DOMESTIC VIOLENCE HEALTH NEEDS ASSESSMENT

Author - Jon Hobday
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Acknowledgements

I would like to thank the following stakeholders for all their input and support during this piece of work

Susan Puffet - Principal Community Safety Officer, Salford City Council (SCC)

Roselyn Baker - Principal Community Safety Officer, SCC

Dawn Redshaw - Head of service for Salford Independent Domestic Abuse Support Service (SIDASS)

Sharon Hubber – Head of Safeguarding, SCC

David Barnes – Business Manager, Salford Safeguarding Children Board

Brian Gatherscole - Principal Manager Adult Safeguarding Review and Extra Care, SCC

Anne Lythgoe - Health and Wellbeing Board Strategy Manager

Dan Kearnes - Business Manager, Salford Children and Young People’s Trust

Andrea Patel - Deputy Designated Nurse Safeguarding Children NHS Salford Clinical Commissioning Group

Jane Mckenzie - Specialist Nurse Safeguarding Children and Domestic Violence, Salford Royal Foundation Trust

Kerry Thornley – Supporting People Team, SCC

Laura Mercer - Policy Development Manager, Office of the Police and Crime Commissioner for Greater Manchester

Rachel Connelly - Service Manager - Supported Housing, SCC

Stuart Barton – Superintendent Operations – Greater Manchester Police

Estelle Mathieson – Detective Inspector – Greater Manchester Police

Manjit Seale – Manchester Probation Service
Executive Summary

**Headlines**

- Domestic Violence is a significant public health problem, with wide reaching implications and huge associated financial costs
- The levels and impacts of domestic violence in Salford are similar to those nationally
- The reported levels of domestic violence have not increased in recent years
- Salford provides some high quality evidence based services
- A more integrated approach to using data, providing training and commissioning services could potentially improve Salford’s domestic violence services for the same resources

**Introduction and Background**

In May 2014 the BBC reported that 7 women and 2 men were killed by their partner or former partner every month in England and Wales. Based on the Department of Health (DH) definition domestic violence is any incident or threatening behaviour, violence or abuse between adults who are or have been intimate partners or family members, regardless of gender or sexuality. It occurs throughout the city in every socio-economic group, across all neighbourhoods and communities. The incidence of domestic violence varies only marginally when analysed by geography, class, age, ability, sexuality, ethnicity and nationality. However these factors do affect the severity of violence, the experience of survivors and the likelihood of them accessing services or seeking help. Crime statistics and research show that within domestic violence most perpetrators are male and most victims are female. Domestic violence is of particular importance as it impacts on a range of other public health agendas including substance misuse, homelessness, sexual exploitation and criminal behaviour.

The health impacts of domestic violence on victims are both physical and mental. It is now well accepted that domestic violence (both in childhood and in adult life) is often the main factor in the development of depression, anxiety and other mental health disorders in victims. It has also been shown that sleep disturbances, self-harm, suicide and attempted suicide, eating disorders and substance misuse are all more common in those who have experienced domestic violence can also affect a parent’s ability to successfully bring up their children and children themselves can be affected in a wide range of ways with the full extend not being realised until they are adults.

This review examines the extent of the issue within Salford. It utilises the data available on domestic violence examining policy context, best practice, actions
required for effective commissioning and the evidence base for what works. Below are the key findings from this review.

**Evidence Base**

There is a broad policy context nationally and locally that supports the importance of domestic violence prevention. Key national policies include the NICE guidance and the ‘call to end violence against women and girls’ strategy while locally there is a ‘violence against women’ delivery plan.

There is a growing body of national evidence on the effectiveness of domestic violence prevention programmes. These include school based education and life skill programmes, community support and advocacy services, substance misuse treatments and community interventions, changing social norms through media campaigns, and identification, care and support interventions. A combination of these approaches has been shown to provide the best results.

The data and intelligence around domestic violence is limited both nationally and locally. To effectively address domestic violence within Salford a range of data/information from different partners e.g. health, police and Local Authority needs to be collated, coordinated, interpreted and shared regularly. This would ensure that any variations in need or changing patterns of domestic violence can be identified and effectively addressed through responsive services.

Direct and indirect costs for domestic violence are huge and can be long lasting. Evidence suggests the cost nationally is £15.73 billion per year. Based on the local population data, evidence suggests domestic violence costs Salford £43.5million per year. Studies that have compared treatment and prevention costs have shown a favourable return on investment. Suggesting additional investment in prevention could reduce the overall associated costs associated with domestic violence.

Evidence has also highlighted that awareness raising and training for front line workers in a range of services is essential to ensure domestic violence is identified within communities. As such it is suggested that coordinated, systematic evidence based training to all front line workers is essential to address the issue.

**Trends**

The number of domestic violence reported crimes in Salford are in line with the North West and England averages. Trends since 2011 suggest that reported levels of domestic related crimes have reduced slightly year on year (using calendar years) over the last 3 years dropping from 1416 in 2011 to 1116 in 2013 (21% reduction). In
all years peaks in domestic related crimes were around the months of March and August.

Since 2011 the number of Multi Agency Risk Assessment Conferences (MARACs) in Salford has fluctuated with no clear pattern. (MARACs are regular local meetings where information about high risk domestic abuse victims is shared between local agencies with the purpose being to bring agencies together to develop a risk focused, co-ordinated safety plan for the victim.) The percentage of repeat MARACs has increased year on year from 13% in 2011/2012 to 24% in 2013/2014. A recent self assessment (with the support from ‘Coordinated Action Against Domestic Abuse’ (CAADA)) of the Salford MARAC, highlighted that Salford has the highest referral rates in the Country and are now hearing over 30 cases every two weeks. CAADA are working with the group to identify why and find solutions.

**Risk factors**

There are some clearly identified risk factors to being a victim of domestic violence; these include being female, aged 16-24 (in women), being a woman who is separated, being pregnant, having recently given birth or being trans, bi, gay or lesbian. In addition perpetrators of domestic violence often target people that are vulnerable in some way. As a result those who have a long term disability or illness, or a mental health problem are also at increased risk.

**Local situation**

Salford police responded to 5831 domestic violence incidents in 2012/2013, 1138 (19.5%) of which were reported as crimes. Wards having the highest numbers of reported crimes in 2012/2013 included Langworthy (125) and Irwell Riverside (87). However, the wards with the highest numbers of reported crimes have varied over recent years suggesting there is no clear geographical hot spot. The low number of domestic violence crimes reported compared to domestic violence incidents police attended fits with evidence which suggests victims of domestic violence are less likely to report their experiences are to the authorities because of beliefs that their abuse is not a matter for police involvement, their experiences too trivial, or from fear of reprisal. According to the British Crime Survey 2010/11, the police will get to know of less than a third of incidents. This suggests the number of domestic violence incidents in Salford could be as high as 20,000 per year.

In 2013 Salford Royal Foundation Trust (SRFT) reported 278 assaults on women and 814 assaults on men. Due to the coding within hospitals it is not known how many cases were due to domestic violence. In Salford in 2013 there were two
homicides, where the victims were killed by their partner or ex partner (both of which were women).

Within Salford exposure to domestic violence is the main contributory factor for children being on a protection plan. 34% of children in Salford were on a protection plan due to exposure to domestic violence. This data emphasises the suffering domestic violence creates for children and young people. It also highlights the prospect of future ongoing issues, as evidence suggests men who witnessed domestic violence as children are twice as likely to abuse their own partners and children. In addition women who witness domestic violence as children are likely to become victims of abuse as adults.

The number of cases discussed in Multi Agency Risk Assessment Conferences (MARACs) in Salford during 2013/2014 was 512. This was 42% higher than the national target set by CAADA, which sets targets based on local demographics. In addition although the number of repeat MARACs in Salford has increased it is still significantly lower than both the North West and National levels. This potentially would suggest the resource, organisation and coordination of the interventions are working well. However, it has been identified that Salford’s criteria for classifying individuals as repeat MARACs varies from other areas nationally, so further work is needed to establish if this is the case.

The responsibility to prevent, identify and address domestic violence falls across a large range of organisations and stakeholders throughout Salford. This highlights the potential for and usefulness of joint commissioning. Multiple organisations investing in domestic violence prevention allows joint priorities and outcomes to be set. This in turn can promote collaborative, systematic planning and working. The challenge is effectively bringing together organisations/partners with different priorities to jointly invest and work in a systematic manner. In addition the savings realised due to the investment by partners may occur in sectors or organisations who have not invested. Therefore, there may be limited direct incentives for some partners to engage.

**Recommendations**

**Recommendation 1**  
**JOINT COMMISSIONING AND STRATEGIC COORDINATION**  
Assess the strategic direction, coordination and commissioning approach to domestic violence prevention.

**Actions**  
Key Stakeholders to use both this document and other relevant local documents to develop a plan outlining how best to produce a multi-agency integrated commissioning approach with shared outcomes.
Identify the key strategic coordination requirements to deliver a robust and systematic DV programme and allocate the appropriate resources to deliver this e.g. the funding of a strategic DV co-ordinator.

Recommendation 2

PRIMARY PREVENTION

Develop a standardised approach to address perceptions and acceptance of domestic violence with a focus on young people.

Actions

Review Salford’s domestic violence awareness raising activities including training within schools and community settings.

Recommendation 3

DATA

Improved use of data to identify any changes in trends and to inform any required service developments.

Actions

- Identify the key data sets available which identify the levels of domestic violence within Salford between all stakeholders.
- Outline a data sharing agreement having one stakeholder responsible for collating, interpreting and sharing the data to identify.

Recommendation 4

REVIEW INTERVENTIONS

Identify if services are appropriate and responsive to the needs of the victims, including those from minority groups (e.g. male, LGBT and BME victims).

Actions

- Review the capacity and quality of the current domestic violence initiatives through service users/victims feedback on their experiences.

Recommendation 5

TRAINING

Develop a systematic process to ensure all those who may come into contact with domestic violence are routinely offered appropriate domestic violence training on a regular basis.

Actions

- Carry out a formal mapping process of all the domestic violence training along with the content of the domestic violence training sessions.
- Undertake a training needs assessment to identify all those staff requiring training and the related resource requirement.
- Develop a suite of domestic violence training options at different levels for all stakeholder organisations, so staff can select the level of training which is appropriate for their role. Finally,

Recommendation 6

**FURTHER RESEARCH**

**Links with other services**
Identify how domestic violence services can link more closely with the available provision to assist in the identification and support of those experiencing domestic violence

**Actions**
- Work closely with other services such as mental health, alcohol, drug and maternity services to develop integrated pathways.

**Perpetrator programmes**
Assess if and how perpetrator programmes should be integrated into Salford’s multi-agency approach to address domestic violence.

**Actions**
- Review the effectiveness of perpetrator programmes available locally and nationally. Then based on the findings

**Criminal Justice System**
Improve victims support following domestic violence incidents

**Actions**
- Identify potential tools that agencies within the CJS could use to reduce the risk of perpetrator attacks and how these could be implemented.
- Explore domestic violence victim’s experiences in dealing with the criminal justice system (CJS), to identify strengths, weaknesses and barriers in the process and how this could be enhanced to further support individuals.
1.0 Introduction and background

Domestic violence (DV) occurs throughout the city in every socio-economic group, across all neighbourhoods and communities. The incidence of domestic violence varies only marginally when analysed by geography, class, age, ability, sexuality, ethnicity and nationality. However these factors do affect the severity of violence, the experience of survivors and the likelihood of them accessing services or seeking help. Crime statistics and research show that within DV most perpetrators are male and most victims are female. In addition the gender of both victim and perpetrator influences behaviour, risk, and the severity of harm caused.

1.1 Scope

This HNA was carried out by Salford City Council public health team to contribute to the joint strategic needs assessment.

Although it is acknowledged within the literature that the physical abuse of children may co-exist with DV, for the purposes of this HNA this area of investigation will be out of scope. In addition, whilst health needs of perpetrators of DV were out of scope of the HNA, the potential benefit to victims resulting from services aimed at perpetrators is acknowledged.

This HNA will cover all areas of prevention including primary, secondary and tertiary along with the services, interventions and need.

The recommendations of this HNA will be aimed at a range of decision makers and stakeholders for consideration.

For the purposes of the report the definition of DV that will be used is

‘Any incident or threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional) between adults who are or have been intimate partners or family members, regardless of gender or sexuality’ (Home Office, 2012)

As recommended by the Home Office the definition of DV will also include so called ‘honour based violence’ (HBV), female genital mutilation (FGM) and forced marriage. With an adult being classified as anyone aged 18 years or older.

In 2012, the Government amended the definition of DV to include coercive control, and extending to include those 16 - 18 year olds (Home Office, 2012).
1.2 Aims and Objectives

Aim

The aim of the DV health needs assessment (HNA) is to identify the extent of DV within Salford, whether there is appropriate provision to address the problem and what can be done to improve the situation.

