Domestic and Sexual Abuse Strategy 2023-2030: Response from the Royal College of General Practitioners Northern Ireland

Background

The Royal College of General Practitioners (RCGP) is the professional membership body for GPs in the UK. Our purpose is to encourage, foster and maintain the highest possible standards in general medical practice.

We support GPs through all stages of their career, from medical students considering general practice, through training, qualified years and into retirement. In addition, we set the standards for competency through our examination process.

RCGPNI represents more than 1,500 GPs, more than 75% of GPs in Northern Ireland.

Consultation response

The Royal College of General Practitioners Northern Ireland (RCGPNI) welcome the opportunity to respond to this consultation on the Draft Domestic and Sexual Abuse Strategy 2023-2030. Domestic and sexual abuse are major public health problems, and GPs are cognisant not just of the acute impacts of abuse but often the long-term physical and mental health consequences for those who experience abuse, and for children and other family members who may witness it. The College supports the vision and aims of the strategy to work in partnership across organisations and communities to tackle the root causes of domestic and sexual abuse, ensure those affected get appropriate support at the earliest opportunity, and hold individuals who are abusive to account.

RCGPNI agree that the definitions of domestic abuse and sexual abuse employed in the strategy are useful, and particularly welcome the recognition that abuse can take many forms and be inflicted upon anyone, irrespective of age, ethnicity, religion, gender, gender identity, sexual orientation, or any form of disability. We welcome the strategy's recognition that specific groups of people (such as different genders, members of the LGBT community, children and young people, ethnic minority communities, older people, people with a disability, and those living in rural communities) may face different or additional barriers to reporting and seeking support, and that nuanced approach to supporting victims, taking their different needs into account, is required.

The College supports the outcomes and key priority areas identified under the four strategic pillars: Partnership, Prevention, Support, and Justice. As often first points of contact and support for vulnerable people within communities, GPs and their practice teams have an important role to play across all four pillars, but in particular within the Partnership, Prevention and Support areas of the strategy. As frontline healthcare staff with a crucial position of trust in their local communities, GPs and other members of their practice team may be trusted with disclosure by abuse victims, and as many victims do not feel comfortable approaching the PSNI, primary care staff offer a crucial non-criminal or justice-based route to support services. GPs have the opportunity to build up an intimate knowledge of patients and family units over time, and the relationship-based care approach GPs can deliver means they may be well-placed to identify signs of abuse, and to support victims and their families following disclosure. It is vital that all practice teams are given adequate support to help them identify the signs of abuse and access

to clear referral pathways and systems to allow those affected by abuse to receive effective support and at the earliest opportunity. The changing nature of GP consultations and the increasing use of telephone-first, both in terms of patient preference and to meet the escalating demand in general practice, risks a change to opportunities for disclosure. With good relationship-based care, remote consulting does not preclude patient-led reporting, but could in some circumstances reduce the frequency of GP-led questioning based on a lack of physical cues that the patient is the victim of abuse. It is important that pressures of demand on GP workload are alleviated to facilitate conversion of remote consultations to face-to-face in appropriate circumstances, such as where this may provide better insight into these non-verbal cues. Practices should also be supported to improve their digital advice and signposting offering to patients, for example through standardised information sharing across practice websites.

The College welcomes that GP practices across some Federation areas have been able to benefit from training offered through the Identification and Referral to Improve Safety ('IRIS') programme to help GPs and other primary care staff identify and refer victims of domestic and sexual abuse to specialist support. We are encouraged by evaluations of the programme in Great Britain, showing it has been proven to be effective in increasing the numbers of referrals received from GPs by domestic violence and abuse service providers[1], and by anecdotal reports that it has been well evaluated by practices trained in Northern Ireland. However, we are concerned that the lack of recurrent funding for this vital initiative means that progress has been stalled, with many practices still unable to access this important source of training and support for their staff. It is vital that all practices are both given the opportunity to implement the IRIS programme, and also are effectively resourced to take this up, due to the considerable time commitment and backfill required to support the necessary multiple sessions of training time.

