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Dheensa, S. (2020). *Recording and sharing information about domestic violence/abuse in the health service: Research report and good practice recommendations for healthcare*. Pathfinder consortium.

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Pathfinder

Recording and sharing information about domestic violence/abuse in the health service

Research report and good practice recommendations for healthcare

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August 2020

Contents

Acronyms

BASHH – British Association for Sexual Health and HIV
BMA – British Medical Association
CAMHS – Child and Adolescent Mental Health Services
CQC – Care Quality Commission
CCG – Clinical Commissioning Group
CP-IS – Child Protection–Information Sharing
DASH – Domestic Abuse, Stalking, and Harassment and 'Honour'–based violence risk indicator checklist
DH – Department of Health
DHR – domestic homicide review
DVA – domestic violence/abuse
ECDS – emergency care data set
ED – emergency department
EMR – electronic medical record
EPR – electronic patient record
GDPR – General Data Protection Regulation
GMC – General Medical Council
GP – general practitioner
HARKS – humiliation, afraid, rape and kick, and safety
HCP – healthcare professional
HRDA – high-risk domestic abuse (HRDA)
IDVA – independent domestic violence advisor/advocate
IRIS – Identification and Referral to Improve Safety
ISA – information-sharing agreement
LARA-VP – linking abuse and recovery through advocacy for victims and perpetrators
MAPPA – multi-agency public protection arrangement
MARAC – multi-agency risk assessment conference
MATAC – multi-agency tasking and coordination
MASH – multi-agency safeguarding hub
MSDS – maternity services data set
NHS – National Health Service
NICE – National Institute for Health and Care Excellence
NMC – Nursing and Midwifery Council
ONS – Office for National Statistics
PRSB – Professional Record Standards Body
RCEM – Royal College of Emergency Medicine
RCGP – Royal College of General Practitioners
RCM – Royal College of Midwives
RCN – Royal College of Nurses
RCOG – Royal College of Obstetricians and Gynaecologists
SAR – safeguarding adult review
SARC – sexual assault referral centre
SCIE – Social Care Institute for Excellence
SCR – serious case review
SNOMED – Systematised Nomenclature of Medicine
UK – United Kingdom

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Acknowledgements

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*Took part in consensus meeting.

Executive summary: research report and good practice recommendations

Aims of the project

The aims of this project were to use multiple methods to form national recommendations, finalised via a consensus process with expert advisors, on good practice around recording domestic violence/abuse in different healthcare settings and sharing information within the health service and between health and other agencies/services. The aim of the recommendations is to benefit and reduce harm to victims/survivors and children.

Context and setting

We focus our research and recommendations primarily on recording in and sharing between:

- Primary care (namely general practitioners [GPs] and practice nurses)
- Emergency medicine
- Maternity (particularly antenatal care)
- Mental health services
- Health visiting, sexual health, and paediatrics (but to a lesser extent)

and safeguarding staff working across these areas.

We also explore and make recommendations on sharing information with police, social care, multi-agency risk assessment conferences (MARACs), and domestic violence/abuse services.

The recommendations will support healthcare professionals in recording and sharing information about domestic violence/abuse **for direct patient care** in cases where there is:

- **Disclosure:** the recommendations will primarily support healthcare professionals to record and share information about disclosures of domestic violence/abuse. It will secondarily support healthcare professionals to record and share information if after **enquiry** no disclosure is made
- **Consent or no consent:** the recommendations will support healthcare professionals to share information when the patient has given consent for such sharing, when the patient has not given explicit consent, and when the patient has withheld consent
- **Cases that fall within and outside of formal safeguarding processes**

Target audience for our recommendations

Our recommendations target healthcare professionals, including senior staff with additional responsibilities (e.g., chief medical information officers, clinical leads), in general practice, acute trusts, community trusts, and mental health trusts. The recommendations are also relevant to allied healthcare professionals, administrators, managers, commissioners, researchers, and policymakers. We focus on England, but the research findings and recommendations are relevant to other United Kingdom (UK) nations.

Methods

A meeting with an expert advisory group informed the priority areas for this research, as outlined in the Context and Setting section. We used multiple methods and drew on numerous evidence sources to conduct and inform the research. These methods included a policy analysis of guidance documents from national (e.g., Department of Health) and professional (e.g., Royal Colleges) bodies; analyses of domestic homicide reviews, serious case reviews, and safeguarding adults reviews; a review of recent academic literature from the UK; discussions with key stakeholders; and an outline of current initiatives that may facilitate recording and sharing. We drew on this work to produce draft recommendations, targeted at specific groups of professionals, for improved practice. We finalised the recommendations through a multi-stage consensus process involving an adapted version of the nominal group technique (World Health Organization, 2014) with a group of expert advisors and a group of survivors.

Outline of the executive summary

In this executive summary, we outline the key findings from our research, focusing on areas where good practice has not been implemented or where good practice is not determined. We first present research about recording information, and then present research about sharing information. Finally, we present the recommendations for improving practice produced through the consensus process.

Recording information: summary of research and key issues

National guidance on recording domestic violence/abuse information

The British Medical Association (BMA, 2014) and Department of Health (2017) both advise what healthcare professionals should document about domestic violence/abuse. Both ask healthcare professionals to document 12 items about

domestic violence/abuse but do not indicate which of these should be prioritised if time is limited, for example. Neither recommend that healthcare professionals use diagnostic codes. The Department of Health recommends that healthcare professionals use the victim/survivor's own words to record the detail of injuries, but also recommends they 'document whether the injury and patient's explanation is consistent', which may undermine the former recommendation. Moreover, the guidelines are ambiguous about which healthcare professionals should have access to domestic violence/abuse information.

Professional groups' guidance on recording domestic violence/abuse information

Six professional groups' guidelines/resources mention recording domestic violence/abuse information. They include the Royal College of General Practitioners guidance (2020, forthcoming; 2017) on recording domestic violence/abuse information; the Department of Health (2013) guidance for health visitors and school nurses; the National Institute for Health and Care Excellence (NICE, 2010) guidelines for pregnancy and complex factors; the Royal College of Emergency Medicine (2015) guideline; the 'Linking Abuse and Recovery through Advocacy for Victims and Perpetrators' or LARA-VP (Yapp et al., 2018) resource for mental health professionals; and the British Association for Sexual Health and HIV (BASHH; 2016) sexual violence group guidance. Some of these guidelines are specific to domestic violence/abuse; some are general. Aside from the LARA-VP resource, no guideline indicates what items should be prioritised for documentation. Except for the Royal College of General Practitioners guidance, none of these resources indicate where to document domestic violence/abuse. Only the Royal College of General Practitioners and LARA-VP has guidance on whether and how to document information about perpetrators, as well as what information to document.

Issues from domestic homicide reviews on GPs and recording information

All analyses of domestic homicide reviews (e.g., Sharp-Jeffs and Kelly, 2016; Neville and Sanders-McDonagh, 2015) cited GPs' poor record keeping as a factor in failing to prevent harm or death. But, in most reviews, GPs did not know about domestic violence/abuse. Rather, their poor record keeping led to missed opportunities to *enquire* about abuse: GPs had not coded risk factors for abuse accurately and had not linked records between intimate partners. Another issue was that information about perpetrators and victims/survivors' risk factors was lost in transfers between GP practices. Awareness of domestic violence/abuse in health did not always lead to domestic violence/abuse service provision. Interestingly, analyses of serious case reviews and safeguarding adults reviews held no relevant issues or guidance around recording information in healthcare.

Research on views and practices around recording domestic violence/abuse information in general practice

Domestic violence/abuse is under-recorded in general practice (Chandan et al., 2020). General practice staff use diverse and inconsistent methods for documenting abuse. Some are uncertain about documenting domestic violence/abuse at all because they do not see it as a health issue or are unsure about taking disclosures at face value (Szilassy et al., 2015). General practitioners often become aware that their patients are experiencing or perpetrating domestic violence/abuse through third-party reports (e.g., from MARACs) and are especially unsure about how to record this information (Pitt et al., 2020). The Royal College of General Practitioners guidance may resolve these uncertainties, but knowledge and implementation of guidance often varies.

Issues from domestic homicide reviews on emergency departments and recording information

The number of different healthcare professionals a patient sees on their journey through emergency departments makes recording and sharing information more difficult but more important. One domestic homicide review showed that a patient attended an emergency department after a partner assault. Ambulance staff did not hand over information about his domestic violence/abuse disclosure to triage staff: the patient requested that nothing be done about his disclosure, and because he had 'capacity', ambulance staff decided not to share the information. Triage staff failed to document a second disclosure of domestic violence/abuse within the same care episode. The patient absconded before the consulting clinician saw him, and the emergency department sent a discharge letter to the wrong general practice. Since the review, all ambulance arrivals are formally handed over to hospital staff in the trust: all patient notes are handed to a nurse, and when there are sensitive circumstances, handover is face to face. Moreover, any information on assault or domestic violence/abuse is noted separately and addressed at a later assessment (Croom, 2014).

Research on views and practices around recording domestic violence/abuse information in the emergency department

Olive (2017) analysed emergency department records where the patient had disclosed partner assault. This research showed that information about assault, and therefore about domestic violence/abuse, can be lost along the patient's journey through the emergency department. As with earlier research (Boyle et al., 2009), clinical notes often lacked detail. Often consulting clinicians documented the term 'assault' in clinical narratives/case notes and GP discharge letters without mention of

the perpetrator's identity. Information was often missing, such as referrals to children's services, frequency of violence, and whether the presenting assault was the first episode. Proformas may improve practice if coupled with training (Basu and Ratcliffe, 2014; Ritchie et al., 2013), but our expert advisory group emphasised that any such form would need to be concise.

Alerts and flags in the emergency department (and hospital trusts more widely)

In some trusts (or in emergency departments) healthcare professionals can use alerts or flags on patients' records to indicate risk information. Some alerts/flags are visible across the hospital and sometimes just in the emergency department. Sometimes only patients heard at MARACs are flagged. Some trusts could use alerts/flags but do not use them because no one has been assigned the responsibility to flag and unflag patients. Independent domestic violence advisors/advocates (IDVAs) in some trusts have access to electronic patient records and can flag/unflag patients, but some have no access at all to these records, or no editing access. No research or audit has explored flagging practices and their potential to benefit victims/survivors and children.

Emergency department frequent attender/high-impact user/high-intensity user teams

Some emergency departments have teams to identify patients who attend frequently and have an additional risk or vulnerability. Domestic violence/abuse cases may be identified through such teams. A dedicated team will place alerts on a patient's record and create support plans for these patients in coordination with other agencies/services, GPs, and other healthcare professionals. Again, no research or audit has determined how this practice may benefit victims/survivors and children.

Research on views and practices around recording domestic violence/abuse information in maternity

There has been no academic research from UK maternity settings about domestic violence/abuse since 2013. This research showed that midwives do not always enquire about domestic violence/abuse, even though NICE recommends (2014) routine enquiry in this setting. Systems-based approaches are emerging that mandate midwives to answer questions about domestic violence/abuse in the electronic patient record. However, these will not overcome the common barriers to routine enquiry: the presence of a partner; language barriers and lack of interpreters; and lack of privacy and time (Baird et al., 2013). Work is underway to replace maternity handheld notes—common unless the pregnancy is complicated—with an interoperable digital maternity record. Research is needed to explore how domestic violence/abuse can safely be documented in these records. Another example of novel practice in maternity is online self-referral for antenatal care, which circumvents the GP. Discussions with stakeholders highlighted that in one trust using

self-referral, women have been frank in disclosing personal details, and the quality of information was better than expected. However, an evaluation of safety is needed, since perpetrators sometimes monitor online activity.

Medical records and court

The potential for records to be used in court affects how healthcare professionals document domestic violence/abuse (Reed, 2020), such as taking care not to document 'opinion' or 'extraneous details' for incidents that may go to court. Several research studies have shown that healthcare professionals use the term 'alleged' and other terms to imply doubt (e.g., 'patient claims'; e.g., Olive, 2017), which, according to victims/survivors, has led to records being seen as less reliable evidence of domestic violence/abuse in court (e.g., Bacchus et al., 2010). Victims/survivors who request their records report feeling disbelieved, which compounds a sense of trauma.

Patient online access to general practice electronic medical records

Patients can access their partial general practice electronic medical record online and will be able to request access to their full general practice record from 2020/21. Easier access to medical records has intensified fears about coercion and breaches in confidentiality in relation to domestic violence/abuse—namely perpetrators getting access to the victim/survivor's record or seeing abuse documented in children's records (Pitt et al., 2020; Drinkwater, 2017; Feder, 2015). General practitioner guidance asks GPs/practice nurses to use redaction and the 'hide from online access' function for domestic violence/abuse information, but this relies on the practice having a reliable redaction policy and on GPs/practice nurses knowing how to use this function and remembering to use it. The function does not apply to previously coded information, so unless GPs/practice nurses in earlier consultations used the function, domestic violence/abuse information may still show in the patient-facing record. Hiding information and redacting information retrospectively will likely be resource-intensive and prone to human error (Paul, 2019).

Access to general practice electronic medical records and hospital electronic patient records by different healthcare professionals

The NHS Long Term Plan (2019) reaffirms the commitment to a fully digitised NHS by 2023/24. Systems are increasingly enabling a wide range of healthcare professionals to access patients' general practice electronic medical records (via shared record systems) or hospital electronic patient records (e.g., through interoperability platforms). A lack of joined-up care in the NHS is a perpetual problem. Domestic homicide review analyses frequently cite the lack of linkage between different health services as a factor in failing to prevent homicide or harm (e.g., Sharp-Jeffs and Kelly, 2016). However, making information accessible to other

healthcare professionals also poses a challenge. There is no nationwide policy on how sensitive information will be managed in digitised records. A healthcare professional who has not had training on how to broach domestic violence/abuse could use this information inappropriately, such as raising it in an insensitive way, talking about it in front of a third party, or not realising it is visible to a third party on their screen. Trained healthcare professionals may worry about recording information if other healthcare professionals can see it.

Sharing information: summary of research and key issues

National guidance on sharing domestic violence/abuse information

National guidelines give subtly different advice on when sharing without consent can happen. Generally, such sharing can happen in the 'public interest' or when there is risk of 'serious crime' or 'serious harm'. But these terms are broad and ambiguous. No guideline mentions coercive control and how it can influence the decision of a patient with capacity to withhold consent. Safeguarding-specific guidelines advise healthcare professionals to share information with carers, family, or friends unless there are good reasons not to do so: however, in some domestic violence/abuse cases, one of these parties may be a perpetrator. The guidelines also give subtly different advice on when sharing information for MARACs is acceptable. Medical defence bodies and medical councils can advise healthcare professionals on sharing, but sometimes give directly conflicting advice. Along with Caldicott guardians, advisors in these bodies and councils may have limited understanding and training around working with domestic violence/abuse victims/survivors and perpetrators.

Professional groups' guidance on sharing domestic violence/abuse information

Eight professional groups have guidelines that variably cover sharing information: the Royal College of General Practitioners (with IRISi and SafeLives; 2014), the Royal College of Nurses (2017), the Department of Health (2013; for health visitors/school nurses), NICE (2010; for GPs, midwives, and other primary care staff seeing pregnant patients), the Royal College of Obstetricians and Gynaecologists (2016), the Royal College of Emergency Medicine (2015), BASHH (2016), and the LARA-VP (Yapp et al., 2018) resource. They variably cover sharing information in an emergency, sharing information with MARACs, sharing with domestic violence/abuse services, sharing with other healthcare professionals, and sharing with other agencies/services. All guidelines mention which other agencies/services healthcare

professionals should consider sharing information with. Otherwise, guidance is patchy. Most notably, only two of eight guidelines (Royal College of Nursing, 2017; Department of Health, 2013) mention anything about sharing information with other healthcare professionals, and only the LARA-VP resource for mental health professionals (Yapp et al., 2018) mentions anything specific about perpetrators. No other royal college or professional group has domestic violence/abuse guidance.

Issues from domestic homicide reviews, serious case reviews, and safeguarding adults reviews on sharing information

Domestic homicide reviews, serious case reviews, and safeguarding adults reviews have found that information sharing is poor between health and other agencies/services. Reviews highlighted that MARAC and safeguarding referrals were sometimes not made, but even when they were, there was insufficient information sharing post-MARAC. Similarly, when information was shared between health and other agencies/services, there was no corresponding assignment of actions. Analyses also highlighted the additional complexities around how much to involve carers in care planning for vulnerable adults—who, as the reviews illustrate, can be victims or perpetrators. Overall, cases of inadequate sharing involved general practice, emergency departments, mental health, maternity, and health visiting. Notably, across all analyses, most cases of inadequate sharing *within health* were about inadequate sharing about the perpetrator, not the victim.

Research on views and practices around sharing domestic violence/abuse information

Very little research explicitly explores whether and how healthcare professionals share information about domestic violence/abuse within healthcare and with other agencies/services. Pitt et al. (2020) found that GPs are unsure what to do upon receiving MARAC and police reports about domestic violence/abuse: reports rarely make clear whether the sending party expects the GP to take any action and whether the patient knows the information has been shared. Another study on the health visitor response to domestic violence/abuse (McFeely, 2016) showed that health visitors have little interaction with other agencies aside from occasional joint visits to families with social workers. Discussions with stakeholders indicate that some sharing happens between GPs, health visitors, midwives, school nurses, and paediatricians. These discussions and the limited available research suggest that the reorganisation of primary and maternity care has impeded effective sharing and means contact is now via phone call or email, which can be unreliable. Good practice around sharing is better determined when there are children under 18, as healthcare professionals can then fall back on child safeguarding processes. Sharing in cases that fall outside of formal safeguarding appears to be on an ad-hoc basis.

Recommendations

We end this report with recommendations for future research and audit, and then good practice recommendations on recording and sharing domestic violence/abuse information.

We make overarching recommendations for healthcare organisations; overarching recommendations for all healthcare professionals; recommendations on recording information; recommendations for sharing information; recommendations about domestic violence/abuse–trained administrators and leads/coordinators; and recommendations for other professionals.

Introduction

Healthcare responses to domestic violence/abuse

Domestic violence/abuse (DVA) is any incident of controlling, coercive, or threatening behaviour, violence, or abuse between those aged 16 or over who are or have been intimate partners or family members, regardless of their gender or sexuality.

An estimated two million adults in England and Wales aged 16 to 59 years experienced DVA in the year ending March 2018 (Office for National Statistics [ONS], 2018). Actual numbers will be much higher given that DVA also affects those aged 60 and upwards. The health consequences of DVA are wide-ranging. In the United Kingdom (UK), the National Health Service (NHS) is often the first point of professional contact for survivors (Howarth et al., 2019). Healthcare professionals (HCPs) are well-placed to respond to DVA.

Despite the development of positive work to tackle DVA, professionals, as well as victims/survivors and children, are often frustrated at how challenging it is to ensure and sustain safe outcomes for those affected. Hester (2011) pins some of the blame on the tensions and contradictions in professional discourses and practices across the DVA sector, child protection and safeguarding, and child contact (such as through family courts). These three areas of work 'are especially difficult to bring together into a cohesive and coordinated approach because they are effectively on separate "planets"—with their own separate histories, culture, laws and populations' (p.839).

Healthcare, which is often called upon to respond to DVA and be a more active part of multi-agency work around DVA, is arguably a fourth planet. It is a huge, complex, and ever-changing planet. And for this reason, it can be difficult for those on the other three planets (and sometimes for those working in one part of the healthcare planet) to understand what is possible within the NHS when it comes to responding to DVA.

In this report, we produce recommendations for improving practice for recording and sharing information about DVA. Problems with information recording and sharing are recurring themes in multi-agency reviews of death and/or serious harm: domestic homicide reviews (DHRs),[1] carried out when the death of a person aged 16 years or

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[1] Domestic homicide reviews were introduced in 2011. Despite their name, DHRs may be conducted after a suicide where DVA appears to be a causal factor.

over has (or appears to have) resulted from DVA, serious case reviews (SCRs), and safeguarding adults reviews (SARs), carried out after a child or 'adult at risk' (i.e., a vulnerable adult as per the Care Act, 2014), is seriously harmed or dies and neglect or abuse are suspected or known factors. In their analysis of 141 DHRs, Chantler et al. (2020) found that that physical and mental health services had the most contact with victims/survivors and perpetrators compared with other agencies/services. Analyses of DHRs often implicate healthcare services—usually along with other services and agencies—in inadequately recording and sharing information (e.g., Chantler et al., 2020; Stanley et al., 2019; Home Office, 2016; Sharp-Jeffs and Kelly, 2016; Neville and Sanders-McDonagh, 2015). Sharp-Jeffs and Kelly (2016) classify these poor practices under two categories: implementation gaps where best practice has not been applied, and evidence gaps, where there is insufficient evidence to inform best practice. There is clearly more work to be done to improve practice.

While our recommendations are about recording and sharing, training around identifying and enquiring about DVA is crucial—particularly identifying coercive control, which can be difficult for professionals to identify (Halliwell et al., 2020). The National Institute for Health and Care Excellence (NICE; 2014) guidelines on DVA acknowledge that insufficient evidence exists for routine enquiry or screening for DVA in healthcare, but HCPs in certain fields are more likely than others to encounter victims/survivors. The guidelines therefore recommend that in antenatal, postnatal, reproductive, sexual health, substance-use treatment, mental health, children's, and vulnerable adults' services, routine enquiry should be part of good clinical practice even where there are no indicators of DVA. In all other settings, NICE recommends targeted enquiry. Good practice around recording and sharing rests on good practice around identifying and enquiring.

Aims of the project

This project was commissioned by the Pathfinder consortium, comprising five DVA agencies: Standing Together, SafeLives, IRISi, Imkaan, and Against Violence and Abuse. The work was commissioned to complement the main Pathfinder initiative, which aimed to enhance the healthcare response to DVA.

The aims of this project were to use multiple methods to form national recommendations, finalised via a consensus process with expert advisors, on good practice around recording DVA in different healthcare settings and sharing information within the health service and between health and other agencies/ services. The aim of the recommendations is to benefit and reduce harm to victims/survivors and children.

Context and setting

Recording and sharing information can happen in three contexts:

1. Recording and sharing for direct patient care
2. Recording and sharing for local use: internal audit, regulation by the Care Quality Commission (CQC), with local authorities to plan services, or with local violence-reduction units
3. Recording and sharing for NHS Digital national databases (e.g., the emergency care data set [ECDS] and the maternity services data set [MSDS]). These primarily allow hospitals to be paid for the care they deliver. They also inform planning of health services and are used for research

We focus this report primarily on recording and sharing for direct patient care. We also identify gaps in understanding of good practice and make recommendations for internal and national audits where these could improve understanding and practice.

We do not focus on recording and sharing for NHS Digital's national databases because as Olive (2018) and Syed et al. (2020, forthcoming) show, national databases are not currently set up to collect information relevant to DVA and so do not contain reliable DVA data. Hospitals are not reimbursed for identifying or providing care related to DVA.

> We focus our research primarily on recording in and sharing between settings that the NICE DVA guidelines (2014) call Level 2 settings[2] and the safeguarding staff working across these areas[3]:

- Primary care (namely general practitioners [GPs] and practice nurses)
- Emergency medicine
- Maternity (particularly antenatal care)
- Mental health services (but to a lesser extent, since Yapp et al.'s [2018] recent and comprehensive work on DVA in mental health has already produced a robust resource on recording and sharing information)
- Health visiting, sexual health, and paediatrics (but to a lesser extent)

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[2] The NICE guidelines (2014) recommend different levels of DVA training. Level 1 staff should be trained to respond to a disclosure of DVA sensitively and safely. Level 2 staff should be trained to ask about DVA in a way that makes it easier for people to disclose it. Level 3 staff should have training that includes risk identification and assessment, safety planning, and continued liaison with specialist support services. This level typically includes safeguarding nurses and midwives and nominated health visitors.

[3] We do not focus in this report on the response of ambulance services to DVA, but more work is needed in this setting about where information is recorded and with whom it should be shared.