Objectives

Identify the scale and pattern of DV in Salford, including those individual and groups most at risk

Outline the existing services and provision for victims and identify areas for development

Review the impacts of partnership working with regard to preventing and responding to DV

Develop recommendations based on the data and evidence identified to enhance the services and provision to address DV within Salford

1.3 National Policy framework for addressing domestic violence

Reducing and preventing domestic violence and sexual violence is a Coalition Government priority which also has cross-party support. Its prevention is recognised as being central to agendas in public health, reducing crime and the fear of crime, reducing the harm caused by serious violent crime, bringing offenders to justice, safeguarding children and vulnerable adults, education and violence prevention, and promoting equality. Domestic and sexual violence is also recognised as constituting part of the continuum of gendered violence that many women and girls experience, at some point in their lives.

The current national policy driver for tackling DV is the ‘Call to End Violence against Women and Girls’ document published in November 2010 (HM Government 2010a). This document does cover a wider scope than just DV; however DV is an important contributor to violence against women and is the main issue addressed within the document. This strategy was the culmination of extensive consultation with the public and with organisations, and included focus groups with women and children survivors of violence. The strategy was broadly supported and welcomed as a demonstration of an integrated approach to all forms of violence against women and girls.
Prevention is the key focus of the ‘Call to End Violence against Women and Girls strategy’ along with adequate levels of provision and support. The policy reinforces how partnership working at a local level is essential and that key stakeholders include local authorities (LAs), health and well-being boards (HWBs), health services, public health, the voluntary and community sector, community safety partnerships and police and crime commissioners (PCCs). The policy also provides an overview of how and where violence occurs. In addition it emphasises the need to reduce the risk to victims and ensure that perpetrators are brought to justice.

1.3.1 Prevention

Three key areas for action were identified to support the overriding aim of preventing violence from occurring

- Tackle attitudes and behaviours that reinforce negative messages on the role of women and facilitate acceptance of Violence Against Women and Girls (VAWG)
- Intervene early ensuring children do no grow up to view VAWG as normal or acceptable
- Ensure frontline partners are able to identify and prevent vulnerable people from becoming victims, or repeat victims of violence

1.3.2 Service provision

The policy suggested that working towards provision of adequate and appropriate services there were three key areas for action

- Assist frontline services to support victims, including the role of ‘independent domestic advice advisors’ (IDVAs), recognising this is a national priority when establishing local priorities and setting expenditure
- Share and develop effective practice, specifically training frontline staff to deliver effective outcomes in tackling VAWG
- Pursue and develop joint commissioning arrangements and potential new models of funding to improve the sustainability of services

1.3.3 Partnership working

The policy reinforces that the responsibility for delivery does not just rest with central government and that stakeholders working in partnership are imperative. The need for collaborative working between voluntary, statutory and community organisations is clearly outlined. This was reinforced further by evidence suggesting that victims
are more likely to engage with voluntary or community organisations rather than statutory ones (Smith, 2012)

The ‘Call to End Violence against Women and Girls’ document clearly outlined that a core ambition was to bring more offenders to justice and increase the confidence of victims to access the criminal justice system. The specialist Domestic Violence Courts (SDVCs) are acknowledged to represent an important partnership approach to dealing with DV, supporting the victim through the legal process. In line with this aim there is a commitment to continue to develop programmes to support the rehabilitation of perpetrators of DV.

In addition there is a significant commitment to reduce the risk for victims of DV, and particularly the risk of repeat cases. An important approach to addressing this is multi-agency risk assessment conferences (MARACs). These assess the needs of high risk victims and put actions in place to reduce risk.

1.4 Local strategic approach

The City of Salford has a number of established thematic partnerships and safeguarding boards that act to support the health, safety and well-being of the residents of Salford. These partnerships aim to ensure all the key agencies come together to provide a collaborative approach to assist the residents of Salford to have healthy happy lives. As such many of these have a role in addressing DV within Salford.

1.4.1 Salford Community Safety Partnership (CSP)

Salford CSP is a statutory requirement which was introduced following the Crime and Disorder Act in 1998. A number of responsible authorities are required to work together to reduce crime and disorder – these include police, fire, local authority (LA), probation and the Clinical Commissioning Group (CCG). In addition there is a section 17 which outlines that the responsible authorities must work together (see appendix 1).

The CSP also has a citywide Partnership Delivery Group (PDG); this is a sub group of the CSP which deals with the day to day practical issues related to CSP matters. If the issues cannot be resolved at the PDG they are escalated to the executive group, where decisions are made on actions at a strategic level. Last year the Office of the Police and Crime Commissioner (OPCC) gave their community safety grant funding back to the CSP to fund activities. However, it has been indicated that for 2014/15 the OPCC has given Greater Manchester CSPs reduced funding for the first 6 months. This is pending the development of a GM Strategic Assessment Framework and local threat assessment which will enable the OPCC to allocate funds from
October 2014. This will be done on a priority and thematic basis to each district with initial indications suggesting funding will be much reduced.

The CSP acts as the coordinating body for tackling the issue of DV within Salford. It has a ‘Violence Against Women’ Board as a subgroup of the CSP. In 2010 they developed the Violence Against Women and Girls strategy and governance structure which outlines the strategic approach to tackling DV in Salford. The full list of strategic objectives around DV from this report are outlined in appendix 2.

The Violence Against Women Board have recently created a task and finish group to develop a Junior MARAC for Salford. However, in the current environment this is proving challenging as all agencies are experiencing reduced funding. An options paper has been written by the Head of Safeguarding but the Violence Against Women Board have yet to consider the most effective option.

In addition the Safeguarding and Violence Against Women Boards have created another task and finish group to develop a domestic abuse strategy for Children and young people in Salford, which is in draft at present.

With regard to resources the CSP has a designated DV lead that coordinates DV activities within Salford. There is a full time crime and disorder analyst who carries out bespoke work and regular monitoring across all of the CSP priorities. The analyst produces monthly reports for the PDG – using a problem solving national intelligence model approach and using a range of partnership data. This data can be used for developing a clear picture of health needs and performance around DV in Salford which can inform the development of appropriate provision.

1.4.2 Salford Health and Well-being Board (HWB)

Salford HWB’s role is to assess the needs and assets of the local population, produce a strategy that addresses these, then influence commissioning plans of organisations and promote joint commissioning and integrated provision.

Although the HWB does not directly commission DV related services they do have a responsibility to agree and allocate ‘innovation fund grants’. These are from a designated funding allocation provided by the Clinical Commissioning Group (CCG). Services within the LA can apply for ‘innovation fund grants’ if they have an innovative piece of work which could potentially be a cost effective method for improving health or reducing health inequalities and delivery of priorities from the joint health and well-being strategy. The applications go to the HWB and if the project is successful they are funded on a short term basis. Then based on the evaluation of the project they may potentially go on to be mainstream funded.
The CSP has recently successfully bid through this fund for a project where an Independent Domestic Violence Advisor (IDVA) is to be placed in Salford Royal Foundation Trust A&E department. Their role would be to identify and support those who have experienced domestic violence. This project was stopped after several weeks due to difficulties ascertaining the most effective way of working. The model is currently being redeveloped based on successful models from other hospitals before being trialled again.

1.4.3 Salford Safeguarding Children Board (SCB)

Salford SCB is a multi-agency forum that holds shared responsibility in promoting and safeguarding the children of Salford. The SCB has a statutory responsibility to ensure children are safe from abuse or neglect, ensuring they grow up in an environment of safe and effective care and enabling them to have optimum life chances.

The board is represented by all key agencies and is a statutory requirement. One of the main functions of the board is to ensure all agencies working with children or in services impacting on the welfare of children have safe recruitment practices. In addition they are responsible for monitoring the effectiveness of what is done in relation to safeguarding and the promotion of children’s welfare.

One aspect of the SCB is protecting children from being exposed to DV. Therefore, a key role for them is to raise the profile of DV and ensure all front line staff working with children are appropriately trained to recognise, identify and report DV.

1.4.4 Salford Adult Safeguarding Board (ASB)

Salford ASB involves a variety of agencies working together to support and protect vulnerable adults. It was established in July 2005 and members of the board meet four times a year to oversee practice and guide improvements to adult safeguarding work in the city. The ASB is not currently statutory but is due to become statutory in 2015. It does not currently have a budget to commission any services directly.

A wide range of agencies including the LA, police, health and voluntary and private sector, work together as part of the board to share responsibility for the welfare and protection of vulnerable adults. It also oversees the work of the implementation group for the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards introduced under the Mental Health Act 2007.

Nationally around 25% of adult safeguarding investigations involving vulnerable adults involve circumstances that also constitute domestic abuse. Locally the figure is a little lower than the national average at 20%. These are situations where an adult who is already particularly vulnerable due to for example a learning disability or
physical frailty is being abused by a member of their family. It is not currently known how many domestic violence incidents involve a vulnerable adult but it is understood only a small number usually meet the scoring threshold for referral to MARAC. This is because a high proportion of domestic abuse incidents involving vulnerable adults are around financial abuse rather than physical abuse, which whilst still very distressing does not involve really high risk such as for example significant physical abuse. Nevertheless there will be a small number of cases which are both high risk and involve the most vulnerable adult so the ASB has a clear responsibility to ensure DV is recognised early within vulnerable adults and adequate safeguarding is put in place.

1.4.5 Salford Children and Young People Trust (CYPT)

Salford CYPT is the city’s thematic partnership for children and young people. It is responsible for policy, strategy and achievement in services to children and young people. The Trust has a three year action plan which is reviewed annually.

The Trust works with Salford SCB and aims to stop children and young people becoming vulnerable. They do this through working with all relevant partners and agencies and taking a coordinated approach. The CYPT has a priority action plan which has identified key priorities for 2012 to 2015.

DV is mentioned in their strategic documents as a factor that needs to be considered. At present there are no specific activities directed by the trust around DV, however the early intervention priority (expected to be refreshed shortly into ‘Early Help’, a shared priority with SCB) would aim to pick up any low level DV issues.

1.4.6 Shared areas for strategy

Each of the partnerships has their own strategic document which outlines their priorities and the issues they are responsible for addressing. Some of the priorities/responsibilities for these partnerships overlap. When reviewing the different priorities, a number either directly or indirectly included DV:

<table>
<thead>
<tr>
<th>Partnership</th>
<th>DV related priority</th>
</tr>
</thead>
<tbody>
<tr>
<td>CSP</td>
<td>Reducing incidents of DV / Protecting victims / reducing violence</td>
</tr>
<tr>
<td>HWB</td>
<td>Provide more effective joined up systems and services to support the wellbeing of people who are vulnerable</td>
</tr>
<tr>
<td>SCB</td>
<td>Keeping children safe from abuse or neglect, ensuring they grow up in an environment of safe and effective care, enabling them to have optimum life chances is everyone's business.</td>
</tr>
<tr>
<td>ASB</td>
<td>Ensuring vulnerable adults who are risk of abuse are kept safe</td>
</tr>
</tbody>
</table>
and that particularly for the most risky cases which also involve domestic abuse, it is recognised that referral to MARAC and other services is crucial

| CYPT               | Early Intervention priority - reducing DV |

This reinforces how DV is an issue that crosses a number of partnerships and therefore effective collaborative working is essential to address the issue.

**Intelligence**

**1.4.7 Salford CSP**

Salford CSP takes the lead role between the partnerships in regards to collating data around DV. In addition to the bespoke analysis provided by the analyst the partnership has access to DV performance data collated by the Greater Manchester Criminal Justice Board about criminal justice interventions. This data could be used to inform both commissioning and the development of services around DV. At present this data is not routinely shared between partnerships.

**1.4.8 Salford SCB**

The SCB is responsible for collating a range of information around children within Salford. This includes.
- The number of children on a protection plan,
- The number of children classified as ‘children in need’.

In addition the SCB has information on the number and percentage of those children either on a protection plan or ‘in need’ where DV was a contributing factor. Therefore, the SCB can potentially provide data on the number of children known to social services who have been exposed to or witnessed some form of DV.

This data could potentially be used to look at patterns of distribution of DV within Salford and to what extent the issue is changing/evolving.

**1.4.9 Salford ASB**

The ASB is responsible for monitoring the number of vulnerable adults. They do not have any formal responsibility to monitor any DV related data. However, there is the potential for collating the number of MARACs which are with vulnerable people and where DV is a factor.
1.4.10 Salford CYPT

CYPT does not currently collect any activity data related to DV, however they include a copy of the SCB’s data on the number of MARACs which involve under 18s in their Integrated Report Card. This is as an element of monitoring the effectiveness of the joint ‘Early Help’ priority.

