HEALTHY PEOPLE
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Northern Devon

NHS
Northern, Eastern and Western Devon Clinical Commissioning Group

Health Independent Domestic Violence Advisors (IDVA)

Next Steps

1.0 Purpose of the Paper

The purpose of the paper is to update the Board on the recent developments since the Board decision to discontinue funding of the service on 13th March 2013; and for the Board to consider whether there is any further evidence to support this project.

2.0 Background

North Devon Against Domestic Abuse (NDADA) offers local case management, support and referral pathways to a number of outreach services. An IDVA has been appointed and is based at Northern Devon District Hospital (NDDH) predominantly in A&E and Maternity departments.

A fundamental element to this role is to provide education and training to NDDH staff to improve confidence and competence when broaching the subject of domestic violence with patients. This enhances relationships and trust in the pathway from referral process to outcome.

The paper presented to the Board on 13th March is enclosed for information and further background and context (see Appendix One below).

The previous paper to the Board was presented on the 13th March. The purpose of this paper was to request an extension for 2 years to support the current project as well as for inclusion into the Themis project. The Themis project is a new health research project and is being launched by CAADA (Coordinated Action Against Domestic Abuse) this autumn.

Themis follows on from the 2009 IDVA evaluation study Safety in Numbers (commissioned by the Hestia Fund and funded by the Sigrid Rausing Trust and The Henry Smith Charity), which recommended that stronger links should be made between domestic abuse services

and health services. The research will explore whether support for domestic abuse victims can be provided at an earlier point in the abusive relationship by co-locating IDVA services in hospital settings. It will also examine whether co-located services can address the gaps in provision for victims who are hidden from criminal justice agencies. The findings of Themis will feed into health commissioning guidance by demonstrating which models are most effective, with the aim of increasing the number of hospital-based services across the UK. An independent expert panel chaired by Professor Gene Feder of Bristol University will guide Themis. The panel is made up of research experts in domestic abuse services, healthcare services, health statisticians and economists, and mental health specialists. The first interim Themis report will be published in November 2013 and the final report will be ready in 2015.

From the report presented to Board on 13th March it was not made clear whether research ethics approval had been acquired by CAADA for the Themis project or whether the project had started. It can be confirmed that CAADA applied nationally through the Central Research Ethics Committee and received a favourable response in March and are now going through research and development permissions process at NDDH. Once NDDH have provided permission then the project will be ready to collect the data which will allow full evaluation of the health IDVA project including cost effectiveness.

The current pilot provided some evidence towards the project meetings its original intentions with reductions in A&E and emergency admissions however this was based on a limited sample over a short time period. However, the results are encouraging.

One of the points of discussion at the Board meeting on 13th March related to sharing of the funding of the project to emphasise the multi stakeholder input required in this project. NDADA can now confirm that a large national charitable trust have expressed a desire to jointly fund the project with the CCG until the completion of the CAADA Themis research project. This will require funding from the CCG for 2 year financial years at £20,000 each year until end March 2015.

The latest Domestic Homicide Review for Devon recommends the placing of an IDVA in acute and community health settings. Therefore there is potential learning from this pilot and other areas of the country have asked NDADA to share learning from this project which, of the six projects involved in the research, is the most successful regarding partnership working, training, referrals and outcomes.

3.0 Recommendation

The Board is asked to note this report and the previous paper presented on the 13th March.

The Board is asked to consider all the evidence and to discuss whether this project should be funded.