We also explore and make recommendations on sharing information with police, social care, multi-agency risk assessment conferences (MARACs),[4] and DVA services.

We intend for the recommendations to support HCPs in recording and sharing information about DVA in cases where there is:

- **Disclosure:** the recommendations will primarily support HCPs to record and share information about disclosures of DVA. It will secondarily support healthcare professionals to record and share information if after **enquiry** no disclosure is made. We focus less on recording and sharing risk factors such that HCPs are more likely to enquire about DVA in future, because skill in this regard often comes down to how much training HCPs have
- **Consent or no consent:** the recommendations will support HCPs to share information when the patient has given consent for such sharing, when the patient has not given explicit consent, and when the patient has withheld consent
- **Cases that fall within and outside of safeguarding**: currently,[5] the formal adult safeguarding process applies to any 'adult at risk'—that is, an adult who
  - Has needs for care and support (whether or not the authority is meeting these needs)
  - Is experiencing, or is at risk of, abuse or neglect
  - As a result of those needs, is unable to protect themselves against the abuse or neglect or the risk of it (Care Act 2014, section 42)

Children's safeguarding procedures would apply when children under 18 are involved (e.g., in the household where there is DVA). Our recommendations should be read alongside child and adult safeguarding practices and policies.

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[4] MARACs are multi-agency risk assessment conferences for victims/survivors of DVA. These are meetings where representatives from different agencies/services share information about the highest risk DVA cases. They are not a statutory provision, so there is no formal obligation for MARACs to exist in every area. SafeLives recommends that professionals should refer if the Domestic Abuse, Stalking and Harassment and 'Honour'-based violence (DASH) risk indicator checklist produces a score of 14 or above. Professionals can also refer based on their judgement of risk (e.g., when the victim scores fewer than 14 ticks or if the professional has not used the DASH). Around 290 MARACs exist across the UK (SafeLives, 2019a).

[5] There have been proposals to change the statutory definition of an adult at risk through the Domestic Abuse Bill and a review of the Care Act, 2014 such that an adult at risk would encompass all DVA victims/survivors. In the current report, we use the existing statutory definition of safeguarding.

Target audience for our recommendations

Our recommendations primarily target HCPs, including senior staff with additional responsibilities (e.g., chief medical information officers, clinical leads), in general practice, acute trusts (i.e., those providing acute and emergency care to patients, including inpatient, outpatient, and emergency department [ED] care), community trusts, and mental health trusts. The recommendations are also relevant to allied HCPs, administrators, managers, commissioners, researchers, and policymakers. We focus on England, but findings and recommendations are relevant to the other UK nations.

Methods

A meeting with an expert advisory group (see page 3) informed the priority areas for this research, as outlined in the *Context and Setting section*).

We used multiple methods and drew on numerous evidence sources to conduct and inform the research:

- A policy analysis of guidance documents from national bodies and different professional groups (e.g., Royal Colleges) on recording and sharing information
- Case analyses of DHRs, SCRs, and SARs from which we extracted recommendations about recording and sharing that involved healthcare. Where possible, we identified and analysed the original DHRs that these analyses mentioned to identify the details of any aspects relevant to recording and sharing in healthcare. We also analysed a selection of recent DHRs, SCRs, and SARs published since these reviews
- A review of recent academic literature (from the UK, unless otherwise specified) on recording and sharing practices around DVA involving healthcare
- Discussions with key stakeholders from NHS England Safeguarding, NHS Digital, hospital-based independent domestic violence advisors/advocates (IDVAs), hospital safeguarding leads, the CQC, DHR chairs, HCPs, DVA agencies/services, and researchers
- An outline of current initiatives that may facilitate recording and sharing (use of alerts and flags in the ED and across trusts; shared record systems in general practice; interoperability platforms; patient-facing portals for hospital records; and multi-agency fora for sharing information)
- An analysis of 22 DVA policies from NHS trusts in England. This is around 10% of trusts in England (n = approx. 223; King's Fund, 2020a) covering a population of around 5.5 million people. We publish this separately from this main report

We drew on this work to produce draft recommendations, targeted at specific groups of professionals, for improved practice. Some recommendations re-iterated previously published recommendations, some adapted or revised those previously

published, but most were new recommendations (e.g., where there had been no previous consensus or guidance on best practice).

We finalised the recommendations through a multi-stage consensus process with members of an expert advisory group.

- A subgroup of members received a research report, summary of key findings, and draft recommendations with specific questions to consider, and were invited to comment on the recommendations
- We then held a three-hour meeting via videoconferencing to discuss a selection of recommendations in an adapted version of the nominal group technique (World Health Organization, 2014). During this meeting, we discussed each recommendation in turn and each person gave their view on its feasibility and acceptability. At the end of each recommendation's discussion, we synthesised the participants' views to identify clear areas of consensus and areas where good practice remained unclear. We then gave participants a chance to comment on this summary. The meeting was audio-recorded
- After the meeting, expert advisory group participants received a set of revised recommendations to help shape final phrasing. In a few cases, at this stage, consensus emerged around a recommendation for which we did not reach consensus in the meeting
- We also sent these revised recommendations to a group of three DVA survivors for their comment and held two meetings, two hours in length, via videoconferencing to discuss the recommendations in turn
- Finally, we synthesised all comments from the expert advisory group and survivors to produce a final set of recommendations

Outline of the report

We split this report into two sections—recording information and sharing information—where we present the research that informed the recommendations. Both sections start with a delineation of guidelines from national bodies and then guidelines from professional groups to highlight areas of uncertainty, inconsistency, conflict, and omission. Given that the existence of a guideline is a necessary but not sufficient condition for its implementation, we then discuss what happens in practice, drawing on findings from DHRs, SCRs, SARs, academic literature, and discussions with HCPs and other stakeholders. We present our recommendations at the end of the report.

A note about. . .

. . . COVID-19

This work took place during the COVID-19 pandemic. The pandemic has made, and will continue to make, videoconferencing and telephone appointments more common. Healthcare professionals will need to follow guidance (e.g., IRISi, 2020; Standing Together, 2020) to inform safe consultations with patients who are known to be at risk of DVA and where there is suspected or disclosed DVA. Given the rise in DVA cases over the lockdown period, there may be cross-departmental government discussions with key stakeholders on safeguarding relating to DVA (NHS Safeguarding, personal communication). We will watch how these developments affect work around DVA and the guidance we produce.

. . . the Domestic Abuse Bill

This report should be read in the context of the upcoming Domestic Abuse Bill. At the time of writing, the bill had made a number of commitments to address DVA; however, very few of these relate to the health sector.

. . . terminology

We use the term 'perpetrator' to indicate a person using abusive behaviour. This term comes from the criminal justice setting and is not our preferred term, but it has gained the most traction in research and policy. We use the term 'victim/survivor' to indicate a person experiencing DVA. We use 'child' to indicate the child of a victim or perpetrator. In some cases, children (aged 16 to 18 years) will be victims or perpetrators; when we mean child victims or child perpetrators, we make this clear.

. . . the Pathfinder project

For a holistic understanding of the healthcare response to DVA, we encourage readers to read this report in conjunction with the Pathfinder toolkit (2020a) and Pathfinder survivor consultation (2020b).

Recording information about DVA

In this section, we begin with an overview of the types of medical records that different clinical departments use. This background information will give context to the subsequent discussions. We then delineate the national guidelines on what HCPs should document about DVA before turning to guidelines from different professional groups (e.g., Royal Colleges). We highlight the areas of uncertainty, inconsistency, conflict, and omission, and areas where recommended best practice may need to change. Guidelines leave room for professional judgement and implementation can vary. Thus, we then look at what DHRs have said about recording information in healthcare and what different HCPs do in practice, informed by academic research and discussions with HCPs. We end on a discussion of more recent developments around medical records—namely sharing of electronic medical and hospital records through shared records systems, patient portals, and interoperability platforms. To an extent, we will discuss sharing information as well as recording in this section, as the two practices are inextricably linked.

Overview of different types of records

The NHS currently uses a combination of electronic and paper medical records. The vision for the NHS to be paperless, with the use of electronic medical records (EMRs) in general practice and electronic patient records (EPRs) in hospitals, is reaffirmed in the NHS Long Term Plan (NHS, 2019a). The NHS uses a variety of software suppliers for EMRs/EPRs. Software is often 'off the shelf'; making changes to the software (e.g., what data it can collect) is often technically impossible or technically difficult and/or costly. We have provided detail of EMRs used in general practice followed by EPRs used in hospital settings.

General practice EMRs

In general practice EMRs, a wide range of clinical conditions, tests, symptoms, and treatments can be easily coded in consultations. Until recently, general practice EMRs and primary care staff used Read codes, a standard vocabulary of findings and procedures used across primary and secondary care. There is now a national transition from Read codes to Systematised Nomenclature of Medicine (SNOMED) codes, an international system of clinical terminology. It is used across the NHS, allowing for easier and more accurate exchange of clinical data across all care settings. The SNOMED codes can be categorised as procedures, situations, events, findings, assessment scales, or observable entities. As GPs or practice nurses type into the EMR, suggested SNOMED codes appear for them to select. Alternatively, GPs/practice nurses can make notes in free text in the comment/history section of the EMR. As Appendix 1 illustrates, at least 120 SNOMED codes are relevant to DVA, but Royal College of General Practitioners (RCGP) guidelines (2020

forthcoming; 2017), which we discuss in the *GP Guidance for Recording DVA Information* section later, recommend that GPs/practice nurses use the code 'history of domestic abuse' for victims/survivors and children. Coding makes the record more easily searchable but use of codes varies between GPs/practice nurses; some use them less frequently within consultation, relying on free text. Reports or letters from other services or agencies (e.g., from mental health or the police, or MARACs) can be scanned into the patient's record without coding any of its content, although good practice is for key data in the letter to be coded. Electronic medical records have alert functions to indicate risk.

Four principal system suppliers (TPP SystmOne, EMIS Web, InPS Vision, and Microtest Evolution) supply EMRs.

We discuss where DVA may be recorded in the *What Recording Happens in Practice: Primary Care* section later.

IRIS-trained practices and HARKS

Identification and Referral to Improve Safety (IRIS) is a specialist DVA training, support, and referral programme for general practices. In IRIS-trained practices, if the GP/practice nurse codes a symptom or condition associated with DVA (e.g., tiredness or abdominal pain), the HARKS (humiliation, afraid, rape and kick, and safety) prompt will pop up—a mnemonic that aims to remind GPs/practice nurses to make targeted enquiries about DVA. Clicking on the prompt provides a template to record disclosures of different types of abuse: psychological, sexual, and physical. The prompt to consider safety is to remind GPs/practice nurses that whenever they have a disclosure of DVA, they must ensure it is safe for the victim/survivor to go home. The HARKS template is visible in that consultation to other GPs/practice nurses or any other clinician with access to the EMR. If the patient's medical records are transferred to a new general practice, the GP/practice nurses will likely know what the HARKS code means only if they have IRIS training.

General practitioners/practice nurses can choose to save the HARKS template even if after enquiry the patient does not disclose any type of DVA. Its recording can be useful for future consultations to function as a reminder or record that there is suspicion or concern about DVA. Often victims/survivors will not talk about DVA initially but may disclose if they are asked again. Integrating the HARKS prompt into EMRs has proven difficult because of technical reasons (e.g., EMIS upgrades).

Hospital setting EPRs

Warren et al. (2019) mapped the different software vendors used in 152 acute NHS trusts in England. Of the 152 trusts, 35 (23.0%) were using paper records and 117 (77%) were using electronic records systems, with 21 different vendors providing the systems. Of these 117 trusts, 92 were using one vendor system (Cerner, DXC, and System C were the most popular), 12 were using multiple systems (i.e., there was no unifying information technology system in the trust), and 13 were using software developed in-house.

The distribution of systems varied around the country. Some geographically close areas used the same vendors (e.g., several London trusts used Cerner), but in other areas (e.g., Bristol), trusts in the same city used different vendors.[6] We return to a discussion of how the differences in vendors impedes on sharing information in the *Expanded Access to General Practice EMRs and Hospital EPRs* section later. We now look more closely at the records used in the ED and maternity.

ED records

Currently EDs use a mixture of electronic and paper records, with paper records scanned into EPRs for future viewing and retrieval. In previous years, more records would have been paper-based.

In EDs, some information must be submitted to a national de-identified dataset called the ECDS, held by NHS Digital. The ECDS informs trust renumeration, commissioning, and research. The NHS trusts are mandated to record this data for each episode of care. Data quality is poor, with low levels of accuracy and completeness (Boyd et al., 2017). The aspects of the dataset that flow into the ECDS use predetermined codes from data dictionaries. As stated earlier, Olive (2018) and Syed et al. (2020, forthcoming) show that national datasets like ECDS are not currently set up to collect DVA data, and so do not contain reliable DVA data.

Like in general practice, ED uses SNOMED codes, but the available codes are restricted to the 650 codes most relevant to ED.

Patient records in the ED are multitudinous. The different types/parts of records are as follows (Olive, 2017; NHS, 2015):

- Ambulance records: for patients brought in by ambulance. In some trusts, ambulance staff will make electronic notes that are automatically uploaded to the ED's EPR[7]
- Registration information: clerical staff (receptionist/administrators) record registration information in the EPR when a patient arrives in the ED. This information is basic, capturing, for example, the patient's demographic information and general practice, and information about the attendance (e.g., how they arrived and the reason and nature of the visit). Selected information flows into the ECDS national data set. Since 2017 in EDs and 2018 in minor injuries units/urgency care centres and walk in centres, clerical staff are asked to

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[6] Some of the trusts were partially using an EPR, and study authors decided if the use was extensive enough to count as an EPR-using trust or whether it should count as a paper-using trust.

[7] We do not focus in this report on the ambulance services' response to DVA, but more work is needed in this setting about where information is recorded and with whom it should be shared. Our expert advisory group highlighted that many victims/survivors who experience DVA will not travel with paramedics to the hospital; information sharing and referrals (e.g., to MARAC and IDVAs) is made difficult as callouts are sometimes to areas in which the victim/survivor does not live (although some paramedics will share information with GPs and/or police); and recording risk assessments using the DASH is sometimes impossible due to time constraints and the uncontrolled environment.

document locally a patient's companion when that person is not a first-degree relative (e.g., parent or child). Staff must choose from a selection of pre-determined answers here

- Assessment, chief complaint, diagnoses, investigations (e.g., radiological, biochemical), treatments, and injury information: clinicians[8] record this information in the EPR. All of this information flows into ECDS. A triage nurse may collect some of this information before the consulting clinician sees the patient. Again, staff must choose from a selection of pre-determined answers. If the chief complaint is an injury, staff are required to ask the place of injury and have the option to ask about 'injury intent' (which is where they would specify whether the injury was accidental, self-inflicted, or by assault)[9]

- Clinical narrative: these are free-text notes to which clinicians who see the patient can contribute. The notes can include detail about the patient's reason for attendance, results from the diagnostic and treatment process, and recommendations for further management and follow-up. Some clinicians will make notes (including body maps and drawings of injuries) on paper and scan these into the record. This information is stored locally

- Discharge (the place to which the patient is discharged from the ED, including to home and to a hospital ward) and follow-up (the agency to which the patient was referred for continuing care following their ED attendance—usually the GP): all of this information flows into the ECDS. Other discharge information (e.g., about medication) is stored locally

- Discharge letter: the Professional Record Standards Body (PRSB) sets standards for the headings that must feature in any emergency care discharge summary (for GPs or other parts of the health service). Generally, the letter is populated by the clinical narrative, presenting compaints, procedures, diagnosis, and discharge details. Letters to GPs should have a 'plan and requested actions' to make clear who is expected to take responsibility for actions following the encounter (e.g., the GP or another HCP). Auto-population of sensitive information or failure of a clinician to discuss what information was acceptable to be included is a recognised hazard of using such summaries (PRSB, 2017)

- Safeguarding referral (e.g., if a child or adult is at risk [i.e., a vulnerable adult] as per the Care Act 2014 or if a safeguarding referral is made for another reason):

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[8] Clinician here is a doctor, emergency nurse practitioner (which may also include other higher grades in the nursing hierarchy [e.g., sister, matron, nurse manager, nurse consultant]), advanced care practitioner or extended scope physiotherapist. Clinician in this context does not include medical student, nursing student, healthcare assistant, or nursing staff not in the specified groups.

[9] An assault that happens in the location 'home' can be used as a rough proxy indicator for DVA.

HCPs can use the codes 'at risk of domestic abuse' or 'suspected domestic abuse' here. Notably, no SNOMED code for disclosed DVA is available[10]

Some ED EPRs will also have alerts/flags to indicate risk. Different staff within the ED use different parts of the record. Liaison psychiatrists who work in EDs will also have records. They facilitate communication between different parts of the health service, as well as other agencies/services.

Maternity records

Unless their pregnancy is complicated, women will receive most care in the community and use handheld records. For each pregnancy, the woman has handheld paper notes which she hands back to the hospital afterwards.

Work is underway to replace the paper notes a pregnant woman has traditionally carried during her pregnancy with an interoperable 'digital maternity record'. The aim is to make the records visible to all HCPs delivering maternity care (e.g., GPs, sonographers, pathology, and health visitors). The record will enable easier information sharing, regardless of the digital system in use or its location. Digital maternity records will use standard terminology (SNOMED) to ensure that different systems can share and interpret the information in the record. Research with women, midwives, clinicians, and support staff is informing this work (NHS Digital, 2020a).

As with the ED, some of the information collected in maternity flows into a national de-identified dataset called the MSDS. This information includes demographic details, diagnosis details, and complex social factors. A newer version of the MSDS allows the submission of clinical coded data, via SNOMED. Like the ECDS, the MSDS is not set up to collect DVA data. A catch-all field, 'complex social factors', includes alcohol or drug misuse, recent migrant or asylum seeker status, difficulty reading or speaking English, aged under 20 years, and DVA. This field requires either a yes, no/null, or missing response. Therefore, the MSDS contains nothing specific on DVA.

Mental health records

Trusts use EPRs for mental health records. Common suppliers of the EPRs are Rio, SystmOne, and Electronic Patient Journeys. Healthcare professionals record day-to-day observations in progress notes. They can upload relevant clinical documentation (e.g., reports and letters from professionals outside of the team or mental health trust).

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[10] Our expert advisory group highlighted that adding a SNOMED code to the ECDS requires an information note standard, which is a lengthy change-management process, and that these options are considered adequate for routine practice.

A note on sexual health

Sexual health records are kept separately from the main hospital records and are not linkable to other hospital and primary care records. Sexual health settings have used a HARKS template in a pilot study (Sohal et al., 2018). Other sexual health clinics in the country use different prompts (e.g., one for DVA and another for sexual violence).

A note on health visiting and paediatrics

Health visitors historically had access to and wrote in the GP records. However, many no longer have access to these records due to changes in primary care structures (although this may change as shared records, which we discuss in the *Expanded Access to General Practice EMRs and Hospital EPRs* section later, are rolled out). Health visitors now record information in the records system they use. Discussions with stakeholders in health visiting and paediatrics have highlighted that different records systems exist in various parts of the country. In some areas, all community health staff, including health visitors and paediatricians, use one electronic records system (e.g., Care Notes), meaning that notes are visible to other professionals, including therapists, school nurses, safeguarding nurses.

A note on commissioning

As well as not being capturable or mandated in national datasets (e.g., ECDS), DVA recording is not currently linked to any commissioning or incentive programmes such as the Quality Premium Scheme or the Quality and Outcomes Framework. Whether linking DVA to such schemes is feasible, desirable, and worthwhile warrants research.

National guidance on recording DVA information

We conducted a policy analysis to identify guidance on recording information about DVA from the key bodies involved in regulating and guiding practice in medicine and healthcare. We found that NICE and the General Medical Council (GMC) do not have specific guidelines on recording DVA information, although the GMC does have some general guidance on record keeping. The relevant documents were:

- Department of Health (DH). 2017. Responding to domestic abuse: a resource for health professionals.
- British Medical Association (BMA). 2014. Domestic abuse. A report from the BMA Board of Science

Both target a generic set of different clinical specialities. Below we summarise what they suggest and comment on areas of uncertainty, inconsistency, conflict, and omission.

DH: responding to domestic abuse—a resource for health professionals

This resource targets all NHS staff and those providing services funded by the NHS. The first edition was published in 2005.

The DH resource says that HCPs should record the following information on DVA:

1. Suspicion of DVA which has led/not led to disclosure
2. Whether routine or selective enquiry[11] has been undertaken and the response
3. Relationship to the perpetrator and name of the perpetrator
4. Whether the woman is pregnant
5. The presence of children in the household and their ages
6. Nature of psychological and/or physical abuse and any injuries
7. Description of the types of DVA/any other abuse experienced and reference to specific incidents
8. Whether this is the first episode, or how long regular abuse has been going on
9. Presence of increased risk factors
10. Results of completed Domestic Abuse, Stalking and Harassment and 'Honour'– based violence (DASH) risk assessment for the adult and a Domestic Violence Risk Identification Matrix or DASH assessments for each child, if relevant
11. Indication of information provided on local sources of help
12. Indication of action taken (for example, direct referrals)

It also says:

- Healthcare professionals should record sufficiently **detailed**, accurate, and clear notes to show the concerns they have and the harm DVA may have caused
- Healthcare professionals should use the patient's **own words in quotation marks**
- Healthcare professionals should document **whether the injury and patient's explanation are consistent**
- A patient's **permission** is not needed to record a DVA disclosure or the findings of an examination
- **Diagnostic codes** for DVA will be included in EPRs
- For confidentiality, ensure that the record can only be **accessed by those directly involved in the victim/survivor's care** and never in handheld notes such as maternity notes
- For **perpetrators,** it recommends that HCPs record the information and file it in the perpetrator's case notes
- Patient records can be used in **criminal proceedings** if a perpetrator faces charges; to obtain an injunction or court order against a perpetrator; in immigration and deportation cases (see the *Whom HCPs May Share with and What Consent Is Needed* section later for more on this); for housing provision; for

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[11] Same as 'targeted enquiry' in the NICE guidelines.

civil procedures in family courts to assess the risks associated with granting an abusive parent contact with children; and for SCRs, SARs, and DHRs

While the value of documenting detailed notes is obvious, and while national guidance on recording DVA in healthcare is much needed and welcome, this resource's recommendations have several issues.

First, the resource does not seem to *encourage* HCPs to use diagnostic codes. In settings that use diagnostic codes (general practice, EDs), using such codes makes it easier for HCPs to search and retrieve information from the EMR/EPR such as that the victim/survivor has been experiencing health conditions that are known to be associated with DVA. If a HCP retrieves such information, it may lead them to enquire about DVA. Conversely, inadequate coding of such symptoms and diagnoses can contribute to missed opportunities for enquiry about DVA, as we discuss in the *Issues from DHRs on GPs and Recording Information* section later. The resource also does not specify where HCPs should record DVA except for saying in a record that is not handheld (because this introduces the risk of the perpetrator and other parties seeing the information) and is accessible to those involved in care. A caveat with both points is that the DH resource targets a generalist audience, and such guidance may be too specific. However, given that SNOMED has been introduced to be used across the whole NHS, we can assume that coding DVA will be important advice for all HCPs.

Second, the recommendations may be undermined by the recommendation to 'document whether the injury and patient's explanation is consistent'. Of course, this latter point is important if the HCP suspects DVA and, for example, a victim/survivor's injury looks like it was caused by an assault but they said they fell down the stairs. However, a HCP with less training may misconstrue the recommendation as encouraging them to question whether the DVA really happened. The recommendation is linked the potential use of records in court, which can affect how HCPs document DVA information and the balance struck between medical opinion and the victim/survivor's account. Very little research exists in this area. As we discuss in the *Medical Records and Court* section later, research has found that HCPs use the word 'alleged' in victims/survivors' records, and according to victims/survivors, this leads to psychological harm as well as records being less effective as DVA evidence in court (Olive, 2017; Bacchus, et al., 2010; Taskforce on the Health Aspects of Violence against Women and Children, 2010).