Training

Systematic, consistent and appropriate training is a key component of any programme that aims to identify and address DV. Within Salford a number of the partnerships conduct their own DV related training which includes a combination of both e-learning and practical training sessions:

1.4.11 Salford CSP

CSP currently commissions four days of training per year from volunteer professionals from Salford City Council. This is practical training predominantly delivered to front line staff around what DV is, how to identify DV and how to report it.

The ‘Violence Against Women’ Board is a multi agency group which has delegated responsibility from the CSP to drive forward the work to reduce violence and abuse against women and girls. A summary of the training provided by and for Partnerships is included in appendix 3.

1.4.12 Salford SCB

The SCB has a strategic training sub-group which identifies and plans the appropriate training for all relevant practitioners. The SCB has a full time coordinator to plan and support the ongoing delivery of the training. In regards to DV the SCB has a programme of specialist training for practitioners working with children and families. This consists of a 2-day course focusing on interventions for those working with children and young people and ensuring they understand the arrangements for the MARAC, Independent Domestic Violence Advocate (IDVA) training and Domestic Abuse Stalking and Harassment (DASH) assessment. The pre-requisite for undertaking the SCB training is that practitioners have attended the training course ‘Introduction to Domestic Abuse’ course commissioned by the CSP.

1.4.13 Salford ASB

The ASB also has a training subgroup which has developed a training strategy. The ASB has no resources to commission training itself but there are limited resources within the council that provide training on essential areas of adult safeguarding for
key staff e.g. training for investigators and safeguarding chairs. ASB provides no training itself to staff or partners on domestic violence. Where issues arise which need to be cascaded to staff, these are cascaded via normal management structures.

1.4.14 Salford CYPT

The CYPT do not provide any of their own specific training around DV.

1.4.15 Salford Clinical Commissioning Group (CCG)

Since April 2012 all Salford GP practices were provided with hard copies and electronic copies of safeguarding information which included domestic abuse (DASH, MARAC, SIDAAS information). Whilst the training and the policy both cover DV it was not until 2013 that the focus was specifically aimed at raising the profile of DV within General Practice.

In May 2013 the CCG started to inform GPs of their high risk DV patients who had been discussed at MARAC. They would receive a copy of the referral (DASH) and the actions form MARAC. The GPs could then code these patients on their systems effectively but also this gave them the opportunity to discuss DV with the patient.

Since September 2013 the CCG has provided level 2 training sessions for Salford GPs to increase awareness of DV potentially engaging GPs within the MARAC process. From October 2013 the CCG started requesting information from GPs to contribute to the MARAC process once it had been identified that a patient of theirs had been referred to MARAC. Since then they have engaged with this consistently and reports from the GPs have found that they are finding this process very beneficial. The CCG is now also providing level 2 training to pharmacists and dentists on how to effectively report and signpost those experiencing DV.

1.4.16 Other DV training in Salford

Several other key partners within Salford provide training around DV for their staff, these include:

Supporting People Service (within Salford City Council) – Provide in house awareness training to staff around identifying and supporting those experiencing DV.

Salford Royal Foundation Trust – A&E staff receive one to one bespoke DV training around identifying, approaching and supporting individuals who have experienced DV.
Overall the training and awareness raising within all the partnerships is strong in parts however the overall approach is inconsistent and variable. The findings suggest staff in all partnerships and associated organisation would benefit from a more robust systematic approach, with quality assured tailored training to meet individual staff needs.

2.0 Evidence base and expert opinion

2.1 The overall impact of DV

The health impacts of DV have been quantified in a report based on the Crime Survey for England and Wales (CSEW) and summarised in a recent Department of Health publication (Department of Health, 2012). Data from the CSEW indicates that approximately one in four (27%) victims of DV experienced physical injury. The most common types of injuries sustained were ‘minor bruising or black eye’ (18%) and ‘scratches’ (13%). Approximately two in five (39%) victims experienced emotional or mental health problems, which ranged from relationship or trust issues (19%) to suicide attempts (4%) (Office for National Statistics, 2012).

In addition to direct physical, emotional and mental health impacts, DV can also impact on health related behaviours, such as drug and alcohol misuse (Department of Health, 2012). In the most severe cases, DV can result in homicide or suicide. It has been reported that on average there are two DV homicides per week in England and Wales, and around 500 suicides per year occur in women who have experienced DV. In addition DV is believed to be a factor in approximately one third of all female suicides (Walby, 2004).

2.2 The impact on specific groups

2.2.1 Black and Minority Ethnic Groups and Refugees (BAMER)

There is little difference in the prevalence of domestic violence by ethnicity. There is however recognition those survivors from BAMER communities are less likely to access services. Furthermore they may have specific needs which may require specialist interventions. Issues for survivors from different communities and the relationship between different cultural beliefs and practices can impact their utilization and availability of relevant services.

In 2012 a report was produced by Thiara and Colleagues about DV and South Asian and African-Caribbean mothers. They found that control, isolation and fear of abduction and/or separation from their children were significant issues for all the mothers interviewed; and mothers from both communities were likely to under-report abuse.
2.2.2 Lesbian Gay Bi and Trans sexual (LGBT)

It has been suggested stereotypes pertaining to same sex relationships and LGBT people along with the assumptions of heterosexuality by service providers can create barriers to help seeking behaviour. Equally, the lack of specialist service provision and inconsistencies in staff knowledge and training around sexual orientation and gender identity can limit the range of options available to survivors or the quality of the service they receive. A review by Hester (2012) suggested there is a lack of UK based research that examines the extent and nature of domestic or sexual violence for the LGBT groups. In addition there is no evidence around their service needs or experience of using services.

2.2.3 Older people

Within the UK there is a lack of services and information aimed specifically at older survivors of DV. Often there is confusion over the distinction between DV and ‘elder abuse’ which means that the needs of this group are overlooked. This can also create barriers to accessing services. More than 250,000 older people (aged 66 and older) living in England in private households reported experiencing maltreatment from a family member, close friend or care worker in the past year (O’Keefe, 2007)

It is commonly assumed that DV is mainly experienced by younger people. Often DV against older people is subsumed under the broader heading of ‘elder abuse’, and so there is no firm data about the extent of DV amongst older people. An overview of the research by Women’s Aid suggests that older women experiencing domestic violence are less likely to come to the attention of statutory agencies or specialist services. In addition they found that older women may be even less aware than younger women of the services and other options available to those experiencing DV.

It may also be assumed that older men are not a serious threat, and/or that DV lessens as people age. A recent Department of Health report estimated that 227,000 older people are neglected or abused in their own homes each year and domestic violence was clearly a significant part of this (O’Keefe, 2007). The British Crime Survey data is limited to the experiences of people aged between 16 – 59 years.

2.2.4 Teenagers/adolescents

Teenagers experience the same level of DV as adults, but it is still generally thought of as an adult issue. DV in teenage relationships can be more hidden for many reasons, including the fact that some teenagers may be more acceptant of or dismissive about this form of abuse. Some may not actually conceptualise what is happening to them as being abusive. In the UK in 2009, 72% of girls and 51% boys aged 13-16 reported experiencing emotional violence in an intimate partner
relationship (Meltzer et al. 2009)

Often teenagers slip through the net in terms of service provision as they are not old enough to access mainstream support services and even though teenage DV should still be seen as a child protection issue, it is not always dealt with as such.

### 2.2.5 Disabled

A lack of integrated service provision and the barriers that exist within support services to meet the needs of this group can create issues. A survey carried out by Wise Women in 2010 of disabled women in Glasgow highlighted the different and additional experiences of abuse and discrimination in this group.

The survey highlighted that 69% felt their impairment made them more vulnerable to additional types of abuse. All of the women surveyed had a direct experience of violence and abuse with 73% experiencing DV. In discussion women stated that reliance on abusers as carers, financial abuse, neglect, family and services unwillingness to believe “a carer” was capable of abuse, lack of alternative accessible housing and fear children would be removed were influencing factors in women’s decisions to leave.

In addition 57% stated they had experienced additional problems getting support attributing these directly to discrimination and stereotyping with 52% stating it had stopped them from accessing support services. Emphasising that this was far beyond limited physical access; poor attitudes, impatience, lack of accessible alternative accommodation, unwillingness to accept someone would abuse a disabled woman, lack of communication equipment and judgemental attitudes surrounding Disabled Women’s sexuality all played a part in creating additional barriers.

These findings highlighted how there is a need for the domestic violence sector to work more closely with disability groups and involve service users to inform good practice.

### 2.2.6 Children

Exposure to DV in childhood has been associated with an increased risk of involvement in violence in later life. Children who witness DV in the home have been shown to be at an increased risk of both suffering and perpetrating DV as adults, as well as increased risk of involvement in youth violence (Department of Health, 2012).

Nationally, 200,000 children in England live in households where there is a known risk of domestic violence (Laming, 2009). A recent national analysis of Serious Case Reviews found evidence of past or present domestic violence in over half (53 per
percent) of the cases (Brandon et al. 2009). Significant evidence now indicates that prolonged and/or regular exposure to domestic violence can have a serious impact on children’s safety and welfare, despite the best efforts of parents to protect them.

2.2.7 General associated risk factors

Evidence suggests perpetrators of DV often target people that are vulnerable in some way. As a result there are a number of risk factors which put people at increased risk of experiencing DV. These include

- Being female
- Being aged 16-24 (in women) or 16-19 (in men)
- Having a long term disability or illness
- Having a mental health problem
- Being a woman who is separated (particularly around the time of separation)
- Being pregnant or having recently given birth
- Being trans, bi, gay or lesbian

2.3 Financial cost of DV

The associated costs related to DV spread throughout a number of areas including health, social services, housing, legal, the local economy and human and emotional cost. This means both locally and nationally DV can have huge financial implications. A study published in 2009 estimated the total cost of DV in England and Wales 2008 (including human and emotional costs) to be around £15.7 billion, of which £1.7 billion were health care costs. A breakdown of these estimated costs across service sectors is provided below in figure 1 (Walby 2009).

**Figure 1: The financial cost of domestic violence in England and Wales 2008 cost (millions)**

<table>
<thead>
<tr>
<th>Organisation / System</th>
<th>Costs incurred</th>
</tr>
</thead>
<tbody>
<tr>
<td>Criminal justice system</td>
<td>£1,261</td>
</tr>
<tr>
<td>Health care</td>
<td>£1,730</td>
</tr>
<tr>
<td>Social services</td>
<td>£283</td>
</tr>
<tr>
<td>Housing and refuges</td>
<td>£196</td>
</tr>
<tr>
<td>Civil legal services</td>
<td>£387</td>
</tr>
<tr>
<td>Economic Output</td>
<td>£1,920</td>
</tr>
<tr>
<td>Human and emotional costs</td>
<td>£9,954</td>
</tr>
</tbody>
</table>

Applying this figure to the size of the Salford population of 16-59 (124,000 – based on 2009 ONS data), the estimated annual cost of DV to Salford is £43.5 million.
It should be noted that these estimates were based on inflation and gross domestic product in 2008; therefore the true cost in 2013 may be markedly different. The cost of DV is similar to other public health priorities, such as smoking, obesity and alcohol misuse. Table 2 provides a comparison of annual costs for public health priorities in England (note: DV costs relate to England and Wales, so cost to England alone will be lower).

Figure 2: Comparison of financial costs of public health priorities

<table>
<thead>
<tr>
<th>Public health priority</th>
<th>Estimated annual cost to economy</th>
<th>Estimated annual cost to NHS per year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smoking</td>
<td>£5.2 billion</td>
<td>£2.7 billion</td>
</tr>
<tr>
<td>Alcohol misuse</td>
<td>£20.0 billion</td>
<td>£2.7 billion</td>
</tr>
<tr>
<td>Obesity</td>
<td>£15.8 billion</td>
<td>£4.2 billion</td>
</tr>
<tr>
<td>Physical inactivity</td>
<td>£8.3 billion</td>
<td>£1.8 billion</td>
</tr>
<tr>
<td>Domestic Violence</td>
<td>£15.7 billion</td>
<td>£1.7 billion</td>
</tr>
</tbody>
</table>

* Data for smoking, alcohol misuse, obesity and physical inactivity refers to England, from 2009 (Kings Fund, 2012). Data for domestic violence refers to England and Wales, from 2008 (Walby, 2009)

2.4 Evidence based interventions

A 2010 review of the evidence for prevention of intimate partner violence identified five successful or promising interventions (Wood, 2010):

- **School-based education programmes** that promote healthy relationships (have been deemed successful in reducing violence toward current partners)
- **Routine enquiry** about DV in health care setting by trained health care professionals (shown to increase disclosure and identification of intimate partner violence; less evidence on protection against future violence)
- **Regulation of alcohol sales** at a community level, for example through increasing prices (associated with reduction in intimate partner violence)
- **Advocacy services** can reduce some forms of physical abuse in the medium, but not long, term (In addition, the use of protection orders and SDVCs have generated successful criminal justice outcomes; these are beyond the scope of this HNA)
- **Substance misuse treatment** among offenders (successful in reducing repeat offending)

The Department of Health recently identified a range of violence prevention initiatives in which health services should have a leading role (Department of Health, 2012):
• **Supporting parents and families** by developing parenting skills and strengthening family relationships (midwives, health visiting and family nurse partnership).

