

In safe hands?

Domestic abuse survivors' experiences of general practice

July 2025



"When you ring up the GP, you have to talk to the receptionist first and they don't know about domestic abuse and how to deal with it. When I first got help, I spoke to 10 different doctors over 16 appointments and had to tell my story each time. No-one knew where to signpost me. I was told I looked nice, so people didn't believe me. "



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Foreword

“This valuable research will enable us to support our GP practices in meeting the needs of domestic abuse survivors, while acknowledging the challenges of modern general practice. By further understanding the response and support needed by survivors, we are better placed to work together to ensure the best possible health outcomes.

We are very grateful to all who gave their time and experience in support of this research.”

Dr Tara Jones, Surrey wide designated GP for safeguarding children and adults (Surrey Heartlands ICB), Co-chair South-East network of named GPs (SENNGP), Sessional GP

Executive summary

Domestic abuse is defined as

“Any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality.”¹

Numbers of domestic abuse cases are rising.

The Crime Survey for England and Wales estimated that 2.1 million people aged 16 years and over experienced domestic abuse in the year ending March 2023, roughly 5 in 100 adults.

In Surrey, 5,224 calls were made to the Surrey domestic abuse helpline in 2023, up by 24% from 2022.

People experiencing domestic abuse are recognised as a priority population within the Surrey Health and Wellbeing Strategy as they are more likely to experience some of the poorest health outcomes.

Primary care is an important point of contact for people to ask for help when experiencing domestic abuse. Whilst people had disclosed to Healthwatch Surrey that they were being abused, they hadn't talked about their experience of getting support from general practice. We asked 117 GP practices across Surrey to provide us with their domestic abuse data and only 2 were able to provide it, supporting our assertion that a knowledge gap existed. The aim of this research project was to explore whether general practice is meeting the needs of people who are experiencing domestic abuse within Surrey, and what improvements can be made to better meet these needs.

We obtained the views, insights and opinions of both domestic abuse survivors and members of the GP practice teams across Surrey. Via an online survey and a series of focus groups and interviews, we sought to gain a deeper understanding of all stages in the survivor's interactions with general practice.

¹ [Domestic Abuse Act 2021](#)

Knowing that people may live with domestic abuse for a significant period before getting help, we were interested in the barriers to first disclosing domestic abuse, as well as the experience people have once they do disclose, and the follow up support which is offered in terms of signposting and referrals.

Pre-disclosure: barriers to disclosing domestic abuse

We identified **7** barriers to people disclosing that they were experiencing domestic abuse, which we have categorised into those related to institutional factors and processes, and those linked to survivor perceptions and beliefs. We have also captured the thoughts of survivors in terms of how things could be improved.

Institutional factors and processes

1. Lack of professional curiosity – GPs not questioning the reason behind presentations and a tendency to prescribe medication as the only solution.

Survivors asked that members of the GP team improve their knowledge of the different forms of domestic abuse and take opportunities to ask questions that may facilitate disclosure.

2. Appointment booking and confidentiality – lack of confidential space and discretion from reception staff, concerns about the digital trail left by online booking systems, and lack of timely and unhurried face to face appointments with a preferred GP.

Survivors asked for easy access for an unhurried appointment without having to specify the reason why they want to see the doctor.

3. Perceived lack of understanding – an underlying fear of not being believed and a perception of a lack of GP understanding of all forms of abuse.

Survivors asked for members of the practice team to develop more awareness of the trauma of domestic abuse and the skills and knowledge to manage their needs, the ability to see the same GP in order to build a relationship and to not to have to repeat their story multiple times, and a domestic abuse specialist and/or advocate within the practice.

4. Fear of authority – feelings of intimidation around GPs.
5. Perpetrator's presence – not being able to disclose with their perpetrator physically present or inhibited by their perpetrator being registered at their GP practice or with the same GP.

Survivor perception and beliefs

6. Generational and cultural attitudes – beliefs around not discussing domestic matters outside the home.
7. Recognition of domestic abuse – lack of awareness that what was being experienced was domestic abuse.

During disclosure

Survivors told us that before disclosing they were experiencing domestic abuse, they were concerned they would not be believed, particularly if their abuse was non-physical, or they were male or a parent. After disclosing, most said their concerns were realised as there was a lack of understanding or knowledge and, in some cases, stereotyping and prejudice. Some survivors cited issues of 'problematism' or being labelled with a specific medical condition or problem (and then being treated for that problem, not supported to deal with the abuse).

Survivors also said that staff at the GP practice did not have adequate knowledge about domestic abuse in order to provide support, and, on occasion, provided harmful or unsafe advice.

Post disclosure

68% of respondents to our survey said that they were not signposted to specialist help from an independent domestic abuse and violence service once they had shared their domestic abuse experience with their GP.

89% of respondents said that a GP or another member of the practice team had not directly referred them to specialist help. **Survivors asked for referral rather than signposting as they did not feel able to get help themselves.**

Survivors identified a lack of communication between GP practices and specialist domestic abuse services as a key issue. We also noted differences and inconsistencies in systems for managing referrals and follow up.

Survivors asked for improved communication between the GP practice and specialist domestic abuse services, better use of technology to signpost to domestic abuse specialist services anonymously, and more standard follow up to be embedded in best practice.

This report is designed to highlight the themes identified through this research and includes quotes from survivors and GP representatives to provide context. Whilst this report accurately reflects what we hear from the individuals we speak to, we are aware that it may not be representative of everyone's views of a particular service.

Any urgent or concerning experiences within this report have been escalated to the appropriate teams. All appropriate information and signposting have already been given.

Approach/Methodology



Surrey Heartlands

The project was endorsed by the Surrey Domestic Abuse Partnership, and, through them, access was given to DA SEEN (formerly the Surrey Survivor Steering Group) who co-produced the research methodology, specifically the design of an online survey.

Project sponsors from Surrey Heartlands Integrated Care Board (ICB) were **Dr Tara Jones**, Surrey wide designated GP for safeguarding children and adults and **Rebecca Eells**, Surrey wide designated Safeguarding Nurse Adults.

Methods – survivors

64 survivors contributed to this research:



32 on-line survey respondents



27 were part of discussions at focus groups



We interviewed **7** people individually

See [Appendix](#) for full demographic information.

Methods – professionals



Engagement with **8** GP practices involved:

- In depth interviews with representatives from the practices
- 2 practices provided data about patients who have disclosed their domestic abuse
- 1 visit to a practice to learn about the systems for coding, flagging, monitoring and masking data about people experiencing domestic abuse.

See [Appendix](#) for full demographic information.

Findings: barriers to disclosing experience of domestic abuse and accessing appropriate support

Someone who is experiencing domestic abuse must be able to disclose their situation to a member of the GP practice team to access support. This involves either proactively volunteering their experience or the team member's recognising potential presentations of domestic abuse and encouraging the patient to talk.

People may live with domestic abuse for a significant time before getting help. On average, high risk victims live with domestic abuse for 2.3 years and medium risk victims for 3 years before seeking support.²

- **20%** of survivors realised that they were experiencing domestic abuse **1-6 months** before disclosing
- **16%** said they disclosed after **10 years** of experiencing domestic abuse
- **16%** said they **never disclosed**.

We identified **7** barriers to people disclosing that they were experiencing domestic abuse, which we have categorised as follows:

Institutional factors and processes

1. [Lack of professional curiosity](#)
2. [Appointment booking and confidentiality](#)
3. [Perceived lack of understanding](#)
4. [Fear of authority](#)
5. [Perpetrator's presence](#)

Survivor perception and beliefs

6. [Generational and cultural attitudes](#)
7. [Recognition of domestic abuse](#)

² [Safelives.org.uk](https://www.safelives.org.uk)

1. Lack of professional curiosity

GPs not questioning the reason behind presentations and a tendency to prescribe medication as the only solution.

During the time they were experiencing domestic abuse:

- **27%** of survivors said they visited their GP practice once every 3 months
- **20%** said that they visited monthly.

Survivors often presented with common complaints, connected to their abuse such as headaches, stomach pain or repeated urinary tract infections (UTIs).

53% of those attending their GP practice during their abuse believed the reasons they were visiting were related to their experience of domestic abuse. These were potential opportunities for disclosure and receiving help and support.

However, 75% of people who completed our survey had not been asked by their GP, or another member of the GP practice team, if they were experiencing domestic abuse.

“I was going every month with a UTI due to sexual abuse which I think should have been picked up by my GP. Instead, he told me that I should make sure I pee after sex.”

Surrey survivor (female)

“I kept going to my GP with head and stomach pain and this wasn’t picked up. It’s hard to say that you are being abused”.

Surrey survivor (female)

“I used to be able to get several months of medication for my UTIs from my pharmacist at a time and no questions were ever asked; I think that is wrong.”

Surrey survivor (female)

"I suffered with acid reflux for a long time which he treated. I did have an endoscopic procedure and that was the end of the investigation, but he didn't think to ask why I had it. Was it stress caused by my situation? At one point he did ask me how I was, and I told him that my mood was low and that I had trouble at home. His response was to say, "Here you go", and send me away with medication for 6 months. My GP never delved into why I was feeling low and the reason. I am a builder so unless it's hanging off or going mouldy, people would think, what are you doing here? You're just batted away; take this and be done with it."

Surrey survivor (male)

GP practices recognised that patients may make several visits before choosing to disclose but that they didn't always recognise that their presenting symptoms may relate to domestic abuse.

"I think they were coming for a while before they plucked up the courage to speak to me. There were no obvious signs."

Surrey GP

Of those who were asked, 67% said that they chose not to disclose at that time.

High risk patients

3 groups of patients particularly at risk of not being identified are:



'Frequent attenders' who make up around 4 in every 10 GP consultation³



People aged 65 or over⁴



Patients with chronic or long-term health conditions.

³ [Consultation patterns and frequent attenders in UK primary care from 2000 to 2019: a retrospective cohort analysis of consultation events across 845 general practices](#)

⁴ [Safe Later Lives](#)

Professionals shared their experience of identifying those at risk, with different approaches taken for each group:

Frequent attenders

“The presenting signs are likely to be mental health issues, then we will ask about their social situation, or if they present with minor injuries. We are less likely to pick up things like UTIs or repeated stomach or headaches.”

