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Submission to Violence Against Women and Girls Strategy 2021-2024 Consultation

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This submission sets out the key findings and recommendations from the **'Recording and Sharing Domestic Violence/Abuse (DVA) Information in Healthcare'** research (2019-2020), funded by the Pathfinder consortium and by UKRI. The executive summary and full research report are available online.

Relevant consultation themes:

- **[Criminal justice and] system response to victims:** specifically, the health service (i.e., NHS) response defined as primary care, acute, mental health, and community hospital trusts. We do not cover the criminal justice response.
- **Perpetrator evidence, and service provision/best practice** since recording and sharing information about DVA enables the health service to identify and respond to perpetrators, through e.g., referral to specialist perpetrator services.

DVA disproportionately affects women. Data from over 800 women accessing DVA services showed that before getting specialist support, 56% had visited their GP. Moreover 30% had attended A&E as a result of the DVA—often mental health crises as well as direct injuries. The health service has a role in helping to shed light on the true **scale** of VAWG crimes and their impact and has a role in **identifying** these crimes and **preventing** escalation.

As Domestic Homicide Reviews, Safeguarding Adults Reviews, and Serious Case Reviews (including child death reviews) make clear, **people die when agencies/services do not record and share pertinent information about risk.** Health related agencies are the most common targets for recommendations from Domestic Homicide Reviews[1].

The research has identified ways in which the health service response to DVA in terms of recording and sharing DVA information can be improved – in particular, better identification and response to victims and perpetrators. This submission sets out the key findings and recommendations from the research.

The health service response should form part of a coordinated community response that brings together health, housing, social care, education, criminal justice, and communities, to ensure local systems keep victims safe, hold perpetrators to account, and prevent VAWG.

[1] Home Office, 2016. Domestic homicide reviews key findings from analysis of domestic homicide reviews. London: Home Office.

Summary

Key findings from this work are:

- Domestic Homicide Reviews often cite inadequate recording and sharing of DVA information in the health service and from health to other agencies/services.
- DVA is under-recorded in general practice.
- Accident and Emergency (A&E) clinicians do not record partner assaults as DVA and do not share DVA information within the A&E and with GPs.
- Maternity services should routinely enquire about DVA, but midwives enquire inconsistently.
- Use of the term 'alleged' in medical records is commonplace but re-traumatises victims and damages evidence in court.
- Trust-wide electronic patient records, and alerts and flags in electronic records, can help healthcare professionals identify victims but aren't used to their potential.
- Digitisation and interoperability platforms improve sharing but may allow a wide range of people to access DVA information.
- NHS Digital datasets miss opportunities to establish DVA scale in the UK.
- Hostile environment deters victims/survivors from seeking healthcare.

Key recommendations from the research: (which if implemented could improve practice)

- Commissioners should fund ongoing DVA training, supervision, and support for healthcare professionals.
- Clinical directors/managers should oversee delivery and evaluation of training.
- Healthcare professionals in hospital trusts should have protected time to organise regular in-house meetings for staff who see or manage patients affected by DVA.
- All healthcare settings should have posts that include a role in the response to DVA. This includes administrative posts and, in trusts, DVA leads and independent specialists, e.g., Independent Domestic Violence Advisers. These post-holders should support healthcare professionals with recording and sharing DVA information.

The recommendations were developed via consensus with an expert advisory group comprising representation from the Royal Colleges of GPs, Midwives, Emergency Medicine, and Psychiatrists, IRISi[2], the UK Caldicott Guardian Council, NHS-based DVA workers, and A&E-based high intensity user programmes. They are based on the following **key principles and assumptions:**

- DVA damages health and wellbeing.
- Recording and sharing DVA information is as important as recording and sharing any other clinical information.
- DVA information should be recorded and shared in a way that protects patients and makes information visible and accessible to healthcare professionals to provide holistic care.
- The problems identified in recording and sharing are largely caused by a lack of training, time, support, and clarity around best practice, rather than wilful ignorance or neglect by healthcare professionals.

[2] IRISi is a social enterprise established to promote and improve the healthcare response to domestic violence and abuse. Its flagship intervention is IRIS is a specialist domestic violence and abuse (DVA) training, support, and referral programme for general practices that has been positively evaluated in a randomised controlled trial.