Third, while the ideal situation is for HCPs to record all 12 items the resource recommends, the resource does not indicate which, if any, of these points ought to be prioritised. As we discuss in the *Professional Groups' guidance on Recording DVA Information* section later, the 'Linking Abuse and Recovery through Advocacy for Victims and Perpetrators' or LARA-VP resource for mental health professionals (Yapp et al. 2018), which was developed with DVA charities, lists seven points that are essential to record and some additional points to record if possible. Mental health appointments tend to be longer than those in general practice, ED, or maternity: a

GP/practice nurse consultation lasts around 10 minutes (Irving et al., 2017), and ED HCPs are under pressure to meet waiting time targets of four hours or less (The King's Fund, 2020b). Maternity HCPs may have little time with a woman if midwives have to ask all DVA questions while the perpetrator is out of the consulting room. Healthcare professionals may not have time to document all 12 items and without realistic guidance on what to record, HCPs may choose to record nothing or record inconsistently or inaccurately.

A final issue is that the resource says, 'ensure that the record can only be accessed by those directly involved in the victim's care' (p.41). The resource does not make clear who 'those' are. The Caldicott information governance review defines direct care as being provided by *care teams*, which can include doctors, nurses, and a wide range of staff on regulated professional registers, including social workers. In other words, information is shared with the team, not just the HCP the patient saw. The Caldicott review clarified that the care team in question should have a legitimate relationship with the patient (i.e., the patient is registered on the system of the organisation that wishes to view their record). The Caldicott review added a seventh Caldicott principle, ostensibly in a bid to overcome HCPs' reticence to share information appropriately: 'The duty to share information can be as important as the duty to protect patient confidentiality' (Caldicott, 2013). Healthcare professionals may not have this background knowledge of the Caldicott principles. Such HCPs may read the DH's recommendation in a restrictive way and be reluctant to record information if, for example, the record is accessible to several different professionals. Our expert advisory group highlighted that Caldicott guardians are concerned that this seventh principle has not gained traction, and that failure to share information appropriately remains an issue in many areas. Indeed, research with HCPs shows that they worry about documenting anything about DVA in EMRs/EPRs in case it breaches confidentiality (Szilassy et al., 2015).

BMA report: domestic abuse

The BMA report on domestic abuse (2014) has specific guidance for EDs, obstetrics and gynaecology, midwifery, psychiatry, and nursing and health visiting. The first edition was published in 2007.

The 2014 version cites the 2005 version of the DH resource discussed in the previous section and provides a list of what to record. Again, there are 12 items, but since the DASH was introduced in 2009 (Richards, 2009), it recommends that HCPs document a safety assessment rather than the DASH. Like the DH, the BMA advises that HCPs use the patient's own words, document as much detail as possible, record whether the injury and explanation given are consistent, and ensure the record is accessible only to those who are directly involved in the patient's care. Therefore, the same limitations apply as with the DH resource.

The BMA report adds that notes on DVA should be kept separately from the main patient record but does not say why—possibly to control access such that only select HCPs have access. It does, however, acknowledge that separating the notes can

have adverse effects as it may mean that the abuse is not put in context with a patient's overall wellbeing. We would also add that it is important to consider how the separation of notes can impede continuity of care. If a HCP were to see that patient in future, they may not have access to these notes. Even if the same HCP saw the patient later, they might not remember that the patient has disclosed DVA. There is a balance to be struck between safe and accessible storage of information.

Perhaps because of its age and its wide-ranging target audience, the BMA report does not mention the value of coding diagnostic information. We now turn to the guidance from different professional groups within healthcare.

Professional groups' guidance on recording DVA information

GP guidance for recording DVA information

There are three sets of guidelines for GPs/practice nurses: (1) the 2014 RCGP, SafeLives, and IRIS guidance (SafeLives, 2014); (2) the 2020 Pathfinder profile: guidance for general practitioners responding to domestic abuse (Pathfinder, 2020c); and (3) the 2020 update to the 2017 RCGP guidance on recording of domestic violence/abuse information in general practice medical records (RCGP, 2020 forthcoming; 2017a).

The 2014 RCGP guidance recommends that the primary healthcare team documents consent to share information (or not), DVA and injuries (for purposes of evidence), risk level if known, and to use a code in patient notes to indicate a disclosure of DVA. It recommends that the team document DVA within patient records safely and keep records for evidence purposes. The Pathfinder Profile for GPs (Pathfinder, 2020c) does not provide specific information on what to record but says that disclosures should be recorded clearly and factually and should reflect what the victim/survivor has said. The 2020 RCGP outlines principles for safe recording. These are that GPs/practice nurses must:

- Hide information about DVA from online access in the EMR
- Link family members' medical records in practices where possible (EMRs enable linking of members of the same household)
- Document the name of anyone accompanying a patient when DVA is discussed and the name of the alleged perpetrator(s)
- Ensure that any decision to record the information in the perpetrator's EMR is made with due regard to the associated risks
- Ensure that reference to DVA is not visible to the perpetrator or third parties during appointments
- Ensure that any reference to DVA in a perpetrator's record is redacted if provided to the perpetrator unless they are certain it is information that the perpetrator already knows

- Be aware of the potential danger of the perpetrator having access to information about their abuse and to information in children's EMRs (via online access to their own information and their children's information, as well as coercive access to the victim/survivor's EMR)
- Ensure that any reference to DVA is redacted from children's medical records if provided to the perpetrator or provided to children who are deemed to have capacity to request their information (we discuss patient online access in more detail in the *Expanded Access to General Practice EMRs and Hospital EPRs* section later)

The guidance specifies whether and what to record in the victim/survivor, child, and perpetrator's medical records when the victim/survivor discloses, the child discloses, or the perpetrator discloses. This guidance says that GP/practice nurses should record information using a diagnostic code and free text. The RCGP guidance (2017a) and IRIS training have previously recommended that general practice staff use the 14XD Read code (which corresponds to 'history of domestic abuse'). The corresponding and recommended SNOMED code is 'history of domestic abuse (situation)', with the distinction between victim/survivor, perpetrator, and child made in free text. The guidance specifies what to record when MARACs send and request information from the general practice, when the practice refers into MARAC, and when information is received from multi-agency tasking and coordination (MATAC) meetings. (See the *Multi-Agency Fora for Sharing* section for more information on MARACs and MATACs.)

Other primary and secondary care guidance and resources for recording DVA information

In Table 1, we summarise the DH (2013) health visiting/school nurse guidance, the NICE (2010) guidelines for pregnancy and complex factors (for GPs, midwives, and other primary care staff seeing pregnant patients), and the Royal College of Emergency Medicine (RCEM; 2015) guideline. We also summarise the LARA-VP resource for mental health professionals (Yapp et al., 2018) and the British Association for Sexual Health and HIV (BASHH) sexual violence group guidance (2016). We outline whether the professional group says what to record, where, how, and other considerations. Although GPs tend to be the only professionals to have access to the medical records of the victim/survivor, perpetrator, and children, HCPs may still record something in a perpetrator's record: i.e., if a patient of theirs discloses perpetration. We therefore include whether the professional group has mentioned what to record when responding to a perpetrator. A blank cell indicates that the document has no guidance or recommendation on that aspect.

Table 1: Professional groups' guidance on recording DVA information

	What to record	Where and how	Additional considerations
DH (2013) Health visiting and school nurses professional guidance	Document any suspicion of DVA …	… in health professional record (not in the service user-held record) Be aware of appropriate Read codes to use	Consider safety and confidentiality when recording information in patient notes Medical records can be used in future criminal justice proceedings and may be called on to be used in MARACs
NICE (2010) Pregnancy and complex social factors clinical guideline (for GPs, primary care staff, midwives)	—	The information disclosed will be kept in a confidential record and will not be included in the handheld record	—
RCEM (2015) Management of domestic abuse guideline	Photograph **injuries** if present If an IDVA is available immediately then they will make adequate records, but if not, **as much information as possible** should be recorded at the time of disclosure	Nothing for victims/survivors Nothing specific for perpetrators, except that if a decision is made to share data about a perpetrator, then a record of this should be kept separate from the perpetrator's notes	Staff should assess safety and whether any children live with the victim/survivor or perpetrator

	What to record	Where and how	Additional considerations
LARA-VP (2018) Resource to help mental health professionals identify and respond to domestic violence and abuse	For victims/survivors: • Enquiry and disclosure • Names (of victims/survivors and perpetrators), date of birth, ethnicity, children and/pregnancy • Questions and answers in service user's words • Symptoms or injuries observed • Information on frequency/severity • Clear statement of who experienced DVA and who was perpetrator including names of people involved • Record of action (e.g., information provided, referral to DVA agency) Records would ideally also include: • Service user's response to questions (use their own words when possible) • Descriptions of types or nature of abuse, including specific incidents wherever possible • Any effects of the abuse e.g., suicide attempt or onset or exacerbation of psychiatric symptoms • Dates and times of incidents, if known • Description of patient's current psychological state, without interpretation/judgments/ assumptions For perpetrators Keep **detailed records** if patient discloses abusive behaviour	For victims/survivors: • In **records** • Document previous and current risks in **system alerts** For perpetrators: • If other HCPs need to be aware of a current or ongoing risk, HCPs should document DVA in the **system's alerts**. If it may be unsafe for the service user to access documented information about DVA, information should be logged in the **system's third-party information section**. If a service user asks for their notes, any information can be omitted if considered to increase risk • MARAC leads should document MARAC cases … in **third-party information and/or alerts** in case the service user accesses their notes	Always make records in an interview with the person experiencing DVA alone Notes can be used in decisions around legal and welfare support, housing, and immigration and may be required in SCRs and DHRs Documentation will enable continuity of care Assess and manage risk on an ongoing basis, and consistently document what has and has not been done Records will enable teams to monitor and assess the degree of risk to inform their clinical decisions

	What to record	Where and how	Additional considerations
BASHH (2016) Responding to DVA in sexual health settings	• Whether it has been safe to enquire • Disclosures • Any referrals offered/accepted • Supervision pertaining to safeguarding adults or children • Any agreed actions or outcomes Option to use proforma, which asks for: • Name/relationship of perpetrator to patient • What happened (last and worse episode) • Whether they have had any support • Children: whether they have witnessed abuse, been in the household, or been affected • Immediate danger assessment for those at ongoing risk • Referrals and information sharing by HCP • Whether list of support agencies and DVA helpline number has been offered	In the notes in patient records Mentions use of alert system so information is accessible when patient re-attends	Ensure clear, accurate, and contemporaneous documentation ideally using a short DVA proforma. Notes should be dated, timed, and signed on every page and the patient informed that documentation can be requested if there is a police investigation

No other Royal College or professional group has DVA guidance. The Royal College of Nurses (RCN; 2017) has a 'Risk assessment pathway to identify domestic abuse', which does not say anything about documentation. The Royal College of Obstetricians and Gynaecologists (RCOG; 2016) Framework for Maternity Standards says nothing specific about DVA documentation. It does, however, mention that documentation can be used as a measurement criterion to audit the numbers of women asked about DVA (but does not say who should do this audit).

Analysis of guidance and resources on recording DVA information

The most comprehensive resource for recording DVA information is the LARA-VP (Yapp et al., 2018) resource for mental health (a speciality in which NICE encourages routine enquiry). The LARA-VP resource was developed with DVA charities and experts from mental health services. Otherwise, guidance on what exactly to document is scant. Department of Health guidance for health visitors/school nurses and NICE guidelines for pregnancy are especially vague. Only the RCGP (2020, forthcoming; 2017a), RCEM (2015), and LARA-VP have any guidance on whether, what, and how to document information about perpetrators.

The LARA-VP (Yapp et al., 2018) and BASHH (2016) resources are the only ones to specify what to record, and LARA-VP is the only one to say which of these items are essential. The overall list of items to document is similar to the list in the DH (2017) DVA resource for all HCPs discussed earlier, and which LARA-VP cites. Again, except for LARA-VP and BASHH, none recommend that HCPs document what action has and has not been taken. In the context of short appointments, guidance on which items to prioritise may facilitate consistent and useful recording of information. Our expert advisory group highlighted that simple and realistic guidance is most likely to be implemented.

Except for the RCGP guidance (2020 forthcoming; 2017a), guidance on where to document is also lacking. All the guidelines say, 'in the notes' or 'in the record', and LARA-VP (Yapp et al., 2018) and BASHH (2016) recommend using alerts. Moreover, only the RCGP guidelines and the LARA-VP resource mention patient access. We discuss this more in the *Expanded Access to General Practice EMRs and Hospital EPRs section later*. Different HCPs may document information in different parts of the record, which can hamper retrieval and visibility of information. If there were some consistency in the way practices and trusts recorded information, it could make retrieval and sharing of that information easier

The RCEM (2015) guideline is the only one to mention IDVAs and how they can facilitate information recording and sharing, even though in some trusts IDVAs work across the hospital with several specialities. We come back to the role of IDVAs in recording and sharing in the *Alerts and Flags in the ED (and Hospital Trusts More Widely)* section later.

This lack of robust guidance may lead to inconsistent and poor recording and inadequate sharing of information in some areas of clinical practice.

The guidance content tells only a partial story of what happens in practice due to variable knowledge and implementation of guidance, and the room it leaves for professional judgement. Given this, we now turn to DHRs, academic research findings, and our discussions with key stakeholders to better understand what happens in general practice, ED, and maternity.

What recording happens in practice: primary care

Issues from DHRs on GPs and recording information

We reviewed seven analyses of DHRs (Chantler et al., 2020; Stanley et al., 2019; Benbow et al., 2018; Robinson et al., 2018; Home Office, 2016; Sharp-Jeffs and Kelly, 2016; Neville and Sanders-McDonagh, 2015) and extracted all details that mentioned healthcare and recording information.[12] All of these analyses make overarching recommendations from DHRs for agencies/services to improve practice and increase the chance of preventing future harm and death.

Neville and Sanders-McDonagh (2015), who analysed 13 DHRs, found four cases with poor standards of record keeping by GPs, which impeded continuity of care between different GPs and subsequent GPs' identification of risk.

An analysis of 32 DHRs by Sharp-Jeffs and Kelly (2016), including 24 cases of intimate partner homicide and eight of adult family homicide, cites numerous examples of poor recording.

The Home Office (2016) analysis consisted of 40 DHRs, 33 cases of intimate partner homicides, and eight of adult family homicide. Of the 33 DHRs about intimate partner homicides, 21 mentioned poor quality or inadequate records from the health service, particularly in general practices, similar to the findings of Neville and Sanders-McDonagh (2015). The analysis mentions that records were missing evidence of routine enquiry, flags for DVA, and outcomes of risk assessment. It also says that in some cases there were no records found, or records were lost or destroyed—but this

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[12] We also reviewed the Social Care Institute for Excellence (SCIE; 2020) analysis of statutory reviews of homicides and violent incidents; an annual review of SCRs 2018–2019 (The Child Safeguarding Practice Review Panel, 2020); a triennial analysis of SCRs 2014–2017 (Brandon et al., 2020), an analysis of 37 SCRs and SARs (Preston-Shoot 2017); and recent SARs, but found nothing specific to recording information about DVA in healthcare. Most issues centred around inadequate sharing, which we discuss in a later section.

finding is not specific to the health service and may refer to records from other agencies/services.

Record keeping is especially important if a patient sees a range of GPs within the practice rather than having one GP, as is now common in general practices (Robinson et al., 2018).

Notably, most issues across these analyses were about missed opportunities to *enquire* about DVA, rather than when DVA was disclosed. For example, Chantler et al. (2020) found that the health service was aware of DVA in around 12.5% of the 141 cases. The Home Office (2016) analysis is unclear about numbers of DHRs where DVA was disclosed. Since our report primarily focuses on recording and sharing when DVA is disclosed, we discuss this context first.

Disclosed DVA

From the DHRs that Sharp-Jeffs and Kelly (2016) reviewed, GPs knew that their patients were experiencing DVA in only two DHRs. General practitioners were also aware that their patient was perpetrating DVA in one of the same DHRs, and in an additional third DHR. Interestingly, poor record keeping is not cited as a factor in these three DHRs. However, the analysis does say that in the third DHR, police made a referral to health, who contacted the victim, but this contact was not recorded as having happened.

Chantler et al. (2020) found that awareness of DVA in health did not always lead to DVA service provision.

Benbow et al. (2018) raised the point that names of partners involved in DVA incidents were not always recorded (which might have been due to HCPs' poor recording) or were removed from historical information (possibly due to HCPs' anxieties around recording information about third parties). Thus, sometimes a so-called domestic incident had been recorded, but it was not known who was involved. The authors raise the more general question of how historical information, which may influence risk assessment and treatment plans, can be made available to future treatment providers. This issue straddles information recording and information sharing and is not just relevant to GPs: the authors raised an example of mental health staff being unaware of a perpetrator's history.

Missed opportunities to enquire about DVA

Enquiry is linked to good-quality record keeping: e.g., if a patient's mental health information or ED attendance is fully coded in their general practice EMR, the GP may be better able to spot the signs of abuse. However, the GP's ability to do so depends on whether DVA is visible in the EMR 'problem list' or whether they have had time to look over the past notes.

In an analysis of 141 DHRs, Chantler et al. (2020) pointed out that in one DHR, the victim had 'contacted all the relevant authorities but there were discrepancies in basic record keeping between agencies. For example, her name was spelt in

different ways by agencies [possibly because her name was Eastern European and therefore unfamiliar] so preventing an overview of her case across agencies and hampering risk assessment' (p.489). In an analysis of 55 of these 141 DHRs where children (under 18) were involved, Stanley et al. (2019) pointed out that omission of basic information, such as whether the patient has young children, spanned general practice and ED records.

Interestingly, the analyses said that HCPs could have noticed risk factors to prompt enquiry if they had looked at both the victim's and perpetrator's records in conjunction (Robinson et al., 2018). Sharp-Jeffs and Kelly's (2016) analysis draws on four DHRs to argue that if GPs had been able to link a victim's record to a perpetrator's record, it might have alerted them to the multitude of risk factors for DVA victimisation or perpetration in the relationship. For example, one DHR noted that a perpetrator experienced a mental health crisis 'linked to his separation from [the victim]' (p.29) around the same time that the victim sought help for depression. Another notes that:

> The use of accurate Read codes identifying the risks and vulnerabilities of [perpetrator] regarding depression, drug and alcohol use, and for [victim] regarding her experiencing schizophrenia … could have triggered an exploration of other risk factors within their relationship (p.25, Safe City Partnership, 2012).

A similar scenario arose in a third DHR from Sharp-Jeffs and Kelly's (2016) analysis, where the lack of connection between patients' medical records was thought to be due to the couple not sharing the same surname. A fourth DHR concluded that had two records been linked, the relationship might have been discussed at a practice meeting. On this note, we are aware of upcoming research from NHS Login/NHS X that suggests GPs are less likely to link records between same-sex partners. The RCGP guidance (2020, forthcoming; 2017a) says that family records should be linked where they use the same general practice. Electronic medical record software automatically links members of the same household: any other linking would need to be manually added and information would need to be redacted or hidden from online access.[13]

Yet another issue arising in relation to record keeping was the importance of transferring medical records between general practices when a patient moves. In two DHRs, a documented history of periods of poor mental health was lost in transition.

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[13] Discussions with stakeholders indicate that accurately linking GP EMRs is difficult as people often change partners, because linking is possible only if both parties are registered at the same practice, and because in general, EMR software links records only if patients live in the same household. In our consultation, survivors were unsure whether record linkage would enable GPs to spot DVA reliably— they thought GPs would identify 'red herrings': i.e., DVA where there was none. They also worried about being linked to their perpetrator. They said that perpetrators often present as victims and worried that if records were linked, the GP might start treating the victim as a perpetrator.

This loss could leave GPs less able to spot signs of risk of DVA perpetration or victimhood.

In sum, then, DHRs point out that poor record keeping manifests in various ways: basic information (correct spelling of names, presence of children) being missing, lack of linkage between the victim's and perpetrator's records, and poorly coded diagnoses in general. However, most cases were about missed opportunities to enquire, and of these, the missed opportunity was often pinned on HCPs not looking at victims' and perpetrators' records in conjunction. Poor recording in general practice was often cited, but this is likely to be because GPs are often the only HCPs who have ongoing relationships with patients, as well as relationships with victims and perpetrators.

We now turn to academic research findings about recording practices. Notably we found little research with victims/survivors and so focus on GP/practice nurses' practices and views.

Research on views and practices around recording DVA information in general practice

Chandan et al. (2020) analysed longitudinal general practice records from 1995 to 2018 to describe the epidemiology of childhood maltreatment and DVA in women. Their analysis showed that the proportion of female patients aged 18 and over recorded as having lifetime experience of DVA between January 1st and December 31st 2017 was 0.37% (368.70 per 100,000 adult population). This figure was substantially lower than the ONS (2018) figure, where prevalence of ever experiencing DVA among women aged 16 to 59 years between April 1st 2017 and March 31st 2018 was 7.9%. Although the figures are not directly comparable due to the difference in time range and age range, the GP-recorded figures are extremely low.

Earlier academic research (Drinkwater et al. 2017; Szilassy et al., 2015) with GPs, practice nurses, and practice managers showed that they considered documenting DVA to be important. But in the absence of DVA training and a lack of awareness of local guidance or national guidance on documenting DVA information (which did not exist at the time of this research), HCPs drew on their child safeguarding training to inform their actions in DVA cases. This training prioritises children's safety but does not always adequately consider the abused parent.

Participants revealed diverse (and inconsistent) methods for recording both DVA and child safeguarding in the patient record, using:

- Read codes from child safeguarding training
- Hidden alerts (e.g., reminders on home screen, safeguarding icon, or code words—personal or practice wide)
- Detailed free-text comments (e.g., documenting injuries)

- Formal and informal messaging systems (rather than documenting in the EMR) to make relevant practice staff aware of DVA and child safeguarding

Most participants worried about documenting information for the victim/survivor's safety while at the same time wanting to keep their confidence. Of these, a few said they would resolve this tension by asking the patient about what to write.

Some participants were uncertain about documenting DVA in the patient's record at all, because they did not see DVA as a health issue. Of these, some considered it appropriate to code just the clinical diagnosis of any DVA-associated health conditions with which the victim/survivor presented (e.g., depression).

A few participants said patients' disclosures should not be taken at face value: they were allegations, not facts.

Another study (Pitt et al., 2020) involved interviews with GPs and police staff about how GPs record reports from agencies/services outside of healthcare (e.g., police reports and reports from MARACs, which are usually police-led). General practitioners considered such notifications valuable because they brought to light hidden issues of DVA and helped them to address the health consequences and safeguard children. But they raised concerns about how to record this information in patients' EMRs. General practitioners felt worried because patients may not know that the third party had shared information with them: they were unsure whether it was safe to contact patients about it, but at the same time they felt paternalistic coding such information without discussing it with patients. Moreover, they worried about what action to take upon receiving the third-party report: sharers did not always make clear what action, if any, they expected GPs to take.

General practitioners were also concerned that victims/survivors, perpetrators, or another person present in the consultation might see DVA information on the computer screen. One USA study (Moerenhout et al., 2020), which was not about DVA or sensitive information, explored how GPs were integrating EMRs into their practice. Some found using the EMR hindered rapport and to overcome this, they shared their screen with patients to discuss results. A well-meaning GP/practice nurse may inadvertently show a patient sensitive information from third parties or show information when the perpetrator is present. Indeed, RCGP guidance (2020 forthcoming; 2017a) recommends that screens showing the medical record should never be seen by third parties (i.e., family or friends accompanying a patient).

In sum, DVA is under-recorded in general practice, and research suggests a lack of consensus on good practice in documenting DVA. General practice staff use diverse and inconsistent methods for documenting DVA. Some are uncertain about documenting DVA at all, because they do not see DVA as a health issue or do not wish to take disclosures at face value. General practitioners are especially unsure about how to record information from third parties.