Surrey GP

“We look for mental health issues, women’s chronic pain, pelvic pain, recurring presentations i.e. frequent attenders, drug and alcohol abuse, families with children with special needs. A big takeaway from the face to face training I did 18 months ago made me think about some of the more subtle ways in which people may be presenting.”

Surrey GP

Those aged 65+

“Sometimes professionals only see medical conditions with older people, and they’re not trained to see domestic abuse.”

IDVA specialist

“If we did get ‘frequent fliers’, usually the elderly, but they can be any age, we do look at them at GP meetings and question why they are coming so often (frequently at A&E).”

Surrey GP

“After I’ve seen a person for a few times I can see where there is low level abuse, such as coercion and this has become their normal. These tend to be older patients. Younger patients tend to present with physical abuse and may have more recently worked with local services so are used to talking about it”.

Surrey GP

Another common barrier for older people with health and mobility issues is instances where the perpetrator of the abuse is also the carer. The person experiencing domestic abuse is often reliant on their perpetrator to get to their health care appointment, who then accompanies them into the consultation.

Patients with chronic or long term health conditions

One reason given by survivors for not disclosing and, having disclosed, not receiving appropriate help is that they felt they were labelled with a specific medical condition or problem, such as mental health or alcohol dependency. This label becomes the focus for treatment, usually with medication, rather than exploring the reasons for why these conditions exist i.e. domestic abuse.

“When my sister went to her GP and told her she was being abused she was prescribed sleeping tablets and anti-depressants for ‘the breakdown of her relationship with her partner.’ Her abuse led to her death.”

Surrey survivor (female)

“I ended up with mental health issues due to abusive relationships but now that’s all that they see. They don’t listen to me.”

Surrey survivor (female)

“There is a lack of respect for you as a person; they just see you as an illness.”

Surrey survivor (female)

“I was drugged and raped. I called the police and then went to see my GP. They said, “here are some pills,” and signed me off work. I don’t like going to the GP anyway; they say everything is down to me being overweight and because I smoke.”

Surrey survivor (female)

GP practices acknowledged this issue and that the reasons behind the ‘label’ may not be fully explored:

“Problematising? Yes, that is a fair criticism and something we should be aware of. It’s very easy to use a code to label like that. If someone pitched up at A&E drunk that could cloud your judgement.”

Surrey GP

Survivors also reported concerns about how this would be documented in their medical records and that this would be the main or only focus for healthcare professionals every time they attend an appointment in the future:

“What they write up in the medical notes is really important. It’s the way in which they are written so if they label you in a particular way, that is how everyone from then on will see you”.

Surrey survivor (female)

“My baby rolled off the bed onto the floor. I was terrified of what my husband would do to me when he found out. When I went to the GP, I was asked if I was scared of my husband. I said yes and the comment written in my notes was that I was suffering from post-natal depression. My daughter was 7 years old when I finally got out of the relationship”.

Surrey survivor (female)

“When I was a teenager, I was sexually abused and turned to drink to cope; I abused alcohol at that age but now, every time something happens, they ask, ‘Are you still drinking?’ I still get judged for it years later. I also get judged on the attempted suicides and feel like I am seen as unfit parent”.

Surrey survivor (female)

GP practices interviewed say that all information is necessary but that the patients' records can be updated and re-organised to reflect what matters now.

“It’s important to have the patient’s whole medical history there and not to delete things; everything from when you

were born to the end of your life. Within that, EMIS [electronic patient record system] can separate out active problems and significant or past problems. A risk of relapse for some issues is lifelong but can be downgraded to significant past problem.”

Surrey GP

How could things be improved? Survivors have their say

Survivors asked that members of the GP team improve their knowledge of the different forms of domestic abuse and take opportunities to ask questions that may facilitate disclosure.

“If the GP asked a series of questions in a way that would look behind the symptoms such as, “Is everything at home, okay?” I think most people would want help if they needed it and wouldn’t mind being asked it if they didn’t.”

Surrey survivor (male)

GP’s response:

There are different approaches, largely dependent on the individual GP’s personal style and the person sat in front of them. However, questioning is covered in training and there is a template set of questions provided by EMIS although this isn’t always implemented.

“We will ask questions like, “How are things?”, “Do you feel supported by your partner?” There is an EMIS template which has the ‘3 questions’ but the reality is that this doesn’t happen in practice.

Surrey GP

2. Appointment booking and confidentiality

A lack of confidential space and discretion from reception staff, concerns about the digital trail left by online booking systems, and lack of timely and unhurried face to face appointments with a preferred GP were all highlighted by survivors.

The 67% of respondents to the survey who chose not to disclose their experience of domestic abuse at the time they were asked said that they didn't feel safe to do so (41% said that they felt scared).

Appointment booking

Survivors reported that they were unable to make appointments at a time and in a way which suited them, specifically in-person appointments with the GP of their choice.

38% of respondents to our survey said that they were unable to make an appointment when they wanted to. Most said that they preferred to make appointments by phone and had to wait a long period of time for their call to be answered. There were also instances of negative responses from the receptionists on answering:

"I've been told that I have to book online when I am on the phone talking to them. I say, 'So you're telling me to get off the phone to book online when you can just make an appointment for me now?'"

Surrey survivor (female)

"I don't ever book online. I call up. You have to listen to the message with all sorts of different options and then you find that there is nothing [available]!!! Or you have to call back in 2 weeks' time and have to remember to do that otherwise you go back to the beginning again."

Surrey survivor (female)

"I have had the phone put down on me before. It depends what mood they are in."

Surrey survivor (female)

Time-limited appointments

50% of people who responded to our survey said that limited appointment times were not conducive to disclosing domestic abuse.

The length of appointments didn't provide sufficient time to explain their situation, with most of the time spent focusing on the presenting condition (this was particularly true if the GP practice had stated that they can only discuss one issue per consultation).

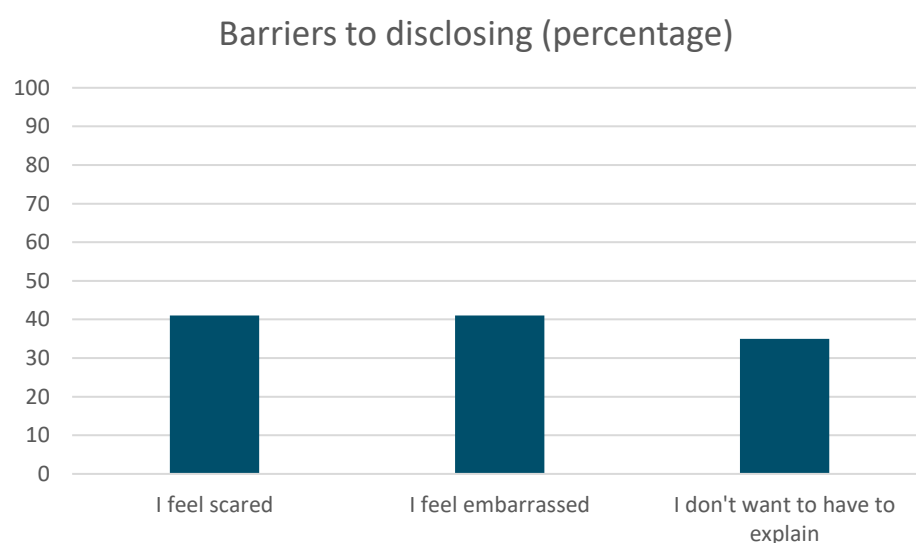
The GP practices interviewed recognised that this was an issue.

"Best practice is a 15 minute appointment – should a double appointment be standard? Things such as repeated UTIs are not picked up as much as they should be due to time and pressure. If we had more time, this would help."

Surrey GP

Concerns around confidentiality: in-person

Survivors were concerned about the lack of confidential space and discretion from reception staff when visiting the practice in person to make an appointment.



The fear identified as a barrier to disclosing was, in part, related to a concern that their perpetrator would learn about the nature of their visit:

“When trying to book an appointment to let my GP know, the receptionist would not accept ‘personal reasons’ as a valid response for an appointment; this was not something I was comfortable in sharing whilst others could hear in an open space”.

Surrey survivor (female)

Concerns around confidentiality: online

People reported that they were concerned making appointments online because this can leave a digital trail which may put them in danger; even giving a common condition would be enough to alert the perpetrator.

GP practices recognised that this an issue and that the move away from face to face or phone requests also reduced the opportunity to pick up on the non-verbal cues that someone may need help:

“The online appointment booking system doesn’t help either as people are not going to say they are experiencing domestic abuse on this form. If they did, they would be offered a double appointment which would allow time to talk about what is going on.”

Surrey GP

“There has been a big push to move to a digital front door; we introduced an entirely new system from December. Any symptoms can be written in to explain the reason they want to see a doctor, but these aren’t protected for online visibility.”

Surrey GP

Survivors were also concerned that their perpetrator may be able to see their notes and that they may be able to influence the notes written about them:

“My perpetrator had called my GP and wrote several letters from himself and his mother claiming that I am a liar, so I don’t feel that I am now able to speak about abuse with my doctor. When I go in to speak with them, they always look

back through medical records and do not realise that him writing in like that is an abuse and a control tactic.”

Surrey survivor (female)

All GP practices described a process of making online records non visible in line with Royal College of General Practitioners ([RCGP](#)) standards.

“There is a code to record a patient as having a history of DA and we can make this not visible online. We follow RCGP guidelines to manage online confidentiality. We do suffer from ‘flag fatigue’.”

Surrey GP

“Once disclosed, we code the patient as victim of domestic abuse and mark it as non-visible; I feed back to the admin safeguarding team and we ask, “Who is in the household?” We link their records so that they all show domestic abuse. We look to see if anyone is a firearm holder or if the family is known to social services. We protect them from online access. If the perpetrator has online access, we will mark it as non-visible and ask the victim if they want this changed. In case of separated parents, where the non-resident parent has asked for access to their child records, we will review this together; this is currently happening, and I have discussed this with one of the partners. We have refused them because I felt the perpetrator would use the records against her.”