What the research found

As summarised above, we identified barriers or failings in the health service response to victims and missed opportunities for service provision/best practice for perpetrators. We address these in detail, in turn.

We provide examples of good practice and limitations of this good practice and highlight where more research or action is needed to determine good practice.

Domestic Homicide Reviews often cite inadequate recording and sharing of DVA information in the health service and from health to other agencies/services.

1. Analyses of hundreds of Domestic Homicide Reviews show that healthcare professionals have **missed opportunities to enquire** about DVA. Enquiry relies in part on good-quality record keeping generally.
   For example, if a patient's mental health information or A&E attendance is fully coded in their general practice electronic medical record, a GP may be better able to spot the signs of abuse. But Domestic Homicide Reviews consistently point to poor record keeping in health:
   - Details about health-related risk factors for DVA (e.g., mental ill health, substance use, frequent absconding from A&E)[3] are often missing.
   - Names are spelled incorrectly hampering an overview of risk across agencies (in some cases this is because names were 'foreign'—one of many additional barriers to support migrant and BAME victims face)[4].
   - Details about whether the patient has young children are missing[5].

2. Analyses of Domestic Homicide Reviews have found that record keeping is poor **even when the patient has disclosed DVA**:
   - Flags for DVA, outcomes of risk assessment, and names of perpetrators are missing[6].
   - Healthcare professionals sometimes remove perpetrators' names from records due to anxieties around recording information about third parties[7].

3. On sharing between agencies/services, analyses of Domestic Homicide Reviews point to **poor information sharing and a lack of multi-agency working** in identifying, assessing, and responding to risk.
   - Key agencies/services cited are general practices, mental health, substance-use services, adult social care, and police[3-7].
   - Analyses have also found inadequate referrals for safeguarding and Multi-Agency Risk Assessment Conferences (MARACs). Even if a MARAC happens, the way information is shared afterwards is inadequate[8].

[3] Sharp-Jeffs, N. Kelly, L. 2016. Domestic homicide review (DHR) analysis. London: Standing Together.
[4] Chantler, K. Robbins, R. Baker, V. Stanley, N. 2020. Learning from domestic homicide reviews in England and Wales. Health & Social Care in the Community, 28(2), pp.485-493.
[5] Stanley, N. Chantler, K. Robbins, R. 2019. Children and domestic homicide. British Journal of Social Work, 49(1), pp.59-76.
[6] Neville, L. Sanders-McDonagh, E. 2015. Preventing domestic violence and abuse: common themes and lessons learned from West Midlands' DHRs. Birmingham: West Midlands PCC.
[7] Benbow SM, Bhattacharyya S, Kingston P. Older adults and violence: an analysis of Domestic Homicide Reviews in England involving adults over 60 years of age. Ageing and Society, 39(6), pp.1097-1121.
[8] The Child Safeguarding Practice Review Panel. 2020. 2018 to 2019 Annual Report.

4. Analyses of Domestic Homicide Reviews where an adult child has killed a parent aged 60+ acting as their carer show that mental health trusts and other **agencies/services have excluded parents caring for adult children with mental health problems from care planning**.
    - As a result, the parent-carer's vulnerability is not recognised, and professionals miss 'a potential treasure trove of information about' the perpetrator[9].

5. Analyses of Domestic Homicide Reviews find that **sharing within the health service is also inadequate**, most commonly between general practices, A&Es, mental health, maternity, and health visiting.
    - Most cases of inadequate sharing within health from these analyses are about the **perpetrator**, not the victim. That is, healthcare professionals miss opportunities to identify perpetrators and refer them to services and in turn increase victims' safety.
    - Sharing within A&Es (e.g., from ambulance crew to triage staff) is also inadequate (discussed in point 9 below)

DVA is under-recorded in general practice

6. In an analysis of longitudinal UK-wide general practice records, the proportion of female patients aged 18+ recorded as having lifetime experience of DVA in 2017 was **over twenty times lower than expected**.
    - GP prevalence was 0.37% (368.70 per 100,000 adult population), versus the Crime Survey for England and Wales prevalence figure (7.9%). Figures are not directly comparable due to the difference in time and age range, but even considering this, GP-recorded figures are extremely low[10].
    - Victims are more likely to disclose to GPs than any other professional[11]—so under-recording is a missed opportunity to intervene.