What recording happens in practice: EDs

The RCGP (2020 forthcoming; 2017a) guidance makes specific recommendations on what GPs/practice nurses should record in the EMR. The RCEM (2015) guideline does not provide specific recommendations: it recommends documenting as much information as possible and photographing injuries where present. Our expert advisory group indicated that survivors less commonly present to the ED after a domestic assault and more commonly present with a health-related consequence of DVA, such as bleeding in early pregnancy, or in mental health crisis. We now turn to DHRs and research from ED.

Issues from DHRs on EDs and recording information

In their analysis of DHRs, Sharp-Jeffs and Kelly (2016) cite one DHR from 2010 where the perpetrator frequently absconded the ED. One such visit was for a mental health crisis. The ED staff referred him to the out-of-hours mental health crisis team, but he absconded before they could offer treatment. The analysis and DHR imply that the crisis team did not document anything about the patient and they recommended that ED visits be recorded on the patient's electronic mental health record so that the team can follow up with the patient. (Liaison staff can create a new record for a patient newly referred.) Since the DHR, some EDs have developed frequent attender/high-impact user/high-intensity user programmes, which may identify patients such as this one. We discuss these later in this section. As mentioned in the *Issues from DHRs on GPs and Recording Information* section earlier, Stanley et al.'s (2019) review described one DHR where ED HCPs did not record basic information such as the presence of children.

No other relevant issues or recommendations about recording information in secondary care emerged from the DHR analyses; the Social Care Institute for Excellence (SCIE; 2020) analysis of statutory reviews of homicides and violent incidents; an annual review of SCRs 2018–2019 (The Child Safeguarding Practice Review Panel, 2020); a triennial analysis of SCRs 2014–2017 (Brandon et al., 2020); an analysis of 37 SCRs and SARs (Preston-Shoot 2017); and recent SARs.

However, one DHR (Croom, 2014) not included in the analyses is relevant to the ED. In this case, ambulance staff did not hand over information about a DVA disclosure to ED triage staff, triage staff failed to document a later disclosure of DVA within the same care episode, and the ED discharge letter went to the wrong general practice. Poor recording and sharing within the ambulance/ED team was linked to a missed chance to intervene. We indicate with bullet points the trusts' response to the DHR.

Case example: DHR Mr C

Mr C died from blunt force trauma on July 21st 2012. His partner, Mr Y, was indicted for murder. The DHR listed a chain of failings, many of which were attributable to the ED at Mr C's local hospital. Two months before his death, Mr C collapsed in a shop. He told the staff there that his partner had assaulted him earlier in the day. Staff called for an ambulance and the call log notes that he had been assaulted by his partner. Mr C told the ambulance crew the same thing when they arrived. The crew member asked if he had reported it, and Mr C responded that he did not want anything to be done about it. The crew member took no further action because he considered Mr C to have the capacity to make this decision. The crew member documented in the patient care record that Mr C was assaulted but did not document that the perpetrator was the partner.

- In response to the DHR, the ambulance service stated that best practice would have required the crew to document that Mr C's partner had assaulted him, but they were respecting his wishes and were of the view that documenting the perpetrator's identity would have made no difference to his care. The DHR review team concluded that the ambulance crew's response suggests a limited understanding of DVA, their responsibility to intervene, and the care pathway for DVA victims. The authors suggested that the ambulance staff responded as if this were an isolated incident with no further threat likely
- The review panel were concerned about the lost opportunity to get help to victims who do not disclose

In an interview conducted as part of the research for the DHR, the triage nurse said that it was a busy evening, so on arrival to the hospital, the ambulance crew did not mention that Mr C had been assaulted (although it was noted in the patient care record). There was no verbal handover.

- This practice has now changed—all ambulance arrivals are formally handed over to hospital staff: all patient notes are handed to a nurse, and when there are sensitive circumstances, handover is face to face. Moreover, any information on assault or DVA is noted separately and addressed at a later assessment

The ED triage nurse then met with Mr C, who was apparently reluctant to say what happened. His partner (Mr Y) arrived during this conversation and introduced himself as Mr C's carer. Mr C told the triage nurse, 'He beats me up'. Mr Y replied, 'You know I don't beat you up'. The triage nurse said Mr C did not seem anxious at the time and was under the influence of alcohol. The triage nurse said he did not document that Mr C had said Mr Y beat him up because, based on his own observations, he did not know if it was true.

- The review panel pointed out that if the ambulance crew had told the triage nurse about the assault perpetrator being the partner, the triage nurse might have recognised that Mr C was experiencing DVA

The triage nurse sent Mr C and Mr Y to the waiting room, but they left before being seen. The hospital did not have a policy on following up ED self-discharges. The ED sent the discharge letter to the wrong GP, as they had spelled Mr C's surname wrong.

- The DHR recommended reviewing training around the dynamics and indicators of DVA, especially in same-sex relationships; around enquiring about DVA; and around the need to believe and respond to all victims (not just those who fulfil the statutory definition of an adult at risk [i.e., vulnerable adult] or those who lack capacity). A specific recommendation was made for the ambulance service to develop its response to DVA. Since the homicide, a model for responding to DVA was piloted in the ambulance service and the DHR recommended this be built upon. The Clinical Commissioning Group (CCG) responded to us that they have increased DVA training in their trust, but not specifically for ED staff
- The DHR also recommended that the local CCG produce guidelines on recording and sharing DVA information. Our correspondence with the CCG suggests this was not done but staff were instead trained around DVA.

In sum, the number of different ED HCPs that a patient sees on their journey though the ED makes recording and sharing information more difficult but more important. The key issue from DHRs about recording information in EDs is that information is not recorded and shared between ED HCPs.

Research on views and practices around recording DVA information in the ED

Little research exists about DVA and UK EDs. Linking on from Croom's (2014) DHR findings (about Mr C), Olive's (2017) work shows that DVA is recorded differently by different professionals within the ED, and information about DVA can be lost along the patient's journey through the ED. This work is robust and informs the subsequent sections of this report.

One aspect of the research looked at how one trust's ED staff documented DVA in a sample of 28 patient records where a patient had been assaulted by their partner.

Across the different parts of the records used in ED, staff used seven different terms to record an assault by a partner. Ambulance staff most commonly documented the term 'assault by partner'; registration staff most commonly documented the term 'assault', and triage and consulting clinicians most commonly documented 'alleged assault by partner'. Use of the word 'alleged' was common. (We discuss this more in the *Medical Records and Court* section later.) The term 'domestic violence' most commonly featured in safeguarding letters. It is infrequently featured in consulting clinicians' notes.

In some cases, a victim/survivor might have told a paramedic, receptionist, or triage nurse that their partner had assaulted them or that they were experiencing DVA, expecting them to tell the consulting clinician. But these staff members might have failed to share the information. Furthermore, in some cases, a HCP might have documented a term like 'assault' even when a patient had explicitly said that they were experiencing 'domestic violence'. Children in the household seemed to be a trigger for recording 'domestic violence'.

Whether and how consulting clinicians document DVA

In Olive's (2017) exploration of patient records, only 24 of the 28 had any clinical narrative (case notes) from consulting clinicians. Looking more closely at what exactly they wrote in these notes, many had:

- Record of injuries (24/24)
- Relationship to perpetrator (22/24)
- Record of violent acts (21/24)

Some records had:

- Body map of injuries (13/24; although just 1/24 had photographs)

Few records had information about:

- Record of children in the household or pregnancy (10/28)
- Previous partner violence (9/24)
- Record of referral to children's services (7/28)
- Record of frequency of violence (2/24)
- Record of whether this was a first episode (1/24)
- Record of risk to person (1/24)
- Referral to violence services (1/24)
- Record of information provided (0/24)

(NB: Denominators differ because four patients had only a triage/nurse record and no consulting clinician record.)

As we discussed in the *National Guidance on Recording DVA Information* section earlier, the DH (2017) lists 12 items that HCPs ought to record. This research shows that ED staff recorded only three items consistently. This lack of detail may mean that the HCP did not ask for details about the DVA and left them unable to determine safety and risk. It also means they were unable to fulfil safeguarding duties to children.

In Olive's (2017) interviews with consulting clinicians, they discussed why they used the term 'assault' rather than 'domestic violence' in their clinical narratives. They assumed that most assaults they had seen were one-off instances of alcohol-fuelled violence, whereas DVA is ongoing. Notably, however, even in the nine patient records that included information on previous partner violence, consulting clinicians had used the term 'domestic violence' in just five. Clinicians said that they would more likely use the term 'domestic violence' when children were in the household or there was risk of serious harm: to quote one doctor, when someone has been "beaten black or blue, or stabbed, or there's major injury" (p.2237). But again, detail of children in the household was recorded in less than half of cases and risk recorded in just one. It cannot be assumed that the absence of this record means no children or low risk.

Disclosing an assault by a partner is essentially a disclosure of DVA: patients will rarely use the phrase 'domestic violence'. SafeLives (2016) data has shown 12 to 17% of ED attendees are experiencing DVA. Victims/survivors often disclose only after several episodes of abuse (e.g., Bewley et al., 1997): intervening early can prevent later assaults. Therefore, HCPs missed opportunities to increase safety and reduce harm. Unless the ED uses flags for vulnerable patients (discussed more in the *Alerts and Flags in the ED (and Hospital Trusts More Widely* section later) there is no easy way for a consulting clinician to be alerted to patients' previous DVA experiences. The clinician would have to read past notes, which they will infrequently have time to read. Notes are often incomplete and are not always available to consulting clinicians (Boyle et al., 2010). Notes may become available as trusts digitise their records, but this depends on whether archived or stored paper records are digitised. Olive (2017) concludes that ED clinicians should ideally respond to all reports of partner violence as if they were cases of DVA.

Olive's (2017) findings support the findings of earlier research by Boyle et al. (2010). They explored cases of patients who had presented at ED after a domestic assault (by a partner or family member) between 2001 and 2004 and identified clinical variables associated with repeat attendances. Staff started using a routine code for domestic assault in the computer system in 2000: researchers used these cases as well as manually examining all ED case notes. They received additional funding for clerical support for obtaining case notes, as this was a time-consuming process. As per Olive's findings, when there were case notes, they lacked basic details; detail about the perpetrator was especially rare. Emergency department staff had also poorly recorded whether the patient was engaged with the criminal justice system and whether they had children, possibly leaving them unable to fulfil safeguarding duties. This trust now uses an EPR, which can make case note retrieval easier, but HCPs may still make incomplete notes. Dalton et al. (2019) also found incomplete DVA information in ED: on referral forms from ED to liaison psychiatrist, the question on whether the person is at risk from DVA was blank in 924/1142 cases.

Nevertheless, DVA-specific proformas can help ED HCPs capture DVA information, although research around how well and how often they are used is limited. Basu and Ratcliffe (2014) combined in-house IDVAs and training with a standardised communications form for assessment and referral plus an electronic coding system to make staff aware of patients with a history of DVA.

Although we focus on UK research in this report, it is worth mentioning the family violence intervention project based in New Zealand EDs as an example of a robust intervention (Ministry of Health, 2018a). The programme started in 2002 and includes a standardised 'family violence identification form' for recording DVA. The form (Ministry of Health, 2018b) asks HCP to document:

- Name and relationship to perpetrator
- Current/previous orders on the perpetrator
- Victim/survivor's health and risk (the form guides HCPs to ask 12 yes/no questions, with one additional question for pregnant victims and two additional questions on risk to any children)
- Children's names and dates of birth
- Victim/survivor's access to support and services
- Details of referral
- Body map of injuries
- Summary of past and present abuse (verbatim quotes, observations of patient's demeanour, description, mechanism, and weapon used in injuries) and safety planning

The recommendations mirror the DH (2017) and BMA (2014) recommendation for HCPs except the DH recommends that HCPs use the 24-item DASH, whereas the New Zealand form recommends that HCPs use 12 items to assess risk. Emergency department HCPs send the form to the hospital clinical records department, who can ensure that a patient's DVA is flagged to staff, and staff can re-assess safety if they

re-attend. Introducing this specialist documentation (importantly, with training) has been associated with an improvement in the standard of clinical assessment (i.e., documenting details, basic risk assessment, safety planning, and referral) of victims/survivors, and this change increased over time, as measured at nine years' follow-up (Ritchie et al., 2013). The authors concluded that a systems approach can lead to changes in practice over time. Our expert advisory group indicated that any proforma would need to be brief. Ansari and Boyle (2017) comment that in a time-pressured and resource-pressured environment such as the ED, staff are more likely to implement change if they are backed by such system changes. In English hospitals, flagging appears to happen on a more ad-hoc basis than this New Zealand intervention, as we discuss later in this section.

EDs recording information in safeguarding referrals and GP discharge letters

This section is relevant to information sharing as well as information recording, but we mention it here as it is an example of where the two practices are inextricably linked.

In Olive's (2017) research, safeguarding referrals (made after a disclosure of DVA) were the only type of record where the term 'domestic violence' was used commonly.

Diagnosis and discharge letters to GPs did not often use the term 'domestic violence' or even 'assault by partner' and most commonly described the injury rather than what caused it. This was the case even when ambulance staff and others had documented 'assault by partner' or 'domestic violence'. Olive concludes that the information is 'erased' when it leaves the ED and goes to the GP. One explanation for this loss is that the software ED clinicians use is set up to record only basic data, and GP letters are auto-populated with this information. However, HCPs have the option to add information to the GP letter in free-text form. If GPs are aware, they can offer referral to DVA services, gauge risk, assist with safety planning, provide long-term and follow-up services, and prevent the patient from re-telling their story. Whether it is safe to write about DVA in the GP letter depends on whether a copy of the letter is sent to the patient. In some trusts, EDs write a separate letter to the GP.

Importantly, Olive's (2017) interviews with victims/survivors shows that they thought the ED would in fact share information with the GP about the DVA. Olive's work was based in one trust, but similar findings come from elsewhere. In a 2010 report, one woman said:

> The A&E [accident and emergency] are supposed to fax over to the doctors what has happened to you … I don't think they record why I'm there or what's happened even though I told them I'd been abused. I don't know if my GP knows or not (p.18, The report of the Taskforce on the Health Aspects of Violence Against Women and Children, 2010).

Indeed, ED doctors in other trusts have said their practice is similar. In our discussions with stakeholders, one ED doctor told us there is no standard practice

for writing a discharge letter to the GP, but information is usually brief and factual. Usually, GPs will file information upon receipt and will not take further action unless there are specific documented action points for them.

It is clear, then, that in a time-pressured and busy environment, recording DVA information is deprioritised. But as the New Zealand intervention shows (Ritchie et al., 2013), alerts can be a useful way to efficiently see information and make HCPs aware of risks. We discuss alerts and flags next.

Alerts and flags in the ED (and hospital trusts more widely)

Through discussions with stakeholders, we have learned that HCPs in some EDs and some trusts use alerts or flags on patients to record risk information.

We summarise some practices around flags for DVA in Table 2 below. Discussions with hospital-based IDVAs and safeguarding nurses, who are usually the staff members to flag patients, has informed this table. Flags can be generic, indicating anything from the patient having a serious allergy to them having disclosed DVA or can be for 'safeguarding' (which can encompass DVA) or less commonly, be DVA-specific. Sometimes only patients heard at MARAC are flagged. Sometimes these alerts or flags are visible across the hospital and sometimes just in the ED. In some systems, the consulting clinicians will need to click on the alert to find out what the risk is (and in some trusts, if the reason for their alert indicates information that is particularly sensitive, the clinician has to phone safeguarding to find out what the alert is).

As a caveat, Table 2 contains a rapid and general review of current practice gathered from discussions with individuals rather than through a robust survey. We have anonymised the trusts.

Table 2: Details of alerts/flags in EPRs to indicate DVA in five anonymous trusts

EPR System	Generic vs safeguarding vs specific	For which DVA cases	In which parts of the hospital	Indefinite flag or automatic expiration	Use of perpetrator flag
Epic	Safeguarding alert with DVA-specific text	Severe cases	ED	Indefinite	—
Epic	Safeguarding (with notes, if hovered over)	Suspicion as well as disclosed	Across hospital	Flag removed when patient discharges. Banner indicates concern if patient re-attends	Uncommon
Cerner	Safeguarding	—	Across hospital	Indefinite	Uncommon
Cerner	—	All victims/survivors heard at MARAC; all patients who disclose DVA during hospital appointments/visits; all patients they receive police disclosures for and are pregnant	Across hospital	Indefinite	No
Cerner	—	—	—	Can be set to expire	Previously used, but now ceased as staff worried it would be discriminatory and breach confidentiality
Symphony	Specific to DVA	All victims/survivors heard at MARAC	ED	Routinely unflagged: MARAC tells hospital safeguarding team when to unflag	
Lorenzo	—	Discussion at MARAC about whom to flag: not all heard at MARAC are flagged	Across hospital	Indefinite	Would discuss at MARAC and make multi-agency decision

In our discussions about flagging, one hospital IDVA said that their flagging system works well. It prompts staff to ensure they are asking safeguarding questions, giving patients opportunities for support, and asking safety trigger questions when they are alone, such as if they are feeling safe at home.

We also spoke to several IDVAs whose hospitals do not use flagging systems but thought such a system would be useful as there are repeat DVA admissions managed by different staff each time, and opportunities can be missed. In another trust, IDVAs do not use flags because they are unsure as to how and when this would be removed and there are difficulties with where to store this information, since different parts of the trust will use different systems.

Some trusts could use alerts/flags but do not use them because no one has been assigned the responsibility to flag and unflag patients. In hospitals where there are IDVAs, they could take on this role but do not always have full access to trust EPR systems, so they cannot do so. The SafeLives report on hospital IDVAs (SafeLives, 2016) points out that getting an honorary contract gave some IDVAs access to EPRs, but this process can sometimes take months (Dheensa et al., 2020; Halliwell et al., 2019).

Some limitations of alerts/flags are that without training, HCPs may not understand the nature, dynamics, risk, and impact of DVA on a victim/survivor and their children, even if they are able to see an alert/flag. Some HCPs may see a lack of alert/flag as a lack of risk. Not all HCPs will look at flags (as one IDVA told us).

In sum, various EPR systems allow flagging, which enables HCPs, hospital IDVAs, and safeguarding teams to be more aware when a patient who has previously disclosed DVA re-attends the ED. Alerts/flags may increase safety and prevent further harm.

ED frequent attender/high-impact user/high-intensity user teams

Frequent attender programmes, high-impact user teams, and high-intensity user teams identify patients who attend ED frequently and have an additional risk or vulnerability. This risk is often their previous violence towards staff. Other risks may be substance use and/or a mental health disorder. Cases can involve DVA (especially where the case has gone to MARAC). Not all EDs have the resource to set up such teams. Among those that do, each will differ in whether it seeks to identify frequent attenders, or frequent attenders whose usage of ED has a high impact, and each will differ in how many attendances counts as 'frequent' or 'high-impact/intensity'.

A dedicated team will place alerts on a patient's record and will create support plans for these patients in coordination with other agencies/services, as well as GPs and other HCPs.

One case example is the high-impact user team in University Hospital Bristol. The team started in 2014 and currently consists of four part-time staff. Domestic violence/abuse is common, alongside problems like mental health disorders, substance-use disorder, and homelessness. Emergency department HCPs refer patients to the team, who then add the patient to their alert system so that they receive an email whenever that person attends. They use a triage tool to risk assess patients (and DVA features on this risk assessment). The team rates risk using a RAG (red, amber, green) rating and implements a support plan for red or amber risks. For green, they monitor them and start working with them if risk increases. The service has been evaluated, and support plans have been shown to decrease attendances.

Informing local violence prevention and violence reduction

Some EDs share de-identified information with local partners as part of violence prevention and reduction initiatives. Such sharing is to inform local services and intervention rather than for patient care. However, some EDs use the same information to identify DVA victims and refer them to services (Quigg et al. 2016). We discuss this in more detail in the *Violence-Prevention and Violence-Reduction Initiatives* section later.

What recording happens in practice: maternity

Research on views and practices around recording DVA information in maternity

Unlike in general practice and ED, NICE guidelines (2014) say that routine enquiry is best practice in maternity. Some evidence shows that midwives do not always enquire (Baird et al., 2013), but no recent research about the maternity response to DVA exists.

Systems-based approaches to encouraging midwives to enquire about DVA more consistently are beginning to emerge. Our expert advisory group shared that the Badgernet system, for example, has three mandatory yes/no questions to be asked at the booking appointment: do you feel safe at home, have you ever been fearful for your safety or the safety of your children, and are you currently frightened of your partner or someone close to you. The midwife can click 'unable to ask', which should be used only in exceptional cases (e.g., when seeing the woman alone has not been possible). More information can then be recorded. This information does not pull through to the handheld reports. Automatic prompts remind the clinician to ask again later in the pregnancy. The system also allows for customised referrals to local DVA services to be created, which allow for referral to be a one-click process. The system

automatically adds a flag to the record when DVA is identified. The flag is not automatically added to future pregnancies, but the clinician can read previous pregnancy records if the woman presents at the same hospital. In other systems, flags from previous pregnancies are carried through to subsequent pregnancies.

A recording system that makes it essential to record DVA questions may not be enough to overcome the most common barriers to routine enquiry: presence of a partner; language barriers and lack of appropriate interpreters; and lack of organisational support (Baird et al., 2013). One underlying issue may be chronic under-staffing in maternity—which as a recent survey by the Royal College of Midwives (RCM) lays out, has far-reaching consequences for care (RCM, 2020). As well, NHS Safeguarding (2020) report that during COVID-19 restrictions, where patients' companions were asked not to attend appointments, DVA disclosures have increased in antenatal settings (Reynolds, 2020).

Unless their pregnancy is complicated, women will receive most care in the community and use handheld records. Guidance states that DVA should not be recorded in handheld notes: these notes can be visible to perpetrators and result in an escalation of risk to the woman and/or her children. Instead, maternity units may have discreet codes for 'enquiry made' and 'DVA disclosed' or 'DVA not disclosed' so that other midwives know the question has been asked and how many times (DH, 2017). Bacchus et al. (2010) evaluated a DVA advocacy intervention in one hospital's maternity and sexual health services. As part of the intervention, the researchers implemented a discreet coding system for maternity records to indicate that a HCP had enquired about DVA, the patient's response, and whether referral to advocacy was discussed. A confidential abuse documentation form was provided for detailed documentation of DVA but used only once out of the 20 instances of DVA recorded in the patients examined. Healthcare professionals felt documentation was time-consuming, could not remember where to find the form, had documented DVA elsewhere, or had simply forgotten to use it. Three out of nine handheld notes contained written notes about the woman being referred for DVA advocacy, and two contained brief accounts of the abuse, which in turn caused women to face increased risk and to lose trust in the advocacy programme. The intervention increased knowledge and enquiry about DVA among HCPs but did not improve documentation. A 2010 report revealed similar issues (i.e., detailed DVA information being recorded in handheld notes) with one woman outlining her feeling towards, and the risks around, this oversight:

> I don't think it should be in my maternity notes that I have fled domestic violence and that I'm in a refuge, which it actually does. I could lose my notes, and someone could find them. I'm not ashamed of what's happened to me but I want control over who knows (p.18, The report of the Taskforce on the Health Aspects of Violence Against Women and Children, 2010).

Research is needed to explore how DVA can safely be documented in interoperable digital maternity records, which are replacing handheld records.

An example of novel practice in maternity is online self-referral for antenatal care, which circumvents the GP. Discussions with stakeholders highlighted that in one trust, women were frank in disclosing personal details, and the quality of information was better than expected. This system may overcome some of the barriers (e.g., if it is available in several local languages and if it allows the woman to give information without her partner seeing it). However, an evaluation of safety is needed, since perpetrators sometimes monitor online activity. Moreover, our expert advisory group highlighted that GPs worry about not being informed about risk.

