

University of Bristol
Centre for Academic
Primary Care

NIHR | School for Primary
Care Research

Making change happen in primary care - the IRIS story

Gene Feder & Medina Johnson

CAPC Innovation and Impact in Primary Care webinar

29th November 2023

#capcwebinar

www.bristol.ac.uk/capc

@capcbristol





Constance

43-year old care worker who had been my patient for 5 years.

Two sons, James (13) and Tyrone (4).

Partner was Tyrone's father.

Three research studies and what happened next

IRIS trial

IRIS interrupted time series

3
1

IRIS ADVISE

7
9

Domestic violence and intimate partner violence





Domestic violence will affect **1 in 4 women**



It takes an average of **2.3 years** for a high-risk victim to get seek help

Domestic Violence

7

Women a month are **killed** by a **current** or **former partner** in **England** and **Wales**.

130,000

Children live in homes where there is **high-risk** domestic abuse



1 in 6 men will experience domestic violence

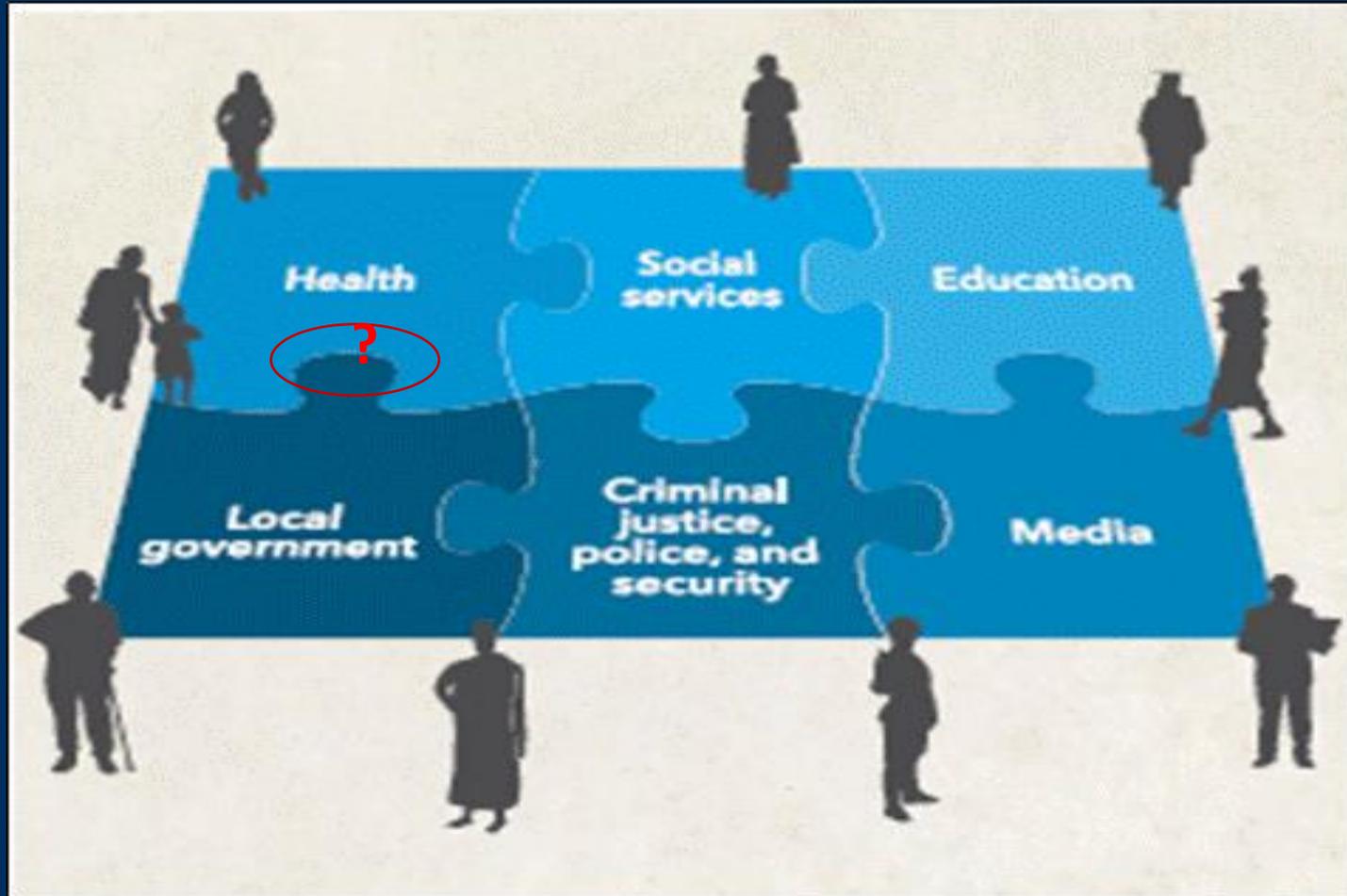
Violence against women has **serious health consequences.**