• **Developing life skills in children and young people**, building social and emotional competencies and skills in avoidance of conflict, poverty and crime (social development programmes, with a focus on healthy relationships, gender and prevention of DV).

• **Reducing the availability and harmful use of alcohol**, which is strongly associated with DV (non-health approaches include reducing the density of alcohol outlets and controlling price; health interventions include screening, identification and brief advice).

• **Community interventions**, including multiagency partnership working in areas such as tackling alcohol related DV, and data sharing.

• **Changing social norms**, through approaches such as mass media campaigns, aiming to shift stigma from victims to perpetrators.

• **Identification, care and support** of victims to protect health and wellbeing and break the cycle of violence. Health settings are highlighted as potentially ideal places to both identify and support victims of DV. (Includes use of screening tools, training needs of health professionals, advocacy programmes, and specialist high risk approaches such as MARAC and criminal justice interventions).

The Identification and Referral to Improve Safety (IRIS) programme provides training to primary care staff, prompts in the medical record system to enquire about abuse and referral pathways to advocacy services. It has been shown in a randomised controlled trial to improve identification and referral of DV victims (Feder, 2011) and is highlighted by the Department of Health as an evidence based method of providing DV training to health professionals in primary care settings (Department of Health, 2012).

2.5 Cost effective interventions

Prevention and intervention to end violence is more cost-effective than dealing with the consequences of long-term DV (Department of Health, 2011). A tool produced by the Department for Education estimated average cost of responding to one DV incident to be £23,315 (Centre for Excellence and Outcomes in Children and Young People’s Services, 2011). The estimated total cost of DV, £15.7 billion in 2008, was a 32% decrease compared to 2001. This decrease in cost of DV has been partly attributed to investment in public services to prevent and better respond to DV (Department of Health, 2011).
A recent publication from the Department of Health has reported that the MARAC process saves public services an average of £6,000 per case in direct costs. The NHS accrues 20% of the savings, police 32% and the wider criminal justice system 40%. (Department of Health, 2011) Based on the number of MARACS in Salford in 2013/2014 (512), it is estimated that the process saves public services approximately £3 million per year.

The cost-effectiveness of the IDVA programme has been nationally evaluated; the cost of providing IDVA support to a victim of high risk DV was estimated to be £500. Compared to the costs to public services associated with ongoing DV, IDVAs were found to be highly cost-effective (Howarth, 2009).

2.6 NICE guidance

The NICE guidance around domestic violence and abuse was published in February 2014. It outlines how organisation and services can respond effectively to identify and address domestic violence. The guidance provided a clear oversight into all the domestic abuse related issues and provided 17 key recommendations of how DV can be most effectively addressed – these include

1 - Plan services based on an assessment of need and service mapping
2 - Participate in a local strategic multi-agency partnership to prevent domestic violence and abuse
3 - Develop an integrated commissioning strategy
4 - Commission integrated care pathways
5 - Create an environment for disclosing domestic violence and abuse
6 - Ensure trained staff ask people about domestic violence and abuse
7 - Adopt clear protocols and methods for information sharing
8 - Tailor support to meet people's needs
9 - Help people who find it difficult to access services
10 - Identify and, where necessary, refer children and young people affected by domestic violence and abuse
11 - Provide specialist domestic violence and abuse services for children and young People
12 - Provide specialist advice, advocacy and support as part of a comprehensive referral pathway
13 - Provide people who experience domestic violence and abuse and have a mental health condition with evidence-based treatment for that condition
14 - Commission and evaluate tailored interventions for people who perpetrate domestic violence and abuse
15 - Provide specific training for health and social care professionals in how to respond to domestic violence and abuse
16 - GP practices and other agencies should include training on, and a referral pathway for, domestic violence and abuse
2.7 Coordinated Community Response Model

The Coordinated Community Response Model (CCRM) to DV was produced by the Against Violence and Abuse (AVA) organisation. The model acknowledges that, while each agency maintains its independence, all agencies involved must work in an integrated and coordinated way with each other to achieve:

- An increase in the safety of DV survivors
- An increase in the safety of children who live with DV
- Holding abusers accountable for their actions
- Effective prevention strategies
- A system where the onus of holding abusers accountable lies with service providers, and the wider community, rather than the survivor.

A coordinated community response ensures that the criminal justice system serves the needs of all victims providing effective sanction against abusers and acting as a deterrent to future abusers. However, the criminal justice system is just one aspect a fully functioning coordinated approach particularly when only a small number of victims report to the police and only a percentage of these cases will carry through into court. Health, children’s services, schools, faith groups, the wider community of family, friends and work colleagues, as well as the plethora of voluntary agencies which support individuals and families all have an important role to play in the response to domestic violence.

3.0 Epidemiological Need

3.1 Population profile

Salford is a contrasting city, with pockets of affluence and extremely deprived areas that are gradually being regenerated. Salford continues to struggle with the burden of high levels of deprivation, unemployment, teenage pregnancy, crime, smoking rates, alcohol and drug abuse and long-term chronic illness.

Salford is classified by the Department for Environment, Food and Rural Affairs (DEFRA) as “Major Urban”. There are roughly 234,000 people living in Salford, mainly in urban areas, with around 250,000 people being registered with Salford’s primary care services. Salford has a higher than average number of women of child-bearing age, which means there are more 0-4 year olds in Salford than there would typically be for the size of population. Salford also has a large Orthodox Jewish population that is estimated to contain around 10,000 people.
Figure 3 Population pyramids showing population structure for Salford compared to England

Notable features of the population distribution are:

- Salford has high levels of 20-34 year olds when compared to England
- The percentage of 10-19 year olds in Salford is lower than in England

Projections going forward

- A declining proportion of the population are aged under-16 and an increasing proportion are aged 65 and over.
- The elderly population is increasing as a result of a decline in the mortality rates and past fertility rates.
- Projections for the over 65s show a steady increase in all age bands for both men and women.
A higher proportion of women than men in the 85 plus age band is predicted, where the ratio is expected to reach 1.5:1 by 2025.

Migration between Salford and other areas within the UK accounts for the vast majority of movement in and out of the city. Population turnover between 2001 and 2006 equates to 11% of the total population of the City.

The health of people in Salford is generally worse than found nationally. Deprivation is higher than average and about 13,100 children live in poverty.

Life expectancy for both men and women is lower than the national average. Life expectancy is 12.1 years lower for men and 8.2 years lower for women in the most deprived areas of Salford than in the least deprived areas. Public Health England’s Living Longer data identified that there were 2542 premature deaths in Salford between 2010 and 2012 (deaths under the age of 75).

The 2011 Census showed that 84% of the population is white British and 6% are ‘other white’ (mainly Irish, Polish and other Europeans). Non-whites make up the remaining 10% of the population (mainly South Asian British/South Asian and Black British/Black).

Figure 4: Breakdown of ethnicity in Salford and England

<table>
<thead>
<tr>
<th>Ethnic Group</th>
<th>Salford (%)</th>
<th>England (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>90.1</td>
<td>85.4</td>
</tr>
<tr>
<td>Mixed/multiple ethnic groups</td>
<td>2.0</td>
<td>2.3</td>
</tr>
<tr>
<td>Asian/Asian British</td>
<td>4.0</td>
<td>7.8</td>
</tr>
<tr>
<td>Black/African/Caribbean/Black British</td>
<td>2.8</td>
<td>3.5</td>
</tr>
<tr>
<td>Other ethnic group</td>
<td>1.1</td>
<td>1.0</td>
</tr>
</tbody>
</table>

3.2 DV Data Sources

There is no single complete source of data relating to DV in Salford. A range of organisations and agencies hold data on cases which are known to them and/or who have used their services. The following are key local data sources relating to reporting of cases DV:

- **Salford police** – Number of reported incidents and crimes of DV
- **Salford Safeguarding Children Board** – the proportion of referrals to children’s social care each year which were related to DV, and the proportion
of families becoming subject to a child protection plan which were related to DV.

- **MARAC** – The number of MARACs that take place where high risk DV cases are discussed plus data on the number of cases discussed and demographics of victims.
- **Routine data collected by Salford Royal Foundation Trust (SRFT)** - provides the number of cases discussed and demographics of victims.
- **Hospital Episode Statistics from SRFT** – the number of admissions due to assault

### 3.3 National data

Data on the prevalence of DV in England and Wales is produced by the Office for National Statistics, based on the CSEW, formerly the British Crime Survey (BCS). In 2011/12, approximately 67,000 households were invited to participate in the survey and around 75% of invited households chose to take part.

The CSEW records DV incidents under the broader classification of intimate personal violence, which is a collective term to describe DV, sexual assault and stalking (full details of the inclusion criteria is in appendix 4.) Data on intimate personal violence are collected using both self-completion questionnaire and face to face interviews.

DV is an underreported crime (HM Government 2010), therefore data held by local agencies on reported cases of DV is likely to represent a significant underestimation of the scale of the problem. CSEW reported the following figures.

Nationally - In one week
- 30,000 women will experience intimate partner violence.
- 10,000 women will be sexually assaulted.
- 2,000 women will be raped.
- 56 women will be at risk of being forced into a marriage.
- 125 girls will be at risk of FGM

Domestic violence forms part of a continuum of violence that many women and children experience at some point in their lives, including rape, sexual violence, stalking, sexual harassment, trafficking and sexual exploitation, and these experiences also need to be considered when commissioning and delivering services for women and children locally.
3.4 Local data

3.4.1 Summary MARAC data

Multi-Agency Risk Assessment Conferences (MARACs) are regular local meetings where information about high risk domestic abuse victims (those at risk of murder or serious harm) is shared between local agencies. The purpose of a MARAC is to bring agencies together to develop a risk focused, co-ordinated safety plan for the victim. Whenever possible the victim is represented by the IDVA.

The organisation ‘Coordinated Action Against Domestic Abuse’ (CAADA) set local targets as to how many MARACs should take place in each locality based on local population data. The data from Salfords MARACs is below in figure 5 and compares the findings to both Greater Manchester (GM) and National data (where available).

Figure 5: A breakdown of MARAC data comparing Salford with both the North West and England

<table>
<thead>
<tr>
<th>2012/2013</th>
<th>Salford</th>
<th>North West</th>
<th>National</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of MARACS completed (based on target set by CAADA)</td>
<td>119.7%</td>
<td>92.2%</td>
<td>Not available</td>
</tr>
<tr>
<td>Percentage of MARACs featuring children</td>
<td>63.1%</td>
<td>66.1%</td>
<td>Not available</td>
</tr>
<tr>
<td>Percentage of repeat cases</td>
<td>17.2%</td>
<td>30.0%</td>
<td>24.3%</td>
</tr>
<tr>
<td>Percentage from BAMER communities</td>
<td>12.3%</td>
<td>11.9%</td>
<td>13.4%</td>
</tr>
<tr>
<td>Percentage from LGBT communities</td>
<td>0.5%</td>
<td>0.9%</td>
<td>0.7%</td>
</tr>
<tr>
<td>Percentage registered with a disability</td>
<td>2.1%</td>
<td>2.1%</td>
<td>3.2%</td>
</tr>
<tr>
<td>Percentage male</td>
<td>1.2%</td>
<td>2.9%</td>
<td>4.0%</td>
</tr>
<tr>
<td>Percentage of cases 16-17 years old</td>
<td>Not available</td>
<td>Not available</td>
<td>Not available</td>
</tr>
</tbody>
</table>
### 2013/2014 data

<table>
<thead>
<tr>
<th></th>
<th>Salford</th>
<th>North West (NW)</th>
<th>National</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of MARACs completed</td>
<td>142%</td>
<td>94.8%</td>
<td>Not available</td>
</tr>
<tr>
<td>(based on target set by CAADA)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percentage of MARACs featuring</td>
<td>66.4%</td>
<td>67%</td>
<td>Not available</td>
</tr>
<tr>
<td>children</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percentage of repeat cases</td>
<td>23.7%</td>
<td>56.2%</td>
<td>Not available</td>
</tr>
<tr>
<td>Percentage from BAMER communities</td>
<td>17.6%</td>
<td>14%</td>
<td>Not available</td>
</tr>
<tr>
<td>Percentage from LGBT communities</td>
<td>1.2%</td>
<td>0.3%</td>
<td>Not available</td>
</tr>
<tr>
<td>Percentage registered with a</td>
<td>2.1%</td>
<td>2.6%</td>
<td>Not available</td>
</tr>
<tr>
<td>disability</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percentage male</td>
<td>4.5%</td>
<td>3.7%</td>
<td>Not available</td>
</tr>
<tr>
<td>Percentage of cases 16-17 years old</td>
<td>1.2%</td>
<td>3.5%</td>
<td>Not available</td>
</tr>
</tbody>
</table>

As you can see from the data the percentage of MARACs achieved in Salford is above the CAADA target set. In addition the percentage of target MARACs achieved is greater than in the NW. This potentially suggests either the identification of cases through referrals is more efficient in Salford, the time committed by key stakeholders committed to discussing cases at MARACs is greater or the threshold for cases to be discussed at MARAC is lower. Either way more cases are being discussed and actions are being taken for a greater number of individuals who are high risk of domestic abuse.