A note on mental health

Agenda (2019) made Freedom of Information requests to all 58 mental health trusts in the UK about their response to DVA and sexual violence. Of these, 42 responded and 11/42 provided information on enquiry and recording of DVA and sexual violence. Twenty trusts did not provide any information: 2/20 said they did not record this information. Other trusts did not collect the information in a reportable way, which may be less relevant to direct patient care and more relevant to local audit. But this depends on why the information is not reportable. If it is because the information is not readily accessible in a specific part of the medical record, this can affect patient care, too, since it then may not be visible to staff who see the patient in future. The LARA-VP mental health resource (Yapp et al., 2018) has been published since this report, so practice may improve over time.

A note on sexual health

Poor recording is a chronic problem across different settings. Sohal et al. (2018) led an intervention pilot (IRIS ADViSE) to explore the feasibility and initial effectiveness of an IRIS-based training programme for sexual health settings. IRIS ADViSE aims to increase enquiry about and disclosure of DVA, improve HCPs' response to disclosure, and increase referrals to DVA advocacy services. The authors found that in the three months preceding the pilot, no cases of DVA were electronically recorded, and no referrals to DVA specialist services were recorded. This is despite NICE (2014) recommending that sexual health HCPs routinely enquire about DVA. The pilot implemented an adapted HARKS template (HARCKS, with the 'c' indicating 'children') in the EMR in two intervention sites. In site 1, staff could skip the HARCKS questions, and the DVA enquiry rate was 10%. In site 2, HCPs had to indicate whether they had asked about DVA before they could complete the electronic notes. Comparison of sites 1 and 2 showed that the DVA enquiry rate increased over fivefold, with an increase in DVA identification. Innovative ways to encourage or mandate DVA recording show promise: indeed, the study authors recommend retaining the mandatory recording in future trials of IRIS ADViSE.

Medical records and court

As some national and professional DVA guidance makes clear, medical records can be used in court. Reed (2020) interviewed a variety of HCPs (GPs, ED doctors, sexual health nurses, and a restorative dentist, oral surgeon, and maxillofacial surgeon) on medical confidentiality and DVA. All HCPs stressed the importance of making accurate, clear, and detailed notes, especially for cases that may go to court, (e.g., those involving assault). Some HCPs said they would talk with patients about what they were documenting, with one GP saying that if the patient objected, they would offer to write something the patient was happy with. One HCP said they would be careful to state facts rather than opinions. One sexual health nurse provided nuance around what exactly to document in cases where a DVA victim/survivor presented with an assault: she would document only those details relevant to that particular assault and would exclude extraneous information in case it harmed a patient's court case. Reed interviewed one DVA survivor who had her medical records used in court in a way she found harmful. She said that she was now wary of what she said in NHS consultations and was critical of the fact that courts can use patient records. Reed does not make recommendations for the health service but does make some recommendations for criminal courts, including that crown court should more clearly communicate to victims/survivors the information that may be recovered and used in court. This research is limited, as Reed did not look at patients' records to see how HCPs had documented detail about DVA.

Olive's (2017) analysis of ED patient records showed that the word 'alleged' was used in half of all triage/nurse records and doctor/nurse records. Interestingly it was rarely used in ambulance records. Using 'alleged' was widespread practice even when—as one ED doctor said—'it's blatantly obvious that it is actual assault' (p.2234). Staff said they did not intend to dispute what the patient had claimed but capture the fact that triage staff had not seen the assault happen. Olive points out that the use of this word can harm victims/survivors who see their records. Indeed, victims/survivors have said that the word 'alleged' has left them feeling disbelieved and traumatised. One survivor said, 'Some GPs and mental health professionals just didn't believe me. Words like "alleged domestic abuse" … are actually on my medical records now. The whole experience traumatised more than I already was' (p.37, Pathfinder, 2020b). Victims/survivors have also said that the way DVA is documented has affected their ability to access civil and legal remedies (Bacchus et al., 2010). One woman compared the documentation provided by her GP and her midwife (who did not use 'alleged'):

> The surgery is very good, but when I needed the notes for the injunction, everything was 'alleged this' and 'alleged that'. But I felt having the midwife's report did help actually … I was able to give the judge other instances of things that had happened. He was satisfied at the initial hearing that this event had taken place (p.155).

Interviews in a 2010 report produced similar findings, with one woman saying:

> The GP wrote 'raped' in inverted commas on my notes, which said everything about his attitude to women who've been raped. But then this affects everything else too. When my case went to court, it got thrown out on the basis that the GP didn't believe me! I was really upset, I still am (p.17, the report of the Taskforce on the Health Aspects of Violence Against Women and Children, 2010).

On the use of inverted commas, the DH resource (2017) discussed earlier recommends that HCPs use the patient's own words in quotation marks. The discrepancy between this recommendation and the victim/survivor's perception of quotation marks highlights the need for HCPs to tell patients how they are documenting DVA and why where possible.

Olive (2017) points out that there is no legal or professional requirement to record a reported assault as alleged in the victim/survivor's record—law permits HCPs to provide information of patients' accounts of events recorded at the time of the consultation. However, through discussions with our expert advisory group, it emerged that NHS DVA training does not cover documentation in any detail. Healthcare professionals worry about what to write and how, particularly because records can be used in court. Coercive control is difficult to define, identify, and in turn document (Halliwell et al., 2020). More training is therefore needed in this regard.

Expanded access to general practice EMRs and hospital EPRs

Patient online access to general practice EMRs

UK patients now have the right to request access to their general practice EMR online, a policy that ostensibly aims to empower patients. Online access gives patients access to part of their EMR, although from 2020/21, all patients will be able to ask to see their full record, including all coded information, free text, past notes, and documents. Currently, MARAC reports and other third-party reports stored in the EMR would not go into the online medical records, but patients can access them through a subject access request. RCGP (2020, forthcoming; 2017) advises GPs/practice nurses to redact these reports before requests are granted. When patients are granted full access, these reports will be visible to patients unless HCPs redact them.

Easier access to medical records has intensified fears about coercion and breaches in confidentiality in relation to DVA—namely perpetrators getting access to the victim/survivor's EMR (Pitt et al., 2020; Drinkwater., 2017; Feder, 2015). Woodman et al. (2015) write that perpetrators can get access '[through] overt threats or physical force in an abusive relationship or … under the guise of helping a

vulnerable relative' (p.280). These issues are not entirely new: patients have been able to request access to their records though a subject access request since the early 1990s. But clearly, records being electronic make it easier for patients and others to gain access.

Blake (2018a) found that victims are anxious about online access, as their abusive partners often have access to their online lives. They worried that their partners could access information about past medical issues and use the information as a weapon (e.g., telling people about a previous sexually transmitted infection). A perpetrator seeing DVA and other health information in a victim/survivor's record can lead them to escalate abuse, restrict access to healthcare for the victim/survivor, or pressure HCPs to change the record. Victims/survivors said that perpetrator access may make them less willing to talk about DVA with their GP. They may lose trust in HCPs if they feel that the GP's record has led to harm. Pitt (2020) found that given these issues, clinicians are also worried: about how to record information safely, what sort of language they should use, and who they should be writing notes for: the patient or HCPs.

Another issue is that online medical records will extend back to birth. Generally, people aged 16 years and over will be able to access records online and see what HCPs have recorded about any DVA in the household in which they grew up. Patients may not always know about such DVA (Woodman et al., 2015).

Guidance from the RCGP (2020 forthcoming; 2017a) recommends that GPs/practice nurses use the 'hide from online access' function for DVA information so that they can record sensitive information and share it with other professionals without it showing in the patient-facing EMR. However, this option relies on GPs/practice nurses being aware of the need to use this function, knowing how to use it, and remembering to use it. Moreover, as our expert advisory group and discussions elsewhere (Paul, 2019) have illustrated, the function does not apply to previously coded information, so unless GPs/practice nurses in earlier consultations used the function, DVA information may still show in the patient-facing EMR. Hiding information and redacting information retrospectively will be resource-intensive and prone to human error.

Blake (2018b) highlights that some practices use an online questionnaire before signing people up to online services. Such a questionnaire could include a safety checklist to help patients to understand what they are signing up to so that victims/survivors can decide not to sign up. However, in some cases, a perpetrator will coerce them into signing up and sharing their password. Another option is for general practice staff to be vigilant for coercion and refuse online access where necessary. One study about patient access to general practice EMRs found that GPs were often aware of the risks of coercion and abuse. General practitioners and practice managers used strategies such as engineering face-to-face consultations with anyone requesting access whom they were worried about to discuss access (Turner, personal communication). However, this study had a small sample of

patients with access to full records. Staff may not have the capacity or resources to do regular audits on which patients should have access. Moreover, the strategy relies on practices being aware of changing risk: vigilance is not failsafe.

These issues are not specific to DVA; they apply all sensitive information and third-party information. However, the risk attached to DVA makes it a particularly worrying example of how shared records and patient access can cause harm.

Access to general practice EMRs and hospital EPRs by different HCPs

As well as allowing patients online access to general practice EMRs, systems are now increasingly enabling other HCPs to access a patient's general practice EMR or hospital EPR. There are various ways in which trusts and general practices are making patient records available to other HCPs.

- First, the 'shared record system' gives access to general practice EMRs to different organisations in the local health community that are providing care to their patients
- Second, interoperability platforms like Connecting Care, which contain general practice and hospital information, give access to a range of local organisations
- Third, portals used in various clinical settings, such as Patients Know Best, are accessible to a variety of HCPs in these settings, as well as patients
- Fourth, trust-wide EPRs make records available to all HCPs within a hospital trust. Only a few trusts use these currently but the NHS Long Term Plan (NHS, 2019a) states that by 2023/24, secondary care providers in England will be fully digitised and that local health and care records (an interoperable record, like Connecting Care, but spanning the entire NHS) will cover the whole country
- Fifth, there is the digital maternity records system, discussed in the *Maternity Records* section earlier, which has started rolling out

Table 3 contains detail about the first four of these. No published guidance makes it clear whether and how these systems hide sensitive data from other HCPs, but discussions with stakeholders have helped to put together this information.

Table 3: Access to DVA information in general practice EMRs and hospital EPRs by different HCPs

Type of system	Who has access	Patient online access?	DVA data flow	Patient control over information flows
Shared records systems in general practice	GPs establish which organisations in the local health community providing care to their patients (including other practices) should access their EMRs, taking into consideration whether information sharing would improve, and is necessary for, care (BMA, 2020a) In some cases, software suppliers have begun treating a collection of individual general practices as a single entity with regard to patient data. The result is a merged database of patient EMRs, which can increase efficiency in working	Patients have access to general practice EMR online	GPs/practice nurses can hide entries in the EMR from other professionals and use role-based access controls	Patients have different options for restricting and tailoring the sharing: (i) blanket dissent from sharing; (ii) HCPs outside the usual care team must seek explicit consent before accessing a record; (iii) tailored consent for which organisations can access their record; (iv) and marking specific items as private and to be hidden in other care settings (BMA, 2020a)
Interoperability platforms (using Connecting Care, in Bristol, North Somerset, and South Gloucestershire CCG as an example)	Organisations that can share and view information are general practices, the two local hospital trusts and mental health trust, out-of-hours GP, social care, and a community health and social care company (Sirona). Additional organisations can view information: the ambulance trust, Care UK (NHS 111), local hospices, the CCG, and certain third-sector organisations	No	DVA codes are not currently shared because GP EMRs exclude certain 'sensitive' codes. However, discussions with stakeholders indicate that DVA information does sometimes flow into Connecting Care. Moreover, DVA information contained in free text will flow unless the GP/practice nurse has marked that as confidential. DVA information in hospital letters will also feature unless the HCP has redacted this information	No official process

Type of system	Who has access	Patient online access?	DVA data flow	Patient control over information flows
Patients Know Best	Some hospitals use Patients Know Best as the local EPR: here, HCPs across the trust can view and record information in Patients Know Best. In other settings, Patients Know Best integrates with whatever the local system is: here, depending on the agreement with the organisation, some data can be added to the local system and will flow into Patients Know Best	Yes	No: the patient has control. However, DVA codes from general practice EMRs are not currently shared in Patients Know Best because the EMRs exclude certain 'sensitive' codes[14]	Patients are offered the choice to mark information as private, such that it is hidden from certain teams. In cases that they do not wish to share any information, patients can enable 'disabled sharing', where no one except the patient and the HCP team that added the data can view it
Trust-wide EPRs, using Epic in University College London Hospitals as an example	HCPs across the trust	It is linked to MyCare patient portal, but DVA information does not show on the patient-facing portal	All HCPs working with the patient can raise a safeguarding concern, including about DVA. The safeguarding team can add a generic flag to the system, which appears in a header at the top of a patient's chart. All staff can see the flag: the header appears wherever the staff member is in the patient's chart. If a staff member hovers over the flag, it displays the concern. The safeguarding team can hide a concern and accompanying notes, such that other staff wanting to read information will need to speak to the safeguarding team	Unclear

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[14] The list of codes that Patients Know Best discards is here: https://docs.google.com/spreadsheets/d/1JK84pGVOiFLo969oLZ3o1PKTM_v7VpgqWnD9-8iby60/edit#gid=1836691564 The guidance has not yet updated to reflect the transition from Read to SNOMED codes.

A lack of joined-up care in the NHS is a perpetual problem. Warren et al. (2019) explored patient transitions between different acute NHS hospitals between April 2017 and April 2018. Millions of patients transitioned between hospitals, but coordination of EPR systems between the hospitals that shared patients was minimal: 9% of all hospital encounters involved patients presenting to a hospital using a different EPR system from their previous hospital attendance. Several pairs of trusts commonly cared for many of the same patients over the one-year study period, but just two of these pairs used the same EPR systems. Limited interoperability[15] exists between different EPR systems. Records are therefore fragmented: HCPs cannot get access to patient records from other hospitals, and this can affect the provision of high quality, cost-effective safe care.[16] Making their systems available to other HCPs is one way in which hospital trusts (as well as general practices, which Warren et al. did not include in their analysis, but which face the same sorts of issues) are trying to overcome this problem.

Making information accessible to other HCPs and organisations can mean HCPs can access information to inform decisions that lead to safer and better care. This opportunity is relevant to DVA: in their analysis of DHRs, Sharp-Jeffs and Kelly's (2016) DHR point out that 'links between health services are crucial for a holistic overview of patterns in appointments, walk-ins and emergency attendances rather than them being viewed in isolation' (p.10). If a HCP sees DVA is recorded, they can be alert to escalating risk and refer a patient for support, and a patient may not need to retell their story. In cases where DVA is not recorded in the EMR/EPR but HCPs see associated conditions are recorded, they may decide to enquire about DVA. No research or guidance exists about whether these systems enable better use of DVA information, but some general practices and community health teams have guidance for using shared records to safeguard children. For example, Nottingham Health Community Partnership group (2015) recommend that GPs 'open share' (i.e., share whole EMR) vulnerable children's records with child and family health teams. This open share can be initiated in the absence of explicit consent in the child's best interest.

Making information accessible to other HCPs also poses a challenge because a HCP who has not had training on how to broach DVA could use this information inappropriately, such as raising it in an insensitive way, talking about it in front of a third party, or not realising it is visible to a third party on their screen. Trained HCPs may worry about recording information if HCPs can see it.

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[15] Interoperability is the ability of systems or software to exchange and utilise information.

[16] Warren et al. (2019) recommend that 'Where trusts that commonly share patients continue to use different EPR systems, they should be encouraged to use open standards and develop suitable APIs [application programming interface] to better link data between their different system'. Such APIs and data standards (e.g., OpenEHR and Fast Healthcare Interoperability Resources) are emerging. But there are technical barriers and a commercial disincentive for vendors to use them, since open standards make it easier for providers to migrate their data to competitor's systems.

Patients Know Best and the trust-wide EPRs allow patients online access to their hospital records, which poses the same issues as access to general practice EMRs. Again, this issue is not entirely new, as patients have been able to request access to hospital records since the 1990s, but online access introduces the risk of perpetrators coercing or gaining access.

Restricting access if the perpetrator is a HCP

No research or national guidance exists on how to manage perpetrators who are also HCPs, although various trusts have policies on processes such as disciplinary procedures.

The Personal Demographics Service is the electronic national database of NHS patient demographic details. It contains details such as the patient's name, date of birth, address, and NHS number. Any HCP with a smartcard can access the service. A sensitive record indicator (the 'S flag') can be placed on a record to prevent access to the Personal Demographics Service, which can be helpful if the perpetrator is a HCP. Patients contact their GP to request this flag (NHS Digital, 2020b; Taskforce on the Health Aspects of Violence against Women and Children, 2010).

Healthcare professionals and pharmacists with a smartcard can also access a patient's Summary Care Record, which contains some aspects of the general practice EMR. Discussions with stakeholders have highlighted that DVA codes are not in the exclusion list for SCR, so the record may contact DVA information. Access will generate an alert, which each organisation's privacy officer will review to ensure access was for a valid reason.

The University College London Hospitals trust-wide EPR has a 'lock' function, whereby an additional password is required to open the file.

More research is needed about how to manage access by HCPs who are perpetrators to health records.

Sharing information about DVA

Domestic homicide reviews, SCRs, and SARs often cite a lack of information sharing as a factor in harm and homicide.

In this section, we begin by outlining with whom HCPs can share information, the different multi-agency for a for information sharing, and the protocols that ought to guide this sharing. We then turn to national guidelines on confidentiality and information sharing and discuss what they say about sharing information with different agencies/services and with different levels of consent. Then, we discuss what different professional groups' guidelines say about information sharing. We highlight the areas of uncertainty, inconsistency, conflict, and omission of good practice, and areas where the recommended best practice may need to change. We then turn to a description of what sharing happens in practice, informed by DHRs, SCRs, SARs, academic research findings, and discussions with stakeholders.

Throughout this section, we discuss cases that fall under formal safeguarding processes and cases that do not. Safeguarding training is better established than DVA training, so sharing of information may be more robust when, for example, the victim/survivor is pregnant or has young children. Decisions to share information in cases that do not fall under safeguarding risks are often left to professional judgement.

We make recommendations to improve practice at the end of the section.

Whom HCPs may share with and what consent is needed

There are various bodies with which a HCP may consider sharing information if they receive a disclosure of DVA. Sharing can be with explicit consent or implied consent.

In some restricted cases, information can be shared without consent. Such cases can include when it has not been practicable to seek consent (e.g., because action must be taken quickly) and when consent is explicitly withheld but significant risk means that this lack of consent needs to be overridden. We summarise the bodies with which a HCP may share information and whether consent is needed in table 4:

Table 4: The bodies with which a HCP may share information and whether consent is needed

Sharing with whom	Consent required (NB: best practice is to always seek explicit consent)
Other HCPs in the NHS	Implied consent
School nurse	Implied consent
Hospital-based IDVA, advocate educator, DVA service	Explicit consent
Third-sector service (including substance and mental health services)	Explicit consent
Safeguarding team in the trust	Without consent and when consent is explicitly withheld
Social care for an adult at risk	Without consent and when consent is explicitly withheld
Children's services	Without consent and when consent is explicitly withheld
Police (in cases of emergency where the patient is at immediate and serious risk[17])	Without consent and when consent is explicitly withheld
Multi-agency meetings (e.g., MARAC)	Without consent and when consent is explicitly withheld

Best practice is for HCPs to always seek explicit consent, and if consent is not needed, or is withheld, for HCPs to tell patients they are sharing the information and why. In all cases, organisations should follow Caldicott principles: to ensure sharing is necessary, relevant, timely, proportionate (in terms of what to share and with whom), well considered, and documented appropriately. A Caldicott guardian or Caldicott lead can support HCPs with decisions around sharing. These are senior roles responsible for protecting the confidentiality of people's health and care information. All NHS organisations and local authorities that provide social services in England must have a Caldicott guardian, although our expert advisory group highlighted that some organisations will implement Caldicott better than others.

There is an inherent tension here: sharing without explicit consent could, in the HCP's professional judgement, protect or benefit the victim/survivor, but at the same, time sharing without consent encroaches on the victim/survivor's autonomy and thus arguably mirrors the power dynamics in an abusive relationship. Inappropriate sharing can damage victims/survivors' trust in HCPs and the NHS (Reed, 2020).

A 2010 report (Taskforce on the Health Aspects of Violence against Women and Children, 2010) found that women wanted more effective, safe, and confidential communication within the NHS and between the NHS and other agencies/services. At the same time, they wanted some control over information sharing and the right to

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[17] Healthcare professionals might share information with the police if they request access to records for a criminal investigation. They can share this information under the Data Protection Act (2018) but need patient consent or to determine that the disclosure would be in the public interest (Wills, 2017).

not have information shared with HCPs and other agencies/services. Women were particularly concerned about their address being shared, because this could lead to perpetrators finding them. Moreover, they shared experiences of HCPs alerting social services to disclosures of DVA and fearing that their children would be removed. The Pathfinder survivor consultation (Pathfinder, 2020b) found that victims/survivors wanted to be asked for explicit consent when information was shared between agencies/services (e.g., GP to external health service). Victims/survivors were not asked whether sharing within the health service should require explicit consent, but many victims/survivors' main concern was having to retell their story in different healthcare settings. This finding implies that victims/survivors are less concerned about sharing resting on explicit consent when sharing is within the health service, but further research is needed in this area.

A note on NHS and Home Office sharing: hostile environment

Another pathway of sharing is NHS Digital's sharing of nonclinical information with the UK Home Office. The government announced a memorandum of understanding between the two bodies in January 2017, describing it as a formalisation of existing processes. Information sharing is part of the Home Office hostile environment policy and aims to help the Home Office identify and deport people deemed to be in contravention of UK immigration law. The memorandum of understanding was suspended after criticism, but information sharing continues. Fear of being notified to the Home Office has led to patients, including vulnerable pregnant women, to not seek care (Parkin and Loft, 2020; Weller and Aldridge, 2019). Research about how this affects HCPs' recording and sharing of information and victim/survivors' use of the health service in the context of DVA is needed.

Multi-agency fora for sharing

MARAC

We have mentioned MARACs throughout this report. The frequency of MARACs varies across the country: the majority are monthly, fewer are fortnightly, and a handful are weekly or daily. Referrals are usually discussed at the next available MARAC, so waiting times between patients' referral and being heard at a MARAC depend on the frequency of the meetings. Referral rates from healthcare are low: in 2018/19, 2.3% of referrals came from primary care, 1.8% from secondary care/acute trusts, and 1.1% from mental health services (SafeLives, 2020a). This is possibly because HCPs refer to DVA services, who then refer on to the MARAC. Indeed, the SafeLives guidance for GPs on MARACs says 'although GPs can refer directly to the MARAC … this assessment may best be undertaken by your local specialist domestic abuse service or the police' (SafeLives, 2020b). Whether GPs and other HCPs are invited and whether they attend varies across the country. However, no audit or research exists about health's involvement with MARAC. Multi-Agency

Safeguarding Hub (MASH) meetings fulfil a similar function to MARAC, but when there is a child at risk or an adult at risk (i.e., vulnerable adult).

High-risk domestic abuse meetings

Southampton local authority holds daily high-risk domestic abuse (HRDA) meetings, chaired by police, with attendance by children's services, adult health and social care, a MASH HCP, and a specialist DVA worker. High-risk domestic abuse meetings relocate work from MARACs to MASHs and help to ensure that families affected by DVA receive a quicker and more coordinated response, with support provided closer to the time of the incident. A few complicated cases will also be heard at a MARAC (Grove et al., 2019).

Other regular meetings

Some hospitals have professionals' meetings or in-house MARACs to discuss DVA. Through discussions with stakeholders, we learned that in Calderdale and Huddersfield NHS trust, there are daily hub meetings in which any DVA incidents that the ED, police, or any other agency identify are risk-assessed within 24 hours. One single health role represents all health agencies and has access to all health records in the trust. The representative can update records with the incident in the same working day and flag victims/survivors' and children's records if their case is heard at a MARAC. Every HCP can therefore see if their patient is at risk. This is the only trust in the country that has successfully signed up all health agencies to allow the one practitioner to share and update their records.