<p>Death</p> 	<p>Physical injuries</p> 	<p>Unintended pregnancies, induced abortions</p> 
<p>Sexually transmitted infections, including HIV</p> 	<p>Depression, post-traumatic stress disorder</p> 	<p>Harmful use of tobacco, drugs, and alcohol</p> 

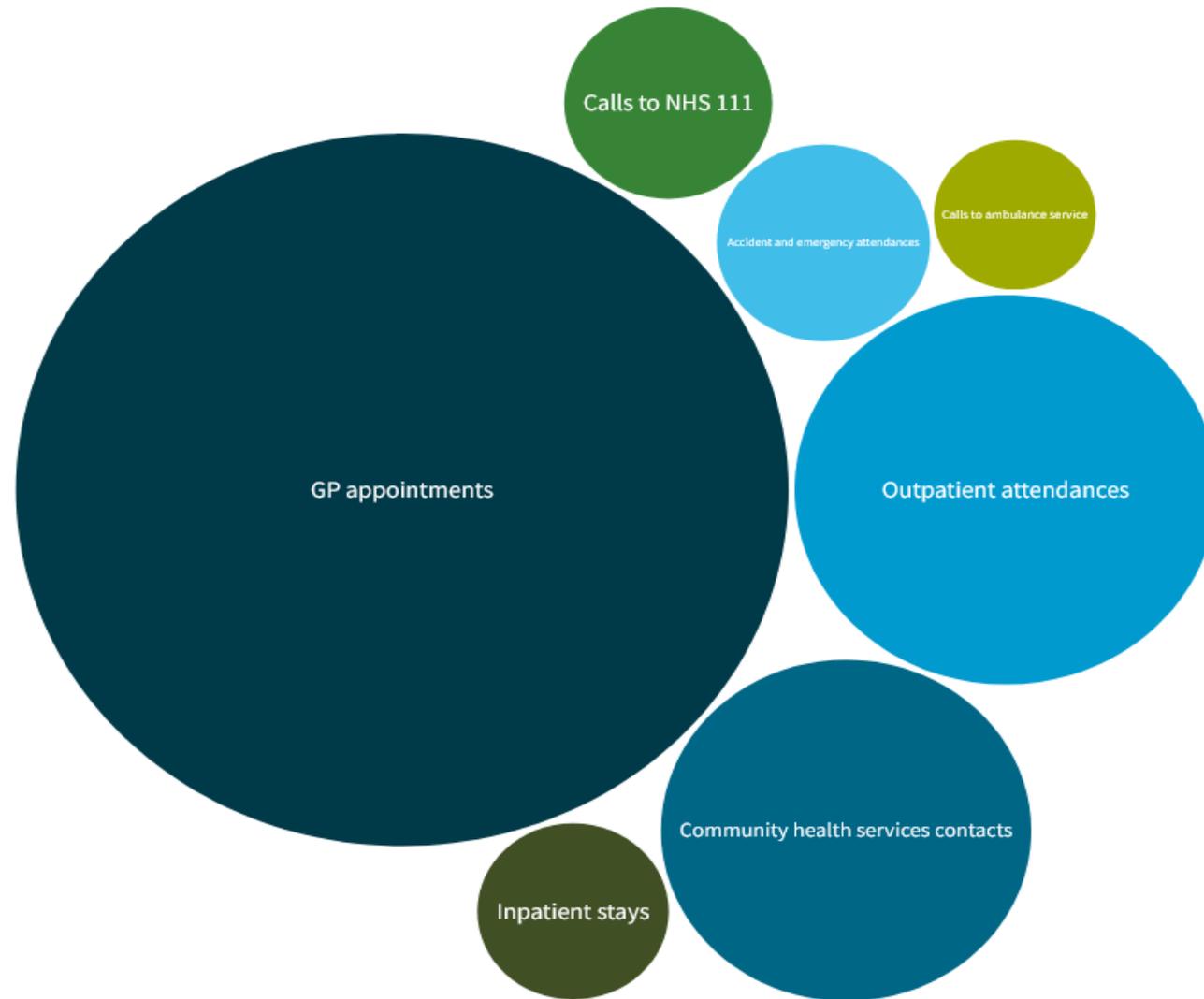