In addition the table identifies that the percentage of repeat MARACs (e.g. the same person coming back to a MARAC for the second time) is lower in Salford than in NW and nationally. It could be inferred from this that the outcomes / safety plans as a result of MARACs are more successful than other areas and are effective in supporting the individuals out of danger. Suggesting the partnership working and organisation within the MARACs is working well. However, it has been highlighted that the criteria for classifying a case as a repeat MARAC varies between Salford and other areas. Therefore caution should be applied when making any assumptions based on this data. Salford are currently working with CAADA to address these differences to ensure data can be affectively compared nationally.
Most of the other variables are similar to the NW and national averages – suggesting Salford is performing as expected in these areas.

From a Salford only perspective the percentage of MARACs that either feature children, are repeat cases, are from BAMER and LGBT communities or include those with disabilities are all increasing. However, it is unclear whether this is a real theme or a chance finding. Data over several more years would have to be looked at in detail to establish whether this was a real trend.

Referrals to MARACs can come from a range of settings – a breakdown of where Salford referrals come from is outlined in figure 6.

**Figure 6: Breakdown of the organisation where referrals to MARACs originate**

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Percentage of total MARAC referrals in 2013/2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Greater Manchester Police</td>
<td>52.3%</td>
</tr>
<tr>
<td>Secondary Care/Acute Trust</td>
<td>19.0%</td>
</tr>
<tr>
<td>Voluntary Sector</td>
<td>7.2%</td>
</tr>
<tr>
<td>IDVA</td>
<td>5.8%</td>
</tr>
<tr>
<td>Housing</td>
<td>5.7%</td>
</tr>
<tr>
<td>Primary Care Trust</td>
<td>4.5%</td>
</tr>
<tr>
<td>Children Social Care</td>
<td>3.0%</td>
</tr>
<tr>
<td>Men’s Health</td>
<td>0.8%</td>
</tr>
<tr>
<td>Probation</td>
<td>0.2%</td>
</tr>
<tr>
<td>Other</td>
<td>1.5%</td>
</tr>
</tbody>
</table>

It is evident from the table that GMP provide the majority of referrals to MARAC with over twice as many referrals as any other agency.

3.4.2 Summary of Child safeguarding data

Salford has several hundred children on a protection plan at any one time throughout the year. A main contributing factor needs to be recorded outlining why children are on these protection plans. A significant proportion of these children are on protection plans due to exposure to DV. A breakdown of the 2013 data can be seen in figure 7.
The data suggests that the average number of children on a protection plan each month is 348, with 120 (34%) of these have a main contributing factor of DV. In addition DV is the most common reason cited to put a child on a protection plan in Salford.

3.4.3 Summary hospital data

In 2013 89 patients disclosed domestic abuse to SRFT A&E staff all of which resulted in MARACs.

The total number of incidents related to DV is more difficult to ascertain as they are coded as assault before being triaged. While the coding carried out gives an insight into the physical details of the assault – it does not specify whether the assault was related to DV. In addition there is no evidence to indicate the average percentage of these assaults which were related to DV. Therefore caution should be taken in making any assumptions from the data. Figure 8 shows a breakdown in the number of assaults recorded by SRFT.
Figure 8. Breakdown of the number of assaults presenting at SRFT, the change over the last 2 years and the change at Greater Manchester (GM) level

<table>
<thead>
<tr>
<th>Salford Royal Foundation Trust</th>
<th>2012</th>
<th>2013</th>
<th>Change</th>
<th>GM Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>All figures</td>
<td>1246</td>
<td>1355</td>
<td>8.7%</td>
<td>2.4%</td>
</tr>
<tr>
<td>Male</td>
<td>848</td>
<td>1012</td>
<td>19.3%</td>
<td>2.4%</td>
</tr>
<tr>
<td>Female</td>
<td>398</td>
<td>342</td>
<td>-14.1%</td>
<td>2.4%</td>
</tr>
<tr>
<td>White</td>
<td>1080</td>
<td>1083</td>
<td>0.3%</td>
<td>-2.0%</td>
</tr>
<tr>
<td>Female Aged 15-29</td>
<td>211</td>
<td>164</td>
<td>-22.3%</td>
<td>-2.2%</td>
</tr>
<tr>
<td>Female Aged 30-44</td>
<td>98</td>
<td>91</td>
<td>-7.1%</td>
<td>5.4%</td>
</tr>
<tr>
<td>Female Aged 45-59</td>
<td>51</td>
<td>54</td>
<td>5.9%</td>
<td>13.8%</td>
</tr>
<tr>
<td>Female Aged 60+</td>
<td>9</td>
<td>11</td>
<td>22.2%</td>
<td>28.0%</td>
</tr>
<tr>
<td>Male Aged 15-29</td>
<td>419</td>
<td>493</td>
<td>17.7%</td>
<td>-0.8%</td>
</tr>
<tr>
<td>Male Aged 30-44</td>
<td>247</td>
<td>311</td>
<td>25.9%</td>
<td>4.0%</td>
</tr>
<tr>
<td>Male Aged 45-59</td>
<td>93</td>
<td>126</td>
<td>35.5%</td>
<td>9.4%</td>
</tr>
<tr>
<td>Male Aged 60+</td>
<td>16</td>
<td>24</td>
<td>50.0%</td>
<td>7.0%</td>
</tr>
</tbody>
</table>

From the data it is evident that the largest increases in assaults in Salford occurred in men aged 30+, with the biggest increase in the 60+ age range. This conflicts with the GM data where the biggest increase was in women aged 60+. In addition the biggest reduction in assaults presenting in Salford occurred in women aged 15-29 which was a much greater reduction than at GM level. It must be noted that these changes do not necessarily represent a trend and more years of data would be required to establish this.

3.4.4 Summary Police data

The number of domestic related crimes reported can be a good proxy measure for levels of DV within a community. The number of domestic related incidents police attend are much greater than the number of crimes reported. This is because a large proportion will choose not to officially report incidents as a crime. In Salford in 2013 over 5000 police responded to over 5000 DV incidents with less than a fifth being officially reported. The low number of DV crimes reported compared to DV incidents police attended fits with evidence which suggests victims of DV are less likely to report their experiences are to the authorities because of beliefs that their abuse is not a matter for police involvement, their experiences too trivial, or from fear of reprisal.
Figure 9. Breakdown of the number of domestic related crimes reported in Salford in each ward from 2011 to 2013

<table>
<thead>
<tr>
<th>Domestic Related Crime - City of Salford</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barton</td>
<td>122</td>
<td>80</td>
<td>65</td>
</tr>
<tr>
<td>Boothstown &amp; Ellenbrook</td>
<td>20</td>
<td>9</td>
<td>7</td>
</tr>
<tr>
<td>Broughton</td>
<td>91</td>
<td>84</td>
<td>93</td>
</tr>
<tr>
<td>Cadishead</td>
<td>35</td>
<td>54</td>
<td>41</td>
</tr>
<tr>
<td>Claremont</td>
<td>16</td>
<td>22</td>
<td>38</td>
</tr>
<tr>
<td>Eccles</td>
<td>64</td>
<td>33</td>
<td>51</td>
</tr>
<tr>
<td>Irlam</td>
<td>62</td>
<td>40</td>
<td>42</td>
</tr>
<tr>
<td>Irwell Riverside</td>
<td>89</td>
<td>92</td>
<td>90</td>
</tr>
<tr>
<td>Kersal</td>
<td>57</td>
<td>41</td>
<td>46</td>
</tr>
<tr>
<td>Langworthy</td>
<td>91</td>
<td>128</td>
<td>100</td>
</tr>
<tr>
<td>Little Hulton</td>
<td>145</td>
<td>85</td>
<td>82</td>
</tr>
<tr>
<td>Ordsall</td>
<td>94</td>
<td>89</td>
<td>73</td>
</tr>
<tr>
<td>Pendlebury</td>
<td>78</td>
<td>78</td>
<td>62</td>
</tr>
<tr>
<td>Swinton North</td>
<td>80</td>
<td>45</td>
<td>35</td>
</tr>
<tr>
<td>Swinton South</td>
<td>68</td>
<td>49</td>
<td>46</td>
</tr>
<tr>
<td>Walkden North</td>
<td>81</td>
<td>97</td>
<td>79</td>
</tr>
<tr>
<td>Walkden South</td>
<td>33</td>
<td>18</td>
<td>20</td>
</tr>
<tr>
<td>Weaste &amp; Seedley</td>
<td>70</td>
<td>76</td>
<td>74</td>
</tr>
<tr>
<td>Winton</td>
<td>109</td>
<td>74</td>
<td>63</td>
</tr>
<tr>
<td>Worsley</td>
<td>11</td>
<td>16</td>
<td>9</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1,416</strong></td>
<td><strong>1,210</strong></td>
<td><strong>1,116</strong></td>
</tr>
</tbody>
</table>

From the table it can be seen the two wards with the highest levels of domestic related crimes varies from year to year. In 2013 it was Langworthy and Broughton, in 2012 it was Langworthy and Walkden North and 2011 it was Little Hulton and Winton. The findings suggest the levels of domestic related crime varies from year to year in each of the wards. This indicates that there is no clear domestic violence hot spot and there are incidents throughout the city.
Figure 10. Citywide figures of domestic related crime in Salford by month for each calendar year.

<table>
<thead>
<tr>
<th>Domestic Related Crime - City of Salford</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>January</td>
<td>147</td>
<td>94</td>
<td>86</td>
</tr>
<tr>
<td>February</td>
<td>121</td>
<td>67</td>
<td>67</td>
</tr>
<tr>
<td>March</td>
<td>136</td>
<td>122</td>
<td>69</td>
</tr>
<tr>
<td>April</td>
<td>127</td>
<td>112</td>
<td>80</td>
</tr>
<tr>
<td>May</td>
<td>117</td>
<td>101</td>
<td>92</td>
</tr>
<tr>
<td>June</td>
<td>102</td>
<td>97</td>
<td>88</td>
</tr>
<tr>
<td>July</td>
<td>110</td>
<td>107</td>
<td>105</td>
</tr>
<tr>
<td>August</td>
<td>126</td>
<td>128</td>
<td>115</td>
</tr>
<tr>
<td>September</td>
<td>110</td>
<td>101</td>
<td>94</td>
</tr>
<tr>
<td>October</td>
<td>125</td>
<td>99</td>
<td>100</td>
</tr>
<tr>
<td>November</td>
<td>100</td>
<td>90</td>
<td>106</td>
</tr>
<tr>
<td>December</td>
<td>95</td>
<td>92</td>
<td>114</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1,416</strong></td>
<td><strong>1,210</strong></td>
<td><strong>1,116</strong></td>
</tr>
</tbody>
</table>

From data from the last 3 calendar years the number of offences have fallen year on year. However, if the figures were reviewed by financial year this would provide a different picture as the figures for the 2013/2014 financial year increased by 4% compared to the 2012/2013 financial year. This suggests that the numbers of reported domestic related incidents overall has stayed relatively stable over the last 3 years.

Peaks in all years were around March and August. In 2013 there was also a peak in December.

3.4.5 Summary housing data

Domestic violence is a significant contributor to homelessness and DV refuges and dispersed housing are essential to support those experiencing DV.

Figure 11. The total number of statutory homeless cases due to DV in Salford in the last 3 years is as follows

<table>
<thead>
<tr>
<th>Year</th>
<th>Total number of homelessness acceptances in Salford due to DV</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011/2012</td>
<td>84</td>
</tr>
<tr>
<td>2012/2013</td>
<td>67</td>
</tr>
<tr>
<td>2013/2014</td>
<td>51</td>
</tr>
</tbody>
</table>
NB - it needs to be acknowledged that these only include the cases which were deemed eligible and a statutory duty to secure accommodation accepted. A number of other applications were rejected due to not meeting the eligibility criteria would have also been experiencing DV.

It is evident from the table that although the number of accepted homelessness due to DV has been reducing year on year the numbers are still significant. In addition as outlined in the caveat these are only the numbers accepted and the number of applications may have not reduced.

Another important issue with DV victims is the average stay within refuges. The service aim is to move individuals into the refuge which is a temporary step which provides the victim with a safe environment. Then once they are no longer in danger support them to move in to more permanent accommodation.

