English is not the first language or there are literacy difficulties.
When working with victims where English is not the first language, professional interpreters who have criminal record bureau check should always be utilised. Family members, friends, community leaders or members of the local community **should not** to be used as interpreters.

j) **Immigration Status**; Women and children may have uncertain immigration status which may prevent seeking help and support.

k**) Mental Health**; Women experiencing domestic violence may already suffer from stigmatisation and social isolation, and are particularly vulnerable to the additional negative effects of being labelled as "mentally ill". They may find it even harder than other women to report or even to name their experience as domestic violence. When they do seek help, their credibility may be questioned and they may be unable to access any suitable sources of support.

l) **Substance Misuse**; Women abusing drug or alcohol may find it more difficult to seek help and to make and adhere to a safety plan to minimise risk. It may be more difficult to access help, and the domestic abuse may be seen as the secondary problem, even if the substance misuse is a result of ongoing domestic abuse. In addition, there is limited refuge accommodation for victims abusing substances.

Appendix 11

1. **Who might experience domestic abuse**?

1.1 It is estimated that one in four women and one in six men will be a victim of domestic abuse in their lifetime (Home Office, 2003). Although the majority of domestic abuse incidents relate to male perpetrators and female victims, this is not always the case. Domestic abuse also affects the lesbian, gay, bi-sexual and transgender community as well as male victims.

Domestic abuse occurs among people of all income levels, ages and among people from all black, white and minority ethnic backgrounds. In terms of domestic abuse and ethnicity, British Crime Survey findings show little variation in the experience of inter-personal violence by ethnicity (Walby, 2004).

Domestic abuse is rarely a one-off incident, and should be seen as a pattern of abuse and controlling behaviour through which the abuser seeks power over their victim.

1.2 Children and young people living with domestic abuse;

The issue of children living with domestic abuse is now recognised as a matter of concern in its own right by both government and key children's services agencies. The link between child abuse and domestic abuse is high with estimates ranging from 30 % - 66% depending upon the study. Therefore, whilst domestic abuse and child abuse do not always co-exist, it can be an important indicator of a child at risk of harm from either actual physical, sexual and/or emotional abuse or by exposure to abusive relationships.

The Adoption and Children Act 2002 extended the legal definition of harming children to include harm suffered by seeing or hearing ill treatment of others, especially in the home.

Living with domestic abuse can adversely affect all of the five outcomes for children identified in Every Child Matters (2004). In addressing the needs of children living with domestic abuse, it is important to be aware that children develop their own coping strategies; however, it is known that adverse experiences in childhood can detrimentally affect cognitive, psychological, physical, social and educational development. This may warrant long term involvement of health services.

Domestic abuse often means that children live in an environment where there are high levels of physical punishment, misuse of power and authority and the generation of feelings of fear, anxiety and helplessness despite the best efforts of the non-abusive partner.

Living with domestic abuse can cause distortion in children's perceptions of relationships, blame, cause and effect. Recent studies suggest violence within adolescent relationships is increasing and there is increasing normalisation of violence within peer groups. (NSPCC, 2009).
The welfare of a child is paramount. In cases of suspected child abuse the duty of care that any health professional owes to a child or young person will take precedence over any obligation to the parent or adult carer. All health professionals must refer to the Local Safeguarding Children Board Domestic Violence Practice Guidance (www.lscb-llr.org.uk) and the Trust's Protocol for Practice and Inter-agency referral form).

1.3 Vulnerable Adults

It is recognised that some victims of domestic abuse may face additional vulnerability factors and these should be taken into consideration when offering help and support. Staff have a responsibility toward safeguarding vulnerable adults and all healthcare staff must follow LPT safeguarding policy and good practice guidelines.