£ € \$ ¥ **Economic Impact** رباي ₱ ₪ ₪

Costs of intimate partner and sexual violence for countries are very high. They include the provision of **health, social, and legal services** and costs of lost earnings.

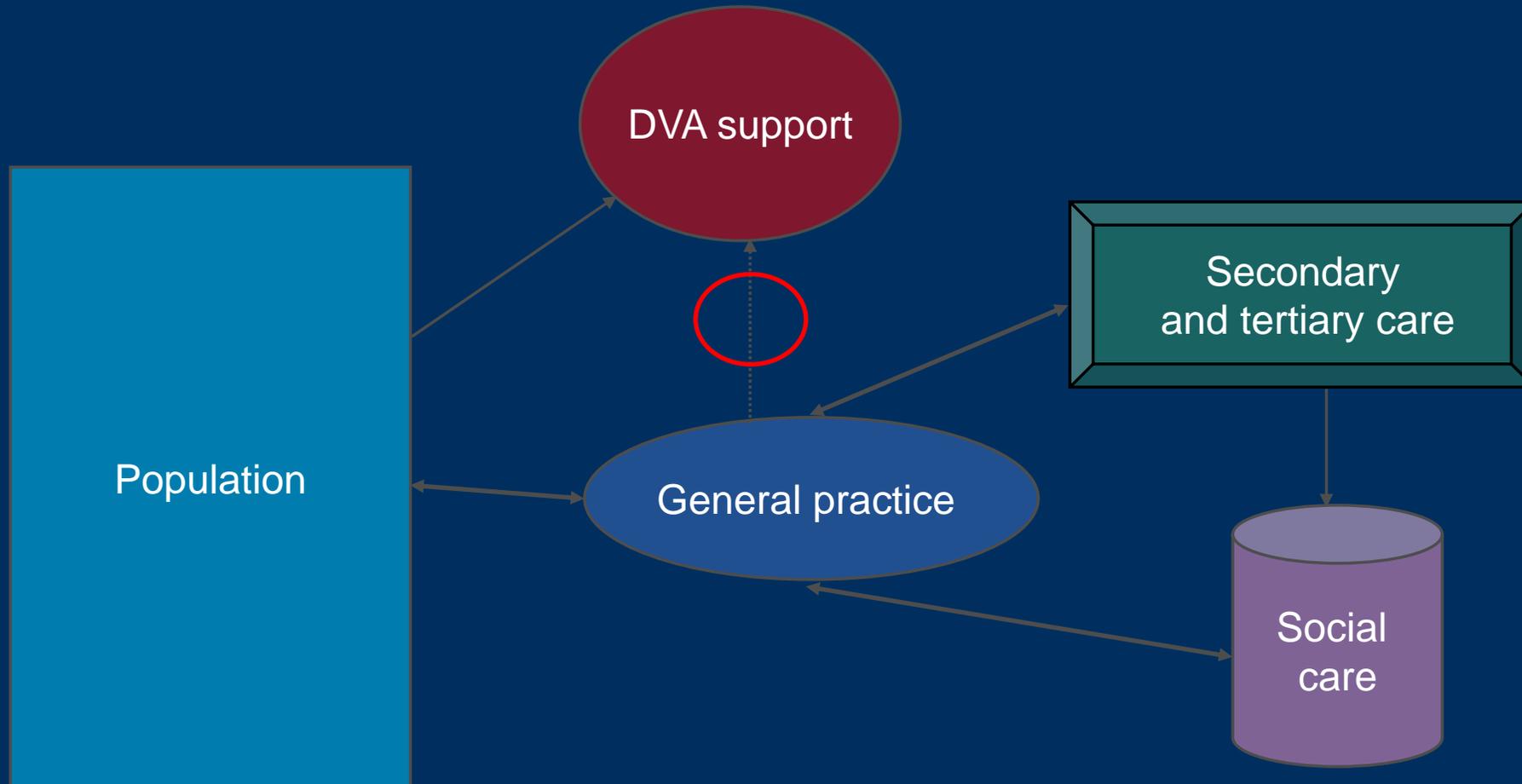
Missing health care response



Why primary care?