7. When GPs do record DVA it is in **diverse, inconsistent, and confusing ways.**
    - Formats include using diagnostic codes, hidden alerts, free text, and formal and informal messaging systems[12,13,14].
    - This inconsistency can hamper information retrieval for future GPs who see the same patient as well as information-sharing with other healthcare professionals and agencies/services.

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[9] Benbow SM, Bhattacharyya S, Kingston P. Older adults and violence: an analysis of Domestic Homicide Reviews in England involving adults over 60 years of age. Ageing and Society, 39(6), pp.1097-1121.

[10] Chandan, J.S. Gokhale, K.M. Bradbury-Jones, C. Nirantharakumar, K. Bandyopadhyay, S. Taylor, J. 2020. Exploration of trends in the incidence and prevalence of childhood maltreatment and domestic abuse recording in UK primary care: a retrospective cohort study using 'the health improvement network' database. BMJ Open, 10(6), p.e036949.

[11] Australian Institute of Health and Welfare. Family, domestic and sexual violence in Australia 2018. Cat. no. FDV 2. Canberra: AIHW; 2018. (p.47)

[12] Drinkwater, J., Stanley, N., Szilassy, E., Larkins, C., Hester, M. Feder, G., 2017. Juggling confidentiality and safety: a qualitative study of how general practice clinicians document domestic violence in families with children. British Journal of General Practice, 67(659), pp.e437-e444.

[13] Szilassy, E. Das, J. Drinkwater, J. Firth, A. Hester, M. Larkins, C. Lewis, N. Morrish, J. Stanley, N. Turner, W. Feder, G. 2015. Researching Education to Strengthen Primary care ON Domestic violence & Safeguarding (RESPONDS). Final Report for the Department of Health, Policy Research Programme Project. Bristol: University of Bristol.

[14] Szilassy, E., Roy, J., Williamson, E., Pitt, K., Man, M. S., & Feder, G. 2021. Reaching everyone in general practice? Feasibility of an integrated domestic violence training & support intervention in primary care. BMC family practice, 22(1), 1-17.

8. GPs are especially **unsure how to record DVA information they receive from third parties** (police reports, MARAC reports, letters from mental health services). In some general practices this is the most common way in which GPs learn about a patient's DVA (i.e., more so than via patient disclosures).
   - Third party information rarely makes clear what, if any, action the sharing party expects GPs to take.
   - GPs are unsure how to safely talk to victims about the information they receive from third parties[15].

Good practice (at national policy level)

IRISi has supported the set up and implementation of IRIS programmes in over 40 localities nationwide. Over 1,000 general practices have been fully IRIS trained on identifying and responding to patients experiencing and perpetrating DVA. In 2017 and again in 2020 the RCGP published national guidance for all practices—IRIS trained or not—on how GPs should record DVA, including reports from third parties.

🔎 **Research** is needed to explore whether all practices have implemented the guidelines and what issues they have encountered, if any.

A&E clinicians do not record partner assaults as DVA and do not share DVA information within the A&E and with GPs

9. Research from three different A&Es shows that **recording of DVA in medical records and GP referral letters is variable**.
   - Key information is often missing, e.g., children in the household or pregnancy, risk to patient, whether presenting case was the first episode of violence, referral to violence services, or information provided[16,17].
   - Information about DVA was not always shared within the A&E.
   - Clinicians commonly document 'alleged assault by partner' rather than recording that the 'patient is experiencing DVA'[16].
   - Referral forms from A&E to liaison psychiatrists are often blank on the question of whether the person is at risk from DVA: 80% (924/1142) were blank in one study[18].
   - Diagnosis and discharge letters to GPs infrequently use the term 'domestic violence' or even 'assault by partner' and most commonly described the injury only meaning the information is erased when it leaves A&E and goes to the GP[16].