MATACs/MAPPA

Multi-agency tasking and coordination meetings intend to target and disrupt serial perpetrators and/or support them to address their behaviour. Representatives from different agencies/services share information, and GPs are being asked to contribute information. Multi-agency tasking and coordination meetings do not require the perpetrator's consent, and sometimes they will never be told about the MATAC because it is considered too risky for them to know; they are new, and guidance around health's involvement is still emerging. Some perpetrators may also be heard at multi-agency public protection arrangement (MAPPA) meetings, which manage sexual, violent, and dangerous offenders.

Violence-prevention and violence-reduction initiatives

Some EDs share anonymised information about violence (e.g., assault location, weapon used, date/time of assault, and ED attendance) with community safety partnerships or violence-reduction units (RCEM, 2009). There are 293 community safety partnerships in England, and 21 in Wales (ONS, 2019). Violence-reduction units are a newer initiative in England, launched in 2019 in 18 police and crime commissioning areas. Information sharing helps to deploy a multi-agency response,

such as additional police presence in certain areas. The Information Sharing to Tackle Violence guidance helps EDs routinely collect and share data with partners (NHS, 2019b). Some EDs also use DVA information to refer victims/survivors to DVA services, MARAC, and safeguarding (Quigg et al., 2016). Not all EDs are part of violence prevention or reduction initiatives.

A note on information-sharing protocols

NICE (2014), DH (2017), BMA (2014), and the Taskforce on the Health Aspects of Violence Against Women and Children (2010) all recommend that agencies/services and healthcare organisations have information-sharing agreements to outline what information can be shared, with whom, and how to maximise safety and confidentiality. Some trusts have information-sharing protocols with other trusts. SafeLives (2019a) has a MARAC information-sharing protocol, which other trusts may rely on.

Local police forces have bespoke information-sharing agreements (ISAs). Our expert advisory group revealed that in one police force area, an ISA allows the police to directly notify probation, substance-use treatment services, mental health services, and housing providers of DVA incidents. Bespoke agreements guide sharing when there are children and adults at risk (i.e., vulnerable adults). Multi-agency safeguarding hubs may use their own ISAs to share info with other agencies (such as health and schools).

National guidance on sharing DVA information

We conducted a policy analysis to identify guidance about information sharing and DVA and about confidentiality more generally from the key bodies involved in regulating and guiding practice in healthcare. We present the policies identified in Table 5.

Table 5: National guidance on information sharing and/or confidentiality relevant to DVA

1. Adass and Local Government Association. (2015). Adult safeguarding and domestic abuse: a guide to support practitioners and managers
2. BMA. (2019). Adult safeguarding toolkit
3. BMA. (2014). Domestic abuse. A report from the BMA Board of Science
4. DH and UK Council of Caldicott Guardians. (2012). "Striking the Balance" Practical guidance on the application of Caldicott guardian principles to domestic violence and MARACs
5. DH. (2003). Confidentiality NHS code of practice
6. DH. (2017). Responding to domestic abuse: a resource for health professionals
7. GMC. (2017). Confidentiality: good practice in handling patient information
8. NICE. (2014). Domestic violence and abuse: multiagency working. Public health guideline
9. NICE. (2016). Domestic violence and abuse: quality standard
10. Nursing and Midwifery Council (NMC). (2018). The code: professional standards of practice and behaviour for nurses, midwives, and nursing associates
11. SCIE and NICE. (2020). Recognising and responding to domestic violence and abuse—quick guide for social workers
12. SCIE (with DH, Adass, and local government association). (2019). Safeguarding adults: sharing information

In the following sections, we present what the national guidance says about sharing in healthcare. We first discuss situations in which sharing information happens without consent: we outline the legal bases for such sharing before discussing what national guidance recommends about such sharing. We then discuss specific types of sharing that can be without consent, for safeguarding and for MARAC, and with implicit consent—within healthcare.

National guidance on sharing without consent

Several laws/duties cited in national guidance legislate on when sharing personal information is allowed without consent. Three of these are the Crime and Disorder Act (1998), common law duty of confidentiality, and the Data Protection Act (2018), which is based on the General Data Protection Regulation (GDPR) 2016. The Mental Capacity Act (2005) is also relevant. Information can be shared without the patient's consent if they lack capacity to make a decision about sharing due to an impairment or disturbance in the functioning of the mind or brain and the sharing is determined to be in their best interest or necessary for their vital interest.

Sharing without consent may be with MARAC,[18] police, or social care. We will look at NICE (2014), BMA (2020b; 2014), GMC (2017), DH (2017), and NMC (2018) guidance.

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[18] SafeLives (2019a; 2018) also has guidance on sharing information at MARACs.

What to do when a patient withholds consent for sharing information

Turning first to the BMA, their report on DVA (2014) says:

> … a refusal to disclose[19] information by a competent adult can be overridden in order to protect a third party, such as a child or vulnerable adult, who may be in the household (p.54).

The BMA does not cite any specific law here. It also says that decisions about sharing information become more difficult when an adult refuses to disclose information to protect themselves. Later guidance on adults at risk, confidentiality, and disclosure of information from the BMA (2020b) sets out when HCPs' disclosure without patient consent is permissible in such situations (Table 6 contains the BMA's wording on this.)

Like the BMA, paragraph 9 in the GMC (2017; which cites the Crime and Disorder Act 1998, Section 115, and the GDPR) says that there are situations where the law permits[20] sharing without consent, including if the patient lacks capacity and sharing would be to their overall benefit, or if sharing can be justified in the public interest. In the main body of the guidance, the GMC defines public interest as about risk to others. In fact, it uses DVA as an example of when HCPs can share information in the public interest ('When victims of violence refuse police assistance, disclosure may still be justified if others remain at risk, for example … domestic violence when children or others may be at risk' [paragraph 65, p.34].)

The GMC (2017) also says that when no one else is at risk, HCPs should usually respect the patient's wish for information not to be shared: 'you should … usually abide by the [competent] patient's refusal to consent to disclosure, even if their decision leaves them (but no one else) at risk of death or serious harm' (paragraph 37, p.32). Healthcare professionals can encourage the patient to reconsider the decision if sharing can benefit their care and support (paragraph 37).

In the recommendation to abide by the patient's refusal, the GMC uses the qualifier 'usually', and it refers to an endnote. This endnote says that HCPs can share a competent patient's information without their consent, albeit in extremely restricted circumstances. However, our expert advisory group highlighted that the recommendation is often read without recognising the importance and relevance of the word 'usually' and without referring to the endnotes. In other words, doctors may not be aware of the cases in which they can share without consent. In Table 6, we compare the BMA and GMC wording (from the endnote) on when sharing information without a competent patient's consent is permissible.

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[19] The guidance uses the word 'disclose' rather than 'share', but here we take the two terms to mean the same thing.
[20] The GMC says that there are also situations where information sharing is *required* by law (e.g., reporting gunshot wounds). Child/adult safeguarding may fall under this category.

Table 6: When is sharing information without a competent patient's consent, or in the face of withheld consent, permissible?

BMA (2020b) adults at risk, confidentiality, and disclosure of information guidance	GMC (2017) confidentiality guidelines
'disclosure of information without consent … is likely to be exceptional. This is likely to be where there is strong evidence of a clear and imminent risk of a serious crime likely to result in serious harm to the individual, and the disclosure of information is likely to prevent it'	'In very exceptional circumstances, disclosure without consent may be justified in the public interest to prevent a serious crime such as murder, manslaughter or serious assault even where no one other than the patient is at risk. This is only likely to be justifiable where there is clear evidence of an imminent risk of serious harm to the individual, and where there are no alternative (and less intrusive) methods of preventing that harm' (endnote 18, p.73)

Guidance from the GMC (2017) and BMA (2020b) are similar: both say that cases are should be *exceptional,* and that there should be *evidence* of an *imminent* risk. But there are subtle differences in wording. The BMA's wording seems to require that there be evidence of risk of crime; GMC's wording suggests the evidence should pertain to harm. The BMA says the disclosure should be *likely to prevent* the harm (or the crime—this is ambiguous), whereas the GMC says nothing on likelihood, but rather that there should be no methods of preventing the harm alternative to disclosure.

In its DVA resource, the DH (2017) gives two recommendations that differ from each other. Its section on responding to victims/survivors says HCPs can share information if this can be justified in the public interest, such as where there is a risk of harm to the victim/survivor, any children involved or somebody else if information is not passed on (p.43). In its section on perpetrators, it says while perpetrators' patient 'records are strictly confidential, if there is a risk of death to an adult or a risk of significant harm to a child, this will override any requirement to keep information confidential' (p.54). Interestingly, then, the recommendations are written such that sharing confidential information about perpetrators can happen in more restricted situations than sharing victims/survivors' information (i.e., where there is risk of death to an adult versus risk of harm, respectively).

The NICE guidelines for DVA (2014) gives much broader guidance on when HCPs can share information without consent: 'information should be shared only with the person's consent unless they are at serious risk' (p.14).

The NMC (2018), which regulates nurses, has a vaguer—less restrictive—recommendation to 'share information if you believe someone may be at risk of harm, in line with the laws relating to the disclosure of information' (p.15). They use

'serious risk' and 'risk of harm' without any of the additional qualifiers GMC (2017) and BMA (2020b) use.

→ **Ambiguous terms**

Further differences and ambiguities emerge when considering what the BMA (2020b) and the GMC (2017) mean by terms such as 'public interest', 'serious crime', and 'serious harm'. The grounds for a public interest disclosure and the definition of serious crime, as we discuss in this section, are unclear. This is despite a 2010 recommendation from the Taskforce on the Health Aspects of Violence Against Women and Children for consistency and clarity about information sharing and confidentiality in the DVA context and for the Government to clarify the grounds for public interest disclosure in relation to 'serious crime' in DVA cases (p.6). The terms we discuss in this section are broad and ambiguous, and while this leaves room for professional judgement, it may also mean that HCPs are uncertain about whether a situation meets the need to share without consent. In the face of this uncertainty, HCPs may (sometimes inappropriately) err on the side of confidentiality (Dheensa et al., 2017).

→ Public interest: does it apply when only the victim/survivor is at risk?

Since 1977, the GMC has moved between different definitions of public interest in its guidelines: in some editions, public interest means 'only third parties'. In other editions, it refers to 'third parties or only the victim' (Cave, 2015). As we have discussed, the most recent 2017 edition says that public interest is usually relevant only when third parties are at risk. In an endnote, it says public interest may also be relevant when only the victim/survivor is at risk, but in very exceptional circumstances. The GMC says that this is an uncertain area of law and that HCPs should consult legal advice before making disclosures on these grounds. It is likely that the definition will evolve further in future editions, in line with case law.

Interestingly, in its 'good medical practice in action' online training, the GMC uses an example of a woman who presents to the ED with injuries that she claims were accidental, but that make the doctor suspicious of DVA. It asks trainees the question of what the HCP should do: (A) persuade the patient to seek help, (B) report the incident to the police, or (C) let the patient go without recording anything about their conversation. Using similar phrasing to its guidance, the GMC training explains that option B may not be in line with GMC guidance, emphasising public interest as applying when third parties are at risk:

> A competent adult patient's refusal to consent to disclosure should usually be respected, even if that decision leaves the patient at risk of serious harm. However, disclosure without consent may be justified if others (apart from the patient) are at risk. [The doctor] should therefore establish whether [the patient] has any children or vulnerable adults living with her.

Again, the word 'usually' signifies exceptions, but the training makes no mention of what these exceptions might be. The possibility of sharing information is not articulated when only the victim/survivor is at risk.

The DH resource (2017) also says that disclosures can be made without consent in the 'public interest', and as we previously state, uses a definition of public interest that encompasses cases where only the victim/survivor is at risk. But it introduces ambiguity because it cites the 2003 guidance Confidentiality: the NHS Code of Practice (DH, 2003). The DH 2010 supplementary guidance to this code of practice provides examples of public interest defences: each one includes harm to third parties (DH, 2010). Cave's (2015) analysis of this 2010 guidance is that 'patients' best interests will not justify disclosure if they have capacity, and neither will the public interest, except to "prevent serious harm or death *to others*"'. (p.18, emphasis added). That is, public interest applies only when third parties are at risk. The DH guidance thus contains inconsistencies.

The SCIE's Safeguarding Adults: Sharing Information guide (2019), which outlines appropriate sharing between local authorities and GPs/health, also appears to interpret 'public interest' as risk to third parties:

> Make sure that *others* are not put at risk by information being kept confidential:
>
> - Does the public interest served by disclosure of personal information outweigh the public interest served by protecting confidentiality?
> - Could your action prevent a serious crime? (p.19, emphasis added)

Thus, all of the guidance that mentions public interest can be read as saying 'only share when there is a third party at risk'[21]; it takes a closer reading for it to become apparent that the public interest can encompass exclusive risk to the victim/survivor. Notably, none of the guidance mentions potential future risk to third parties, such as the risk of the perpetrator abusing subsequent partners. One likely reason for the lack of clarity is that there is currently no agreed-upon public interest test mechanism for establishing what is 'in the public interest'.

$\rightarrow$ **Serious crime**

The BMA (2020a) and GMC (2017) say that sharing information without consent can happen if there is a risk of serious crime (BMA) or to prevent a serious crime (BMA and GMC). The GMC gives some examples of serious crime: murder, manslaughter, or serious assault, while Confidentiality: NHS Code of Practice (2003) points out that 'serious crime' is not clearly defined:

> The definition of serious crime is not entirely clear. Murder, manslaughter, rape, treason, kidnapping, child abuse or other cases where individuals have

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[21] DH/Caldicott guidance (2012) on sharing information for MARACs does not cite public interest in terms of harms to others, and in fact does not explicitly mention public interest at all. Rather, it states that that information can be shared 'on the basis of prevention and detection of crime or serious harm' (p.6).

suffered serious harm may all warrant breaching confidentiality. Serious harm to the security of the state or to public order and crimes that involve substantial financial gain or loss will also generally fall within this category. In contrast, theft, fraud or damage to property where loss or damage is less substantial would generally not warrant breach of confidence (p.34).

In the supplementary guidance from 2010, the DH adds that serious crimes will 'include crimes that cause serious physical or psychological harm to individuals … and will likely include other crimes which carry a five-year minimum prison sentence but may also include other acts that have a high impact on the victim' (p.9). Arguably, then, DVA, including coercive control which became an offence in 2015 (Serious Crime Act, 2015), will always count as a serious crime. The qualifier of 'serious crime' is therefore potentially unhelpful for guiding HCPs' practice on when disclosure without consent is acceptable.

→ Serious harm

Serious harm is also undefined. As DH/Caldicott guidance (2012) on information sharing for MARACs (2012) points out, HCPs must assess the risk of harm, but 'the concept of harm is nebulous; it can include physical, emotional, financial, sexual abuse or neglect factors or a combination' (p.8).

While HCPs may be adept at evaluating the harm of their clinical decisions (e.g., whether to administer a certain drug or procedure on a patient), their evaluation of harm related to DVA may again rest on their views and attitudes towards DVA and the quality of their DVA training. Healthcare professionals, teams, trusts, and agencies may conceive of harm differently. While it is important to judge harm on a case-by-case basis, such judgement requires an understanding of the nature and dynamics of DVA and its long-lasting effects, which some HCPs do not have (e.g., Mackenzie et al., 2019).

In sum, it is appropriate that national bodies' guidance leaves room for professional judgement, but their inconsistent and conflicting guidance on when it is permissible to share information without the patient's consent is concerning. These inconsistencies make what is already a difficult to navigate area more complicated. This complexity may result in HCPs choosing what they think is the least risky option, and not sharing information in situations when it is appropriate to do so for fear of breaching confidentiality.

Missing from guidance: coercive control

Information can be shared in certain circumstances under the Mental Capacity Act (2005). This act applies only to people who have an impairment of, or disturbance, in the functioning of mind or brain. Examples of what can cause such an impairment or disturbance are mental health disorders and substance use. Guidance from most national bodies says that if the patient has the capacity to make a decision as defined by the act, HCPs should generally respect their decision, even if they think this decision unwise.

None of the guidance mentions coercive control and how it can influence a patient's 'free' decision. Coercive control can be subtle and difficult for HCPs and other agencies/services to spot. It is also implicated in many DHRs (Halliwell et al., 2020; SafeLives, 2019b).

As we presented in the DHR about Mr C (Croom, 2014) in the *Issues from DHRs on EDs and Recording Information* section earlier, and as has been reported in other reviews (e.g., Report of learning together safeguarding adults review, 2020), sometimes HCPs will decide not to share information about DVA because the patient 'has capacity' to withhold consent for sharing and because there are no safeguarding issues (i.e., no children or 'adults at risk' [vulnerable adults]). But in some of these cases, sharing will be beneficial for patients: it would lead HCPs to refer them to DVA services and put safety measures in place. Nevertheless, whether this would prevent domestic homicide is uncertain. In sum, HCPs need to factor coercive control into their decisions about good practice. Future guidelines should take coercive control and its relationship with capacity into account and reflect case law as it emerges.

National safeguarding-specific guides on sharing information without consent

When formal safeguarding processes apply, HCPs will generally share information with safeguarding leads in their general practice or trusts. Safeguarding leads will advise HCPs on with whom to share information. Healthcare professionals will sometimes directly refer to children's social services or adult social services.

The SCIE (2020) guide outlines that in safeguarding situations, there are additional circumstances in which a professional can override a person's refusal to consent to information sharing with safeguarding partners:

- The alleged abuser also has care and support needs
- The person has the mental capacity but may be under duress or being coerced

Hence, unlike the guidance for non-safeguarding cases, safeguarding guides explicitly state that coercion can affect a person's decisions, even if they have capacity. The SCIE does not say what happens if the victim/survivor does not have care and support needs and the perpetrator does, but the guidance is likely to be the same.

Notably the SCIE advises that in safeguarding cases, the professional should share information with carers, family, or friends unless there are clear reasons not to do so. Sharing information with these people should always be with the consent of the individual. This can be tricky to navigate, as these parties might also be perpetrators, and consent can be coerced.

National guidance on sharing with MARACs

Although our expert advisory group highlighted that HCPs opt to make referrals to DVA services who can then make referrals to MARACs, the GMC guidance (2017) and DH resource (2017) both provide guidance for HCPs referring to MARACs. The GMC says, 'personal information may be disclosed to a MARAC with consent, or if the disclosure can be justified in the public interest' (paragraph 21, p.73). Given that the GMC defines public interest as applying when third parties are at risk (except in 'very exceptional' circumstances), it is plausible that a HCP may read this as saying they should generally disclose information to a MARAC only when the patient consents. The DH resource, says, 'You will need the consent of a competent adult victim to refer them to a MARAC, unless the public interest test is engaged with the high threshold risk' (p.36). Thus, both the DH and GMC take consent and confidentiality as the default position.

The DH/Caldicott guidance (2012) on sharing information for MARACs takes a slightly different approach. It points out that there is also a professional responsibility to share information, and in some circumstances, this duty outweighs 'the duty of confidentiality owed to the individual' (p.7). It says that although victims should usually be told about the referral to MARAC, 'consent is not asked for, because the decision has already been taken that a MARAC is needed, based on the risk to the victim' (p.6). Moreover, it points out that even if the HCP asks for explicit consent, whether that consent is valid is disputable, as they cannot know what they are consenting to: the victim/survivor may not know the full extent of the issues to be discussed and level of information already held by agencies that will be shared. The SCIE guide (2020) says local authority professionals can share information for MARAC without consent.

In sum, and as with sharing information without consent with other agencies/services, all guidance around sharing or MARACs leaves room for professional judgement—not only about whether to share information, but also how much information they should share. While leaving such room is appropriate, the inconsistencies and conflicts outlined may introduce confusion over whether the conditions are necessary to refer to MARAC.

Seeking advice about sharing from medical defence bodies, Caldicott guardians, and others

When making decisions about sharing information in cases of DVA, the BMA (2014) points out that decisions to share involve a difficult balancing of harms and benefits. They suggest, 'discussion of the case on an anonymised basis with colleagues or with other agencies, including medical defence bodies, the BMA and GMC' (p.54, BMA 2014). We are aware that medical defence bodies and the GMC sometimes give directly conflicting advice (anonymous GP interview, unpublished data, Dheensa et al., forthcoming) and may have limited understanding about working with DVA victims/survivors and perpetrators.

The DH/Caldicott guidance (2012) on sharing information for MARACs says that it will often be the Caldicott guardian who decides whether to share information (and how much to share) in cases where information sharing is not mandatory but permitted. Our expert advisory group highlighted that some Caldicott guardians are troubled by authorising information sharing for MARACs, possibly because of the range of agencies attending and how far that information may be shared (although all parties sign a confidentiality agreement).

The 2010 report of the Taskforce on the Health Aspects of Violence Against Women and Children reported that there is inconsistent support available to HCPs around information sharing and stated the need for HCPs to be able to consult Caldicott guardians to support decisions around information sharing in difficult cases. Our expert advisory group added that it would be valuable to understand what training Caldicott guardians receive around information sharing in the context of DVA.

National guidance on sharing information between HCPs

The BMA (2014) report emphasises that DVA is a multi-disciplinary concern and needs a joined-up approach across teams. Guidance from NICE (2014) and SCIE/NICE (2020) recommend that where needed, professionals should refer victims/survivors and perpetrators to substance-use treatment services and mental health services (NICE, 2014; SCIE/NICE 2020). The DH (2017) resource similarly says that HCPs should refer victims/survivors, where needed, to substance-use services, trauma-focused mental health treatment, and sexual assault referral centres (SARCs) in cases of DVA that involve sexual violence. It also says that if the HCP to whom the patient has disclosed is not a GP, they should refer the patient to their GP, who can refer them for mental health support where needed. Aside from the context of making referrals, there is no national guidance on whether and how HCPs should share DVA information with GPs and other HCPs who are already providing care to the patient. As we point out in the *Issues from DHRs, SCRs, and SARs on Sharing Information* section later, lack of sharing *within* the health services has been implicated in various reviews after harm or a person's death. More guidance is therefore needed on good practice here.

We now turn to professional groups' guidance to explore what they say about information sharing.

Professional groups' guidance on sharing DVA information

In Table 7, we summarise guidance from the RCGP (with IRISi and SafeLives) (2014), the RCN (2017), the DH (2013) for health visiting/school nurse, NICE (2010) (for GPs, midwives, and other primary care staff seeing pregnant patients), the RCOG (2016), the RCEM (2015), BASHH (2016), and the LARA-VP (Yapp et al., 2018) resource. No other royal college or professional group has DVA guidance.

The table illustrates what the guidance says about sharing information in different contexts: in an emergency, for MARAC, with DVA services, with other HCPs, and with other agencies/services (e.g., social care). Where a cell is blank, it means the guidance/resource does not provide any information. As is clear from the table, professional groups' guidance/resources give incomplete information on when, with whom, how, and with what consent HCPs should share information about DVA.