Primary care connections



Identification and *Referral* to Improve *Safety*



3RD SECTOR IRIS HOST

- Advocate Educator
- Specialist advocacy



General practices with up to 200,000 patients

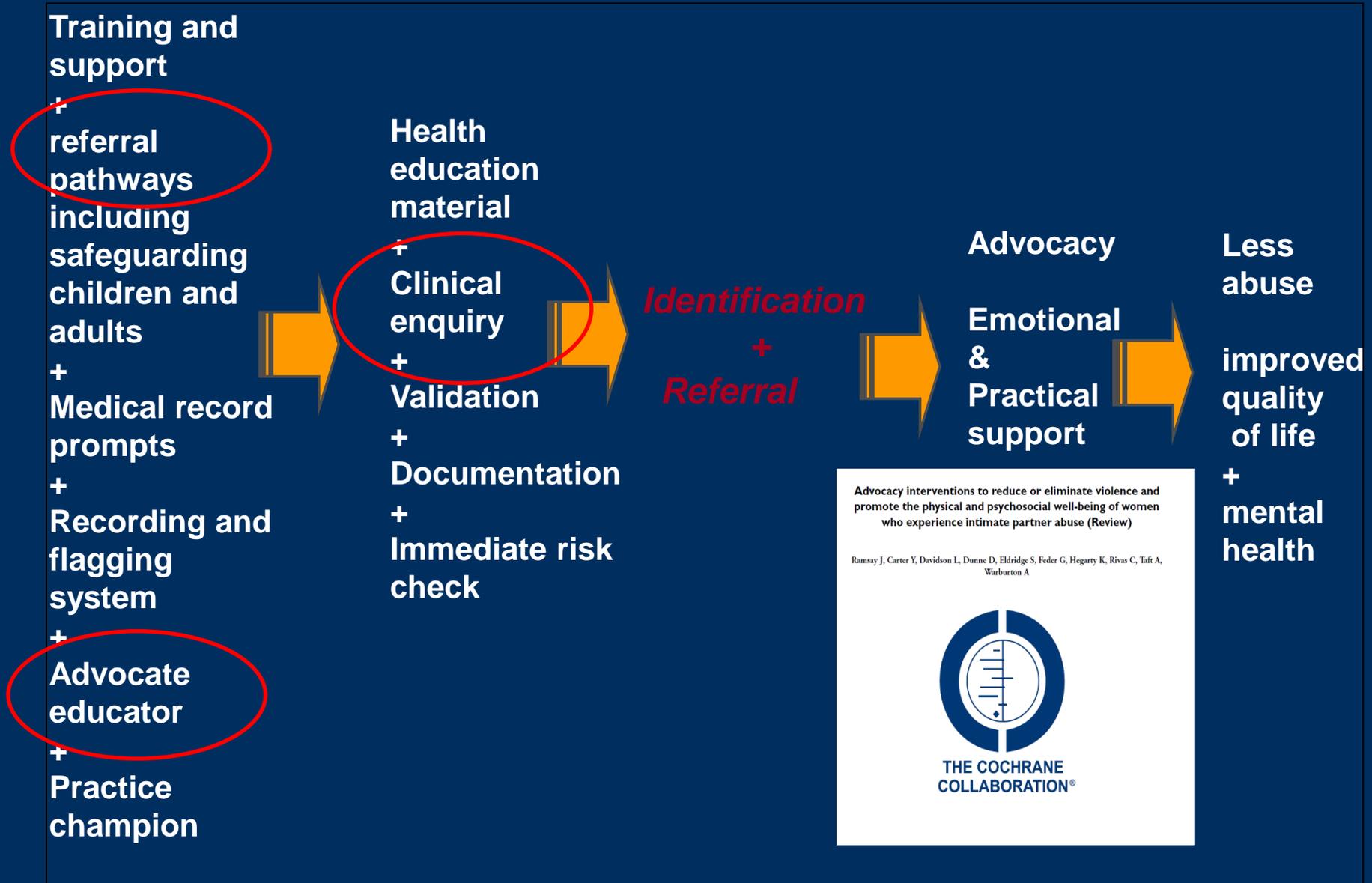
- In-house training
- Patient and professional resources
- Referral pathways
- Single point of contact
- Specialist consultancy
- On-going support



General practice team

- Clinical enquiry
- Validation
- Emotional support
- Referral/signposting
- Documentation
- Treatment for health conditions

IRIS intervention model



IRIS Identification and Referral to Improve Safety

Domestic Violence Aware Practice

If you are a woman being hurt by someone in your family, are afraid of someone at home or are in a violent relationship you can talk to doctors, nurses and other staff working here, in private.