1.4 National and Local Context

- 1 in 4 women and 1 in 6 men will experience at least one incident of domestic abuse in their lifetime. Women are more likely to experience multiple repeat incidents and fear as a result of this pattern.
- In Europe, domestic abuse is the major cause of ill health for women aged between 16-44, more common than cancer or traffic accidents.
- In the UK at least 2 women are killed each week by a current or former partner. 21 males are killed annually.
- The Police in the UK receive one call from the public every minute for assistance for domestic violence.
- In an average year 1 in 10 women are known to have experienced violence form a partner or ex-partner.
- Domestic abuse has direct health consequences including higher rates of mental illness in women, contributing to depression, anxiety, stress, self-harm and suicide.
- For children the emotional effects of witnessing domestic violence are very similar to the psychological trauma associated with being a victim of child abuse.
- Culturally it's difficult for men to bring these incidents to the attention of the authorities. Men are reluctant to say that they've been abused by women, because it's seen as unmanly and weak. Because men are traditionally thought to be physically stronger than women, they are less likely to talk about or report incidents of domestic violence in relationships due to embarrassment or fear of ridicule.
- 130,000 children live in homes where there is high risk DVA. 62% of children are directly harmed by the perpetrator (SafeLives 2014).
- DVA is a factor in over half of Serious Case Reviews (Sidebottom 2016).

CONTRIBUTION LIST **APPENDIX 12**

Key individuals involved in developing the document

Name	Designation
Sally Clare	Specialist Nurse Domestic Violence
Claire Silcott	Senior Safeguarding Practitioner

Circulated to the following individuals for comments

Name	Designation
LPT Legislative Committee	
LPT Safeguarding Team	
Alun Elias-Jones	Named Doctor Children Safeguarding
Neil King	Trust Lead for Safeguarding
Carmela Senogles	Lead Safeguarding Practitioner – Named Nurse
Heather Darlow	Governance Lead CHS
Lynne Moore	Professional Lead Nurse LD
Lyn Williams	Head of Service for MHSOP
Joanne Wilson	Lead Nurse
Mark Randell	Lead Nurse
Anne Scott	Interim Executive Director of Nursing/AHP's & Quality
Helen Thompson	Divisional Director FYPC Services
Mark Roberts	Head of Communities & Youth Services
Janet Harrison	Head of Service – Group 2
Dr Krutika Patel	Consultant Paediatrician
Laura Belshaw	Head of Nursing & Quality, FYPC
Suzanne Ziegler	Clinical Lead Children's Physiotherapy
Becky Pope	Advance Practitioner Childrens OT
Craig Hunting	MAPPA Co-ordinator
Leon Herbert	Prevent Co-ordinator
Michelle Churchard-Smith	Head of Nursing AMH/LD
Emma Wallis	Associate Director of Nursing & Professional Practice
Claire Armitage	Deputy Head of Nursing for Community Services, AMH & LD
Laura Belshaw	Head of Nursing & Quality, FYPC
Neil King	Trust Lead for Safeguarding

Training Needs Analysis

Training Required	**<u>YES</u>**	NO
Training topic:	Domestic Violence & Abuse	
Type of training: (see study leave policy)	☐ Mandatory (must be on mandatory training register) ✓ Role specific ✓ Personal development	
Division(s) to which the training is applicable:	✓ Adult Mental Health & Learning Disability Services ✓ Community Health Services ✓ Enabling Services ✓ Families Young People Children ✓ Hosted Services	
Staff groups who require the training:	All staff employed by LPT	
Regularity of Update requirement:	3 yearly	
Who is responsible for delivery of this training?	Whole Family Safeguarding Team Learning and Development Team	
Have resources been identified?	Yes	
Has a training plan been agreed?	Yes, Training and Education Strategy Safeguarding Adults, Children and Young People identifies safeguarding training requirements.	
Where will completion of this training be recorded?	✓ uLearn ☐ Other (please specify)	
How is this training going to be monitored?	Safeguarding Committee oversee the training compliance on a bi- monthly basis.	