Surrey GP

How could things be improved? Survivors have their say:

Survivors asked for:

- Easy access for an unhurried appointment without having to specify the reason why they want to see the doctor.

“Being allowed time and space to speak to someone. Feeling safe when being in the appointment. Being able to have a safe word for receptionist not to question and to get you an appointment quicker.”

Surrey survivor (female)

GP response:

GP's agreed that normal appointments are not long enough to facilitate talking about domestic abuse but, in order to make longer appointments times, they would need to know in advance why this was necessary.

3. Perceived lack of understanding

An underlying fear of not being believed and a perception of a lack of GP understanding of all forms of abuse.

Survivors reported an underlying fear that they would not be believed (41%) and a lack of confidence in the GP practice team members' knowledge of domestic abuse, particularly the broad scope of abuse:

- Coercive control
- Post separation abuse
- Male survivors.

Coercive control

Survivors felt that, whilst presentations of physical abuse – such as bruises, broken bones etc. – were more likely to be picked up, evidence of other forms of abuse, particularly coercive control, were not being recognised.

The [Safer Later Lives report](#) identified that 83% and 73% of domestic abuse was controlling behaviour, for the under 60s and the over 60's respectively.

“GPs and receptionists need to know what coercive and controlling behaviour looks like, and what the signs of violence are. It's not just black eyes and broken ribs.”

Surrey survivor (female)

GP practices recognised that this form of abuse is not always considered and that, until relatively recently, training has fallen under the umbrella of safeguarding, rather than specifically focusing on domestic abuse.

“Even though I had been a practising GP since 2000 and throughout that time I had frequent safeguarding training, we were always given very extreme examples e.g. bruising or a black eye or “No, you can't wear that”, and the training is the same now; the more subtle emotional abuse like coercive control isn't covered or understood.”

Ex Surrey GP

“What would make the difference is to be believed. Just because I don’t have a black eye doesn’t mean it isn’t happening. But even when you have disclosed, then what? The GPs are gatekeepers for everything and sometimes it’s difficult to even get an appointment.”

Surrey survivor (female)

Post separation abuse

Being separated, or in the process of separating from an abusive partner, is considered a higher risk of abuse situation, including increased risk to physical safety, due to the perpetrator's perceived lack of control. Some survivors reported a lack of understanding of post separation abuse.

GP practices recognised that the complex set of circumstances surrounding the abuse, and how this might be manipulated by the perpetrator, is not understood. For example, the perpetrator may ask the GP for written statements confirming their mental health or the survivor’s mental health and this may be used as evidence for custody battles.

“GPs are good at picking domestic violence up but not at understanding the complicated issues around it. More training is needed on controlling and coercive behaviour, how abusers manipulate the system and post separation abuse; abusers will continue to abuse through the court systems, trying to get psychiatry opinions claiming that their ex-partner is mentally unstable and go through children by interfering with children’s health appointments to control children’s health needs, turning up at medical appointments, wanting to be primary contact for children’s health, withholding children’s medical information, not administering children’s medication and coaching children to say abuse is coming from the other partner.”

Surrey GP

“I had very little to do with my GP about the abuse. My husband got there first.”

Surrey survivor

Male survivors

Male survivors felt a lack of understanding that men can be subject to domestic abuse; many believing there is significant stereotyping of survivor and perpetrator roles and that the automatic assumption in different sex relationships is that the woman is the victim and the man is the perpetrator:

“During all of this I didn’t seek any help from the GP because I don’t feel that I would have been listened to. It didn’t matter how loud I shouted, no one would listen to me; if I was a woman and I had been pushed down the stairs, locked out, children taken away from me, it would have been a different story. But, if a man said that he’s not having a great home life, would anything be done about it? Male DA victims do not get the same help as female ones do, but if a person is suffering, they should get the help regardless of their gender.”

Surrey survivor (male)

How could things be improved? Survivors have their say:

Survivors asked for:

- Their GP or member of the practice team to develop more awareness of the trauma of domestic abuse and the skills and knowledge to manage their needs
- The ability to see the same GP in order to build a relationship and to not have to repeat their story multiple times
- A domestic abuse specialist and/or advocate within the practice.

“The more people you have to tell your story to, the shorter and shorter it gets. You leave bits out and eventually lose the will.”

Surrey survivor (female)

GP response:

All patients have a named GP but they are able to see any GP with whom they feel most comfortable. However, they recognise that this is not always possible.

"Every patient has a named doctor and runs a personal list. A patient can change to new doctor if the relationship has been established."

Surrey GP

4. Fear of authority

Feelings of intimidation around GPs.

Some survivors felt intimidated by the authority that GPs and other healthcare professionals represent – as with police, teachers or social services – and were concerned about the consequences to both them and their children of disclosing their domestic abuse.

“They are just not the go to people for help with this, doctors and like police and teachers. They are a different set of people to me. They are not like me. Do they have the empathy to understand when they have never lived it? I feel like I need to keep it a secret, even if I’m not doing anything wrong.”

Surrey survivor (female)

“I didn’t disclose to my GP because I feel like I would have got in trouble. It’s like calling the police. It’s hard to admit that you’re in a situation when you’re in it.”

Surrey survivor (female)

“She advised me to speak to my GP but what is my GP going to do? Even if I did, I am going to get judged. I also feel that I am going to be the one who loses everything. It will be tougher for me than for anyone else. I am not the perpetrator, but I am made to feel that I must have done something. I have lost my trust.”

Surrey survivor (female)

“Telling someone means that you immediately lose control. You could end up being moved away from your home, miles away from anyone you know. If my GP had asked me, I would have said no.”

Surrey survivor (female)

5. Perpetrator presence

6% of respondents to the survey said that their perpetrator wanting to attend their appointment with them was a barrier to disclosing their domestic abuse experience (a further 16% said that their perpetrator being registered with the same GP was also a barrier).

“I was asked by a midwife at my GP surgery, with my husband in the room, whether I have suffered, or do suffer from abuse from an intimate partner. My response was shock, and my husband said, ‘Let’s hope not as you have just asked her in front of me’.”

Surrey survivor (female)

“My issues are about seeing your doctors in relation to your child. I was repeatedly told that my husband had the right to be present because the child was his too, but this meant that I couldn’t tell them what was going on as he was always there.”

Surrey survivor (female)

6. Generational and cultural barriers

Discussing domestic matters outside the home not being appropriate.

The [Safe Later Lives](#) report recognises that generational and cultural attitudes towards marriage and relationships – such as the belief that what goes on at home is private and that it is socially unacceptable to discuss matters outside of the home – can prevent a victim from disclosing. This attitude is exacerbated for older black and Asian minority ethnic women, particularly those from a religious background who may face additional personal and familial pressures to stay with an abusive partner.

In these circumstances, a person experiencing domestic abuse is more likely to attend health care appointments with their perpetrator, particularly where English is not the first spoken language.

“When I arrived in the country (many years ago now) [as a refugee] I didn’t speak the language. My husband would come with me to translate. It was a huge barrier for me. At the time I was brainwashed. I wanted to do everything to please him, and I didn’t want to leave him. I wanted to stay with him as I thought he was amazing and I was nothing.”

Surrey survivor (female)

Some GP practices have mechanisms in place to manage patients regularly attending appointments with another adult. However, these were sometimes ad hoc and not recognised practice protocol.

“We also have an increasing number of non-English speakers whose partners act as interpreters so are always with them. We get round this by offering one to one appointments with language line or say they need a female examination so it’s not appropriate for their partner to come.”

Surrey GP

“If a young person were never to appear without their partner or another adult, I would give them the opportunity to see them alone. I’m not sure what the protocol is if the perpetrator is at the same practice, possibly seeing the same GP. We have the means of making notes not visible. Staff members can’t be patients here but may have a relative who is.”

Surrey GP

GP practices were aware of this issue and did not pressure patients into disclosing information when they felt uncomfortable.

“We encourage our patients to do Rapid Health and, if they can’t do it themselves, we can take someone aside into a room and do it for them – if they say they don’t want to tell us why they want to speak to a doctor, we might say we are trying to triage to ensure the best outcome for you, but we wouldn’t push it. If they say, we need to see someone now, we ask the duty doctor to speak to them.”

Surrey Practice Manager

“Receptionists will ask the question, ‘Why do you want to see the doctor?’ and explain that they do it to provide more information to help the doctor but, if they were uncomfortable, they wouldn’t press on that.”

Surrey GP

7. Lack of victim awareness of domestic abuse

Survivors reported that, at the time they were asked questions about domestic abuse, they did not recognise that they were relevant to them. There was evidence that the healthcare professional they might have disclosed to didn't recognise that this was their situation either.

This was particularly the case for those who were experiencing abuse from their children:

"All the health and social care professionals say is that 'you are their safe person, that's why they take it out on you'. They make it feel like it's your job to do that. You have to put up with it to keep them safe. It's heartbreaking to realise that it is actually domestic abuse."

Surrey survivor (female)

"It's only been in the last year (he is now 11) that we have started getting the right help. I didn't realise I was a domestic abuse survivor until about 18 months ago on the advice of the child psychologist. I was heartbroken when I did recognise it. I am on my own with him".

Surrey survivor (female)

Findings: experience once the decision to disclose is made

Who in the GP practice team to disclose to?

The majority of respondents chose to disclose to their GP. A few respondents disclosed to the Practice Nurse and there were isolated cases of disclosing to a Physiotherapist, Associate Physician and Midwife.

Gender

People reported that the gender of their GP made a difference to their disclosing and to maintaining an ongoing relationship. Most survivors we engaged with were female, preferring to see a female GP.

Different members of the practice team (not GPs)

Overall, there was a lack of confidence in disclosing to staff who weren't GPs. However, time limited appointment times for GPs to see their patients impacted on their ability to deal with domestic abuse disclosures and it was felt that other team members, such as social prescribers (who had more time) were sometimes better placed:

"Most patients will choose to disclose to their GP, but someone did disclose to the clinical pharmacist during a medication review, and they didn't feel confident in dealing with it. As well as GPs, it can also be nurses."

Surrey GP

"Social prescribers are more acceptable. They are talking to them about housing, finance, mental health etc and are able to ask about support for domestic abuse at the same time. There is also nothing about domestic abuse in their title. We would refer to ESDAS first."