Appendix One

Enclosure x

North Devon Locality Commissioning Board Report

Date	March 6th 2013	
Report title	Health IDVA	**Written**
Author(s)	Nykayla Stockham Commissioning Manager – Urgent Care. North Devon Locality	
Supporting Executive(s)	Dr Tim Chesworth. North Devon Locality Board GP	

Executive Summary	Priority one of the Joint Health and Wellbeing Strategy for Devon 2013–2016 is 'A focus on families'. The strategy states: It is essential to address domestic and sexual violence and abuse from a life course perspective. This approach explicitly acknowledges the impact of early abuse on later risk, the implications of abuse on the whole family and the value of primary prevention of abuse. Early intervention and prevention of domestic abuse has significant impact on the health and social care economy. An Independent Domestic Violence Advisor has been appointed and is based at North Devon District Hospital (NDDH) predominantly in the A&E and Maternity departments. Evidence shows this project is identifying victims much earlier in the abuse cycle resulting in high conversion rates and total cessation of abuse post intervention. NDDH could be one of 5 acute hospitals in England to contribute to the Themis research project which has kudos for the Northern Locality. Please see appendix 2.
Actions Requested	For the Board to note the on-going successes of this project, the alignment to QIPP, partnership working, National strategy and the Health and Wellbeing board objectives. For the board to note the NHS research and ethics information required from the Executive meeting held on 27th February 2013. For the Board to agree extension of 24 months with a 'without cause' notice period of not more than three months.
Which other committees has this item been to?	Covering paper and Report: North Devon Executive Board
Reference to other documents	CAADA and Themis reports
Has an equality impact assessment been completed for this report?	Yes
Have the legal implications been considered?	N/A

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Health IDVA
Evaluation and Next Steps

1. Purpose of paper

1.1 The purpose of this paper is to update the Board on the progress of this scheme, to share the interim Co-ordinated Action Against Domestic Abuse (CAADA) report, and to advise as to planned actions to assess the quantitative benefits to health care system to complement the process already underway to assess qualitative impact on patients.

1.2 To seek approval to fund service extension until 31 March 2015.

2. Context and Background

2.1 Domestic and sexual violence and abuse has the highest repeat victimisation of any crime and can have a major impact on the physical and emotional health of adults and children.

2.2 It is estimated that there are 22,000 victims of domestic violence in Devon each year, with 6,000 victims of sexual assault (often perpetrated by a partner). Last year police in Devon attended an average of one domestic violence incident every hour (8,798 incidents in 2010-11).

2.3 The British Crime Survey suggests over 7000 victims of Domestic Abuse per year in North Devon yet only just over 300 recorded within healthcare systems, problem being due to no referral route which acts as barrier. 2 Domestic Violence homicides occurred in Devon, both in North Devon, during 2010/11. These 2 patients had only presented to Primary care – these statistics give the perception of a large scale issue with health being a positive initiator to improve the health and wellbeing of North Devon patients.

2.4 Priority one of the Joint Health and Wellbeing Strategy for Devon 2013–2016 is ‘A focus on families’. The strategy states: It is essential to address domestic and sexual violence and abuse from a life course perspective. This approach

explicitly acknowledges the impact of early abuse on later risk, the implications of abuse on the whole family and the value of primary prevention of abuse.

2.5 An analysis of the multi-agency safeguarding hub found that the neediest families had three out of four risk factors including; substance and alcohol misuse, mental health, domestic violence and sexual abuse in the family. There are a range of services needed, including acute services through to universal services for all children. There are also serious safeguarding implications when patients have children, which are missed completely when there is no recognition of DVA.

2.6 In late 2011 the Health Independent Domestic Violence Advisor (IDVA) project was funded to the tune of £40,000 annually to begin in January 2012. The project employs one full time (37hrs) trained IDVA. 1 in 4 women and 1 in 6 men are a victim of domestic abuse in their lifetime. It is known that the Health Services spend more time dealing with the impact of domestic violence and abuse than almost any other agency and are often the first, sometimes only, point of contact for people who have experienced violence.

2.7 This test of change scheme forms part of the work that aims to improve voluntary sector involvement in improving health care in North Devon. Following the positive evaluation of WORTH services in West Sussex where a team of Independent Domestic Violence Advisors have found that an Acute Hospital was an ideal setting in which to increase patient disclosure and offer a service to those most at risk of escalating abuse.