Table 7: Professional groups' guidance on sharing information in different contexts:

	Sharing in an emergency situation	Sharing with MARACs	Sharing with DVA services	Sharing with HCPs	Sharing with other agencies/services
RCGP, SafeLives, IRISi (2014) Responding to DVA: guidance for general practices	Contact local police (999) and initiate child protection/ adult safeguarding procedures	If patient assessed as high-risk, liaise with MARAC coordinator Sharing without consent can be done only 'in exceptional circumstances', which will include some cases considered at MARAC	Make referral if the patient consents Signpost if the patient is unwilling to engage with services at this time	—	Talk to the patient about risks to children, and if the children are at risk, initiate child protection procedures
RCN (2017) Risk assessment pathway to identify domestic abuse	For high-risk referrals and imminent danger, 'always contact the police'	For high-risk patients *always* contact … local safeguarding lead/ MARAC'. For 'other risk' referrals, 'contact your local safeguarding lead/MARAC'	For high-risk patients: an IDVA will contact patients following any MARAC referral	Nothing for high-risk patients For 'other risk' referrals, inform other health and social care professionals (e.g., GP, health visitor. If the woman is pregnant, contact midwife or health visitor	Consider additional child-focused safeguarding support. Inform social care professionals. Refer to and follow safeguarding polices and protocols
DH (2013) Health visiting and school nurses programme: DVA professional guidance	—	'Professionals need to … be aware of … MARAC'	'Be aware of local services and referral pathways'	Work closely with midwifery and the family nurse partnership colleagues to assess risk Ensure seamless transition to the school nursing service, with clear reporting to highlight risk factors where known	Encourage informal information exchange (i.e., children's centres/schools) Be aware of when to share information with other agencies, including child protection and adult safeguarding. Use policy on child protection and adult safeguarding

	Sharing in an emergency situation	Sharing with MARACs	Sharing with DVA services	Sharing with HCPs	Sharing with other agencies/services
NICE (2010) Pregnancy and complex social factors: clinical guideline (for GPs primary care staff, midwives)	—	—	There should be a local protocol which 'is developed jointly with social care providers, the police and third-sector agencies, written by a HCP with expertise in the care of women experiencing domestic abuse' that includes 'clear referral pathways; sources of support for women; … plans for follow-up care, such as additional appointments or referral to a domestic abuse support worker; contact details of other people who should be told that the woman is experiencing domestic abuse, including her GP'		
RCOG (2016) Providing quality care for women	—	—	Repeats NICE (2010) guideline and adds that all HCPs caring for women should be aware of the pathway and escalate to senior staff if necessary		
RCEM (2015) Management of domestic abuse guideline	—	'A representative from the ED should attend the MARAC. The contact details of the MARAC coordinator … should be available to all ED staff'	—	—	'Any concerns about child welfare should lead to the prompt activation of local child protection services'
BASHH (2016) Responding to domestic abuse in sexual health settings	Ring 999 and emergency accommodation if needed	If very high-risk, prompt referral to MARAC	If high-risk, recommend referral to IDVA. If standard risk, consider referral to IDVA/floating support	If standard risk, consider referral to counselling/GP, arrange follow-up with health advisor, or another clinical DVA champion Proforma asks for community psychiatric nurse's details	If vulnerable adult or children affected, follow local adult safeguarding/ child protection policies

	Sharing in an emergency situation	Sharing with MARACs	Sharing with DVA services	Sharing with HCPs	Sharing with other agencies/services
LARA-VP (2018) resource to help mental health professionals identify and respond to DVA	In an emergency, always call the police on 999	'In cases of high risk … consider … referring to MARAC	'Inform that you … can refer them to a local DVA support service' For perpetrators: 'know local perpetrator services and procedures for referral'	'Inform that you can provide psychiatric support … offer responses and support within the multi-disciplinary team' For perpetrators: 'considering discussion with the team, forensic psychiatry colleagues and/or collaborating with specialist DVA perpetration services on a case-by-case basis'	There are several agencies with which you may be required to share information in cases of DVA: police, social care, MARAC, MAPPA, MASH

LARA-VP has additional guidance to 'explain limits of confidentiality … Share with consent where appropriate [and] possible. Base decisions about information sharing on risks to victim/third party's safety. Sharing should be necessary, proportionate, relevant, accurate, timely, and secure'

And for perpetrators: if 'sharing information you should tell the perpetrator that you are going to do so, unless this is likely to increase risk of harm to them or someone else. It is not appropriate to seek consent from a perpetrator of DVA if you are considering sharing information/reporting a crime

Analysis of guidance and resources on sharing information

As with our analysis of professional guidance/resources on recording information, we note that the most comprehensive resource is the LARA-VP (Yapp et al., 2018) resource for mental health (a speciality in which NICE encourages routine enquiry). The LARA-VP resource was developed with DVA charities and experts from mental health services. All guidelines mention which agencies/services outside of health HCPs should considering sharing information with. Only the LARA-VP mental health resource goes into any detail about when sharing without consent is permissible. Otherwise, guidance is patchy.

Only four of eight guidelines—RCGP (2020), RCN (2017), BASHH (2016), and LARA-VP (Yapp et al., 2018)—mention what to do in an emergency situation, and none make explicit that emergency action (e.g., calling the police) does not need consent.

All, except the NICE (2010) pregnancy and complex factors (for GPs, primary care, and midwives) and RCOG (2016) mention when and how to refer to a MARAC. This is interesting, since pregnancy is a particularly risky time for DVA. It is not clear from national or professional groups' guidance/resources whether HCPs who make the MARAC referral themselves should refer to DVA agencies at the same time so that the victim/survivor can receive support straight away.

All mention that HCPs may need to share information with some agencies (e.g., in cases of child or adult safeguarding). The NICE (2010) and RCOG (2016) guidelines notably recommend drawing up a local guideline for pregnant women. As we mention in *A Note on Information-Sharing Protocols* earlier, we found no such protocols through our research for this report or through the main Pathfinder project.

Only RCGP (2020), BASHH (2016), and LARA-VP (Yapp et al., 2018) make direct referrals to DVA services. The others are vague, say nothing, or as RCEM (2015) says, suggest signposting, although the SafeLives guidance that RCEM cites recommends that clinicians make direct referrals (SafeLives, 2015). Sometimes the victim/survivor will turn down support from the HCP offering it. Victims/survivors do not always accept support straight away. Guidance does not say anything specific on how HCPs should deal with the issue. None of the guidance mentions anything about HCPs receiving or seeking feedback on referrals.

Only two guidelines (RCN, 2017, and DH, 2013, for health visitors and school nurses) mention sharing information with other HCPs, although others mention making referrals. No other guidance mentions whether HCPs who receive the disclosure should tell the GP, and whether HCPs can rely on implied consent to tell them. General practitioner guidance does not mention that DVA information should be discussed at clinical meetings and should be visible to GPs/practice nurses who

see the patient in future,[22] which may include locums who do not attend clinical meetings.

Only LARA-VP (Yapp et al., 2018) mentions anything specific about perpetrators. Domestic homicide review analyses, which we discuss in the next section, make it clear that sharing information about perpetrators in the health setting is inadequate. We now turn to findings from DHRs, SCRs, and SARs, as well as from academic research and our discussions with stakeholders, to better understand what happens in practice.

What sharing happens in practice: healthcare-wide

Issues from DHRs, SCRs, and SARs on sharing information

We have extracted all information relevant to health from seven analyses of DHRs (Chantler et al., 2020; Stanley et al., 2019; Benbow et al., 2018; Robinson et al., 2018; Home Office, 2016; Sharp-Jeffs and Kelly, 2016; Neville and Sanders-McDonagh, 2015), an annual report of SCRs (The Child Safeguarding Practice Review Panel, 2020), a triennial analysis of SCRs (Brandon et al., 2020), an analysis of 37 SCRs and SARs (Preston-Shoot, 2017), a SCIE (2020) analysis of statutory reviews of homicides and violent incidents, and recent SARs. In this section, we begin by discussing sharing between healthcare and other agencies, and then discuss sharing within healthcare. We focus here on cases where there is known DVA, although many cases better sharing of all risk factors could improve identification of risk.

Sharing between agencies

In an analysis of SCRs and SARs, Preston-Shoot (2017) concludes that individual reviews have cited examples of good relationships between practitioners in different agencies/services (e.g., community psychiatric nurses and social workers). However, reviews often cite that agencies/services within and outside healthcare need to strengthen information sharing with GPs, EDs (particularly regarding frequent attenders and absconders), MARAC, and MAPPA. Analyses of DHRs (Chantler et al., 2020; Stanley et al., 2019; Home Office, 2016; Sharp-Jeffs and Kelly, 2016; Neville and Sanders-McDonagh, 2015) all urge better multi-agency working to identify, assess, and respond to risk, with key agencies being general practices,

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[22] The RCGP (2017b) safeguarding guidelines, however, explicitly state 'Safeguarding information needs to be immediately obvious on a patient's notes to all health practitioners'—this information can encompass DVA information.

mental health, substance-use services (some of which are NHS-based and some are third-sector-based), adult social care, and the police.

Domestic homicide review analyses show that several DHRs have found inadequate referrals for safeguarding/MARACs. In some cases, no professional sought a safeguarding referral, or a safeguarding referral was made too late. For example, in one DHR, where the GP was aware that the victim was experiencing DVA, the victim presented with a rib fracture and asked for the police not to be involved. The GP respected her wishes but, as the DHR states, should have made a MARAC referral (Sharp-Jeffs and Kelly, 2016).

Even if a MARAC happens, the way information is shared afterwards is sometimes inadequate. The SCR annual report (The Child Safeguarding Practice Review Panel, 2020) mentioned that in one SCR involving DVA, the trust representative at MARAC did not communicate the minutes to the health visitor, which would have heightened her awareness of the risks to the mother and child. The SCR emphasised the importance of clearly recording multi-agency meetings, decisions, and actions, and distributing the minutes promptly to all attendees and relevant professionals who were not at the meeting. Both Neville and Sanders-McDonagh (2015) and Sharp-Jeffs and Kelly (2016) found that GPs were the only stakeholder group with whom victims and perpetrators were consistently and actively engaged. Thus, GPs are uniquely positioned to have information about victims and perpetrators. Sharp-Jeffs and Kelly (2016) say that given this, the importance of GPs attending MARACs to facilitate sharing between services cannot be overemphasised.

In at least one case (reported in Sharp-Jeffs and Kelly, 2016), information sharing happened between agencies but there was no coordination of action. The DHR reports that the police had told the hospital, who had in turn told the GP, that the perpetrator had called the police for help, saying that he would kill himself or his girlfriend. Neither the police, the hospital, nor the GP initiated actions to find and/or assess risk, and no one attempted to identify his girlfriend.

Victims and perpetrators moving between areas can hamper information sharing. Robinson et al. (2018) and Chantler et al. (2020) found that a change of address contributed to a lack of free-flowing information between local authority, police, and health services areas, which might have decreased support and protection. Transient populations can be especially at risk if no rigorous mechanism is in place for transferring records from one locality to another.

Another type of sharing that DHRs have found to be inadequate is sharing information with carers. Benbow et al. (2018) looked specifically at DHRs where the victim was over age 60 years and found that mental health trusts and other agencies/services excluded parents caring for adult children with mental health problems from care planning. As a result, the parent-carer's vulnerability was not recognised, and professionals missed 'a potential treasure trove of information about' the perpetrator (p.10). On this, Sharp-Jeffs and Kelly (2016) recommend that

GPs and mental health trust should develop joint strategies for working with carers to assess and address their own mental health needs and risk. However carers' involvement in general is complicated by the fact that in some cases the carer will be a perpetrator, as illustrated by Croom (2014) in the DHR for Mr C mentioned earlier, and in the DHRs Benbow et al. (2018) analysed.

Sharing within the health service

Notably, across all analyses, most cases of inadequate sharing within health were about inadequate sharing about the perpetrator, not the victim.

In their analysis of DHRs, Sharp-Jeffs and Kelly (2016) found inadequate sharing between general practices, EDs, mental health, maternity, and health visiting. Moreover, as mentioned in the recording information section, HCPs knew about DVA in very few cases. Most DHRs in the analyses were about missed opportunities to enquire about DVA.

Several DHRs cited a lack of communication between GPs and mental health. In one case, which cited inadequate sharing between a GP and psychologist, 'each professional appeared to assess the situation afresh every time [the perpetrator] presented himself, rather than looking at the pattern of information and help-seeking, and using information supplied by others' (p.30, Sharp-Jeffs and Kelly, 2016). In this case, the GP and other HCPs agreed that one professional should coordinate care, but no one decided who that professional should be. Domestic homicide reviews also highlighted that mental healthcare plans were sometimes inadequately transferred back to the GP, so the GP was unaware of triggers to crises. Similarly, one DHR from the Home Office analysis noted that 'it is not apparent that information held by the GP on [the perpetrator's] compliance to prescribed medication was passed to [the mental health service]' (p.19).

Two DHRs cited sharing from the ED to other HCPs. In both, women and their children attended the ED multiple times. Sharp-Jeffs and Kelly (2016) do not say which service the ED should have spoken with, but that there was an absence of coordination across health services: coordination might have to make clear these patterns in attendance. In another case where a woman (who had children) disclosed DVA, a referral to universal services was allocated to the school nurse, but information was not shared with the GP and Child and Adolescent Mental Health Services (CAMHS), which was already involved.

A more recent DHR not included in these analyses highlighted the importance of the method of sharing: a drug liaison midwife shared information about the victim's ED attendance with the community midwifery team through an answerphone message, which may not have been heard (Bristol Community Safety Partnership, 2015).

Given all of this, Sharp-Jeffs and Kelly (2016) point out that the health service needs 'better coordination … [which] … would help pick up … patterns in appointments, walk-ins and emergency attendances rather than them being viewed in isolation'

(p.12). They recommend that a coordinated health response would include co-working pathways and holistic responses.

In sum, DHRs, SCRs, and SARs have found that there is poor information sharing within health and between agencies/services, poor post-MARAC communication, inadequate assignment of actions following information sharing between agencies or even within the health service, poor information sharing between agencies/services in different areas for when a victim/perpetrator moves, and additional complexities involving carers—who, as DHRs illustrate, can be victims or perpetrators.

We now turn to findings from academic research and discussions with stakeholders to better understand what sharing happens in practice.

Research on views and practices around sharing DVA information

While there is some research around HCPs sharing information for child safeguarding (e.g., Szilassy et al. 2017), very little research explicitly explores whether and how HCPs share information about DVA with other HCPs, with MARAC, or with police. In an evaluation of the IRIS+ study (which extends the general practice IRIS model to male victims and children), most of GPs' identifications of DVA were from reports (e.g., MARAC and police report) that another agency had shared with the practice. Pitt et al. (2020) explored GPs' views on receiving such reports. General practitioners were unsure what to do with these reports: the reports rarely made clear whether the sending party expected the GP to take any action, or what that action should be. General practitioners also wanted to know what action other agencies/services would be taking. They were concerned about whether to bring a patient in for an appointment after receiving such a report: they worried that the patient might not know that information had been shared, and that enquiry about DVA based on the report might be intrusive or upsetting. They were more reassured when the report said that patients knew the information had been shared with them. General practitioners also described making assumptions based on the information in the reports was risky; they worried that they did not know the full extent of the story from the report. The findings from the study have informed IRIS+ training, which should help them to broach DVA in such cases.

Aside from this, we found just two unpublished studies that mentioned DVA information sharing between health and other agencies/services. First, recent research about EDs and sharing information with the police for violence prevention in Avon and Somerset has shown that there is no routine data sharing between the ED and other agencies. Agencies instead rely on informal arrangements (such as ED staff attendance at meetings based) to gain insight into local violence (Behavioural Insights Team, 2019). Second, research with health visitors about their response to DVA has shown that health visitors have little interaction with other agencies. Participants said they receive information regarding so-called domestic incidents from the police or social workers, after which they make visits to the families in

question, occasionally with social workers. But they did not describe regular contact, information sharing or joint support planning with other agencies. Health visitors said they find the initial information sharing from social workers useful because, in their view, women feel stigmatised by contact with social services, but not to contact with HCPs. Health visitors felt that their involvement, such as through joint visits, could encourage women to engage (McFeely, 2016).

Some research has shed light on sharing practices between HCPs and DVA services (Dheensa et al., 2020; SafeLives, 2016; Szilassy et al., 2015). This research has shown that it is motivating for HCPs when DVA services share feedback with them about the patient and whether they are now receiving support. Feedback is an integral part of the IRIS model.

There is no research about how HCPs share information about DVA with other HCPs, although IRIS training gives GPs/practice nurses guidance on sharing information. Training advises them to consider making health-related referrals (such as initiating a health visitor review) and encourages them to talk to victims/survivors about with whom they will share information and why (unpublished IRIS+ training slides, 2020). However, this may not be possible when receiving and sharing information received from another HCP or another agency/service, as receiving such information would usually happen outside of a consultation.

Table 8 contains an outline of informal discussions with stakeholders, including researchers who have recently published about DVA (Asiegbunam, 2020; Boddy, 2020) about sharing between HCPs. These discussions indicate that:

- GPs sometimes share information with health visitors, midwives, and school nurses
- Health visitors sometimes share information with GPs, and where relevant, midwives
- Paediatricians sometimes share information with health visitors, and if the child is older, the school nurse
- Midwives will encourage patients to tell GP themselves

Good practice was better determined when there were children under 18, as HCPs could then fall back on child safeguarding processes: sharing in cases that fall outside of formal safeguarding appears to be on an ad-hoc basis. Notably, all said that they would ask the patient before sharing information with another HCP.

Table 8: Examples of practice around sharing between HCPs

HCPs	When a patient discloses DVA, who they share with and how	How they share
GPs	May share information with a midwife if the woman is pregnant and/or health visitor if she has young children In a few general practices, health visitors and/or midwives will be practice-based, so GPs can have face-to-face discussions. However, health visitors are increasingly distanced from general practices and have to manage enormous caseloads, which has led to a cut in the number of face-to-face checks with families (and sometimes checks are over the phone). Moreover, health visiting teams cover a different geographical area to the GP, so a child in one general practice may be under a health visitor in another practice In cases involving high levels of physical violence and children, GPs may involve hospital paediatric consultants, community paediatricians, or designated safeguarding nurses Sometimes GPs will speak to schools (school nurses, pastoral care, wellbeing officers) to seek information (e.g., likelihood/severity/type of abuse towards the parent or child) but they are difficult to contact Notifying other specialities is on an as-needed basis: for a clinician to contact different specialties, they would need to be sufficiently concerned	Communication is usually by email, letter, or phone, but making contact over phone can be difficult because HCPs are busy General practices have regular safeguarding and clinical meetings where HCPs can discuss families at risk. Sometimes health visitors will attend. The lead GP for safeguarding has a key role for these families, and in some practices will have regular routes of communication, especially with health visitors
Health visitors	Health visitors may make MASH referrals and share information with the GP and midwife (after gaining consent) and encourage the victim/survivor to disclose to other professionals involved in their care	Since health visitors no longer have access to GP records, liaison with GPs is through emails, meetings, and phone calls
Paediatricians	If there are children under age five years in the family, may share information with the health visitor. With children over five years paediatricians would discuss with parents about offering the child an opportunity to speak with the school nurse No routine sharing with the GP, but it would be good practice to do so safely and with consent	Health visitors can access paediatricians' records in some trusts

HCPs	When a patient discloses DVA, who they share with and how	How they share
Midwives	Safeguarding team will advise midwife what to do, specific to that case. Midwife generally recommends that the woman tell her GP and does not inform the GP unless the woman wants her to do so	Individual midwives used to attend practice meetings to share information, but most care is now delivered in hubs away from practices, meaning they no longer have this contact

On sharing between GPs and midwives, stakeholders and our expert advisory group also highlighted that when GPs refer women for pregnancy care, referral forms often have scant information, even when the woman has disclosed DVA. Moreover, GPs said they rarely receive information about disclosures of DVA made or risk assessments undertaken in the antenatal setting. This lack of communication makes it difficult to ensure a robust mechanism for transferring DVA information disclosed in pregnancy to the babies' records when they are born.

As indicated in the table, the re-organisation of primary and maternity care—with health visitors no longer general practice-based and midwives' care delivered in hubs away from general practices—impedes effective sharing. Only health visitors mentioned sharing information at multi-disciplinary team meetings (MASHs). The RESPONDS (Szilassy et al., 2015) study about how GPs/practice nurses respond to child safeguarding and DVA pointed out that GPs wanted to involve health visitors, but reorganisation of health visitor services had reduced their contact: 'limited knowledge of the other agency's sphere of operations, poor engagement in joint decision making … a perceived lack of feedback and isolation from other professional groups can all have an adverse impact on … decision making' (p.76). Since accessing each other's records and meeting face to face is often impossible, sharing information relies on HCPs emailing or phoning each other, and HCPs sometimes 'end up in a game of missed call tennis' (GP, personal communication, 2020). This is despite the fact that NICE guidelines say to 'ensure information-sharing methods are secure and will not put anyone involved at risk [and] ensure any information shared is acknowledged by a person, rather than by an automatically generated response' (p.14). Acknowledgement is important: as mentioned in the *Issues from DHRs, SCRs, and SARs on Sharing Information* section earlier, one recent DHR found that a drug liaison midwife shared information about the victim's ED attendance with the community midwifery team through an answerphone message: while it is not clear how much of an effect this had on failing to prevent the homicide, the DHR recommends that staff should speak directly to colleagues or send written information if time allows (Bristol Community Safety Partnership, 2015).

Our expert advisory group highlighted that the number of different software systems within and across trusts mean that any more sophisticated information sharing (e.g., automated information sharing) will not currently be possible. Initiatives such as the shared records systems in general practice and the digital maternity record may

improve sharing over time. New systems can be costly to develop, but can be effective. One example of good practice is the Child Protection–Information Sharing project (CP-IS). This project has linked the information technology systems used across health and social care so that if a child known to social services (e.g., because they are on a child protection plan) attends an unscheduled NHS care episode, CP-IS alerts the healthcare team about the plan. The team is also given contact details for the social care team. Both parties can see details of the child's previous 25 visits to unscheduled care settings (NHS Digital, 2020c). Whether a similar system could be developed for high-risk victims/survivors (e.g., those heard at MARAC) warrants research.

Stakeholders notably said they ask for patient permission before sharing information about DVA with other HCPs, even though sharing information relevant to health with HCPs involved in direct care can be based on implied consent. Information about DVA is sensitive, so HCPs may feel it is best to seek explicit consent before sharing. However, some research suggests that victims/survivors expect information to be shared between HCPs (Olive, 2017) and that they want information to be shared between HCPs so that they do not have to retell their (Pathfinder, 2020b). Moreover, better information sharing is a constant recommendation in DHRs, SCRs, and SARs. Nevertheless, other research suggests that victims/survivors want to be in control of their information (Taskforce on the Health Aspects of Violence Against Women and Children, 2010), and giving explicit consent to share is one way of wielding this control.

In sum, there is very little research and a lack of standard practice regarding sharing practices between health and other agencies/services outside of formal safeguarding processes, and no research about victims/survivors' views on what sharing should happen and with what consent. More research is needed here to determine good practice.

Conclusions

The aims of this project were to form national recommendations on good practice around recording DVA in different healthcare settings and sharing information within the health service and between health and other agencies/services. Multiple research strands informed the draft recommendations. These were then finalised through consensus-forming with expert advisors, using a multi-stage process that involved an adapted version of the nominal group technique. The recommendations aim to benefit and reduce harm to victims/survivors and children. We intend the recommendations to function as a standalone document.

This work has also highlighted several areas where more research is required. Below, we list recommendations for research and audit. We end this report with recommendations for improving practice.

Audit and research recommendations

🔍 Research to explore commissioning incentives for recording and sharing information such as linking good practice to the Quality Premium scheme and/or the Quality and Outcomes Framework, and to make DVA recording mandatory in national datasets, such as the Maternity Services Dataset and Emergency Care Data Set.

🔍 Research with general practices to determine whether they implemented the RCGP 2017 guidelines for recording DVA information, and what issues they encountered, if any. This work could this inform practices in general practice and potentially other areas, and future versions of GP guidance.

🔍 Research in maternity to identify the barriers to recording DVA in maternity, with an audit of the EPR systems maternity units are using, and these systems allow midwives to skip questions about DVA, as well as research to evaluate maternity staff's use of such systems. This work can inform practice around accurate recording.

🔍 Audit of all ED frequent attender/high-impact user/high-intensity user programmes to determine the level of DVA training staff have to support victims/survivors and children, and the percentage that work with DVA specialist services (including health-based IDVAs). This audit can highlight which teams need more DVA training and which teams need to set up partnerships with DVA services.

🔍 Audit of trusts to identify the percentage of hospitals that have IDVAs, the percentage of IDVAs who have access to information relevant to DVA in EPRs, and the processes IDVAs need to go through to gain access. The audit can inform a strategy to enable easier access to EPRs for IDVAs.

🔍 Audit and research with general practices and trusts that use alerts/flags to indicate DVA to identify whether only high-risk victims/survivors are flagged, whether *suspected* victims/survivors are flagged, whether perpetrators are flagged (and the safety implications therein), whether alerts/flags expire or prompt manual review, who adds and removes alerts/flags, to whom these alerts/flags are visible, whether information from alerts/flags in hospitals auto-populates GP discharge letters, and whether the information that alerts/flags contain transfers if the patient moves general practice or trust. This work can inform recommendations about the safe use of alerts/flags and highlight technical support needed to address challenges.