Surrey GP

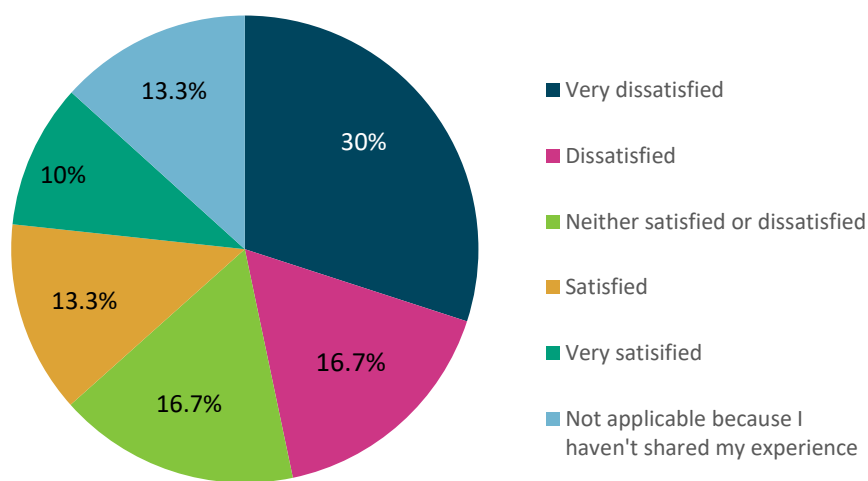
"There has been a disclosure to a physician associate; they have longer appointment times. It's 15 minutes for a routine appointment for GPs and 10 minutes if urgent. It's not long

enough, especially as most domestic abuse patients are likely to be urgent.”

Surrey GP

Experience during disclosure

We asked survivors to tell us how satisfied or dissatisfied they were once they had made a disclosure of domestic abuse to a member of the GP practice. Their responses are shown in the following pie chart with 46.7% of people saying they were dissatisfied or very dissatisfied.



Survivors’ experience of disclosing was mixed, with some respondents saying that they didn’t feel heard or taken seriously and that there was no action as a consequence of their disclosure.

“They listened but didn’t take me seriously.”

Surrey survivor (female)

“No understanding whatsoever from the GPs about what I was telling them.”

Surrey survivor (female)

“Unheard.”

Surrey survivor (female)

“Not great. Receptionists and Practice Manager are always very lovely but there is never any follow up from GPs or specialist advice or signposting. I’ve explicitly asked for signposting for sexual abuse support but received no help. One male doctor was kind and gave me antidepressants and arranged a follow up appointment – I found the offer of a follow up really helpful and it was the first time I felt like someone cared really.”

Surrey survivor (female)

For some survivors, the support given when they made the decision to disclose was inappropriate and potentially harmful.

“The nurse told me that I should get out more, to go to the pub for a drink. For a nurse to “prescribe” that to someone who has experienced DA...?! That could be the exact environment where I have been hurt, or I could have a problem with alcohol because of the abuse.”

Surrey survivor (female)

Some Survivors also felt that there was a lack of understanding and compassion for people experiencing domestic abuse and that their GP or practice team members didn’t have the confidence, skills or time to deal with this issue.

“I was young and needed more encouragement at the time. I was not comfortable providing this information and, on reflection, now understand that the professional asking me was not confident in asking. It very much felt as though he didn’t want me to say yes, and it was a tick box.”

Surrey survivor (female)

“I was asked by the physiotherapist and felt safe enough to speak to her about it. I didn’t feel that the GP I saw had the time, or even compassion, to deal with my personal life.”

Surrey survivor (female)

“When you go the GP, you are vulnerable and need respect, but they just hurry you along. I’d like the receptionist to take a more empathic approach.”

Surrey survivor (female)

However, others said that they felt relieved, reassured and supported.

“The GP was very helpful and supportive and offered follow up”.

Surrey survivor (female)

“I was supported really well by the doctor, and he put me in touch with EDAS and provided sick notes as I suffer from complex post traumatic stress disorder from the abuse”.

Surrey survivor (female)

“I was nervous about not being believed because I’m a man. I thought just get the words out and see what happens. I braced myself first before I told him. If I couldn’t have got help there, I would have felt helpless.”

Surrey survivor (male)

“I was scared to admit it, but once I did it was a relief, and I felt listened to and was able to ask for help.”

Surrey survivor (female)

“I felt so relieved that I wasn’t going crazy and that I was actually just stressed, and it was valid and not made up.”

Surrey survivor (female)

Findings: signposting and referrals following disclosure

68% of respondents to the survey said that they were not given details of how to seek specialist help from an independent domestic abuse and violence service once they had shared their experience of domestic abuse. 89% of respondents said that a GP or another member of the practice team had not arranged for them to receive specialist help (a referral).

“When I went to see my GP he said that he could see that I was embarrassed so he wouldn’t write anything in my notes. Nothing was recorded and I wasn’t offered any help.”

Surrey survivor (female)

“When I went to see my GP, I was recognised as a victim and my perpetrator was named. But this was all I got. I wasn’t referred to anyone else. GPs work in silos. It was the police who referred me for help, but I don’t think I had an expectation that the GP would do this. I would go to them for a sore throat or a cold but not for this.”

Surrey survivor (female)

“I have only had antidepressants from my GP. He has listened to me and suggested I try some tips, but I have not been signposted or referred to any specialist services.”

Surrey survivor (female)

Signposting

There was some confusion amongst survivors as to what a specialist domestic abuse service is.

Those that were signposted recognised Your Sanctuary and East Surrey Domestic Abuse Service (EDAS) as domestic abuse services but Mindworks, Child and Adult Mental Health Services (CAMHS), online IESO therapy and the police were also identified as specialists in providing domestic abuse

support. Those that were referred also identified post traumatic abuse disorder (PTSD) therapy as a domestic abuse specialist service.

Signposting information

Respondents to the survey were asked to identify what signposting information is available in the GP practice for people experiencing domestic abuse. They identified Your Sanctuary poster, stickers on toilet doors, and Talkplus, but many commented that there was nothing.

Respondents were asked if they felt that the signposting information available in their GP practice for people experiencing domestic is sufficient and 71% said that it wasn't. Male survivors commented that there is nothing available which is targeting men only.

GP practices described a range of signposting material available, but not in a consistent way across Surrey. There is a shift away from printed literature, post-Covid, to digital forms of signposting although some were unsure what their GP practice provided:

"We have [South West Surrey Domestic Abuse Service (SWSDA)] stickers on the back of women's and men's toilet doors as appropriate. I'm not sure if there is anything on the website."

Surrey GP

"We have done some signposting advertising on our Facebook page. We don't have posters in the waiting room but do have template texts to send to patients with all information on there."

Surrey GP

"We have laminated cards for key numbers left in GP rooms and the numbers are given to patients. There are stickers in the toilets."

Surrey GP

“Our notice boards are covered with help for mental health, Prevent, but I don’t think we have anything on domestic abuse.”

Surrey GP

Referrals

Poor communication between GP practice and other health care and specialist services

Survivors identified a lack of communication between the GP practice and specialist domestic abuse services.

“There is a lack of communication between different professionals etc. and a lack of understanding of parent/child abuse.”

Surrey survivor (female)

GP practices recognised this issue and noted that this was compounded where they operate across county boundaries.

“Borders can make referrals difficult, and they are sometimes made incorrectly”.

Surrey GP

Fear of the consequences of a referral

GP practices tend to signpost rather than refer, explaining that many people experiencing domestic abuse are concerned about the ramifications of being referred – both to themselves and to their families – and so choose to decline.

“I believe there is 50:50 split between referrals and signposting, but we’ve not done a lot as some [patients] decline referrals or support.”

Surrey GP

“I signpost or refer then and there, which depends on level of risk. I would denormalise it by saying this is domestic abuse. There is apprehension about referrals. I would show

them the website and how they can refer online. We don't have any signposting material displayed in the practice, but I can send a text with contact details. I have said to patients to call while here from a private space like another consulting room. I have also liaised with domestic abuse services and got a patient seen by them at our practice. They sometimes don't want help as they are worried that their perpetrator will find out 'Let's not poke the bear.' Suffering means things won't escalate. 'How is it [disclosing] going to rock the whole family?' For some it's just really hard to talk about. Women are so convinced that it's their fault. They think, 'If I change my behaviour, then he won't treat me that way.' One lady we managed to get into a refuge has just gone back to her perpetrator."

Surrey GP

"The hardest thing is to get them to accept help and support. I persuaded them to take a barcode sticker with emergency contact number on two occasions."

Surrey GP

"I always refer people, rather than signpost, but people decline as they don't want it on their record and are worried that their perpetrator might find out. I suspect that people are signposted when they should be referred."

Surrey GP

"Normally I would be signposting but there may be occasions where it is necessary to intervene, e.g. when children are involved. The referral statistics make sense as normally they refer themselves and it's not done by the GP. Most of them don't want to be referred. The reason varies from patient to patient: fear of making things worse, worried if there is no local support or family, concern that it's becoming a criminal matter and, if they are subject to manipulative or verbal abuse, they may question if they are being abused. They may not be fearful for their safety?"

Surrey GP

Systems/technology for managing referrals

GP practices use differing systems for managing referrals.

One GP practice had created its own “swipe right” system to reveal the referral form on the computer screen to enable ease of referral. There were examples where similar technology could be used to identify people with domestic abuse and provide the GP with information to know how to help them. Having a system such as this was considered very helpful to encourage GPs to consider referral as an option. At the other extreme, another GP practice said that they didn’t know that they could make a referral.

“It would be great to have an embedded referral form on the system; it would act as a prompt and makes it easy to a make the referral.”

Surrey GP

“We’ve just done a big piece of work to improve recognition of people at risk of suicide and have implemented and created our own alert system; we now have pop ups appear, saying what needs to be done if someone needs help, and the patient is automatically flagged up to see duty doctor.”

Surrey GP

“I had assumed patients could only do a self-referral. I didn’t realise I could. I would follow up to see if they have got help. There was one time we arranged for a DA patient to come into the surgery to make the phone call.”