2.8 Alcohol, substance misuse and mental health forms the majority of the risk factors included in domestic abuse. North Devon hospital is currently equipped with an embedded alcohol service within the acute which is integrated with the mental health services. This puts North Devon in a stable position to tackle a range of interconnected health and social care inequality issues.

2.9 The main intended outcomes are:

- To reduce repeat victimisation.
- Reduce presentations for unplanned care and dependence on healthcare system for treating effects of Domestic Abuse

2.10 This project is aligned to all three of the Clinical Commissioning Group's strategic commissioning intentions: Joint working and sustainability, best use of resources and the prevention, health and wellbeing agenda.

3. Current Model of provision

3.1 North Devon Against Domestic Abuse (NDADA) offer local case management, support and referral pathways to a number of outreach services. An Independent Domestic Violence Advisor has been appointed and is based at Northern Devon District Hospital (NDDH) predominantly in the A&E and Maternity departments. They are contactable office hours Monday to Friday for advice and referrals. A robust evaluation system is in place which allows analysis of referral numbers and the impact on patient safety.

3.2 A fundamental element to this role is to provide education and training to NDDH staff to improve confidence and competence when broaching the subject of Domestic Violence with patients. This enhances relationships and trust in the pathway from referral process to outcome. January 2012 to December 2012, over 20 briefing sessions, including 'asking the question' have engaged over 100 staff throughout the Hospital and other providers throughout North Devon's health care community including South West Ambulance Service Foundation Trust (SWASFT).

3.3 Interventions have been taken to improve patient safety and prevent repeat victimisation within the hospital, this proactive approach has compounded the need for the service and the realisable yet measurable impact this service has and can continue to provide with increased education, confidence and referrals. Appendix 1, CADDA report summarises the benefits and emerging trends of the NDDH based IDVA.

3.4 North Devon currently has the opportunity to be included in the Themis project. Themis are about to start working with a small number of Health IDVA's and their services to implement the Insights outcomes measurement service. This project will collect additional health outcome data to provide practical and robust data analysis to access the impact of the practitioner location on victim's access to services and safety outcomes. The evaluation of the Themis project will provide cost benefit analysis to stakeholders and inform the future of service design. Participation in Themis costs approximately £2000 per year, however this nationally recognised research project would be fully absorbed within the financial envelope with NDADA and therefore at no extra expense to NHS Devon.

4. NHS Research and Ethics

4.1 The data that was used in the interim CAADA report is separate to the Themis research project- Themis involves actual research with patients, which is why CAADA are going through the ethics and governance processes. The data for this interim report comes from the Insights outcomes measurement tool, which is a data monitoring tool not a research tool. NHS Bristol (the lead R&D office) have made it clear that they do not require permission or ethics for Insights because it is not actually research and is a monitoring tool. The information contained on the Insights paper based system was collected by the IDVA either at NDADA's offices or the client's home as with all NDADA clients.

4.2 CAADA attended the NHS Research Ethics Committee in Exeter on the 7th Feb 2013. They are content to give a favourable opinion subject to a few amendments (please see attached letter from the committee outlining this and the amendments). CAADA are currently making those amendments and once these have been approved and have a firm favourable opinion CAADA will then be able to progress the applications to each of the R&D offices in each site. For some sites this is already quite advanced and SSI's have been submitted so that the application can be progressed as soon as the favourable opinion is obtained; however for North Devon District Hospital CAADA is waiting to hear about the future of the service before completing the application. As soon as CAADA know the service will continue they will complete and submit the SSI and REC form to the R&D office.

5. Outcomes Achieved

5.1 Clients accessing NDADA are experiencing on average 3 years of abuse. This figure is consistent, and higher, across other outreach services. In the year prior to NDADA intake, 63 people presented 89 times into North Devon A&E department. More than three quarters had visited their GP. It is important to note that this service is engaging with a different cohort of patients compared to NDADA's regular client group.