10. Interviews with victims/survivors show that they expect A&Es to share information about DVA with the GP[16].

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[15] Pitt, K., Dheensa, S., Feder, G., Johnson, E., Man, M. S., Roy, J., ... & Szilassy, E. (2020). Sharing reports about domestic violence and abuse with general practitioners: a qualitative interview study. BMC family practice, 21(1), 1-10.
[16] Olive, P. (2017). Classificatory multiplicity: intimate partner violence diagnosis in emergency department consultations. Journal of clinical nursing, 26(15-16), 2229-2243.
[17] Boyle, A. Frith, C. Edgcumbe, D. McDougall, C. 2010. What factors are associated with repeated domestic assault in patients attending an emergency department? A cohort study. Emergency Medicine Journal, 27(3), pp.203-206. available on request
[18] Dalton, T.R. Knipe, D. Feder, G. Williams, S. Gunnell, D. Moran, P. 2019. Prevalence and correlates of domestic violence among people seeking treatment for self-harm: data from a regional self-harm register. Emergency Medicine Journal, 36(7), pp.407-409.

Good practice

The New Zealand Violence Intervention Programme funded by the Ministry of Health, supports health sector family violence programmes throughout New Zealand. As part of the programme, A&Es introduced a pro forma (the 'Intimate Partner Violence Assessment and Intervention Documentation') to capture DVA. Healthcare professionals send this to the clinical records department, who can ensure that a patient's DVA is flagged to clinical staff. Staff can then re-assess safety if they attend again. Introducing this document—crucially, with training—has been associated with an improvement in the standard of clinically assessing victims (i.e., documenting details, basic risk assessment, safety planning, and referral), and this improvement increased over time, as measured at 9 years' follow-up[19].

At Brighton & Sussex hospital, in response to one particular 2014 Domestic Homicide Review, which noted that a patient's disclosure of DVA was not handed over from ambulance staff to triage staff (because the patient 'had mental capacity' and did not want the information reported), all ambulance arrivals are now **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.

More generally (not in response to this Domestic Homicide Review), some A&Es have developed frequent attender programmes or high-intensity user services, which may identify patients at risk of DVA.

Moreover, Addenbrooke's hospital holds regular in-house meetings for staff (e.g., from A&E, maternity, paediatrics, mental health, and safeguarding) who see or manage patients affected by DVA. Meetings enable information sharing about patients to build a picture of risk, harm, and safety. Discussions include cases that do not reach the MARAC referral threshold (i.e., very high-risk cases) and cases that have been heard at MARAC to ensure all post-MARAC actions are undertaken.

🔎 **Research/audit** is needed of all A&E frequent attender programmes/high-intensity user services to determine the level of DVA training staff have to support victims and the percentage that refer into victim and perpetrator specialist services.

Maternity services should routinely enquire about DVA, but midwives enquire inconsistently.

11. Unlike in other areas of healthcare, **NICE guidelines (2014) recommend routine (rather than targeted) enquiry in maternity** because it is a high-risk time for DVA onset and exacerbation. However, evidence shows that midwives do not always enquire:
    - Common barriers are women not speaking fluent English and lack of appropriate interpreters, lack of organisational support (midwives have expressed anxieties around time constraints and their capacity to respond to a positive disclosure alongside other workload demands), and presence of a partner[20].

[19] Ritchie, M. Nelson, K. Wills, R. Jones, L. 2013. Does training and documentation improve emergency department assessments of domestic violence victims? Journal of Family Violence, 28(5), pp.471-477.
[20] Baird, K. Salmon, D. White, P. 2013. A five-year follow-up study of the Bristol pregnancy domestic violence programme to promote routine enquiry. Midwifery, 29(8), pp.1003-1010.

- NHS Safeguarding (2020) has said that during COVID-19 restrictions, where patients' companions were asked not to attend appointments, DVA disclosures have increased in antenatal settings.

Good practice

The most recent UK DVA research from maternity is a 2013[20] study that evaluated outcomes of an educational intervention in DVA enquiry. Five years on, the skills, knowledge, and confidence associated with antenatal enquiry for DVA were maintained, with the support of mandatory training. **However,** despite this training, the common barriers to enquiry persisted (presence of a partner; lack of interpreters; and lack of organisational support).

The Royal College of Midwives is developing systems-based approaches to encouraging midwives to enquire about DVA more consistently. Badgernet system, for example, has three mandatory yes/no questions to be asked at the antenatal booking appointment. The midwife can click 'unable to ask', to be used in exceptional cases. **However,** this system may not help midwives overcome the most common barriers listed above.

🔎 **Research/audit** is needed to explore ways to overcome barriers to documenting DVA in maternity and whether systems-based approaches can help, and to explore the ongoing impact of COVID-19 restrictions on disclosures of DVA in maternity settings.