You can also call
**Next Link domestic abuse
services** on:

0117 925 0680

Or call the 24 hour
National Domestic Violence Helpline
on: freephone **0808 2000 247**

If you are a man who is a victim of domestic
violence contact the Men's Advice Line on:

0808 801 0327

If you have been violent or are worried
about your own behaviour, call Respect on:

0808 802 4040

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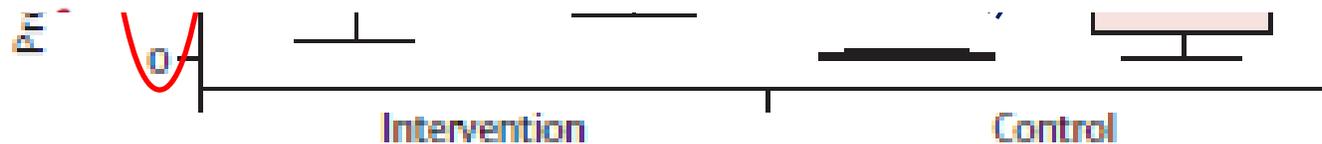
IRIS trial results



■ Proportion of referrals
■ Proportion of identifications

👤 Identification and Referral to Improve Safety (IRIS) of women experiencing domestic violence with a primary care training and support programme: a cluster randomised controlled trial

Gene Feder, Roxane Agnew Davies, Kathleen Baird, Danielle Dunne, Sandra Eldridge, Chris Griffiths, Alison Gregory, Annie Howell, Medina Johnson, Jean Ramsay, Clare Rutterford, Debbie Sharp



Beyond the ivory tower

14

The domestic abuse quarterly Winter 2010

Safe

'Herding cats': the experiences of domestic violence advocates engaging with primary care providers

Medina Johnson from Next Link in Bristol reports on a recent Identification and Referral to Improve Safety (IRIS) randomised control trial in general practices with domestic violence spe-

Engaging health care services in support of women experiencing domestic violence has been a challenge for domestic violence for specialist agencies. Reluctance to talk about domestic violence may be for a variety of reasons: clinicians may feel that domestic violence is not their remit; are not aware of related health issues; fear offending women they ask about abuse; do not want to open Pandora's Box and then not be able to deal with what comes out of it; domestic violence does not fit with what many see as the traditional medical model of symptom > diagnosis > treatment > cure (even if much of what clinicians and nurses do lies outside that model)¹.

Notes

1. Grenell DH, Kanof EP. Overcoming barriers to physician involvement in identifying and referring victims of domestic violence. *Ann Emerg Med.* 1996;27:769-773.

2. Sugg NK, Thompson RS, Thompson DC, Makino R, Rivera FP. Domestic violence and primary care: Attitudes, practices, and beliefs. *Arch Fam Med.* 1999;8:301-306.

The Identification and Referral to Improve Safety (IRIS) randomised control trial has been working to engage general practices providing primary care teams with information, confidence and skills to ask female patients about domestic abuse and creating an easy and clear referral route to a named advocate who is able to meet v-

IMPROVEMENT IN PRACTICE:

THE IRIS CASE STUDY

February 2011



Identify Innovate Demonstrate Encourage

Responding to domestic abuse:



Royal College of General Practitioners



IRIS
Identification & Referral
to Improve Safety



caada
Coordinated Action Against Domestic Abuse

Guidance for general practices

This document provides guidance to general practices to help them respond effectively to patients experiencing domestic abuse,¹ a Department of Health strategic priority:
www.dh.gov.uk/en/PublicHealth/ViolenceagainstWomenandChildren/index.htm

This guidance includes key principles to help you develop your domestic abuse policy.²

1. The role of management

A senior person within the practice should be identified to clarify the practice's response to domestic abuse by:

- Finding out what **existing domestic violence services** are available (a list of national organisations is on page 4).
- **Engaging** with local domestic abuse services – and the Domestic Violence Co-ordinator – to develop an effective working partnership.
- Commissioning **training** for the practice team.
- Establishing a **simple care pathway** for patients disclosing domestic abuse by identifying a local **designated person** who will be responsible for the initial assessment of victims.
- Ensuring that the practice's response to disclosure always adheres to its **information sharing** protocols.