5.2 At the point of exit (usually 3-5 months after intake) over 67% reported total cessation of all abuse.

5.3 This test of change not only focuses on early detection and prevention; however this is where we are seeing early stage positive impacts. The intervention point is a matter of months compared to 3 years. So far 110 referrals have resulted in a 78% conversion rate, being significantly higher than that which is achieved through traditional IDVA intervention techniques;

59 of which have children or are pregnant and 25 high risk and referred to Multi Agency Risk Assessment Conference. 5 staff members have engaged, 1 becoming a champion for the service in the A&E department. 7 referrals have been taken from the psychiatric liaison team.

5.4 Experience suggests additional unforeseen benefits will occur. This new caseload of patients demonstrates the effectiveness of having the proactive intervention, in the safe environment health care setting. The high conversion rate demonstrates the earlier intervention point of the abuse. Victims are more likely to engage earlier in the abuse cycle. It has been established that demand is likely to exceed capacity based on the current caseload and number of referrals. This will be addressed by the IDVA referring to mainstream NDADA where that is appropriate.

5.5 North Devon practices have been offered a 40 minute 'asking the question' training session delivered by NDADA. Last year only 6 referrals were made by GP's to NDADA, however over 110 have been referred through the acute since the start of this project. This shows an overwhelming amount of unmet need in North Devon, bearing in mind embedding services into the acute takes time. 8 practices have engaged so far meaning patients at these practices are more likely to have abuse identified and get the intervention they need.

5.6 The toilets in both maternity and A&E departments have been separated to male and female so that Dot on the Pot can be initiated safely. Women have been identified and then worked with through this identification method. This is a sticker placed on a urine sample which is passed to a nurse.

5.7 Plain Lypsyl style lip balms have been produced with NDADA contact number on the barcode. This is to be used in a situation when asking the question cannot be backed up with an information leaflet. They are in A&E for all NHS staff to hand out especially SWASFT as in some situations they are the only contact with the victim. 4 referrals have been taken via this method of contact.

6. Financial Modelling and Evaluation

6.1 To identify the resource benefits and impacts on the health system of a domestic abuse victim a sample of 89 patients that have engaged with the Hospital IDVA - during the time period January 2012 to December 2012 - have been used to identify the number of attendances and admissions to NDDH they had in the year previous to intervention, during intervention, and then the number of contacts in the year post discharge from the service where

available. NHS numbers were shared with Shane Coe Senior Information Analyst and run through secondary care data. This will test the robustness of methodology. Note that in all cases explicit consent to use anonymised information in this way is sought from patients and the service provider in line with NHS Governance requirements.

6.2 This shows that there were 58 A&E attendances pre intervention and 33 post intervention, giving a reduction of 43% and a reduction in costs from £5k to £2k. There were 28 Admissions pre intervention and 18 post intervention giving a reduction of 36%, a reduction in costs from £44k to £19k (-£25k) The average intervention period is 4 months which currently limits post intervention evaluation.

3.6 Of the patients that where on the scheme earlier and so have a longer post IDVA period to assess, the level of A& E and Inpatient admissions seems to be holding and not reverting to pre-IDVA intervention levels. This evidence suggests the IDVA intervention is successful in the longer term and breaking the cycle of abuse.

6.4 “This is encouraging and suggests that when we have data for Jan-March 2013 we would expect to see a greater impact in terms of reduction in both A&E and Inpatient admissions.” Shane Coe, Senior Information Analyst.

6.5 67% of hospital IDVA clients report a cessation of all abuse types; this reduces unplanned care presentations including GP appointments and the need for prescriptions. Cessation of abuse not only increases the standard of living for the victim and their family but also reduces the need for multi-agency intervention such as housing, police, SWAST, Devon Doctors On Call etc.

7. Risks

7.1 Great amounts of time, effort and input into building valuable relationships have been invested into this project by commissioners, NDDH and NDADA.