Surrey GP

How could things be improved – survivors have their say:

- For some, referral rather than signposting as they did not feel able to get help themselves
- For others, better use of technology to signpost to domestic abuse specialist services anonymously
- Improved communication between the GP practice and specialist domestic abuse services

"My ex used to go through my phone and delete comms between me and my brother; if there was an email that would go to/from all DA specialist organisations but masked (e.g. 1001 recipes for banana bread); safeguarding approaches are needed to protect person for being abused. You need a trojan horse to help victim in a big way (a QR code in docs surgery). This would mean there is no paper trail to avoid".

Surrey survivor (male)

Findings: follow up appointments/outcomes

Survivors reported that, having disclosed their domestic abuse experience, there was sometimes little or no follow up.

“Somewhere along the line I would’ve hoped that there would have been a courtesy call to check in with me, making sure that I am okay. That would have been enough for me to say this is what is going on.”

Surrey survivor (male)

Others had positive experiences of follow up and ongoing support.

“I used to think that I would be wasting the GP’s time and didn’t go unless there was something really wrong. My GP made me feel that it was ok to go to the GP, she said to make sure I did – ‘We want to know how you are’ – and I have had constant review and monitoring.”

Surrey survivor (female)

There wasn’t a standard practice or protocol for following up with domestic abuse patients, with some proactively managing follow ups and others leaving the patient to take the lead.

“We follow up on a case by case basis. I book an appointment or follow up phone call. I may say, ‘Check in with me in a month or two. If another GP were to see this patient, there is a danger it will get lost in the consultation notes. It would need to be flagged on the notes and date stamped.”

Surrey GP

“We will always advise the patient to book a follow up call and will offer support again in the form of a referral or remind them of signposting information, but there is no written protocol for this. It would be around a month but within a week if we felt the risk was high.”

Surrey GP

“I would encourage them to have another appointment. If I were more concerned, I would book that there and then but otherwise leave it to them.”

Surrey GP

How could things be improved – survivors have their say:

- Standardised follow up to be embedded in best practice

The GP response:

“There is no standard follow up. It would it be good to make this best practice too?”

Surrey GP

Recommendations and next steps

These findings were discussed at a Convening Workshop held on 14 May 2025, which was attended by system partners and external stakeholders representing both domestic abuse survivors and general practice. The aim of the workshop was to review the findings and work collaboratively to develop pragmatic and practical solutions to improve access to and experience of general practice for survivors.

Specific suggestions from the workshop include:

Barriers to disclosing

- A “Trojan Horse” is developed which enables people experiencing domestic abuse to alert their GP practice that this is their situation and, in return, the GP practice is able to share signposting information discretely.
- Domestic abuse specialists within GP practice are promoted through the use of a slogan/logo, created with survivors, which demonstrates alliance against domestic abuse.

Experience following disclosure

- On going education and training to improve understanding of the different forms of domestic abuse, specifically coercive control, will be provided within general practice.
- Front line staff in general practice will receive training in trauma informed approaches to care.
- Work continues on the development of a health passport for survivors of domestic abuse.
- Examples of best practice in individual GP practices are shared with a view to ensuring consistency of practice in general practice throughout Surrey.

Signposting/referrals

- A pathway for domestic abuse survivors is created and the scope of support required and available is identified.
- A standardised referral form is created and managed at a central point and embedded in GP practice computer systems.

- Stronger links are developed to strengthen links between outreach providers/link workers and local GP practices.
- A directory of specialist domestic abuse services is created for use within GP practice.

Principles for action

Key principles to support any future action are that:

- There is a survivor led approach.
- There is consistency across general practice in Surrey.
- That momentum is maintained.

This report, including the recommendations, will now be presented to key decision making forums within Surrey Heartlands ICB and Frimley ICB, for response and commitment to action. It is intended that all actions taken will be survivor led consistently applied across all GP practices in Surrey.

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Summary/conclusion

This research took a deep dive in to the experience of general practice for domestic abuse survivors at all stages of their primary care journey.

This report – summarising the findings – gives survivors a voice and begins to provide system partners with tangible suggestions for ways in which experiences can be improved.

Pre-disclosure

We identified 7 barriers to people disclosing that they were experiencing domestic abuse and thus accessing support. These could be categorised in to those related to institutional factors and processes (issues such as GPs not questioning the reason behind clinical presentations) and those linked to survivor perceptions and beliefs (such as survivors not being aware that what they were experiencing was domestic abuse).

Survivors asked that members of the GP team improve their knowledge of the different forms of domestic abuse and take opportunities to ask questions that may facilitate disclosure.

During disclose

Some of the issues identified as barriers to disclosing were also evident during the experience of disclosure, with survivors citing concerns that they would not be believed or would be labelled with a specific medical condition or problem rather than being supported to deal with the abuse.

Survivors asked for easy access for an unhurried appointment without having to specify the reason why they want to see the doctor, the ability to see the same GP and a domestic abuse specialist and/or advocate within the practice

Post disclosure

The research identified a lack of consistency in terms of referrals, signposting and follow up and a disconnect between the GP practice and specialist domestic abuse support services.

Survivors asked for improved communication between the GP practice and specialist domestic abuse services, better use of technology to signpost to domestic abuse specialist services anonymously and a more standard follow up procedure.

This list of survivor asks is not exhaustive, but it begins to shine a light on where the problems lie and where improvements can be made. We now look forward to working with our system partners to implement changes to ensure that general practice really meets the needs of current and all future survivors across Surrey.

Acknowledgements/thank yous

With thanks to:

- Survivors from across Surrey who shared their stories with us
- The Surrey Domestic Abuse Partnership (SADP)
- East Surrey Domestic Abuse Service (ESDAS)
- South West Surrey Domestic Abuse Service (SWSDAS)
- DA SEEN (formerly the Surrey Survivor's Steering Group)
- Good Company, Epsom
- The Well Women's Centre, Woking
- Yuva Surrey Service, Waythrough (formerly known as Richmond Fellowship)
- The Barnardo's Family Centre, Hale
- Men's Mental Health & Emotional Wellbeing County wide (AMC)
- Dr Tara Jones, Designated GP for safeguarding children & adults, Surrey Heartlands ICB
- Rebecca Eells, Designate Safeguarding Nurse Adults, Surrey Heartlands ICB
- Stoneleigh and Spring Street Surgery, Epsom
- Austen Road Surgery, Guildford
- Brockhurst Medical Practice, Betchworth
- Woodbridge Hill Surgery, Guildford
- Haslemere Health Centre, Haslemere
- Hersham Surgery, Walton-on-Thames
- The Bartlett Group Practice, Frimley Green & Ash Vale
- Station Road Surgery, Camberley

Appendices

Monitoring data of people who experience domestic abuse

GP practices across Surrey were asked to provide figures relating to numbers of patients in their practice who had disclosed DA, how and any follow up.

Only 2 of the 117 GP practices provided this information and they were from the group of 8 practices who chose to engage with this project. The other practices from this group of 8 were able to provide some of the data, reporting that, whilst there may be a safeguarding register, there may not be a register specifically for people experiencing domestic abuse (and if this did exist it would not include outcomes for these patients).

There is also no evidence that practices review why patients have not chosen to disclose to them earlier (or at all), once they become aware of their situation.

“There isn’t a central register. Just coding which is easy to respond to and is helpful.”

Surrey GP

“There are approximately 35 names on the domestic violence register but I am not sure how up to date it is and there isn’t detailed information there, such as if they have been referred and where to.”

Surrey GP

“We don’t review why we may have missed that someone was experiencing domestic abuse by not telling us and perhaps we should?”

Surrey GP

Survivor stories

Survivor story 1

"I had great support when my abusive husband and I split up. The GP was the first person I called, I was having a nervous breakdown. I'd been seeing her about my mental health and she had given me a direct phone number for her. I called the surgery and she said come down immediately. I arrived and she saw me. She referred me on, and I didn't need to go back really, her referrals were spot on. When I arrived in the country (many years ago now) [as a refugee] I didn't speak the language, my husband would come with me to translate. It was a huge barrier for me. At the time I was brainwashed, I wanted to do everything to please him and I didn't want to leave him – I wanted to stay with him as I thought he was amazing and I was nothing. However, I did want to have personal GP appointments and so I began to learn the language. He said I didn't need to but I said 'Darling you don't want to have to go to the GP every time I go do you?' I had repeated trips to the GP with stress related health complaints and ill health. Over that time I had seen two GPs. I'd been with so many health issues but a couple of times there were pains. The male he asked me lots of questions to help get a picture of the stress my body was showing. Whilst doing this he just asked me, he said 'Does your husband ever hurt you?' He didn't make me feel ashamed, he made it an open conversation. I said no, but I knew I could tell him. My husband said I was going mad and I was crazy so I kept going to the GP for mental health reasons too, I would see both the GPs and they were so supportive, the female GP said call me anytime you need to, they both built up trust with me and it was a safe place for me. When I needed evidence in the divorce and court case they had many notes and observations over my health issues. With these notes I could document the abuse over many years, they helped me to win and prove that I was not crazy like he said."

Surrey survivor (female)

Survivor story 2

"It was four months before I disclosed. The first place I went to for help was the church, but they didn't adhere to their safeguarding policy and told me not to go to the GP, but family said go. So this was 3 years ago to a locum. I asked to see a female GP. I was in a distressed state; she listened to me, and I felt no time pressure. She was very concerned and said she would have a chat at the end of the morning with other GPs at the practice to discuss a way forward. She did that and rang me later that day. She was very supportive. At the time I was living with my abusive husband. I told him that I was going to discuss our children's behaviour because they were being really badly behaved at the time. While I was there, I told the GP what was happening and was referred to the Children's Centre in Guildford. They asked if I would be prepared to do this, and I said yes but that I'd like that to talk to my husband first. She gave me the time to talk to him. She then put me on anti-depressants. I always asked for her after that. When it got to the point when she wasn't there anymore, I was allocated to another female doctor. She monitors my anti-depressants. I can see her on any day I want to. She's very supportive. I hadn't seen her for a while but then went in and she told me she was going to ring me if she hadn't seen me soon to check that I was okay. I will see someone else if necessary".