**Figure 12. Average length of stay in DV refuge**

<table>
<thead>
<tr>
<th>Year</th>
<th>Average stay</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Up to 1 year</td>
</tr>
<tr>
<td>2011/2012</td>
<td>64</td>
</tr>
<tr>
<td>2012/2013</td>
<td>59</td>
</tr>
<tr>
<td>2013/2014</td>
<td>59</td>
</tr>
</tbody>
</table>

It is evident from the table that over the last 3 years the majority of those staying in the DV refuge do so for less than 1 year. This is as expected as these services are designed to be temporary before moving into more permanent options.

**Figure 13. Percentage of those staying in DV refuges which are Salford's Residents**

<table>
<thead>
<tr>
<th>Year</th>
<th>Percentage which are Salford Residents</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011/2012</td>
<td>39%</td>
</tr>
<tr>
<td>2012/2013</td>
<td>14%</td>
</tr>
<tr>
<td>2013/2014</td>
<td>15%</td>
</tr>
</tbody>
</table>

Due to the nature of DV when victims move in to refuges the majority will move out of area to ensure they are away from the perpetrator. This results in the majority of individuals accessing the refuge being from out of area. This can result in a costly service which has little direct benefits to Salford residents.

A new model of delivery has been developed to address this, which offers refuge through dispersed housing. In addition there is a stricter criterion for being referred, which in turn ensures Salford residents are given priority.
4.0 Service Mapping: current services

4.1 Greater Manchester Probation Trust supervises offenders over the age of 18 who are given a community order by the court or are released from prison on licence. The aims are to assist offenders in changing their behaviour; to reduce their risk of reoffending; to raise their awareness of the impact of their crime on victims and to protect the public. Community Payback undertake projects that benefit to local communities including litter clearance, graffiti removal, repairing and redecorating community centres and environmental work. Offenders work in a team, monitored by a supervisor or individual placements. The offender is paying back to the community for their crime and as the same time developing important life skills.

4.2 Greater Manchester Police has a Public Protection Investigation Unit which is managed centrally with a hub in each division. The officers have undertaken specialist domestic abuse training, some support the victims and other officers are trained detectives to investigate incidents. These officers will form part of an initial referral and assessment team and will review every incident in Salford which has been coded with Domestic Abuse markers.

The initial risk assessment completed by the uniform officers will be reviewed, and secondary enhanced risk assessments will be completed. From this process referrals to outside agencies and the MARAC can be made. Specialist officers will continue to provide safety measures and advice to victims, take statements where applicable, and deal with high risk offenders in custody. Officers from this unit also attend and contribute to the MARAC process, they progress actions highlighted for the police from MARAC.

Domestic Violence Disclosure Scheme – Clare’s law

Greater Manchester was a pilot site for The Domestic Violence Disclosure Scheme. This was a scheme to let people find out from police if their partner has a history of DV. The Domestic Violence Disclosure Scheme - known as Clare’s Law - is intended to make them aware of the perpetrators background in order that they can make an informed choice about the future of their relationship. Along with several other locations Greater Manchester has been used as a pilot site since 2012. In March 2014 the scheme was rolled out nationally.

Domestic Violence Protection Notices (DVPN)

Greater Manchester was also a pilot site for DVPN’s. A DVPN is the initial notice issued by the police to provide emergency protection to an individual believed to be the victim of domestic violence. This notice, is authorised by a police superintendent and effectively bars the suspected perpetrator from returning to the victim’s home or otherwise contacting the victim. A DVPN may be issued to a person aged 18 years
and over if the police superintendent has reasonable grounds for believing that:
- the individual has been violent towards, or
- has threatened violence towards an associated person, and
- the DVPN is necessary to protect that person from violence or a threat of violence by the intended recipient of the DVPN.

DVPNs can last up to 48hrs and during that time the Police must apply to a Magistrate to grant a Domestic Violence Protection Order (DVPO). A DVPO can last up to 28 days and will include conditions which the perpetrator must comply.

Examples of conditions include:

- prohibit them from making you leave your home
- prohibit them from entering your home
- require them to leave your home
- prohibit them from coming within a specified distance of your home

These notices were introduced across England and Wales in March 2014. Since January 2013 there has been 64 DVPN’s issued within Salford.

4.3 St Mary’s Sexual Health Centre provide a one stop shop facility for victims of rape and sexual assault included forensic examination, counselling and support workers and specialist key workers to give ongoing support.

- Forensic medical examination
- Emergency contraception and sexual health screening/advice
- Immediate crisis support
- Ongoing support through the criminal justice process, access to other healthcare services and community based services
- Counselling for clients and their significant others

The Centre offers a dedicated children’s service to provide care and assessment for child victims of sexual abuse. Centre staff work in collaboration with the police and children and families services in the safeguarding of children who have experienced sexual crimes. The St Mary’s SARC is based in St Mary’s Hospital.

4.4 Manchester and Salford Magistrates Court deals with a wide range of cases in both civil and criminal. Specialist domestic violence court (SDVC) that sits everyday and the local criminal Justice Board are monitoring cracked cases.

4.5 Crown Prosecution Services decide whether there is sufficient evidence to prosecute a case in court. Vulnerable witnesses can apply for special measures so they can assist them to give evidence. The crown prosecutor will prosecute the case either in the magistrates or crown court.
4.6 Greater Manchester West Mental Health NHS Foundation Trust are Salford Mental Health and Social Care Directorate. Providers of secondary Mental Health and Social Care based across 3 Functional Community Mental Health Teams, Early Intervention Team and Dementia Community Team. We also provide Acute Inpatient, Rehabilitation services and Primary Care Psychology Services in Salford

4.7 Safeguarding Adults
Domestic abuse can involve adults who are known or should be referred into adult social care because they have additional vulnerabilities which warrant specific action by specialist adult social work staff. This may be where an individual has significant physical disabilities, age related issues such as dementia, learning difficulties, mental health or other conditions that make them additionally vulnerable or disadvantaged for example anyone with issues around mental capacity. Adults services work with all the agencies involved including the Police, NHS, housing, voluntary sector and informal carers to ensure individuals are protected from further abuse

4.8 Salford Family Court deals with orders e.g. Non-molestation Orders (no contact) and Occupation Orders (sole right to the property). Also parental rights and contact with absent parent. Cafcass looks after the interests of children involved in family proceedings. They work with children and their families, and then advise the courts on what we consider to be in the best interests of individual children.

4.9 General Practitioners practices refer patients who disclose domestic abuse to appropriate support services. Where it is apparent that there are safeguarding children concerns, the Practice makes a referral to Salford City Council Children’s Services. From the beginning of May 2013, information from the MARAC meetings has been circulated to GP Practices to ensure that Practices are aware of patients who are high risk victims of domestic abuse.

Agencies working with victims

4.10 Salford Women’s Aid operates Salford’s two residential units (refuges) providing shared accommodation for 14 families and providing support for the women and their children. The average stay for a family/individual at a residential unit is 6-9 months.

4.11 Salford Independent Domestic Abuse Support Service (SIDASS) is a registered charity under Women’s Aid. It has 5 trained Advisors to support to all victims of domestic abuse, including risk assessment, safety planning, crisis support, civil and criminal work, referral and signposting, and aim to provide a holistic package of support to the family as a whole. The team also offer advice and support on safety planning, crisis work, civil and criminal remedies, housing advice, finances, health issues and work with families to improve issues around child protection where
domestic abuse is a prevalent factor. The support is mainly done via a telephone helpline which due to limited resources now only runs during afternoons.

The project was developed by Salford City Council's Community Safety Unit and Salford Women's Aid working together in partnership. So far, SIDASS has supported more than 2,200 victims of domestic abuse and work over the short to medium-term, to put victims on the path to long-term safety. The early interventions and safety planning given to victims of systematic abuse has resulted in there being a reduction of repeat victims to 13%.

SIDASS also provide trained Independent Domestic Advice Advocates (IDVAs) to deal with high risk clients from MARAC. Where possible the IDVAs will support the victims to try and keep them in their own home.

4.12 The Together Women Project provides a one stop shop for Salford women, providing one to one support from a key worker, a drop in, counselling, holistic therapies and a wide range of services focusing on the health and well being of women. The centre works with women who have offended or are at risk of offending and welcomes women who have or are currently experiencing domestic abuse, providing a women-only safe space for service users to receive support.

4.13 Victim Support & Witness Service Salford helps Salford residents cope with the effects of crime. The trained local volunteers talk to victims in their own home in confidence listen to what has happened and support and sign post to other agencies. The Witness service provides confidential support and information to victims of crime and to witnesses attending local courts.

4.14 The MARAC (Multi-agency Risk Assessment Conference) has been developed to help high risk victims of DV and their families. Local agencies meet fortnightly to discuss cases and share information about the risks faced by those victims, the actions needed to ensure safety, and the resources available locally is shared and used to create a risk management plan involving all agencies. This is chaired by the GMP Inspector in charge of the DV unit.

4.15 The Sanctuary Scheme is designed to enable victims of domestic abuse to remain in their own home by providing a tailored package of home security measures. The Scheme helps to ensure the safety of the victim and her children by target-hardening the property and can also be used as a homelessness prevention method.

Housing services

4.16 Salix Homes has a Tenancy Management Team that aims to deal with all reports of Domestic Abuse within 24 hours by working closely with partners to
provide a tailored service to the individual. In addition, one of the Tenancy Management Officers has been identified as the lead contact within Salix Homes for Domestic Abuse issues and attends Salford’s MARAC. Salix homes also have a clear pathway to outline the steps to be taken if DV is identified in one of their properties. The pathway aims to ensure the appropriate support and signposting is offered to each case. Salix Homes introduced a case management system called REACT in April 2014. The system ensures that everything dealt with by the Tenancy Management Team is logged and coded appropriately. This can allow mapping of incidents such as DV and anti social behaviour. Annual reviews will take place to assess the extent and distribution of reported DV within Salix homes. In addition, Salix are currently in the process of reviewing their policies and on completion will produce one specifically related to DV.

Salix also commission DV training from SIDASS for their tenancy management staff. This provides staff with a clear understanding of DV and what to look out for in their day to day work. They also intend to roll out general awareness training and signposting training to all their frontline staff including lettings, rent and customer involvement teams.

4.17 City West Housing Trust’s Housing and Neighbourhood services are delivered on a local area basis, with West Salford being divided into four areas of operation. Any member of staff taking a report of domestic abuse will ensure that an appointment is made with a Neighbourhood Officer within 24 hours if violence or threats of violence have been made, and two days in all other cases; working in partnership with other agencies to ensure a coordinated response. From June 2013, City West will be delivering annual Domestic Abuse Awareness training for staff specifically looking at a number of real life case studies.

4.18 Salford Royal Foundation Trust (SRFT) is a hospital and provides community and primary care services. SRFT also provides training in respect of domestic abuse awareness and referrals are made to MARAC from different departments. In addition SRFT receive domestic abuse notifications from GMP which are then distributed to relevant healthcare professionals.

4.19 Salford City Council Supporting People – Domestic Abuse Safe Accommodation Service. Salford City Councils Supporting People Team commissions (via public money) the Domestic Accommodation Safe Accommodation Service which is delivered by specialist workers within the Supported Tenancy Service. The service provides support for individuals experiencing DV in the form of providing temporary accommodation and support in finding alternative more permanent accommodation. Salford Housing Options Point carries out assessments on individuals who present to see if they are eligible for support. Where possible a number of homelessness prevention measures are put in place e.g. referring to the sanctuary scheme for additional security measures. However, if they are eligible and
the prevention measures are not adequate then the team are legally obliged to support them to find them new housing within 33 days. If the individual presenting is in imminent danger Salford Housing Options Point will provide an immediate short term measure in the form of a referral into the Safe Accommodation Service, a refuge or placement in a B&B.

Domestic Abuse Safe Accommodation Service provides 10 dispersed houses throughout the city to support those who are experiencing DV who have become homeless. This is a capacity of 26 individuals or a combination of families and individuals. A key factor with both the refugees and the dispersed houses is that if the victim of DV is working they will be required to self fund. As a result of the assisted support that comes with the accommodation the rent is generally high. The average rent of one of the dispersed homes would be £160 per week and up to £400 in a refuge, potentially preventing those workers on low wages from being able to access these.

**Perpetrator projects**

4.20 **Integrated Domestic Abuse Programme (IDAP)** may form part of the risk management/rehabilitation plan in the community. For offenders who receive a custodial sentence a Healthy Relationship programme is available in some prisons.

4.21 **Integrated Offender Management (IOM)** targets 180 of the most prolific and serious offenders in Salford. The multi agency team are made up of Probation, Police, Community Safety Unit, Youth Offending Service and Salford Drug and Alcohol services and work closely with the third sector and Housing Services to reduce their offending behaviour and link them back into the community, family and employment. IOM now have domestic abuse perpetrators on the cohort and work closely with the domestic violence unit.