Use of the term 'alleged' in medical records is commonplace but re-traumatises victims and damages evidence in court.

12. That **medical records can be used in court shapes how healthcare professionals document DVA and this in turn can affect victims' abilities to access justice.**
    - Some healthcare professionals are anxious about only documenting 'facts' and not 'opinions'[21].
    - Evidence shows that use of the word 'alleged' is commonplace and that this word leaves victims feeling disbelieved and traumatised[22].
    - Victims have also said that the way DVA is documented (i.e., use of alleged, use of quotation marks around certain words implying doubt) has affected their ability to access civil and legal remedies[23,24].

Trust-wide electronic patient records, and alerts and flags in such records, can help healthcare professionals identify victims but aren't used to their potential.

13. The multitude of electronic patient record providers within individual hospitals and between hospitals precludes automatic and efficient information sharing.
    - Research with 152 acute hospital trusts showed 117 (77%) were using electronic records systems, with 21 different vendors providing the systems.

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[21] Reed, D. 2020. Medical confidentiality and domestic abuse. PhD thesis.
[22] Olive, P. (2017). Classificatory multiplicity: intimate partner violence diagnosis in emergency department consultations. Journal of clinical nursing, 26(15-16), 2229-2243.
[23] Bacchus, L.J. Bewley, S. Vitolas, C.T. Aston, G. Jordan, P. Murray, S.F. 2010. Evaluation of a domestic violence intervention in the maternity and sexual health services of a UK hospital. Reproductive Health Matters, 18(36), pp.147-157.
[24] Taskforce on the Health Aspects of Violence against Women and Children. 2010. Responding to violence against women and children – the role of the NHS. London: Taskforce.

- Few trusts have a trust-wide record: within the hospital, several systems are used.
- Between April 2017 and April 2018, millions of patients transitioned between hospitals, but coordination of electronic patient record systems between hospitals that shared patients was minimal.
- In most cases, trusts in the same/neighbouring city used different vendors. In South London, St George's uses Cerner, neighbouring trust Epsom and St Helier uses DXC – but they share 69,435 patients[25].
- Interoperability between different electronic systems is limited. Records are therefore fragmented: healthcare professionals cannot get access to patient records from other hospitals, and this can affect the provision of high quality, cost-effective, and safe care. Analyses of Domestic Homicide Reviews consistently point out that a lack of linkage between health services and inability to spot patterns in appointments, walk-ins, and emergency attendances are a key failing in preventing homicide[26].

Good practice

Trust-wide electronic patient records make records available to all healthcare professionals within a hospital trust—which helps to facilitate DVA sharing information within trusts.

The Epic electronic patient record in University College London Hospitals allows healthcare professionals to raise a safeguarding flag, which can indicate a range of issues including DVA. All staff can see the flag: the header appears wherever the staff member is in the patient's chart. The safeguarding team can also hide a concern and accompanying notes, such that other staff wanting to read information will need to speak to the safeguarding team.

A hospital-based Independent Domestic Violence Advisor (IDVA) in another hospital that uses a flagging system told us that flagging prompts staff to ensure they are asking safeguarding questions, giving patients opportunities for support, and asking safety trigger questions when the patient is alone, such as if they are feeling safe at home.

Several other trusts use flags. In Royal Sussex hospital, the in house IDVA has developed a flag specific to DVA which likely increases efficiency at identifying at risk patients.

14. In some trusts, staff recognise that electronic patient records allow flagging but **no one uses flags because no one has been assigned the responsibility** to flag and unflag patients.
    - IDVAs could take on this role but they infrequently have full access to trust electronic patient record systems, so they cannot do so. Getting an NHS honorary contract gives IDVAs some access, but this process can sometimes take months[27,28,29].