In line with the first pillar of the strategy (Partnership), RCGPNI affirms that it is everyone's responsibility to work together to ensure that abuse is appropriately reported and that victims receive the support they require. Effectively integrated primary care Multidisciplinary Teams (MDTs) which include first-contact allied health professionals such as social workers and mental health workers who work closely with GPs, nursing staff, and other members of the practice team, may play an integral role in identifying patients who may be experiencing abuse, and in building the vital partnerships with other practices, secondary care, and local community and voluntary organisations required to support them. The incomplete rollout of MDTs across Northern Ireland must be addressed as currently only one GP Federation has a full complement of MDT, leaving many patients with no access to these important first-contact professionals, resulting in fewer avenues of support being open to them and reinforcing existing inequities.

The third strategic pillar (Support) rightly recognises that the impacts of domestic and sexual abuse can be wide-ranging and lifelong. Victims of domestic and sexual abuse need timely and effective interventions not just at the point of disclosure but will also need to be supported with their health and wellbeing throughout their lives, and this is particularly salient for patients who require greater and more complex support, including children and young people and other groups who may face multiple and additional barriers. Since 2019, RCGP has been calling for 15-minute GP appointments as standard, as opposed to the current 10-minute appointment time limit[2]. The capacity for longer consultations would allow GPs more time to build a trusting relationship with patients, which may facilitate vital earlier disclosure and intervention in active cases of abuse, as well as allowing them to provide the personalised, relationship-based care that abuse survivors may require on a longer-term basis. While GPs are involved in lifelong care for patients who are victims of domestic and sexual abuse, it is vital that appropriate and timely

[1] https://www.arc-nt.nihr.ac.uk/news-and-events/2021/october/iris-study-wins-rcgp-study-of-the-year/
[2] https://www.rcgp.org.uk/getmedia/ff0f6ea4-bce1-4d4e-befc-d8337db06d0e/RCGP-fit-for-the-future-report-may-2019.pdf

referral pathways which meet the needs of victims; including mental health, sexual health, and social services; are available. It is unconscionable to allow victims of domestic and sexual abuse to languish on secondary care waiting lists while their acute and long-term needs are not being met, and GPs cannot be left to manage the impact without the specialist input that these victims require.

Unfortunately, the reality is that primary care in Northern Ireland has been dealing with an escalating demand-capacity mismatch for a number of years, and growing numbers of GP colleagues already face an unsustainable workload, with numbers of daily patient contacts already going far beyond what they should safely be expected to cope with. In addition, due to many years of inadequate workforce planning, general practice faces a chronic and severe workforce shortage, which has resulted in a domino effect of staff burnout, early retirements, and risks total destabilisation of existing services. It is imperative that alongside the implementation of this strategy, the Department of Health put in place a comprehensive workforce plan for primary care in Northern Ireland to safeguard GPs' capacity to provide the enhanced level of support which victims of domestic and sexual abuse need and deserve, both now and in the future. As an immediate priority, we would call upon the Department of Health to implement the roll-out of Multidisciplinary Teams to enable victims of domestic and sexual abuse access to a community-based social worker and mental health worker, both to manage acute needs, and for ongoing support and advocacy needed to assist them in recovering from their experiences in the long-term.

In conclusion, RCGPNI welcome the opportunity to respond to this consultation. The College shares the strategy's commitment to partnership working across organisations to prevent abuse from occurring, to ensure that victims of domestic and sexual abuse receive timely and appropriate support, and to hold individuals who are abusive to account. The introduction of this strategy is a welcome step towards tackling the serious harms caused by domestic and sexual abuse in our communities. It must also be accompanied by sustainable investment to allow the strategy to be implemented in full, to allow full rollout of evidence-based, specialist training to allow GPs and practice teams to support victims of abuse effectively, and a comprehensive suite of interventions to tackle the workload and workforce crisis in primary care, including the full roll-out of MDTs as an immediate priority.

We would be happy to discuss our response further with the Department should this be useful.