Decommissioning this service will have a negative opportunity cost for patients of North Devon and trust in commissioning intentions of the PCT.

7.2 NDADA have spent considerable effort into implementing efficient and effective pathways and training in 'asking the question' which empowers staff and clients alike to benefit from the health IDVA. Training and education will be forgotten relatively quickly without the continued presence and reassurance of the health IDVA in the medium term.

7.3 Domestic Abuse prevention and intervention is a fundamental part of the National Strategy on Domestic, Sexual and Gender-based Violence 2010-2014. The short term outcomes of this IDVA project are mainly qualitative however the long term gains will be evidenced in reduced unplanned care contacts.

7.4 NDDH are well engaged and would like to progress awareness training more formally through safeguarding, however there are concerns regarding the longevity of this project.

7.5 This project has substantial added value and sustainability. NDADA are offering the 22 North Devon Practices training in 'asking the question' and raising awareness delivered in practices in their practice meetings. At the point where the Hospital IDVA reaches full load capacity extra demand will be absorbed within NDADA at no extra cost to the locality. Stop Abuse For Everyone (SAFE) is working with commissioners in the Eastern Locality to set up a similar pilot. The western locality has commissioning plans for the Plymouth domestic abuse partnership 2012-2019.

7.6 Pending the Mid Staffordshire enquiry, media will be focussing on patient quality and safety in acute hospitals. Decommissioning this quality focussed project at a time when quality and safety will be rising to the top of the agenda could be potentially damaging to the reputation of the Northern Locality if this project is not given enough time to provide evidence.

7.7 No action or funding has been secured to work with Resolved to End the Perpetration of Abuse In Relationship (REPAIR) to address the perpetrators that cause domestic abuse. REPAIR works with men over a year long course

to change behaviour patterns. Victims of domestic abuse are still at risk while the underlying problem remains unaddressed.

7.8 NDADA training in the community has been welcomed by practitioners who have been waiting to be helped with the difficulty of "asking the question", recognising the signs and referring to specialist agencies. Practitioners need support in order to deliver excellent patient care and they appreciate that in the commissioning of this project their employers are recognising their needs and offering that support. Decommissioning now could compound a cynical impression of the pending CCG with regard to commitment to support them in their roles.

8. Action for the Board

For the Board to note the on-going successes of this project, the alignment to QIPP, partnership working, National strategy and the Health and Wellbeing board objectives.

For the board to note the NHS research and ethics information required from the Executive meeting held on 27th February 2013.

For the Board to agree an extension of 24 months, with a 'without cause' notice period of not more than three months.

Appendix 1

North Devon Against Domestic Abuse-

Hospital IDVA

CAADA Insights emerging trends summary February to September 2012

Emerging trends within the Hospital IDVA data

This brief report highlights some of the early emerging data trends from the data collected relating to the NDADA hospital IDVA role in the last 6 months. Whilst based on a small number of clients, some clear patterns and trends are evident within the data that point to some key differences between the clients of the hospital IDVA and clients of the wider service. These trends are also consistent with evidence we have from other hospital-based services. The key features emerging from the dataset from the hospital IDVA role are indicated below.

- **Higher referral rates from health practitioners**
  The primary referral route for the hospital IDVA service is health, with 69% of referrals being received from health practitioners. Within the wider service, only 10% of referrals come from health practitioners.

- **Young clients**
  Across hospital-based services who collect Insights data, we can see the age profile of the client is significantly younger than clients of non-hospital based IDVA services. This early data indicates this is also the case with the NDADA

hospital IDVA, with 19% of the hospital IDVAs clients aged under 20 years old, compared with only 9% in the wider service.

- **Women with young children**
  In keeping with the younger profile of the client, the children of the clients of the hospital IDVA are generally younger than children of clients accessing the wider service. 41% of children of hospital IDVA clients are aged under 2 years old as opposed to 23% of children of IDVA clients from the wider service.