[25] Warren, L.R. Clarke, J. Arora, S. Darzi, A. 2019. Improving data sharing between acute hospitals in England: an overview of health record system distribution and retrospective observational analysis of inter-hospital transitions of care. BMJ Open, 9(12).
[26] Sharp-Jeffs, N. Kelly, L. 2016. Domestic homicide review (DHR) analysis. London: Standing Together.
[27] SafeLives, 2016. A cry for health: why we must invest in domestic abuse services in hospitals. Bristol: SafeLives.
[28] Halliwell, G. Dheensa, S. Fenu, E. Jones, S.K. Asato, J. Jacob, S. Feder, G. 2019. Cry for health: a quantitative evaluation of a hospital-based advocacy intervention for domestic violence and abuse. BMC health services research, 19(1), p.718.
[29] Dheensa, S., Halliwell, G., Daw, J., Jones, S.K. Feder, G., 2020. "From taboo to routine": a qualitative evaluation of a hospital-based advocacy intervention for domestic violence and abuse. BMC Health Services Research, 20(1), pp.1-13.

Digitisation and interoperability platforms improve sharing but may allow a wide range of people to access DVA information.

15. The NHS Long Term Plan states that by 2023/24, secondary care providers in England will be fully digitised and local health and care records (an interoperability platform) will cover the whole country. This initiative might get around the difficulties posed by fragmented records systems but requires consideration of how sensitive data is shared.

Good practice

Many parts of the UK already have a local interoperability platform. Connecting Care in Bristol, North Somerset and South Gloucestershire CCG is especially comprehensive and contains general practice and hospital information. It is accessible to healthcare professionals from a range of NHS services (general practices, hospitals, private care providers), as well as local authorities and third sector organisations (hospices, substance use services, British Red Cross, and St Mungo's). Such platforms help to overcome the barriers to sharing caused by trusts' use of different electronic patient record providers.

However, there is no clear policy on whether and how interoperability systems share sensitive data such as DVA codes with other professionals. While some safeguards are in place to prevent sensitive GP codes flowing into such platforms, DVA information contained in GPs/practice nurses' free text notes will flow unless the GP/practice nurse has marked it as confidential. DVA information in hospital letters sent to GPs will also flow unless the author has redacted this information. Many of the professionals who have access to interoperability platforms will not have had thorough training on DVA. While sharing DVA information is important, information in the wrong hands can be harmful – for example professionals might raise it in insensitive ways, discuss it in front of a patient's companion (potentially the perpetrator), or not realise it is visible on-screen during discussion.

All GP practices in England must now offer their patients online access to their full record. Perpetrators can coerce access to records and see disclosures about DVA (see here, here, and here). GPs can 'hide from online access' any sensitive information recorded in a consultation, but the function does not apply to previously coded information. Redacting information retrospectively will be resource-intensive and prone to human error.

🔎**Research/audit** is needed to determine best practice on sharing DVA information in all interoperability platforms and the eventual local health and care record: Connecting Care has recognised this as an area for further development and we are in the early stages of starting a project with them on best practice.

🔎 **Research is needed** with general practices and victims' views around recording DVA in records that are available online. This work could inform safe, feasible, and acceptable practices around recording information and highlight technical support needed.

NHS Digital datasets miss opportunities to establish DVA scale in the UK.

16. NHS Digital holds several national datasets including the Emergency Care Dataset (ECDS), Maternity Services Dataset (MSDS) and Mental Health Services Dataset (MHSDS). These datasets inform trust renumeration, commissioning, and research. Some data are mandatory (trusts must submit them); other data are not. Datasets are not set up to collect DVA data and so are a missed opportunity for the health service to determine the scale of DVA. [30]
    - In **ECDS**, clinicians can choose to submit optional information in cases of safeguarding (i.e., where the adult is vulnerable according to the Care Act 2014). The options clinicians can submit are pre-determined (there is no free text in ECDS) but there is no code for 'disclosure of domestic abuse'. There are no codes about DVA at all for adults who would not be subject to formal safeguarding.
    - **MSDS** contains a catch-all field, 'complex social factors', which 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 and does not contain parsed data on DVA.
    - **MHSDS** contains high-level summaries and no data on treatment or diagnoses.

🔎 **Consultation with stakeholders** (NHS Digital, patient record providers, Royal Colleges, and healthcare professionals) is needed to determine whether and how national datasets should be adapted so that they better capture DVA if a patient discloses it (as per NICE guidelines, we do not advocate routinely asking all patients about DVA).