4.22 **Improving Relationships – Supporting Change** is a partnership approach to reducing abusive behaviour by adult males and support for other family members. Greater Manchester Probation Service to provide a group work programme for male perpetrators of domestic abuse and SIDAS to provide support and advice to victims of domestic abuse. Health Visitors support individual families when domestic abuse has occurred, and, incorporate it as part of a health assessment for all women they visit and Children’s Services supporting the children and families affected by domestic abuse through Social Workers and Family Support Workers.
5.0 GAP analysis

5.1 Current gaps in services

Prevention
There is little focus on early identification and intervention, instead more attention has been paid to responding to crisis and high risk intervention.

Advocacy
There is a gap in independent support and community outreach provision to provide advocacy. This helps to ensure that standard to medium risk cases do not become high risk, but also provide critical protection and support to many high risk victims/survivors not referred to the police (e.g. those who seek emergency refuge).

Specific groups
There is currently a gap in the provision of services to meet the needs of BAMER survivors, with many BAMER survivors unable to access language or culturally-appropriate services that are able to take into account their specific cultural context. Survivors with insecure immigration status, or “no recourse to public funds”, will also experience additional barriers to seeking help and support.

Few services have the capacity to meet the needs of victims who have experienced domestic violence and who are disabled or have additional support needs, for example, substance use or mental health issues. Therefore, the most vulnerable victims may end up in the most high risk situations.

There are no effective interventions for young people either being abusive in their own relationships or being the victims of abuse. In addition there is no specialist domestic violence services for children and young People which Provide specialist advice, advocacy and support to children as part of a comprehensive referral pathway.

Multi agency working
Where survivors are already engaging with other specialist treatment/support agencies, it is important that the support they receive for their experiences of violence and abuse is able to work alongside these agencies in a partnership model. This can involve the development of more specialised services within the domestic violence sector (for example, a substance-use refuge) or the involvement of local mental health and substance-use services to ensure a coordinated approach and clear referral pathways.
5.2 Areas where best practice is not being implemented

The NICE guidance suggests the most effective approach is to pool resources and have an integrated commissioning approach. At present this is not the case and a range of services are commissioned from different organisations.

In addition the evidence also reinforces the need for effective partnership working to effectively address domestic violence. At present there is some silo working, however there is an ongoing dialogue between key partnerships within Salford to come together to address domestic violence and other cross cutting issues.

6.0 Recommendations

6.1 Joint Commissioning and strategic coordination

DV is still seen as a minority issue and in the current economic climate with the financial pressures as they are it needs to be ensured that it is established as a priority. Given the findings of this HNA and the recent partnership work review (see appendix 5) it would be appropriate to review the strategic direction and approach with regard to DV.

**Recommendation 1**

**JOINT COMMISSIONING AND STRATEGIC COORDINATION**

Assess the strategic direction, coordination and commissioning approach to domestic violence prevention.

**Actions**

Key Stakeholders to use both this document and other relevant local documents to develop a plan outlining how best to produce a multi-agency integrated commissioning approach with shared outcomes.

Identify the key strategic coordination requirements to deliver a robust and systematic DV programme and allocate the appropriate resources to deliver this e.g. the funding of a strategic DV co-ordinator.

6.2 Prevention

It has been identified that prevention is always going to be the most effective approach. Therefore the culture of acceptance of DV needs to be addressed both at community and professional level.
**Recommendation 2**

**PRIMARY PREVENTION**

Develop a standardised approach to address perceptions and acceptance of domestic violence with a focus on young people.

**Actions**

Review Salford’s domestic violence awareness raising activities including training within schools and community settings.

Develop opportunities to challenge acceptance of domestic violence in the community, with a view to target these initiatives in areas with higher levels of DV.

Integrate DV awareness raising opportunities from a young age to prevent it from being normalised within all community groups.

**6.3 Data/Intelligence**

Data activity and information on DV and responding to DV was in places patchy and fragmented. The different data sources which highlight the situation regarding DV have been identified and when used collectively help to produce a robust picture. There may be some concerns regarding data protection however it could be ensured that everything shared is non-patient / individual identifiable data.

**Recommendation 3**

**DATA**

Improved use of data to identify any changes in trends and to inform any required service developments.

**Actions**

Identify the key data sets available which identify the levels of domestic violence within Salford between all stakeholders.

Outline a data sharing agreement having one stakeholder responsible for collating, interpreting and sharing the data to identify.

Identify one stakeholder/organisation to pull together the relevant data quarterly from the various sources to identify how the levels of DV are fluctuating (allowing an appropriate response in services if necessary).

Review the data / measures used – and where possible identify outcome measures in addition to the process measures.
6.4 Services

While the majority of the available services seem to fit with the evidence base, the HNA did not carry out any formal engagement with service users to find their views of the service. This is essential to know as if services are fit for purpose and accessible for all individuals and groups.

**Recommendation 4**

**REVIEW INTERVENTIONS**

Identify if services are appropriate and responsive to the needs of the victims, including those from minority groups (e.g. male, LGBT and BME victims)

**Actions**

Review the capacity and quality of the current domestic violence initiatives including the capacity of the IDVA through service users/victims feedback on their experiences

Identify specific areas for improvement

Carry out an equality impact assessment on current services to ensure that they are appropriate and responsive to the needs of the victims, including those from minority groups (e.g. male, LGBT and BME victims)

6.5 Training

To ensure awareness, understanding and competence in dealing with DV in front line staff appropriate training is required. It has been highlighted by this work that robust training is taking place in patches but there are still some areas where front line staff are not accessing training for a combination of factors.

**Recommendation 5**

**TRAINING**

Develop a systematic process to ensure all those who may come into contact with domestic violence are routinely offered appropriate domestic violence training on a regular basis

**Actions**

Carry out a formal mapping process of all the domestic violence training along with the content of the domestic violence training sessions.

Undertake a training needs assessment to identify all those staff requiring training and the related resource requirement.
Develop a suite of domestic violence training options at different levels for all stakeholder organisations, so staff can select the level of training which is appropriate for their role.

Develop a systematic process to ensure all those who may come into contact with DA are routinely offered appropriate DA training on a regular basis.

Consider whether a communications campaign for practitioners would help address any gaps in awareness that may be weakening Salford’s response to DA – for example, raise awareness of services, partnership governance and training offer.

6.6 Further research

There are a number of gaps in evidence relating to what current links domestic violence interventions have with wider services and what indirect domestic violence related interventions are effective at addressing the domestic violence agenda.

Recommendation 6
FURTHER RESEARCH

Links with other services
Identify how domestic violence services can link more closely with the available provision to assist in the identification and support of those experiencing domestic violence.

Actions
Work closely with other services such as mental health, alcohol, drug and maternity services to develop integrated pathways.

Perpetrator programmes
Assess if and how perpetrator programmes should be integrated into Salford’s multi agency approach to address domestic violence.

Actions
Review the effectiveness of perpetrator programmes available locally and nationally. Then based on the findings.

Criminal Justice System
Improve victims support following domestic violence incidents

Actions
Identify potential tools that agencies within the CJS could use to reduce the risk of perpetrator attacks and how these could be implemented.
Explore domestic violence victim’s experiences in dealing with the criminal justice system (CJS), to identify strengths, weaknesses and barriers in the process and how this could be enhanced to further support individuals.

7.0 Areas for further work

Links with other services
Work closely with other services such as mental health, alcohol, drug and maternity services to identify how DV services can link more closely with the available provision to assist in the identification and support of those experiencing DV.

Perpetrator programmes
Review the effectiveness of perpetrator programmes available locally and nationally. Then based on the findings assess if and how these should be integrated into Salford’s multi agency approach to address DV.

Criminal Justice System
The criminal justice system has an important role to play in risk reduction, aiming to ensure the perpetrator is unable to cause further harm to the victim. The consultation at a GM level suggested that service users had mixed views on the effectiveness of the criminal justice system. Given the importance of the criminal justice system in reducing the immediate and a longer term risk of repeat victimisation, it may be useful to explore the Salford specific victim’s perceptions of the criminal justice system.

In addition the police have a range of legislations and tools which, if used effectively could potentially reduce the risk of repeat victimisation. These include enforcing legislations such as the stalking and harassment act and using tools such as police bail, conditional cautioning and restricting perpetrators movements and contact with victims or their children. The Police could also potentially work with housing providers to ensure that perpetrators are not bailed within the vicinity of the victims, victims’ family or their children.

Effective collaborative working between agencies is a key part of this as when cases do go to court they must have the cooperation of the victim or find other evidence such as photographic evidence, statements from officers in the case, evidence from other agencies, medical records, 999 call taker recording, previous conviction and cautions. If this is done effectively it could increase the number of convictions and provide harsher penalties for the perpetrators sending out a clear message that violence and abuse is not tolerated in Salford.
8.0 References


Appendix 1

Statutory requirements of the Responsible Authorities pertaining to community safety (Community Safety Partnerships (CSPs))

Responsible Authorities:

Section 17 of the Crime and Disorder Act 1998 provides a legislative duty on responsible authorities to take account of crime and disorder within all planning and decision-making processes. The legislation states:

‘Without prejudice to any other obligation imposed on it, it shall be the duty of each authority to which this section applies to exercise its various functions with due regard to the likely effect of the exercise of those functions on, and the need to do all that it reasonably can to prevent, crime and disorder in its area.’

As amended by the Crime and Disorder (Formulation and Implementation of Strategy) (Amendment) Regulations 2011 (Statutory Instrument no. 2011/1230), responsible authorities have a duty to:

- Have a strategy group which will have in place arrangements governing the review of expenditure of partnership monies and the economy, efficiency and effectiveness of this expenditure (CSP Executive Group).

- The strategy group is responsible for commissioning and implementing a strategic assessment and partnership plan (the community safety strategy and delivery plan). CSPs can now agree the period covered by the partnership plan (i.e. it does not have to be a 3 year plan).

Scrutiny of Responsible Authorities:

As amended by the Police and Justice Act 2006, every local authority shall ensure that it has a committee (the “crime and disorder committee”) with power-

a/. to review or scrutinise decisions made, or other actions taken, in connection with the discharge by the responsible authorities of their crime and disorder functions;

b/. to make reports or recommendations to the local authority with respect to the discharge of those functions.
Merger of CSPs

Section 5 of the Crime and Disorder Act 1998 as amended by Section 97 (3) of the Police Reform Act 2002 and Section 108 of the Policing and Crime Act 2009 sets out the circumstances whereby the responsible authorities for each CSP area can join together to work as a combined partnership to carry out their functions.

Applications need to be submitted to the Home Office and must set out how the merger is in the interests of reducing crime and disorder, combating the misuse of drugs or reducing reoffending. The application must be made jointly by all the responsible authorities concerned.

The Home Office will take into account:

- How the merged partnership will retain local sensitivity, consult with and be accountable to local people.
- How the merged partnership will manage its relationship with all the responsible authorities in the area and other local agencies, structures and partnerships.
- How the pooling of local resources (financial as well as expertise, skills and knowledge) will achieve better results, and how the merger will lead to value for money and economies of scale.
Appendix 2

Strategic Objectives from ‘Salford violence against women’ strategy 2013.

**Strategic Objective 1**
The CSP is taking the lead to reduce violence against women
We will develop a range of measures to reduce the prevalence of violence against women over time with a strong emphasis on cultural change. Our approach will address violence against women as a whole and its roots in gender inequality. We will promote an ambitious approach within which Salford will continue to develop innovative policy and practice.

**Strategic Objective 2** Improving access to support
We will improve the safety, wellbeing and freedom of women and children through access to better services that meet the needs of Salford’s diverse communities. Our goal is to build capacity across the voluntary sector and seek funding to developing rape crisis provision and to help friends and family of victims, to whom women often turn first, to provide informed support.

**Strategic Objective 3** Addressing health, social and economic consequences of violence
We will support measures that reduce the long-term consequences of violence for women who experience it, improve their life chances and support them in rebuilding their lives. We want to make violence against women a priority for service providers. We will champion integrated support services for the most marginalised and at risk women. We will give a voice to survivors in shaping policy and delivery.

**Strategic Objective 4** Protecting women at risk
We will ensure that the criminal justice system provides protection to women who need it, e.g. target hardening security equipment and panic alarms to ensure safety. Greater Manchester Police to flag addresses and names for quick response.