The NHS Constitution

The NHS will provide a universal service for all based on clinical need, not ability to pay. The NHS will provide a comprehensive range of services

Shape its services around the needs and preferences of individual patients, their fam and their carers	✓
Respond to different needs of different sectors of the population	✓
Work continuously to improve quality services and to minimise errors	✓
Support and value its staff	✓
Work together with others to ensure a seamless service for patients	✓
Help keep people healthy and work to reduce health inequalities	✓
Respect the confidentiality of individual patients and provide open access to informa about services, treatment and performance	✓

Appendix 15

Due Regard Screening Template

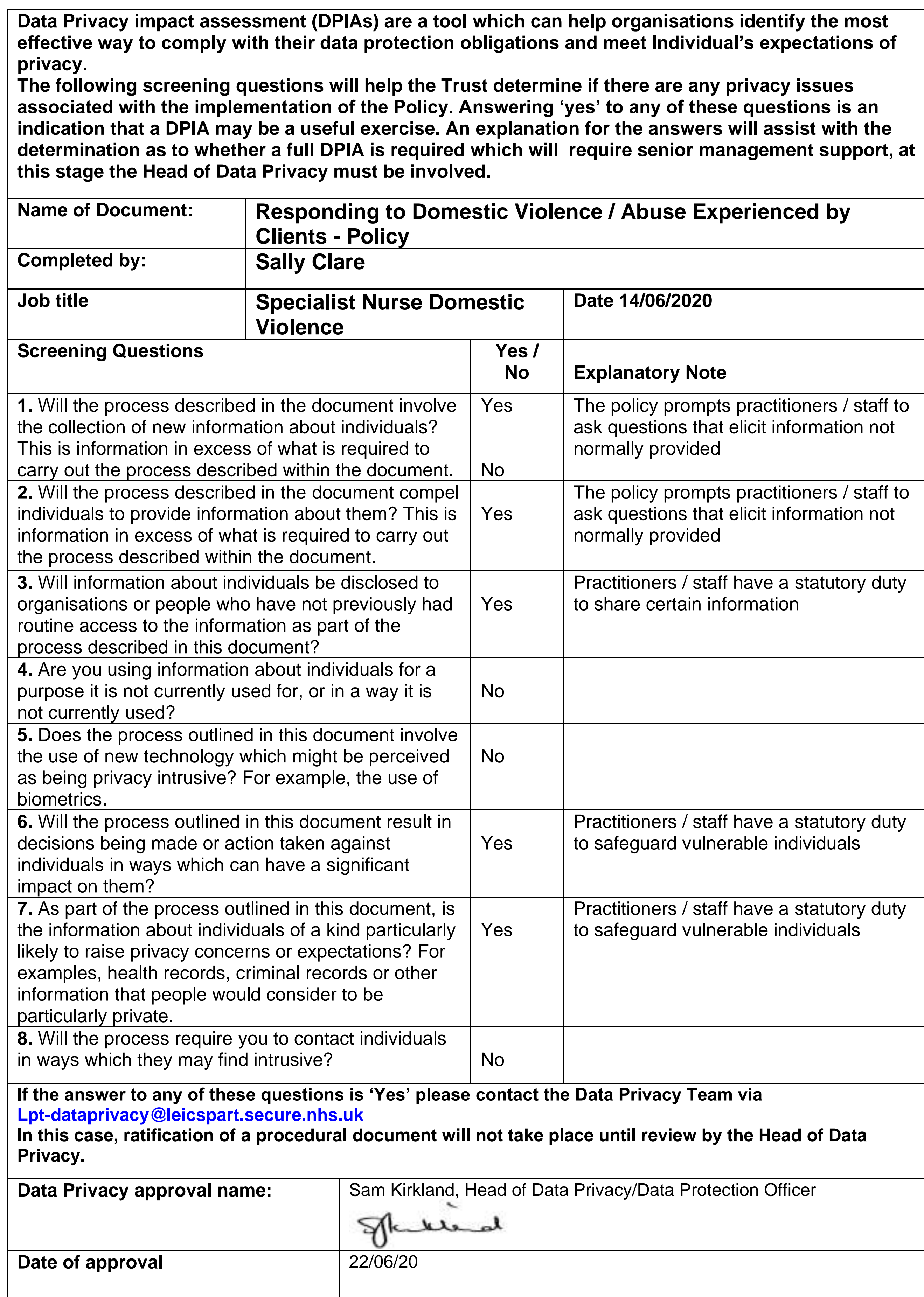
Section 1	
Name of activity/proposal	Domestic Violence / Abuse Experienced by Clients Policy
Date Screening commenced	7th September 2020
Directorate / Service carrying out the assessment	Enabling
Name and role of person undertaking this Due Regard (Equality Analysis)	Carmela Senogles
Give an overview of the aims, objectives and purpose of the proposal:	
AIMS: This policy describes the principles & procedures of supporting and responding to domestic violence/ abuse experienced by clients, and staff roles & responsibilities to apply this in practice.	
OBJECTIVES: The policy objective is for Leicestershire Partnership NHS Trust to ensure staff are give appropriate information to support and respond to domestic violence/ abuse experienced by clients. Adherence to this policy will ensure that no differential treatment will occur as a result of a person's protected characteristic.	