Hostile environment deters victims/survivors from seeking healthcare

17. While sharing is important, a harmful form of sharing is NHS Digital's sharing of nonclinical information with the UK Home Office as part of the hostile environment policy. Fear of being notified to the Home Office has led vulnerable pregnant women, made destitute by the policy, to not seek care and remain trapped in violent relationships with no option but to stay (see pg. 54-55 here See also here) Services in Bristol have confirmed that locally, pregnant women with perinatal mental illness experiencing DVA are too frightened to seek healthcare.

🔎 **Research** is needed to provide empirical data on the hostile environment's impact on system response to victims of DVA

[30] Olive, P. (2018). Intimate partner violence and clinical coding: issues with the use of the International classification of disease (ICD-10) in England. *Journal of health services research & policy*, *23*(4), 212-221.

Conclusion

The following recommendations were developed in response to this research, in consensus with our expert advisory group.

Below we present broad recommendations for the health service, providers, and commissioners, which require funding.

In *Annex 1* we present specific recommendations for healthcare professionals, which do not necessarily require specific funding but rely on good training.

If implemented, these recommendations could help to improve the health service response to victims: identifying victims and perpetrators, appropriate referrals to DVA/perpetrator services, and preventing escalating abuse.

Key principles and assumptions underpinning these recommendations are:

- 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 healthcare professionals to provide holistic care.
- The problems identified in recording and sharing are largely caused by a lack of training, time, support, and clarity around best practice, rather than wilful ignorance or neglect by healthcare professionals.

1. **Commissioners should fund ongoing DVA training, supervision, and support for healthcare professionals.** 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 (in general practices) and electronic patient records (in trusts) and how to use redaction for subject access requests confidently.
- help professionals identify and respond to perpetrators.

2. **Clinical directors/managers should**

- oversee delivery and evaluation of training.
- ensure monitoring and evaluation of training to assess its effectiveness (e.g., evidence of healthcare professionals' behaviour change regarding coding and sharing) and to identify where training needs revision.
- ensure DVA training is in place for administrators and DVA coordinators, DVA leads, and DVA advocates to enhance implementation of recommendations.

3. **Healthcare professionals in hospital trusts should have protected time to organise regular in-house meetings for staff who see or manage patients affected by DVA** (e.g., from A&E, 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. **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. Advocates can be in house or via a relationship with an external specialist service. These post-holders should support healthcare professionals 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 healthcare professionals with writing to the GP to inform them of DVA disclosures; organising in-house meetings to discuss DVA cases. These workers should have access to EPRs.
- 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.
- The role should help to develop clear pathways into safe and effective perpetrator interventions where available.

Annex – full set of recommendations

The following recommendations were developed in response to this research, in consensus with our expert advisory group.

Overarching recommendations for all healthcare professionals (HCPs)

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

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

Recommendations for all HCPs on recording information

4. 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.

5. Whenever possible, HCPs should record brief details about the patient's DVA disclosure in their medical record.
   - HCPs should use phrases like '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.

6. 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.

7. 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.

8. 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.

9. If a patient who has previously disclosed experiencing DVA requests online access to their electronic medical record, 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.

10. If printing out parts of the patient's electronic medical record (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.

11. If making e-referrals that are auto-populated with information from the electronic medical record, 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.

12. General practice ‘shared records systems’ make information in electronic medical records directly accessible to other organisations. Trust-wide electronic patient records 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.

13. If electronic medical record/electronic patient record 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.

14. Healthcare professionals should use alerts/flags in the electronic medical record/electronic patient record 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.
    - 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.

15. 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

16. If a patient who has experienced or perpetrated DVA is referred to mental health liaison within the A&E 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.

17. In A&Es 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.

Recommendations for all HCPs on sharing information.

Sharing within the health service

18. 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.

19. 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.

45 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.

46 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.

47 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 A&E, this follow-up appointment can be with an independent domestic violence advisor/advocate (IDVA) or DVA lead.

48 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.

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

- The set of DVA information above (see Recommendation 49)
- 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.

50 Healthcare professionals in hospital trusts should organise regular in-house meetings for staff who see or manage patients affected by DVA (e.g., from A&E, 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.

51 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.

Sharing between healthcare services and other agencies

52 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.

53 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.

54 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.

55 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.

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

56 In the A&E, 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 A&E staff and staff within the A&E. 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 A&E, and ensuring continuing named responsibility for action completion and confirmation of action completion.

Recommendations for other professionals

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

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

59 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.