Surrey survivor (female)

GP practice training in domestic abuse

All members of the GP practice team receive training in domestic abuse in line with the requirements of their professional bodies, such as the [RCGP safeguarding standards](#). Specialist support such as the [Pathfinder Toolkit for GPs](#) and the [IRIS Framework](#) help to facilitate this training.

All GPs and other healthcare professionals are accountable for their own training and mandatory updates (which take place every 3 years) and for evidencing this training. Regular training opportunities are provided by Surrey Heartlands ICB. Typically, the safeguarding lead for the practice will attend these sessions and disseminate key learning points to the rest of the practice team at regular safeguarding meetings. The training looks at how a victim of domestic abuse might present, including less obvious symptoms, and helps professionals frame the questions they might ask a potential victim. Guidance suggests that questioning should be determined by the individual, based on their own style, and recognises that they will need to adapt their approach according to the person they are communicating with at the time. Administrative team members will undertake Level 1 and 2 training through a series of units available online through the [Blue Stream Academy](#). Some practices were proactively embracing the training opportunities available to them.

“I did some update training with Surrey Heartlands recently on referral processes and what signs to look out for. Prior to that I attended training about a year and a half ago. I share what I’ve learnt with the rest of the clinical team and hold bi-monthly meetings focusing on domestic abuse. We review and reflect on cases, and I provide safeguarding supervision.”

Surrey GP

“All clinical members are trained to level 3 safeguarding. I last went to a face to face domestic abuse update about 18 months ago. I took our care co-ordinator with me and fed back on key points including referral contacts, non-fatal strangulation and use of the coercive control wheel for everyone. We promote lunch and learn safeguarding

sessions within the practice and any recordings are on our training hub.”

Surrey GP

“The admin team are trained to level 1 & 2. Last March, I worked with the team to produce a plan of what to do if someone disclosed to them, i.e. find a private room, assure they are safe and notify the duty doctor; this hasn’t been needed/actioned yet”.

Surrey GP

Others were less proactive, with the safeguarding leads/GPs having less understanding of their own and others’ training requirements. Others noted a lack of training, specifically in domestic abuse, citing that the emphasis has been on safeguarding and child protection.

“The pharmacy technician is, I think, L2 but will have done nothing beyond mandatory training”.

Surrey GP

“We have all the blue stream training modules, everything from PREVENT to child and adult safeguarding but domestic abuse has only been recently added as a unit. I feel that there isn’t enough training/information on domestic abuse. We have seven Surrey Heath Education (SHED) days a year from the ICB. It should be covered then.”

Surrey Practice Manager

“I had no real training until I became a GP – nothing at medical school. The annual requirement for safeguarding training is compulsory but it’s not compulsory for domestic violence. This training is more ‘ad hoc’ and focuses on the child’s perspective and not the bigger picture.”

Surrey GP

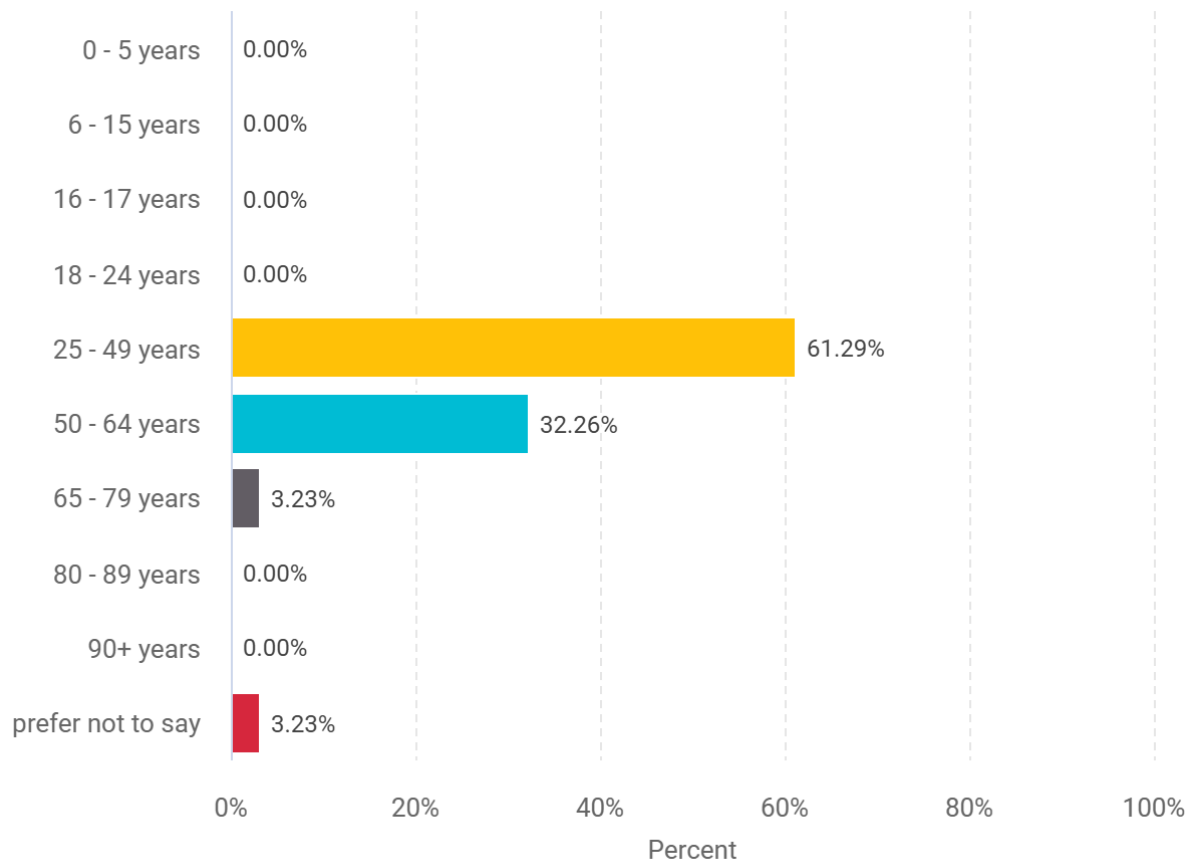
Relevant research or project outputs

- [Women's Aid survey](#)
- [Healthwatch Camden, October 2021 report](#)
- [The Domestic Abuse Act 2021. Statutory Guidance](#)
- [Surrey Against Domestic Abuse Strategy 2024-2029 | Healthy Surrey](#)
- [The Surrey Context: People and Place | Surrey-i \(surreyi.gov.uk\)](#)
- <https://irisi.org/how-can-iris-help/>
- [Pathfinder Toolkit](#)
- [NICE Guidelines](#)
- [Safe Later Lives Report](#)
- [The Surrey Context: People and Place | Surrey-i \(surreyi.gov.uk\)](#)
- [Independent Domestic Violence Adviser \(IDVA\) – Family Rights Group](#)
- [RCGP safeguarding standards.](#) (relating to GP training)
- [Pathfinder Toolkit for GPs](#)
- [RCGP standards](#) (relating to protecting online data).

Demographic information (survey): survivors

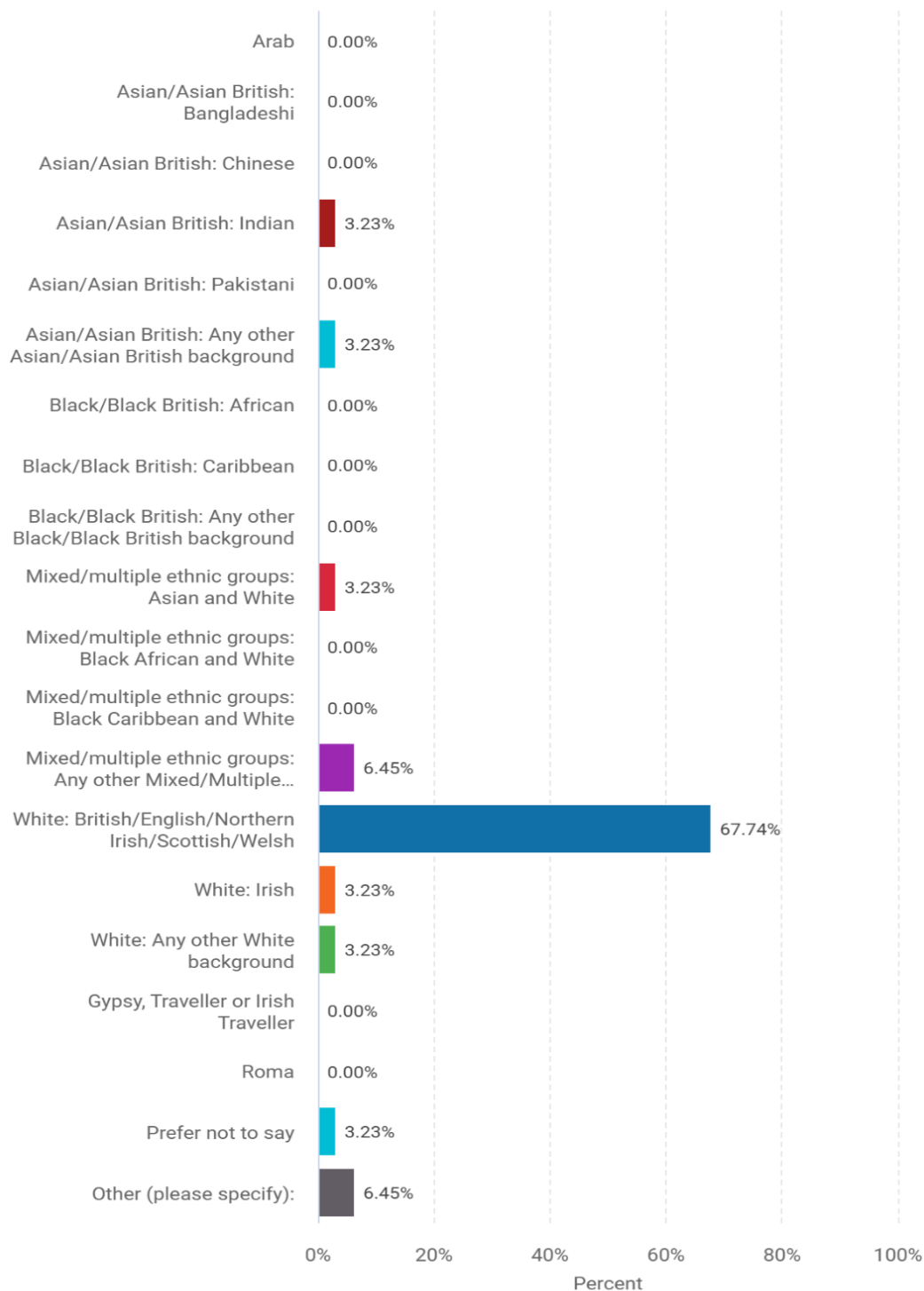
Age of respondents

The bar chart below shows the age ranges of our respondents who were mainly in the 25 – 49 years age range (61%) with 50 – 64 year olds being the other main age for respondents (32%).