Identifying the designated person

The practice's designated person can either be:

- An external specialist domestic abuse service practitioner who undertakes the initial assessment on behalf of the practice and liaises with the GP. Specific evidence based training and support programmes for general practice are available: www.irisdomesticviolence.org.uk
- An internal practice nurse or other health professional who is trained to carry out this work.

2. Establishing a domestic abuse care pathway

The primary healthcare team's role

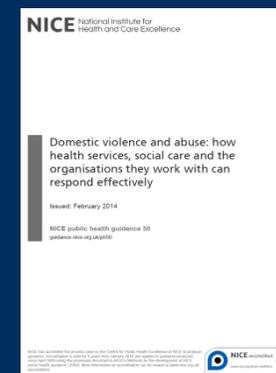
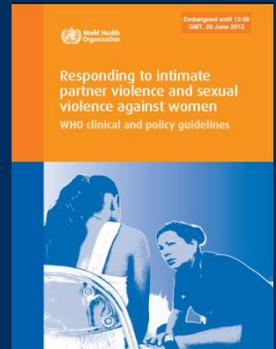
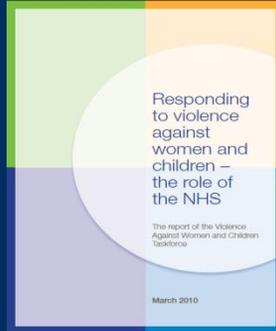
- Recognise patients whose symptoms mean they might be more likely to be experiencing domestic abuse.
- Enquire sensitively and provide a safe and empathetic first response.
- Understand the practice's process for responding to disclosure, and know what to do when there is immediate risk of harm to patients and their children.
- Know who the designated person is for their practice.
- Understand the process for arranging the patient's initial assessment with the designated person.
- Document domestic abuse within patient records safely and keep records for evidence purposes.
- Share information appropriately. Information will be shared **only with the consent** of the patient, subject to practice policy on child protection and adult safeguarding. In exceptional circumstances information may be shared without the patient's consent. Some cases considered at MARAC³ meetings are likely to constitute exceptional circumstances because MARACs discuss the most serious cases of alleged or suspected domestic abuse.

1. For the Home Office's definition of domestic abuse visit: www.homeoffice.gov.uk/crime/violence-against-women-girls/domestic-violence/

2. For more information about the guidance contact iris@nextlinkhousing.co.uk or info@caada.org.uk

3. Multi-Agency Risk Assessment Conference – where information is shared and a coordinated safety plan implemented to protect the highest risk victims of domestic abuse: www.caada.org.uk/aboutus/faqs.html For guidance about the application of Caldicott Guardian Principles to domestic abuse and MARACs visit: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_133589

Translation into policy



- cited in Department of Health Violence Against Women and Children taskforce report as an exemplar programme
- cited in WHO partner violence guidelines as evidence for recommendation on training interventions
- part of NICE domestic violence guidelines evidence review
- cited as a “particularly effective remedy” by the Task and Finish Group for the Welsh Government’s *Ending Violence Against Women and Domestic Abuse (Wales) Bill*

Can IRIS be implemented outside of a trial?

Sohal et al. *BMC Medicine* (2020) 18:48
<https://doi.org/10.1186/s12916-020-1506-3>

BMC Medicine

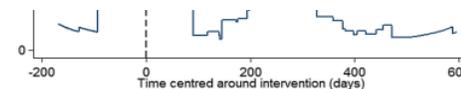
RESEARCH ARTICLE

Open Access

Improving the healthcare response to domestic violence and abuse in UK primary care: interrupted time series evaluation of a system-level training and support programme



Alex Hardip Sohal^{1*} , Gene Feder², Kambiz Boomla¹, Anna Dowrick¹, Richard Hooper¹, Annie Howell³, Medina Johnson³, Natalia Lewis^{1,2}, Clare Robinson¹, Sandra Eldridge¹ and Chris Griffiths¹