- **Vulnerable families**
  In keeping with trends we see across other hospital-based services, a high proportion of clients of the hospital-based IDVA have CYPS involvement with the family. 25% of hospital IDVA clients have CYPS involvement with the family compared to 17% of IDVA clients of the wider service. Therefore, early indications suggest that hospital IDVAs are working more frequently with young, vulnerable families.

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- **Clients with complex needs**
  In keeping with trends we see across other hospital-based service, the NDADA hospital IDVA service has a higher proportion of clients with complex needs in terms of substance misuse issues and mental health problems. For example, 19% of hospital IDVA clients have drug misuse issues compared with just 4% of clients accessing the wider service. Similarly, 38% of hospital IDVA clients have mental health problems compared with 29% of clients from the wider service. Additionally, 31% of hospital IDVA clients have threatened or attempted suicide compared to 17% of clients of the wider service.

Clients of the hospital-based service also report increased use of health services: 28% of hospital IDVA clients report attending A&E in the last 6 months compared with 11% of clients of the rest of the service. Similarly, 88% of hospital IDVA clients report presenting at the GP compared with 55% of clients of the wider service. Furthermore, the average number of visits to the GP by hospital IDVA clients per year is 4.3 compared with 3.5 from clients of the wider service and the general population average of 3.6. As such, the clients of the hospital IDVA have increased health needs and higher proportions of complex needs than clients accessing non-hospital based services, indicating that the hospital IDVA is effective in reaching this vulnerable group and addressing their health needs.

- **Early intervention**
  Our research and evaluation project, of which NDADA is a part, will explore whether hospital-based IDVAs intervene earlier in the abusive relationship than IDVAs whose primary referral route is not health. Early data from the research indicates that this is the case: the data from the NDADA hospital IDVA shows that 47% of clients are still in the abusive relationship when they access the service, as opposed to only 31% of clients of the wider service. Similarly, clients of the hospital IDVA have been experiencing abuse for 2 years less on average than clients of the wider service (2 years as opposed to 4 years).

- **Cessation of abuse**
  67% of hospital IDVA clients report a cessation of all abuse types, compared to 51% of clients of the rest of the service and 63% of clients from across all our Insights

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services. Clients of hospital IDVAs also report feeling 'much safer' on exit from the service: 58% of hospital IDVA clients report this compared to 43% of clients

from the wider service. Similarly, 67% of clients of the hospital IDVA report feeling 'not at all frightened' on exit from the service compared with 33% of clients from the wider service.

- **Intense support**
  Data indicates that clients of the hospital IDVA receive more intensive support than clients of IDVAs based in other locations: 33% of hospital clients received more than 10 contacts compared with 22% of clients from the wider service. Similarly, 33% of hospital IDVA clients receive 6 or more interventions compared to 15% of clients from the wider service. More of the hospital clients are also referred to MARAC, with 42% of hospital IDVA clients referred to MARAC compared to 32% of clients of the wider service.

Summary

Early data suggests that the hospital IDVA is effective in reaching a different profile of client to the wider service; namely, these clients are younger with higher levels reporting complex needs and increased health service use. Early indications are that the hospital IDVA intervenes earlier in the abusive relationship, since more hospital IDVA clients are still in the abusive relationship and the length of abusive relationship is shorter than clients of the wider service. The work hospital IDVAs do is characterized by intensive support and an increased number of interventions, with clients of the hospital IDVA receiving more contacts and a higher number of interventions on average than the clients of the wider service. Importantly, the outcomes for the hospital IDVA show that 67% of clients experience a cessation of abuse (slightly higher than the wider service and national Insights average), and a higher proportion of hospital IDVA clients report feeling 'much safer' and 'not at all frightened' upon exit than clients of the wider service.