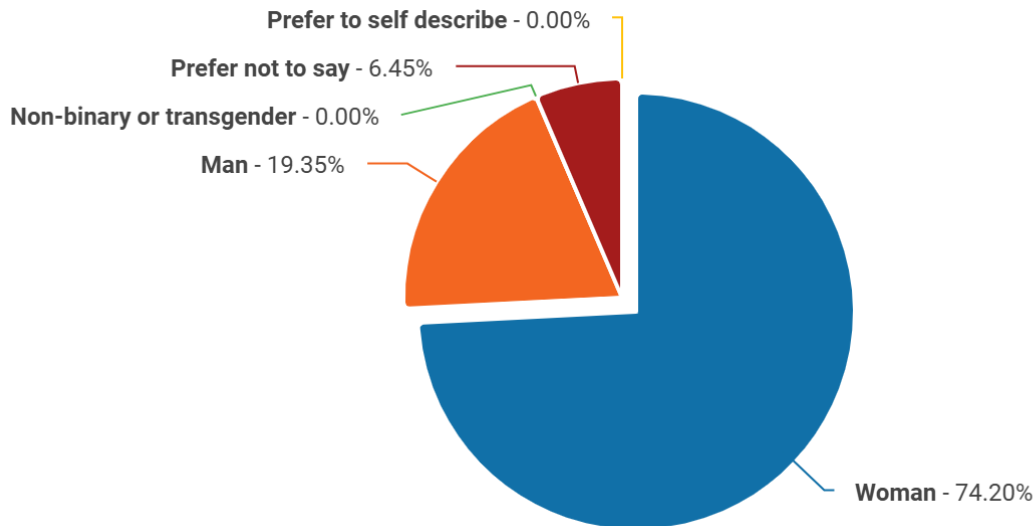
Ethnicity of respondents

The bar chart below shows the ethnicity of respondents. 68% of respondents were White British. The ethnicities of other respondents includes Asian/Asian British, mixed/multiple ethnic groups, White Irish, and people choosing Other or preferring not to say.



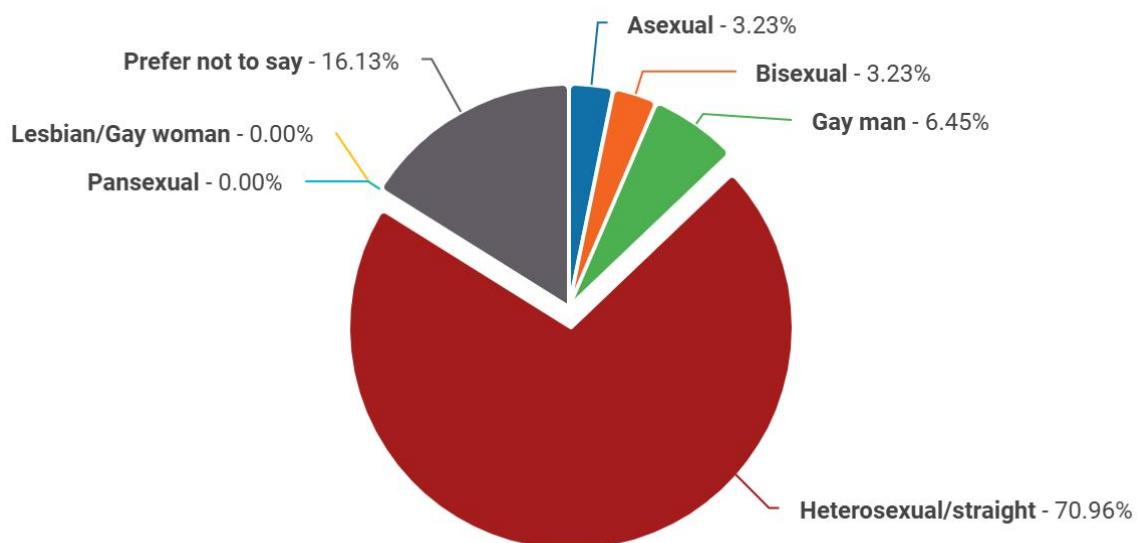
Gender of respondents

The pie chart below shows the gender of those who responded to our survey. 74% were women, 19% men and 6% preferring not to say. Everyone who responded to the survey said their gender identity was the same as their sex recorded at birth.



Sexual orientation of respondents

The pie chart below shows the sexual orientation of those who responded to our survey. The majority of people stated their sexual orientation as heterosexual/straight (71%), and others stating they are gay men (6%), bisexual (3%) and asexual (3%). 16% of respondents chose not to provide this information.

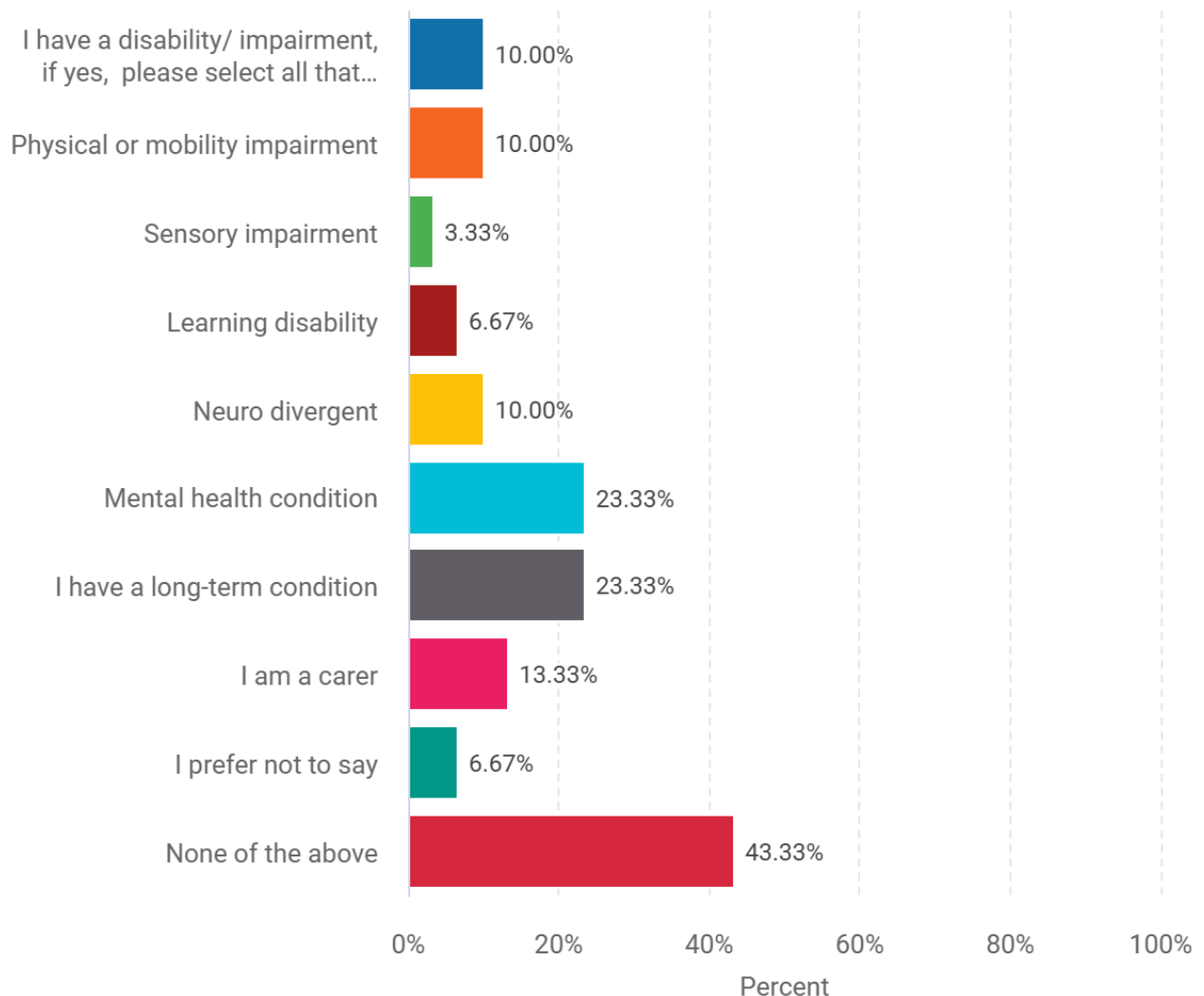


Disability/impairment and/or carer

The bar chart below provides the percentage of respondents who selected that they had a disability or impairment or were a carer. Respondents were able to select more than one answer. 10% of people stated they had a disability or impairment. Of those 23% stated they had a mental health condition. The same percentage stated they had a long term condition. 10% said they had a physical or mobility impairment and 10% said they were neurodivergent. A smaller percentage said they had a learning disability or sensory impairment.