🔍 Research with mental health trusts to determine whether using an equivalent of the HARKS template may facilitate safe and effective recording of DVA.

🔍 Research with general practices and trusts to determine how HCPs are managing sensitive information in shared medical records and trust-wide EPRs, which are accessible to a wide range of HCPs. Research should explore victims/survivors' views about good practice and the information patients are given about hiding information in their EPR. This work could inform safe, feasible, and acceptable practices around recording information and highlight the technical support needed to address any challenges.

🔍 Research with general practices and trusts on HCPs' practices and victims/survivors' views around recording DVA in EMRs/EPRs that are accessible to patients online. This work could inform safe, feasible, and acceptable practices around recording information and highlight technical support needed.

🔍 Research with victims/survivors, perpetrators, and HCPs to explore what they see as appropriate sharing within the health service, including what information should be shared, how, and based on what types of consent. This research can inform additional recommendations for improving practice.

🔍 Research with nationwide MARAC chairs to determine numbers of MARACs with health representation, who these health representatives are, and numbers of MARACs that invite GPs. This research can facilitate mutual learning.

🔍 Research to devise appropriate DVA training for Caldicott leads and Caldicott guardians. This work will improve their ability to support HCPs with recording and sharing DVA information.

🔍 Research with victims/survivors and HCPs to explore recording and sharing DVA when the victim/survivor is migrant with no recourse to public funds to identify additional issues faced by, and inform ways to support, such victims/survivors.

🔍 Research to explore the feasibility of a system like CP-IS to make HCPs aware when a patient has been heard at a MARAC. This work will shed light on ways to improve information sharing between health and other agencies.

Recommendations on recording and sharing information about domestic violence/abuse in the health service

Target audience

Healthcare professionals (HCPs) and administrative staff in primary and secondary care.

Purpose

The recommendations articulate good practice around recording domestic violence/abuse (DVA) information in medical records (e.g., using diagnostic codes, alerts/flags, or free text). They clarify good practice around sharing DVA information for direct patient care within the health service and between agencies/services.

Development process

An expert advisory group consisting of members from healthcare, Caldicott, safeguarding, police partnerships, academia, and third-sector organisations identified priority areas for this work. Multiple research methods informed a draft set of recommendations, including a policy analysis of guidance documents from national bodies (e.g., the British Medical Association) and different professional groups (e.g., the Royal Colleges) on recording and sharing DVA information; analyses of domestic homicide reviews, serious case reviews, and safeguarding adults reviews; a review of recent academic literature from the United Kingdom; discussions with key stakeholders; and an outline of current initiatives that may facilitate recording and sharing. Recommendations were finalised through a multi-stage consensus process involving an adapted version of the nominal group technique with a group of expert advisors and a group of survivors.

Key principles

- DVA damages health and wellbeing
- Recording DVA information is as important as recording any other information in clinical records
- DVA information should be recorded and shared in a way that protects patients and makes information visible and accessible to HCPs to provide holistic care
- Information should be recorded and shared in a way that is safe (i.e., does not increase risk to victims/survivors and children)
- Each recommendation leaves room for professional judgement. Some recommendations will require a case-by-case assessment to ensure safety of implementation
- It is not always clear who is experiencing and who is perpetrating DVA. Our recommendations address the safety, care needs, and safeguarding issues for all parties

Disclosures of DVA will infrequently be spontaneous or overt (e.g., people will not always use the terms 'abuse' or 'violence') and will rely on HCPs identifying and enquiring about DVA. Domestic violence/abuse may be current, but even if it is not (i.e., if it is 'historic'), the effects can be long-lasting. While the recommendations below are about recording and sharing, specific training around identifying and enquiring about DVA is crucial—particularly identifying coercive control, which can be difficult for professionals to identity. Good practice around recording and sharing rests on good practice around identifying and enquiring.

1. Overarching recommendations for healthcare organisations

1.1 Commissioners should fund ongoing DVA training, supervision, and support for HCPs. Training should:
- → Cover safe and effective recording of DVA information as relevant to that organisation, including examples of how and where to record information
- → Include how to share information safely, and what consent is needed for sharing
- → Cover how to engage patients in decisions around recording and sharing
- → Encompass technical elements, such as how to hide DVA information from others in electronic medical records (EMRs) and electronic patient records (EPRs) and how to use redaction for subject access requests confidently

Computer monitor privacy screens should be made available to general practices where possible to support implementation of good practice around recording information.

1.2 Clinical directors/managers should ensure monitoring and evaluation of training to assess its effectiveness (e.g., evidence of HCPs' behaviour change regarding coding and sharing) and to identify where training needs revision.

1.3 Clinical directors, and managers should ensure DVA training is in place for administrators and DVA coordinators, DVA leads, and DVA advocates to enhance implementation of recommendations.

2. Overarching recommendations for all HCPs

2.1 General practice staff should use these recommendations in conjunction with Royal College of General Practitioners guidance on recording domestic abuse in the electronic medical record, Mental health professionals should use them in conjunction with the LARA-VP resource on identifying and responding to DVA.

2.2 All recommendations should be read in conjunction with safeguarding guidelines around sharing information with other agencies/services.

2.3 Information about DVA should not be visible (e.g., on screen or on paper notes) to people who accompany the patient in consultations. Additionally, DVA information from third parties should not be visible to the patient unless the patient knows that the HCP in question has the information.

2.4 Information about DVA should be hidden from online access (in EMRs and hospital EPRs that patients can access online). Information about DVA may also require redaction from records if a subject access request is made.

2.5 In cases where there is any imminent risk of harm or danger, HCPs can share information without consent (e.g., with police).

3. Recommendations for all HCPs on recording information

3.1 If a patient discloses that they are experiencing DVA, HCPs should routinely document the following items:
    i.   Patient has disclosed DVA

ii. Who else is present during the consultation

iii. Victim and perpetrators' relationship

iv. Who else is in the household, noting any children and their ages and any 'adults at risk' (vulnerable adults; as per the Care Act, 2014)

v. Pragmatic assessment of immediate risk and ongoing risk

vi. Action the HCP takes or plans to take (action may include referrals, signposting, safety-planning advice given, and information shared. If the HCP takes no action, they should document 'no action' plus the reason for taking no action)

→ If a patient discloses that they are perpetrating DVA, HCPs should routinely record the same items

→ If a child discloses there is DVA in their household (e.g., between their parents), HCPs should routinely record the same items but acknowledge that relying on a younger child's perspective may make it more difficult to accurately assess risk

→ Healthcare professionals should document if the patient discloses that they are experiencing *and* perpetrating DVA

3.2 Whenever possible, HCPs should record brief details about the patient's DVA disclosure in their medical record.

→ HCPs should use phrases like 'patient says', 'patient describes', or 'patient discloses', followed by their own words. Verbatim quotes should be indicated with quotation marks

→ When documenting what a patient discloses, HCPs should avoid phrases like 'patient claims' or 'patient alleges', which imply doubt

→ Where possible, HCPs should tell patients what they are documenting and explain that they will use quotation marks to signify their words

3.3 Healthcare professionals should record DVA in the patient's medical record such that it is visible to other HCPs in the care team, so the team can respond appropriately and be aware of current/ongoing risk should they see the patient in future.

3.4 If a third party (including multi-agency risk assessment conference [MARAC], police, and other HCPs) sends information about DVA to a general practitioner (GP) or another HCP, and there is any doubt over whether the patient knows that the third party has shared the information, the information should not be visible (on screen or in paper notes) to the patient in subsequent consultations. The information should be recorded in the third-party section of the medical record and be redacted/hidden from records that patients can access.

→ The GP may consider arranging a discussion with the patient upon receiving this third-party information if it presents an opportunity to increase safety and support and reduce harm

3.5 If a HCP suspects and enquires about DVA victimhood or perpetration, but the patient does not disclose, the HCP should document in the medical record (e.g., in free text that they have asked about DVA). Healthcare professionals in departments that use Systematised Nomenclature of Medicine (SNOMED) codes should also use the 'family is cause for concern' code, rather than a specific DVA code. (NB: practice staff trained on Identification & Referral to Improve Safety [IRIS] can use the humiliation, afraid, rape and kick, and safety [HARKS] template to record enquiry even if no disclosure is made.) If the HCP thinks re-enquiry would be beneficial, they can consider adding a note for any HCPs who subsequently see the patient, or for themselves in future, to re-enquire. Such patients should be considered for discussion in general practice clinical meetings.

3.6 If a patient who has previously disclosed experiencing DVA requests online access to their EMR, GPs/practice nurses should consider refusing access if there is a risk that the perpetrator could gain access to the record. If a patient who already has online access discloses experiencing DVA, GPs/practice nurses should consider withdrawing their access. Practice staff should have a policy on safely responding to any resulting complaints from patients, but where possible should make decisions about online access with patients. Since online access is available to under-18s in some practices, the same recommendation applies to any children whose parents/guardians have disclosed experiencing or perpetrating DVA.

3.7 If printing out parts of the patient's EMR (e.g., to refer them to another department or for their admission for acute care), GPs/practice nurses should redact information about DVA unless the information is relevant for their direct care or if the patient has said they want that information shared. Redaction may need to be done manually.

3.8 If making e-referrals that are auto-populated with information from the EMR, HCPs should delete information about DVA—again, unless the information is relevant for their direct care or if the patient has said they want that information shared.

3.9 General practice 'shared records systems' make information in EMRs directly accessible to other organisations. Trust-wide EPRs make information available to all HCPs within that hospitals trust. General practices and trusts using these systems should decide whether to record DVA information such that it is visible to other HCPs. Healthcare professionals should balance the

risk of other HCPs not having access to the DVA information against the risk of HCPs who do not have DVA training having access to it. Healthcare professionals should consider involving patients in such decisions.

3.10   If EMR/EPR software allows, HCPs should consider using (i) role-based/tailored access, whereby only groups of HCPs who are likely to have had DVA training have access to DVA information, and/or (ii) a DVA indicator that only trained HCPs would recognise.

3.11   Healthcare professionals should use alerts/flags in the EMR/EPR for all patients who disclose experiencing or perpetrating DVA, if safe to do so. To determine safety, HCPs should consider whether alerts/flags would make DVA disclosure visible to people who accompany the patient to future consultations. HCPs should also consider whether the alert/flag can be hidden or redacted if the patient has, or requests, access to their medical record.

$\rightarrow$ Trusts should use or develop alerts/flags specific to DVA, rather than generic flags. Since the effects of DVA can be long-lasting, HCPs should not routinely unflag patients or set flags to expire, but may set reminders to review alerts/flags manually

3.12   Information about DVA should be recorded in a part of the medical record that will transfer to a new general practice or trust if the patient moves. Alerts/flags are sometimes localised to a general practice or trust's software system and will therefore not transfer.

Specific recommendations for emergency departments

3.13   If a patient who has experienced or perpetrated DVA is referred to mental health liaison within the emergency department (ED) but absconds before being seen, mental health liaison should record as much information as they can in their records, including the minimum set of DVA information mentioned above.

3.14   In EDs where time is limited and patients may only present once, staff may consider using a short standardised form (either electronic or paper to be uploaded) to capture the minimum set of DVA information mentioned above. The form could also provide guidance for HCPs around the relevant actions to consider (such as onward referrals) and contact details for support.

Specific recommendations for maternity

3.15   Maternity units should devise markers to record DVA enquiry and disclosure discreetly, consistently, and safely in handheld notes such that only other midwives in the team will recognise the markers.

4. Recommendations for all HCPs on sharing information

4.1 Sharing within the health service

4.1.1   If a patient discloses to a HCP that they are experiencing or perpetrating DVA, the HCP should inform the patient's GP. Healthcare professionals who see a patient during pregnancy or perinatally should consider also informing the patient's midwife and health visitor.

4.1.2   If a patient discloses to a GP/practice nurse that they are experiencing or perpetrating DVA, the GP/practice nurse should consider whether to share this information with HCPs in other clinical departments involved in the patient's direct care.

4.1.3   Sharing DVA information can be based on implied, rather than explicit, consent if the sharing will inform direct care. However, it is usually good practice for HCPs who receive a disclosure of DVA to seek the patient's explicit consent before sharing this information with other HCPs.

4.1.4   If a patient says they do not want the HCP to share DVA information with the GP/another HCP, the HCP should try to clarify the patient's concerns, keeping in mind that victims/survivors may be withholding consent due to fear or coercion. Healthcare professionals should address any concerns and emphasise the benefits of sharing, such as to their care and risk.

4.1.5   If a patient still withholds consent for sharing DVA information with the GP/another HCP, the HCP should consider arranging a follow-up appointment to revisit concerns. In the ED, this follow-up appointment can be with an independent domestic violence advisor/advocate (IDVA) or DVA lead.

4.1.6   In some cases, it will be appropriate for the HCP to share the DVA information without consent (e.g., because sharing is needed for the patient's benefit, to prevent harm, or to raise a formal safeguarding concern). Healthcare professionals who decide to share information without the patient's consent should follow guidance from their own profession (e.g., the General Medical Council). The HCP should document their decision and its reasoning in the patient's medical record. The HCP should inform the patient of their decision and its reasoning unless doing so would increase the risk of harm.

4.1.7   Any correspondence about DVA between professionals within the health service and between agencies/services should make extremely clear:

→ The set of DVA information above

→ Actions the sending party has taken in response to DVA, or actions they will take and by when

→ Actions they expect the recipient to take in response to DVA and by when

→ Whether the patient knows they have shared the DVA information.

4.1.8 Healthcare professionals in hospital trusts should organise regular in-house meetings for staff who see or manage patients affected by DVA (e.g., from ED, maternity, paediatrics, mental health, and safeguarding). Meetings should enable information sharing about patients affected by DVA to build a picture of risk, harm, and safety. Discussions should include cases that do not reach the threshold for MARAC referral. Discussions should also include cases that have been heard at MARAC to ensure all post-MARAC actions are undertaken. If feasible, chairs of the in-house meeting should communicate relevant outcomes of the meetings with patients' GPs.

4.1.9 Healthcare professionals should seek advice from DVA leads, safeguarding leads, or Caldicott leads and guardians if they are unsure about recording and sharing information in DVA cases.

4.2 Sharing between healthcare services and other agencies

4.2.1 In many cases where a patient discloses that they are experiencing DVA, it will be appropriate for HCPs to refer them to DVA services, who can then make an onward referral to MARAC. However, HCPs can refer victims/survivors to MARAC themselves and can do so without the victim/survivor's consent, even if only the victim/survivor is at risk. Healthcare professionals should tell patients that they are referring them to MARAC unless this would itself increase the risk of harm.

4.2.2 Agencies such as social care, DVA services, and MARACs should send the referring HCP, referring care team, or designated DVA lead in the general practice/trust an email to confirm receipt of any referrals.

4.2.3 Regarding 'adults at risk' (vulnerable adults; Care Act 2014), if there is a suspicion of DVA, or if the adult discloses that they are experiencing or perpetrating DVA, HCPs should work closely with adult social care to manage risk and to plan care for the adult in question.

4.2.4 Healthcare professionals should apply caution if sharing information with the carer for any adult at risk if there is any suspicion that they are perpetrating DVA.

5. Recommendations for DVA-trained administrators and DVA leads/coordinators

5.1 All healthcare settings should have posts that include a role in the response to DVA. This includes administrative posts and, in trusts, DVA leads or IDVAs. These post-holders should support HCPs with recording and sharing DVA information.

→ Roles for general practice-based DVA administrators/leads should include processing incoming DVA notifications (e.g., from MARAC); ensuring any such correspondence is recorded in EMRs as third-party information; ensuring DVA information is redacted where appropriate; scheduling reviews of EMRs that contain DVA information to ensure the 'hide from online access' function is applied and to help ascertain risk of others gaining access to the record; and highlighting key information about DVA from incoming letters to the appropriate GP or practice safeguarding lead

→ Roles for hospital DVA leads/coordinators should include reviewing DVA information contained in trust-wide EPRs; reviewing alerts/flags; supporting HCPs with writing to the GP to inform them of DVA disclosures; organising in-house meetings to discuss DVA cases

→ In both settings, the role could include contacting agencies/services to which a HCP has made a referral to confirm that they have received and actioned it, and to track the outcome of the referral

5.2 In the ED, if a patient discloses that they are experiencing DVA (or there is indication of DVA (e.g., assault by [ex] partner or family member), an advocate, IDVA, or DVA nurse specialist should facilitate the recording and sharing of information between ambulance and ED staff and staff within the ED. Responsibilities should also include communicating with the consultant in charge and clinical team (e.g., radiographers) about any risk, facilitating and recording handover to the next responsible person at 'shift end', assigning follow-up care for when the patient leaves the ED, and ensuring continuing named responsibility for action completion and confirmation of action completion.

6. Recommendations for other professionals

6.1   All Caldicott leads and Caldicott guardians should have training on DVA so that they can effectively support decisions around recording and sharing DVA information.

6.2   All Caldicott leads and Caldicott guardians should ensure that their organisation is effectively engaged with the MARAC process and should help to set up referral pathways to DVA services.

6.3   National bodies such as the General Medical Council, the Nursing and Midwifery Council, and the British Medical Association should appoint trained DVA champions who can help with more consistent advice on recording and sharing information.

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Appendix 1: DVA SNOMED codes

Over 120 SNOMED codes for DVA are available in general practice (excluding forced marriage and female genital mutilation codes). We organise them thematically below. None are for coercive control or stalking and harassment.

Routine enquiry
Routine enquiry about domestic abuse (procedure)
Screening for physical abuse (procedure)

Not discussed
Routine enquiry about domestic abuse declined (procedure)
Routine enquiry about domestic abuse not made (procedure)
Domestic abuse not discussed (situation)

Suspected
Suspected domestic abuse (situation)
Suspected victim of domestic violence (situation)
Suspected victim of emotional abuse (situation)
Suspected victim of elder emotional abuse (situation)
Suspected victim of physical abuse (situation)
Suspected victim of elder physical abuse (situation)
Suspected victim of sexual abuse (situation)

DASH
DASH risk checklist (assessment)
DASH risk checklist – initial risk classification (assessment)

HARKS
Humiliation, Afraid, Rape and Kick questions (assessment scale)
Assessment using Humiliation, Afraid, Rape and Kick questions (procedure)

Domestic abuse/violence and its types
Domestic abuse (event)
Domestic violence (event)
Domestic sexual abuse (event)
Domestic physical abuse (event)
Domestic emotional abuse (event)
Domestic abuse of adult (event)

Domestic sexual abuse of adult (event)

Specifies that patient is victim
Victim of domestic abuse (finding)
Victim of domestic violence (finding)
Victim of intimate partner abuse (finding)
Victim of financial abuse (finding)
Victim of emotional abuse (finding)
Victim of honour-based violence (finding)
Victim of psychological abuse (finding)
Victim of physical abuse (finding)
Victim of sexual abuse (finding)
Adult victim of emotional abuse (finding)
Adult victim of physical abuse (finding)
Adult victim of sexual abuse (finding)

Specifies patient as victim and perpetrator identity and sex
Adult victim of physical abuse by male partner (finding)
Adult victim of physical abuse by female partner (finding)
Victim of abusive sexual relationship with wife (finding)
Victim of abusive sexual relationship with husband (finding)

Unclear victim/perpetrator dynamic
Abusive emotional relationship with wife (finding)
Abusive emotional relationship with husband (finding)
Abusive sexual relationship with wife (finding)
Abusive sexual relationship with husband (finding)

Physical abuse
Physical abuse (event)
Physical abuse of adult (event)
Physical abuse of elderly person (event)
Physical abuse of disabled person (event)

Psychological/emotional abuse
Psychologically abused woman (finding)
Psychologically abused parent (finding)
Psychologically abused spouse (finding)
Psychological abuse of adult (event)
Psychologically abused elderly person (finding)
Psychologically abused elder (finding)
Emotional abuse (event)
Adult abuse, emotional (event)
Emotional abuse of adult (event)
Emotional abuse of elderly person (event)
Emotional abuse of disabled person (event)

Sexual abuse
Sexual abuse (event)
Sexual abuse of adult (event)
Adult abuse, sexual (event)
Sexual abuse of disabled person (event)
Intrafamilial sexual abuse (event)

In pregnancy/childbirth
Physical abuse in pregnancy (finding)
Physical abuse in childbirth (finding)
Physical abuse complicating pregnancy (finding)
Physical abuse complicating childbirth (finding)
Psychological abuse in pregnancy (finding)
Psychological abuse in childbirth (finding)
Psychological abuse complicating pregnancy (finding)
Psychological abuse complicating childbirth (finding)
Sexual abuse in pregnancy (finding)
Sexual abuse in childbirth (finding)
Sexual abuse complicating pregnancy (finding)
Sexual abuse complicating childbirth (finding)

Historical
History of being victim of domestic violence (situation)
History of domestic violence (situation)
History of domestic emotional abuse (situation)
History of domestic physical abuse (situation)
History of domestic sexual abuse (situation)
History of being emotionally abused (situation)
History of physical abuse (situation)
History of sexual abuse (situation)

Health effects
Late effect of domestic violence (disorder)
Physical injury due to abuse (disorder)
Physical injury due to physical abuse (disorder)

Discussions
Discussion about domestic abuse (procedure)
Discussion about domestic abuse for maternal wellbeing (procedure)
Advice about domestic abuse (procedure)
Advice about domestic violence (procedure)

Counselling
Counselling for domestic abuse (procedure)
Domestic abuse counselling (procedure)
Physical abuse counselling (procedure)
Sexual abuse counselling (procedure)
Counselling for physical abuse (procedure)
Counselling for sexual abuse (procedure)

Referral
Referral to domestic abuse agency (procedure)
Referral to domestic violence advocate (procedure)

MARAC
Subject of multi-agency risk assessment conference (finding)

Battered wife/husband
Battered wife—history (finding)
Battered wife (finding)
Battered husband—history (finding)
Battered husband (finding)

Unclear meaning
Domestic partner abuse prevention (procedure)
Abuse protection support: domestic partner (procedure)
Domestic violence education (procedure)
Domestic violence screening interpretation (observable entity)

Patient at risk
At risk of domestic violence (finding)
At low risk of domestic violence (finding)
At high risk of domestic violence (finding)
At risk of emotional abuse (finding)
At risk of emotional/psychological abuse (finding)
At risk of financial abuse (finding)
At risk of honour-based violence (finding)
At risk of intimate partner abuse (finding)
At risk of physical abuse (finding (
At risk of psychological abuse (finding)
At risk of sexual abuse (finding)

Children and other household members
Domestic abuse victim in household (finding)
Domestic violence victim in household (finding)
Witness to episode of adult domestic abuse (finding)
Present during episode of adult domestic abuse (finding)
Mother victim of domestic violence (situation)
Notification received of alleged domestic violence in household (situation)

General
Family is cause for concern
Child is cause for concern
Family is no longer cause for concern
Child is no longer cause for concern

Perpetrators
$\rightarrow$ Notably, all here use the word 'alleged'
Subject of multi-agency public protection arrangements (finding)
Alleged perpetrator of domestic violence (finding)
Alleged perpetrator of abuse or violence (finding)
Alleged perpetrator of emotional abuse (finding)
Alleged perpetrator of physical abuse (finding)
Alleged perpetrator of sexual abuse (finding)

For disclosures of DVA, RCGP recommends that GPs/practice nurses use 'history of domestic abuse' in the records of victims/survivors, perpetrators, and children. General practitioners/practice nurses may also or alternatively use 'alleged perpetrator of domestic violence' for perpetrators, as well as 'subject of multi-agency risk assessment conference' if information is shared with or received from a MARAC.

A smaller subset of SNOMED codes is available in the ED: 'domestic abuse victim in household', 'at risk of domestic violence', and 'suspected domestic abuse'. Therefore, no ED SNOMED codes adequately capture DVA disclosures.