IRIS ADVISE

Health services research



ORIGINAL ARTICLE

Assessing for domestic violence in sexual health environments: a qualitative study

Jeremy Horwood,^{1,2} Andrew Morden,^{1,2} Jayne E Bailey,² Neha Pathak,^{2,3} Gene Feder²

Health services research



SHORT REPORT

Improving the healthcare response to domestic violence and abuse in sexual health clinics: feasibility study of a training, support and referral intervention

Alex Hardip Sohal,¹ Neha Pathak,² Sarah Blake,³ Vanessa Apea,⁴ Judith Berry,⁵ Jayne Bailey,^{5,6} Chris Griffiths,⁷ Gene Feder⁸

Generalisable lessons from the IRIS story

- think about pathways to impact at conception of study: different audiences have different tastes
- include a cost-effectiveness analysis for evaluative studies
- get funding for knowledge mobilisation: NIHR gets this now
- produce non-academic outputs
- form strategic partnerships
- be lucky

Thank you



to survivors
to their families
to colleagues
to funders





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MOVING FROM RESEARCH TO PRACTICE

STEP 1

IRIS RCT – 2007 to 2010
Health Foundation funding

STEP 3

2013-16
Dept of Health funding
Development of funding model

STEP 2

Post trial research into practice –
2010-2012
Health Foundation funding

STEP 4

2016 to date
Funding via sales and grants
IRISi established in 2017

WHO ARE WE AND WHAT DO WE DO?

VISION

A world in which gender-based violence is consistently recognised and addressed as a health issue.

MISSION

To improve the healthcare response to gender-based violence through health and specialist services working together.

IRIS: Our flagship programme



A general practice based domestic violence and abuse training and referral programme



Recognise; Ask; Respond; Refer; Record



Increases identifications and referrals



Improves clinical practice



Improves quality of life for patients

WHAT DO SURVIVORS WANT FROM HEALTH CARE PROFESSIONALS?

To feel comfortable and supported to disclose

An immediate response to disclosure

To be asked directly – low threshold for clinical questioning

A response in later consultations – continuity of care

IRIS: Our flagship programme

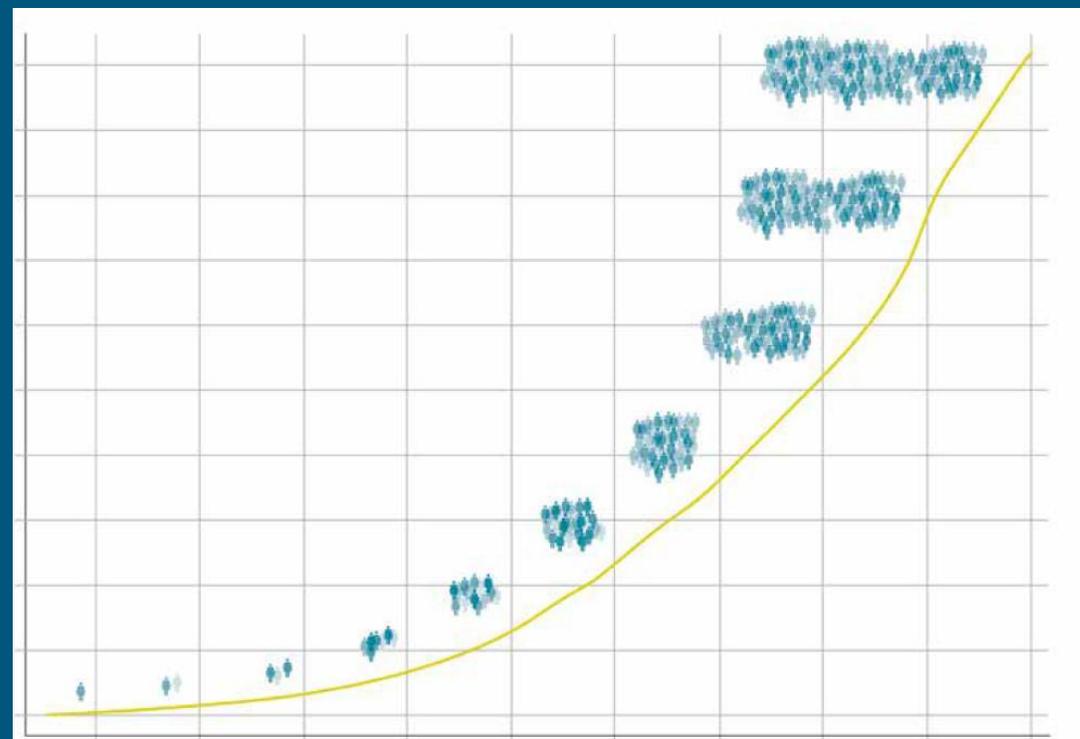
57 Commissioned sites since 2010 and 39 active sites

1,498 RIS trained practices

30,194 Patients referred

Up to March 2022

UK REFERRALS



WHAT DO PATIENTS SAY?