Section 2	
Protected Characteristic	**If the proposal/s have a positive or negative impact please give brief details**
Age	Policy applies to all age groups with no exceptions in line with Human Rights Approach as set out in LPTs Single Equality Approach and Equality, Diversity and Human Rights Policy.
Disability	Policy available in: -Braille -Other language formats (Translation & Interpretation) -Reasonable adjustments -Carers In line with Human Rights Approach as set out in LPTs Single Equality Approach and Equality, Diversity and Human Rights Policy.
Gender reassignment	Policy applies to all groups with no exceptions in line with Human Rights Approach as set out in LPT's Single Equality Approach and Equality, Diversity and Human Rights Policy. As with any known characteristic will be treated in strictest confidence and underpinned by Caldicott Principles ensuring confidentiality is maintained.
Marriage & Civil Partnership	Policy applies to all groups with no exceptions in line with Human Rights Approach as set out in LPTs Single Equality Approach and Equality, Diversity and Human Rights Policy
Pregnancy & Maternity	Policy applies to all groups with no exceptions in line with Human Rights Approach as set out in LPT's Single Equality Approach and Equality, Diversity and Human Rights Policy
Race	Policy applies to all groups with no exceptions in line with Human Rights Approach as set out in LPTs Single Equality Approach and Equality, Diversity and Human Rights Policy. -Training/FAQ's -Information/Language (Written/Verbal) formats available upon request via LPTs Interpretation, and Translation Service.

<table>
<tr><td colspan="2">Religion and Belief</td><td colspan="4">Policy applies to all groups with no exceptions in line with Human Rights Approach as set out in LPTs Single Equality Approach and Equality and Human Rights Policy.
-Training/FAQs
-Information/Language
-Information/Language (Written/Verbal) formats available upon request via LPTS Interpretation and Translation Service.</td></tr>
<tr><td colspan="2">Sex</td><td colspan="4">Policy applies to all groups with no exceptions in line with Human Rights Approach as set out in LPTs Single Equality Approach and Equality, Diversity and Human Rights Policy</td></tr>
<tr><td colspan="2">Sexual Orientation</td><td colspan="4">Policy applies to all groups with no exceptions in line with Human Rights Approach as set out in LPTs Single Equality Approach and Equality, Diversity and Human Rights Policy.</td></tr>
<tr><td colspan="2">Other equality groups?</td><td colspan="4">Policy applies to all groups with no exceptions in line with Human Rights Approach as set out in in LPTs Single Equality Approach and Equality, Diversity and Human Rights Policy- these may also include:
-Homeless
-Asylum Seekers/Refugees
-Veterans</td></tr>
<tr><td colspan="6">Section 3</td></tr>
<tr><td colspan="6">Does this activity propose major changes in terms of scale or significance for LPT? For example, is there a clear indication that, although the proposal is minor it is likely to have a major affect for people from an equality group/s? Please <u>tick</u> appropriate box below.</td></tr>
<tr><td colspan="3">Yes</td><td colspan="3">No</td></tr>
<tr><td colspan="2">High risk: Complete a full EIA starting click <u>here</u> to proceed to Part B</td><td></td><td colspan="2">Low risk: Go to Section 4.</td><td>✓</td></tr>
<tr><td colspan="6">Section 4</td></tr>
<tr><td colspan="6">If this proposal is low risk please give evidence or justification for how you reached this decision:</td></tr>
<tr><td colspan="6">Having reviewed the policy it meets the Trust’s Equality, Diversity and Human Rights Policy.
It does not discriminate on the grounds of any Protected Characteristic and follows clear Human Rights Approach. The policy consultation process has included:
-Safeguarding Committee Members
-Clinical Governance Leads
- Operational Managers</td></tr>
<tr><td>Signed by reviewer/assessor</td><td colspan="2">Carmela Senogles</td><td>Date</td><td colspan="2">7th September 2021</td></tr>
<tr><td colspan="6">Sign off that this proposal is low risk and does not require a full Equality Analysis</td></tr>
<tr><td>Head of Service Signed</td><td colspan="2">Neil King</td><td>Date</td><td colspan="2">7th September 2021</td></tr>
</table>