**Strategic objective 5** Getting tough with perpetrators
We want perpetrators to stop the violence and be held to account. Our approach will champion the effectiveness of the criminal justice system and call for tougher sanctions and consequences. Perpetrators must be deterred from violence against women. We need to explore interventions with perpetrators to help reduce their offending behaviour
Appendix 3

**Probation**

In Greater Manchester Probation Trust all the Probation Officers and managers have had training on DV Awareness, Report Writing and undertaking Pre and post work for the Accredited DV Group Programme. As the Lead Assistant Chief for Domestic Abuse for the Trust Manjit has also commissioned further DV training this year for both Probation Officers and Probation Service Officers (PSO’s). The PSO’s will have DV Awareness Training, training on appropriate skills and approach to take when working with DV perpetrators and using a 1:1 DV resource pack in order to undertake offence focused work. The Probation Officers will this year also receive training on the 1:1 DV Resource Pack and a workshop on reminding them of the key expectations and standards from the Trust Domestic Abuse Policy and Practice Directions. Probation also has mop up training for any staff that are new to the trust.

The above training is mandatory and all practice staff and middle managers are required to attend it. Safeguarding Children training is also delivered which includes domestic violence.

**SIDAS**

All staff CAADA trained Domestic Violence advocates.

**City West Housing**

City West have delivered joint MARAC and DASH risk assessment training with Nicky Fagan for Neighbourhood Officers. In the past, they have also used a theatre company called ‘Aftathought’ to deliver Domestic Abuse awareness raising sessions for our wider staff base.

They are currently carrying out a review of our internal Domestic Abuse Policy and Procedure, including staff training. Jill Fenlon, one of our ASB Officers is leading on this. As part of the review, Jill is going to speak to Dawn Redshaw about assisting us with future staff training.

**Salford CSU**

Salford Council contributes to the End the Fear website which has a great deal of useful information on and can be accessed by anyone: [http://www.endthefear.co.uk/](http://www.endthefear.co.uk/)

2013 there is a great deal of information and leaflets on the Salford Council website: [http://www.salford.gov.uk/search.htm?postback=true&qt=domestic+violence](http://www.salford.gov.uk/search.htm?postback=true&qt=domestic+violence)

Salford Council have signed up to Virtual College, this means that every Council employee has access to over 150 on line e-learning package, the relevant ones are;

- An Awareness of Domestic Violence including the Impact on Children and Young People V2 – mandatory for frontline staff in Adult and Children Services
- Safeguarding Adults V2 - mandatory for frontline staff in Adult and Children Services
- Safeguarding everyone
<table>
<thead>
<tr>
<th>Adult Services</th>
<th>Children Services</th>
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<tbody>
<tr>
<td>Staff from Children’s Social Care receives Safeguarding Unit Domestic Violence training. They are also in the process of commissioning a single agency course from the AGMA Domestic Abuse Training Framework. Staff trained by the SSCB training pool.</td>
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<tr>
<td>Children’s Services have face to face training <a href="http://www.partnersinsalford.org/sscb/domesticabusechildprotection.htm">http://www.partnersinsalford.org/sscb/domesticabusechildprotection.htm</a></td>
<td></td>
</tr>
<tr>
<td>Domestic abuse and child protection</td>
<td></td>
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<tr>
<td><strong>Course aim</strong></td>
<td></td>
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<tr>
<td>To encourage sensitive and effective work with families and other agencies in domestic abuse situations.</td>
<td></td>
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<tr>
<td><strong>Course objectives</strong></td>
<td></td>
</tr>
<tr>
<td>Participants will be able to:</td>
<td></td>
</tr>
<tr>
<td>- Identify the wide range of behaviours involved in domestic abuse and dispel some of the myths.</td>
<td></td>
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<tr>
<td>- Describe the impact of domestic abuse on women and their children.</td>
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<tr>
<td>- Describe some of the barriers to seeking help.</td>
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<tr>
<td>- Describe the assessment that may be undertaken as part of the child protection process.</td>
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<tr>
<td>- Consider different methods of intervention.</td>
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<tr>
<td>- Identify the range of services offered to women, children and young people from the various agencies.</td>
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<tr>
<td>- Be aware of the issues to consider when making decisions about contact between the perpetrator and any children in the family.</td>
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<tr>
<td>- Consider actively the issues of staff safety and effective supervision and support within the context of domestic abuse work.</td>
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<tr>
<td>Participants are often asked to reflect on the emotional impact of the work they do and how it can be managed.</td>
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<tr>
<th>Victim Support</th>
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<tbody>
<tr>
<td>Victim Support staff and volunteers receive initial four day classroom training after completing 6 distance learning modules. There is an overview of DV issues in this initial training.</td>
</tr>
<tr>
<td>Following on from initial training, where a volunteer wants to do specialist DV training, they are invited to a formal interview to assess capability, then, if successful they will attend four day in depth DV training followed by 1 day on risk assessment and safety planning.</td>
</tr>
<tr>
<td>Our training is CAADA accredited and delivered consistently within Victim Support across England and Wales.</td>
</tr>
</tbody>
</table>
### Housing Options

Housing Options staff is sent on the SSCB DV training course when they first start their job and don’t have access to any other training.

### GMW

GMW do not have any specific domestic abuse training within mental health services though we do provide mandatory training in Adult and child safeguarding which does cover this. Additionally all clinical staffs are trained in risk assessment and management which includes risk of exploitation and vulnerability from others plus the potential risk of violence towards others in terms of perpetrator violence.

### NHS Salford CCG

All GP Practice Staff receive Level 2 safeguarding children training- this includes information in relation to domestic abuse
All GPs are in the process of undertaking Level 3 safeguarding children training- again this includes information about domestic abuse
All GP Practice Staff are being offered safeguarding adult training- again this includes information about domestic abuse
A session on domestic abuse has been provided within a small number of GP Practices on request
A domestic abuse seminar is being provided for GPs and Practice Nurses in September which includes information about the DASH and MARAC processes
Further domestic abuse seminars will be provided- dates not yet arranged.

### Salix homes

We haven’t had any training this year in relation to domestic Abuse. We have been asking for some training via Dawn at SIDASS in relation to Domestic Abuse awareness and MARAC process, however this is still outstanding.

### GMP

Depending on their specialism, police officers receive different levels of training. Public Protection Division Domestic Violence Officers receive a 4 day training course on Domestic Abuse Investigation at Sedgley Park Training School.
Public Protection Division also holds Continuous Professional Development days whenever new legislation or procedures are introduced.
GMP rolls out force wide NCALT (computer based) training packages where a need is highlighted or new procedures/legislation are introduced e.g. DASH/Stalking and harassment.
Officers also attend Multi Agency Training when we are made aware/allocated spaces.
Officers from other departments receive DA training when they join the Police. These officers are also expected to complete the compulsory NCALT Packages and training is delivered on a Wednesday to response teams at Sedgley Park Training School, this training is optional.

### Appendix 4

Within the CSEW, intimate personal violence includes the following categories:
• **Any domestic abuse**: non-sexual emotional or financial abuse, threats, physical force, sexual assault or stalking carried out by a current or former partner or other family member.

• **Partner abuse (non-sexual)**: non-sexual emotional or financial abuse, threats or physical force by a current or former partner.

• **Family abuse (non-sexual)**: non-sexual emotional or financial abuse, threats or physical force by a family member other than a partner (father/mother, stepfather/mother or other relative).

• **Emotional or financial abuse**: includes being prevented from having a fair share of household money, stopped from seeing friends or relatives or repeatedly belittled.

• **Threats** are classified as an affirmative response to the statement ‘frightened you by threatening to hurt you/someone close’.

• **Minor force** is classified as an affirmative response to the statement ‘pushed you, held you down or slapped you’.

• **Severe force** involves being kicked, hit, bitten, choked, strangled, threatened with a weapon, threats to kill, use of a weapon or some other kind of force.

• **Sexual assault**: indecent exposure, sexual threats and unwanted touching (‘less serious’), rape or assault by penetration including attempts (‘serious’), by any person including a partner or family member.

• **Rape** is the legal category of rape introduced in legislation in 2003. It is the penetration of the vagina, anus or mouth by a penis without consent.

• **Assault by penetration** is a legal offence introduced in 2003. It is the penetration of the vagina or anus with an object or other body part without consent.

• **Stalking**: one or more incidents (causing distress, fear or alarm) of receiving obscene or threatening unwanted letters, e-mails, text messages or phone calls, having had obscene or threatening information about them placed on the internet, waiting or loitering around home or workplace, following or watching, or interfering with or damaging personal property by any person, including a partner or family member.

It is important to note that the CSEW defines an adult as being 16 to 59 years old, which is not consistent with the government’s current definition of DV. However, this is the only source of national level data available.

**Appendix 5**
Executive summary

1.1 The City of Salford has a number of established thematic partnerships and safeguarding boards that act to support the health, safety and well-being of the residents of Salford. These partnerships aim to ensure all the key agencies come together to provide a collaborative approach to assist the residents of Salford to have healthy happy lives.

1.2 Evidence suggests good partnership working can generate solutions single agencies cannot solve, improve the services local communities receive, enhance the coordination of services throughout a geographical area and avoid wasteful duplication and gaps in services (Health Development Agency, 2003). To investigate the strength of the partnership working between Salford’s thematic boards and partnerships a formal review was initiated by the partnerships with the Community Safety Partnership (CSP) leading. The review aims to identify how Salford partnerships/boards can best achieve synergy and improve their operation when the responsibility for addressing an issue falls across several partnerships. To examine this, the issue of domestic abuse (DA) will be used as an example.

1.3 The roles and responsibilities concerning DA were outlined for each of the partnerships and it was established that the CSP had the main role acting as the coordinating body. They have developed the ‘Violence Against Women’ strategy which outlines the strategic approach to tackling DA in Salford. The Salford Safeguarding Children Board (SCB) were responsible for ensuring all front line staff working with children are appropriately trained to recognise, identify and report DA. Salford Adult Safeguarding Board (ASB) has a clear responsibility to ensure DA is recognised early within vulnerable adults and adequate safeguarding is put in place. The Children and Young People Trust (CYPT) prioritises early interventions to ensure low level DA issues are picked up. While the HWB prioritises providing effective joined up systems and services to support the wellbeing of vulnerable people which covers identifying victims of crime.

1.4 One of the highlighted advantages of collaboratively partnership working is access to additional information and data which can lead to more effective decisions and processes. With regard to DA intelligence, the CSP takes the leads role between the partnerships in collating data. The partnership is responsible for collating and reporting on DA related police data. The SCB have information on the number and percentage of those children either on a protection plan or ‘in need’ where DA is a contributing factor.

1.5 Training of staff was highlighted as a key aspect in effectively addressing DA within Salford. An ideal approach would be to provide systematic and consistent training for all
front line staff based on need. The report highlighted that while awareness raising was good the current approach to training could be improved as in places it is disjointed and variable. The findings suggest staff in all partnerships and associated organisation would benefit from a more robust systematic approach, with quality assured tailored training to meet individual staff needs.

1.6 Strong involvement is another key feature of effective partnerships. The report highlighted that Business managers from the different partnerships now meet on a regular basis and the group is currently working to confirm the purpose and function of the meetings.

1.7 A key finding concerned difficulties in identifying the most appropriate approach to ensuring joined up collaborative work on issues that overlap several partnerships (domestic abuse is one example, mental wellbeing may be another) including data and information sharing, reporting and leadership.

2.0 Specific recommendations for integrating partnership working around DA

2.1 Carry out a formal mapping process of all the DA training along with the content of the DA training sessions
2.2 Develop a suite of DA training options at different levels, so staff can select the level of training which is appropriate for their role
2.3 Undertake a training needs assessment to identify all those requiring training and the related resource requirement
2.4 Develop a systematic process to ensure all those who may come into contact with DA are routinely offered appropriate DA training on a regular basis
2.5 Review all DA related data collected by each partnership and identify what would be useful to share
2.6 Consider whether a communications campaign for practitioners would help address any gaps in awareness that may be weakening Salford’s response to DA – for example, raise awareness of services, partnership governance and training offer

General recommendations for partnerships

2.7 Business managers to have an initial planning meeting to identify key topic areas for 2014/2015 where multiple partners would have an input. Then setup meetings between the relevant partners to agree action plan contributions / workload distribution.
2.8 Ensure each partnership theme has a lead-coordinating partner who takes overall responsibility. This will include setting the overall direction, ensuring systematic and robust training is in place and establishing data collection and sharing protocols.
2.9 Establish an agreement with appropriate partners where all partners ensure they routinely update the lead partner of any work in this area.
2.10 Continue the quarterly meetings between business managers with a focus on comparing agendas to identify duplication or gaps which can be highlighted to relevant boards. Develop of a terms of reference for this group.
2.11 Prepare one page summary bulletins to be shared with other partnerships providing information on key areas of work at each of the business manager’s quarterly meetings.
These are to then be shared/distributed with wider teams/staff within the partnership for comments or discussion points at the next meeting.

2.12 Prepare twice yearly highlight reports for Salford City Partnership’s City Partner Group to raise issues and risks that require a whole city approach.