Whatever you have going on with GPs in (name of area) is so important - that link is incredible - I am forever indebted to my GP for piecing it all together and for getting me that help

I have seen that there were agencies that could support people with abuse but I would never have called or seen anyone if it wasn't for my GP referring me to see someone in my surgery. What a difference this has made to my life and future.

My Doctor is one of the best , I have now had another very helpful and caring professional, it's like an extension of my GP. Thank you (name of AE) for all your hard work.

I feel my physical and mental health has improved, I visit the GP less, and I feel that my child is safer now.



WHAT DO CLINICIANS SAY?

Great! Where was this years ago! Good to empower us as GPs to feel we can do more about this now.

A good application of real world data and 'what to do' compared to standard training which is easily done and forgotten.

Simple concept and big impact.



WHAT ARE OUR BLOCKS AND CHALLENGES?

Clinicians don't want to invest time if the programme isn't sustainable – don't want to engage.

Unfair to set up something and then it disappears – what happens to patients?

Everyone thinks it's a good idea but no one wants to pay.

Interventions are more than training.

Short commissioning and funding cycles.



"IRIS IS EXPENSIVE!" - NO, IT'S NOT!

AS WE HAVE SHOWN...

IRIS provides a full intervention: training, consultancy, embedded specialist who supports patients, referral pathways.

VALUE FOR MONEY

Net monetary benefit – 4.8 x better value for money than flu vaccine!

SPEND TO SAVE

Spending in primary care saves money elsewhere – A&E, acute care, mental health - so there is more £ in the health pot.



THE LOCAL PICTURE

New cost calculator is currently being tested – a large urban area showed societal savings of £42 per woman per year; cost of 2p for NHS per woman per year (i.e. cost neutral).



CEA from research trial = positive.



NICE says we need to be cost effective not cost saving.



CEA from “real world” ITS = positive

WHAT IS ADVISE?

- Programme to support sexual health clinicians to identify and respond to patients affected by Domestic Abuse and Sexual Violence
- Facilitates referral to specialist support via simple care pathway
- Adds capacity to local specialist third sector
- Meets an unmet patient need and strengthens local partnership work
- First ADVISE programmes began in October/2021.
- Now running in 4 areas of Greater Manchester, 2 in London, 2 in South West – high levels of referrals – different patient population from IRIS

FEEDBACK ON ADVISE

Patients have welcomed being asked about domestic violence and abuse, even if they've not ever been involved in an incident of domestic abuse themselves, they appreciate that people are asking that question."

- Sexual Health Nurse



MOVING FROM RESEARCH TO PRACTICE

Transition from academic to operational

- Consistency of staff
- Institutional memory

We have a product

- Need to market selves
- Need to market product

Led by sector partners

- Time
- Passion
- Funding

Maintenance of core partners

- Advocate
- GP and academic
- Commercial lead

BARRIERS

Limitations of team
experience and expertise

Constantly changing health
system and structure

Paucity of sustainable
funding

Cheaper and less robust
alternatives

FACILITATORS

Passion
Connections
Credibility

Academic rigour
Evidence base

Robust, successful, scalable
programme
Demonstrable outcomes

Policy
Legislation
Recognition of issue

WHAT NEXT?

Constant reinforcement

Best practice

Creative fundraising

Work smarter

Continue to scale

Continue to innovate

Early intervention

Reduce risk
Improve health & life

THANK YOU!

Any questions?

RECOGNISE, ASK & RISK CHECK, RESPOND,
REFER AND RECORD

IRISi
interventions

IRiS

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IRISi

Website: www.irisi.org

Email: info@irisi.org



The freephone, 24-hour National Domestic Abuse Helpline **0808 2000 247** |

Respect
Men's advice line

Freephone **0808 8010327**