Appendix 16

DATA PRIVACY IMPACT ASSESSMENT SCREENING



Data Privacy impact assessment (DPIAs) are a tool which can help organisations identify the most effective way to comply with their data protection obligations and meet Individual's expectations of privacy.
The following screening questions will help the Trust determine if there are any privacy issues associated with the implementation of the Policy. Answering 'yes' to any of these questions is an indication that a DPIA may be a useful exercise. An explanation for the answers will assist with the determination as to whether a full DPIA is required which will require senior management support, at this stage the Head of Data Privacy must be involved.

Name of Document:	**Responding to Domestic Violence / Abuse Experienced by Clients - Policy**	
Completed by:	**Sally Clare**	
Job title	**Specialist Nurse Domestic Violence**	**Date 14/06/2020**

Screening Questions	**Yes / No**	**Explanatory Note**
1. Will the process described in the document involve the collection of new information about individuals? This is information in excess of what is required to carry out the process described within the document.	Yes No	The policy prompts practitioners / staff to ask questions that elicit information not normally provided
2. Will the process described in the document compel individuals to provide information about them? This is information in excess of what is required to carry out the process described within the document.	Yes	The policy prompts practitioners / staff to ask questions that elicit information not normally provided
3. Will information about individuals be disclosed to organisations or people who have not previously had routine access to the information as part of the process described in this document?	Yes	Practitioners / staff have a statutory duty to share certain information
4. Are you using information about individuals for a purpose it is not currently used for, or in a way it is not currently used?	No	
5. Does the process outlined in this document involve the use of new technology which might be perceived as being privacy intrusive? For example, the use of biometrics.	No	
6. Will the process outlined in this document result in decisions being made or action taken against individuals in ways which can have a significant impact on them?	Yes	Practitioners / staff have a statutory duty to safeguard vulnerable individuals
7. As part of the process outlined in this document, is the information about individuals of a kind particularly likely to raise privacy concerns or expectations? For examples, health records, criminal records or other information that people would consider to be particularly private.	Yes	Practitioners / staff have a statutory duty to safeguard vulnerable individuals
8. Will the process require you to contact individuals in ways which they may find intrusive?	No	

If the answer to any of these questions is 'Yes' please contact the Data Privacy Team via Lpt-dataprivacy@leicspart.secure.nhs.uk
In this case, ratification of a procedural document will not take place until review by the Head of Data Privacy.

Data Privacy approval name:	Sam Kirkland, Head of Data Privacy/Data Protection Officer
Date of approval	22/06/20

Acknowledgement: This is based on the work of Princess Alexandra Hospital NHS Trust