Appendix 2

Themis Project

Introduction

In 2009 the evaluation 'Safety in Numbers' was published by the Hestia Fund and the Henry Smith Charity. The study represented a major step forward in the availability of evidence about 'what works' in terms of support for high-risk victims of domestic abuse. It proved the positive impact of independent specialist support for victims, the value of a comprehensive safety plan including multiple agencies, and the need for intensive support. It reinforced the confidence of practitioners and funders in the value of the CAADA model that incorporates dedicated, independent advocacy with practical support aimed at protecting the lives and wellbeing of the most high-risk victims. However, it also highlighted some gaps in terms of accessibility of services and the skills of practitioners, particularly for victims who are marginalised. This includes both younger and older victims, victims from minority communities and those with substance misuse and mental health problems.

CAADA now plans to repeat the Hestia model in a new project called 'Themis' to address the gaps in accessibility to services by evaluating the impact of domestic abuse service provision where the point of access for victims is in a health based setting rather than through the criminal justice route. In conjunction with the evaluation, CAADA will offer enhanced CPD training for specialist practitioners to meet the needs of victims with additional vulnerabilities, regardless of their point of access.

For the purposes of this document;

- A 'Health IDVA' means a dedicated IDVA or domestic abuse practitioner who is located in a hospital setting and who either is part of an IDVA service or has clear established referral pathways to an IDVA service.

- An "IDVA service" can include broader domestic abuse services where IDVA services are offered.

We will work with the small number of existing health IDVAs and their services to become Themis sites, to highlight them as examples of integrated and professional practice providing accessible support to victims suffering domestic abuse.

We will implement the Insights outcomes measurement service, collecting additional health outcome data, at the Themis sites and matching control sites to provide practical and robust data collection in order to analyse the impact of practitioner location on victims' access to services and safety outcomes.

We will undertake a robust evaluation of the interventions initiated at the Themis sites and matching control sites with the aim of identifying the impact of Health-based IDVAs in both financial and human terms.

We will use the learning from this project to inform health funding and commissioning bodies about the most effective links between the health service and IDVA provision, with a view that this should be integrated into a standard health response.

For the health IDVAs and their associated IDVA services which agree to become 'Themis' sites the benefits include:

Evaluation of your service:

Costing anywhere from £30,000 to £150,000, it is not cost effective for individual services to undertake a robust evaluation of their services, but many funders and policy makers expect to see evidence of outcomes and an accompanying cost benefit analysis of service provision before they commit to longer term funding. CAADA has the data collection tools, capacity, access to funding, and the expertise to carry out an evaluation and cost benefit analysis. The evaluation will be designed and overseen by an expert panel of academics and policy makers to ensure credibility and maximum impact. Participating in Themis will not only provide your service with much needed evidence of impact but enhanced credibility with funders and decision makers and confidence in your impact on the safety of victims accessing your service.

Benefits to your practice:

Our experience with the Hestia project showed that participation gave rise to unanticipated benefits such as positive changes to case management processes and post intervention follow up which remained in practice after the evaluation. Participation in the evaluation involves not only data collection, but regular meetings with all Themis participants to present interim findings and garner feedback. These meetings provide opportunities to network with other professionals in similar settings and many of the Hestia service managers reported back to us the morale boosting effect the interim evidence had on their front line practitioners.

National Recognition of your Service

We will appoint a distinguished expert panel and expect this to bring considerable attention to the projects involved in the evaluation. Participation in the project provides those involved

with the opportunity to create a strong evidence based message to policy makers about what works for victims of domestic abuse accessing health services.

CAADA training;

CAADA provides both initial IDVA training equivalent to NVQ3 for IDVAs plus CPD training for IDVAs.

Two CPD units are available currently;

- Substance use and domestic abuse
- Safeguarding children living with domestic abuse.