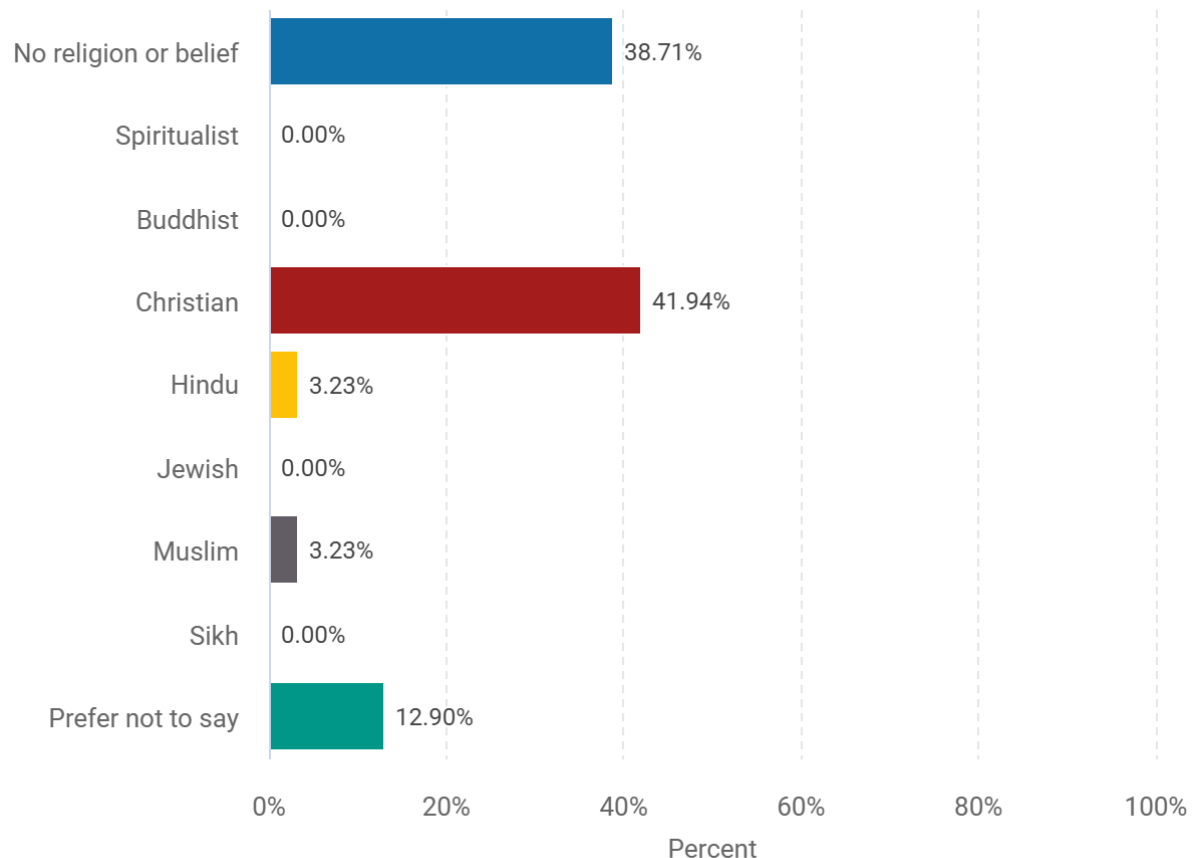
13% of respondents said they were a carer.

43% selected none of the above.



Religion or beliefs of respondents

The bar chart below shows the religion or belief of survey respondents. 38% said they had no religion or belief. 32% were Christian, with 3% each of people stating that they were Hindu or Muslim.



Demographics: GP practice

Patient populations

The GP practice patient numbers range from 8,500 to 28,000, with relatively diverse populations:

- Pockets of both affluence and deprivation
- Urban, suburban and rural communities.
- Diverse age profiles (some young families, though, generally, with a greater number of aging patients)

- Minority groups including the Gypsy Roman Traveller (GRT) and Nepalese communities, asylum seekers and one reported that there is a women's hostel within catchment area.

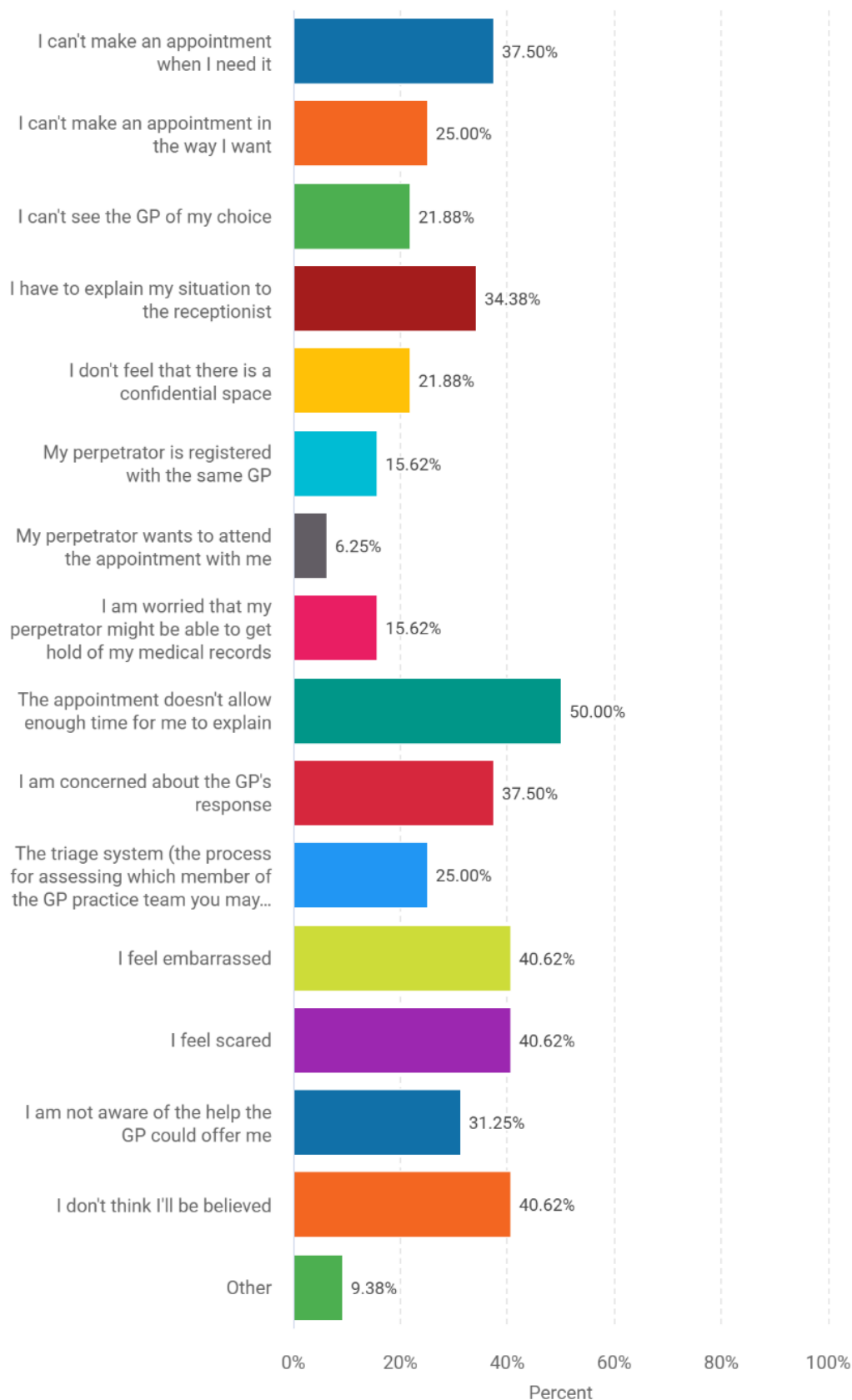
Practice staff

Staffing profiles range from 80 practice team members to approximately 20. All practices are staffed by multi-disciplinary teams which can include advanced nurse practitioners, paramedic practitioners, prescribing pharmacists, pharmacy technicians, phlebotomists, community matrons, first contact physiotherapists, associate physicians and health care assistants, and are supported by practice managers and reception and administrative teams.

GPs are a mix of full time and part time, salaried and non-salaried and gender. Every GP practice has a designated safeguarding lead who supports practice colleagues with patients identified as experiencing domestic abuse appropriately (though does not take responsibility for the clinical management of these patients). Every GP operates a patient list though patients can choose the GP they wish to see regardless of their named GP.

Barriers to disclosure

The following bar chart shows respondents answers to the following question, "Are any of the following barriers to you sharing your experience of domestic abuse with your GP, or another member of the team at your GP practice?". The largest percentage responses were: 50% of people said there wasn't enough time, 40.62% said one or more of the following: I feel embarrassed/I feel scared/I feel I won't be believed. 37.5% said either one of the following (or both) I am concerned about the GPs response/I can't make an appointment when I need it.



Introduction to Healthwatch Surrey

Healthwatch Surrey champions the voice of local people to shape, improve and get the best from NHS, health and social care services. We are independent and have statutory powers to make sure decision makers listen to the experiences of local people.

We passionately believe that listening and responding to local people's experiences is vital to create health and social care services that meet the needs of people in Surrey. We seek out people's experiences of health and care services, particularly from people whose voices are seldom heard, who might be at risk of health inequalities and whose needs are not met by current services. We share our findings publicly and with service providers and commissioners to influence and challenge current provision and future plans.

We also provide reliable and trustworthy information and signposting about local health and social care services to help people get the support they need.

Contact us

Website: www.healthwatchsurrey.co.uk

Phone: 0303 303 0023

Text/SMS: 07592 787533

WhatsApp: 07592 787533

Email: enquiries@healthwatchsurrey.co.uk

Address: Freepost RSYX-ETRE-CXBY, Healthwatch Surrey, Astolat, Coniers Way, Burpham, Guildford, Surrey, GU4 7HL.

 [healthwatchsurrey](https://www.facebook.com/healthwatchsurrey)

 [healthwatch_surrey](https://www.instagram.com/healthwatch_surrey)

 [Healthwatch Surrey](https://www.linkedin.com/company/Healthwatch Surrey)



We are proud to be shortlisted in 2025, and commended in 2024, for the National Healthwatch Impact Awards recognising our work helping to improve local NHS and social care.



We are committed to the quality of our information.
Every three years we perform an audit so that we can be certain of this.



The Healthwatch Surrey service is run by Luminus Insight CIC, known as Luminus.

Registered office: GF21, Astolat, Coniers Way, Burpham, Surrey, GU4 7HL.