A further eight units are in development and will become available over the course of the Themis project;

- Working with victims with mental health problems
- Supporting victims of sexual abuse- the health response
- Advanced skills for practitioners
- Specialist support for victims from black and minority ethnic communities, including 'honour'-based violence and forced marriage.
- Advanced safety planning for high risk victims
- Working with women offenders (only for those who have completed both the substance misuse and mental health modules)
- Understanding perpetrators
- Supporting victims of sexual abuse through the criminal justice system

CPD units cost £750 each for practitioners from statutory services and £450 for those from registered charities. Themis sites would be offered places on up to 5 of these CPD units as they become available at a 10% discount to the normal price.

Initial IDVA training costs £2,800 per IDVA to practitioners to statutory services and £1,100 to those from registered charities. Themis sites would be offered one place on this course at a 10% discount to the normal price.

Commitment required from Themis services:

Insights

Themis sites would be required to take the CAADA Insights service in order to deliver the required data on time and in the prescribed format. The cost of Insights is £7,500 per year with subsidies of up to 75% available to voluntary sector services. The service includes:

- Tools for data collection which support case management
- Analysis of outcomes in the context of your local circumstances
- Analysis of outcomes in comparison to a national benchmark
- Reports that can be used to evidence impact to funders and commissioners
- Automated SDVC reports produced quarterly

In addition to the evaluation an analysis of outcomes will be produced every 6 months for the individual participants. The benefits of the Insights service are manifest; it is a valuable tool for understanding the profile and needs of service users, enabling the service to be funded and shaped according to specific need. Current service users tell us that the Insights reports are received very favourably by funders and commissioners.

In addition to the regular Insights service, we intend to design and develop health specific data collection tools and outcomes which will be aggregated and analysed in the evaluation. We will compare accessibility and safety outcomes for Themis sites against control sites without health IDVAs.

All case workers involved in data collection and the Service manager will need to attend a training session (about half a day) to understand Insights, why it is important, how it will fit in with their existing working and how they will collect the data. There is an ongoing administrative requirement for someone to collate and send off the data forms, but this is considered minimal.

CPD

There is an expectation that whoever is deemed the most appropriate within the Themis sites will undertake CPD units on Safeguarding and Substance misuse unless they have existing relevant qualifications in these areas.

Other

Over the 2 year evaluation period there will be 3 meetings in London to present interim findings plus a conference to Launch to the final report which we would like a representative from the service to attend.

Financial commitment to be made by Themis site participants;

Statutory sector services	Year 1	Year 2	Year 3
Insights service	£7,500	£7,500	£7,500
Two CPD units at 10% discount	£1,350		
Total	£8,850	£7,500	£7,500
Saving	£150		

Voluntary sector services (income between £500,000 and £1m, 25% subsidy)	Year 1	Year 2	Year 3
Insights service	£5,600	£5,600	£5,600
Two CPD units at 10% discount	£810		
Total	£6,410	£5,600	£5,600
Saving	£1,990	£1,900	£150

Voluntary sector services (income between £250,000 and £500,000, 50% subsidy)	Year 1	Year 2	Year 3
Insights service	£3,800	£3,800	£3,800
Two CPD units at 10% discount	£810		
Total	£4,610	£3,800	£3,800
Saving	£3,790	£3,700	£3,700

Voluntary sector services

(income less than £250,000 75% subsidy) Year 1 Year 2 Year 3

Insights service £1,900 £1,900 £1,900

Two CPD units at 10% discount £810

Total £2,710 £3,800 £3,800

Saving £5,690 £5,600 £5,600

Project plan:

- Jan 2012 – Appoint expert advisory panel to plan and oversee the evaluation
- Jan- Feb 2012 –Meet with potential Themis sites to explain evaluation process
- Mar-Apr 2012 – Design evaluation / Health data points
- June 2012 - Implement Insights service at Themis and control sites
- July 2012 – First intake of data
- July 2013 – Interim findings analysed
- Sept 2013 – Interim findings published
- July 2014 – Data collection ends
- Dec 2014 – Final findings published
- Dec 2014 / Feb 2015– Conference to launch the report