Health Pathfinder: Full Technical Report

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Key messages

Responding to domestic violence and abuse forms part of the core business of the NHS. Domestic violence and abuse constitute a gendered phenomenon that drives health inequities accruing to women, with particular intersectional impacts that disproportionately and inequitably accrue to women experiencing multiple forms of oppression.

Health Pathfinder is a multilevel system change intervention to transform the health response to domestic violence and abuse, including training professionals, co-locating domestic violence and abuse services in clinical settings, implementing new interventions, supporting domestic violence and abuse coordinators, undertaking needs assessments, enhancing data collection strategies, and reviewing clinical policies relating to domestic violence and abuse.

Health Pathfinder was implemented across eight sites comprising acute trusts, mental health trusts and primary care (clinical commissioning groups) between 2017 and 2019. Despite differences in the nature and scope of the projects, all eight sites shared a set of underpinning principles, components, mechanisms and outcomes. Based on analysis of national monitoring data, we found that Health Pathfinder generated meaningful system-level changes in both the identification and referral of cases, while at the same time identifying and supporting victim-survivors of domestic violence and abuse at an earlier stage in the process. The combination of victim-survivor-level and system-level impacts suggests that key outcomes of more disclosures, earlier identification, more and more appropriate referrals for specialist support, more people helped to safety and sooner, and shifts in organisational culture and response to domestic violence and abuse were achieved.

However, due in part to data limitations—namely, our inability to include data from services working in the most ethnically diverse implementation areas—our analysis was unable to evidence greater system awareness and responsiveness to the needs of victim-survivors belonging to groups that are underserved by health services, including victim-survivors who identify as Black or minority ethnic or as LGBT, or who live with a disability.

Our qualitative analysis, driven by interviews with victim-survivors (n=20) and professionals (n=27), suggested that Health Pathfinder was effective as an ecological intervention by generating awareness, expertise, relationships, empowerment and evidence over multiple levels in each organisation. These five change mechanisms fired sequentially, with sites moving down the chain to differing degrees across the implementation period. Positive progress in respect of each mechanism had meaningful impacts on victim-survivor experiences of enquiry, disclosure and uptake of services, and had the potential to meaningfully impact health inequities. However, we were unable to specifically 'test' impacts on health inequities due to the sample size and challenges in recruiting a sample reflective of victim-survivors whose needs are historically poorly met by health services.

We also identified key site-level factors affecting the implementation of Health Pathfinder: history of addressing domestic violence and abuse; preconceptions and stigma relating to domestic violence and abuse at professional and organisational levels; and logistical factors relating to the embedding of Health Pathfinder roles in organisations. The domestic violence and abuse coordinator was central to successful implementation via appropriate data recording, robust referral pathways, support for co-located specialist services, development of site policies and delivery of quality training.

Further research is recommended to extend our understanding of the impact of Health Pathfinder on victim-survivors with specific vulnerabilities or protected characteristics, as due to data limitations and sample size our analyses were unable to be representative of these characteristics.

Executive summary

The need for a Whole Health approach to domestic violence and abuse

Domestic violence and abuse are so prevalent in our society that NHS staff will be in contact with adult and child victim-survivors (and perpetrators) across the full range of health services. Domestic violence and abuse constitute a gendered phenomenon that drives health inequities accruing to women, with particular intersectional impacts that disproportionately and inequitably accrue to women experiencing multiple forms of oppression. This disproportionate and inequitable burden, which has its basis in structural inequalities, is reflected and refracted across a range of health conditions. For example, Black women die of breast cancer at a higher rate and a younger age than white women (Barlow & Johnson, 2020); pregnant women from Black and minority ethnic groups disproportionately experience poor childbirth outcomes (Fernandez Turienzo et al., 2021). The mental and physical health consequences of domestic violence and abuse mean that the NHS spends more time dealing with the impact of domestic violence and abuse on women and children than almost any other sector, and is often the first point of contact for women who have experienced violence. The cost of domestic violence and abuse to health services has been calculated at £1.73 billion (with mental health costs estimated at an additional £176 million). Despite the pressing need to find cost effective and safe ways of supporting victim-survivors, the response of health services is variable and best practice is frequently short-term and dependent on individual practitioners.

What is the Health Pathfinder intervention?

The Health Pathfinder project was designed to transform healthcare's response to domestic violence and abuse by ensuring a coordinated and consistent approach across the health system including acute, mental health and primary care services. The crux of the Health Pathfinder intervention is to improve the awareness, knowledge and skills of health professionals and the systems within which these professionals work, in order to increase professionals' ability to routinely and sensitively enquire about domestic violence and abuse and to increase system ability to support professionals in doing this work effectively and consistently. This is expected to increase the confidence of victim-survivors to disclose, and to receive a professional response that in turn leads to a timely referral to specialist services. Intervention components included training professionals, co-locating domestic violence and abuse services in clinical settings, implementing new interventions and related governance structures, establishing and supporting domestic violence and abuse coordinators, undertaking needs assessments, enhancing data collection strategies, and reviewing clinical policies relating to domestic violence and abuse.

The sites that were evaluated

The eight Health Pathfinder projects that were evaluated were set in acute health, mental health and primary care settings within the following eight locations in England:

- Blackpool
- Exeter and North Devon
- Haringey and Enfield
- Somerset
- London Tri-Borough
- Camden and Islington
- North Staffordshire
- Southampton

The evaluation brought together different methods, including qualitative interviews with victim-survivors and healthcare professionals and routinely collected quantitative data, to answer this primary research question:

> *What is the effectiveness of Health Pathfinder as a model for improving the health service response to domestic violence and abuse?*

What did Health Pathfinder achieve?

Taken together, findings from the quantitative data clearly show that the key intended outcome of Health Pathfinder was achieved: more victim-survivors, generally women, helped to safety, and sooner. It is important to acknowledge that we were unable to analyse long-term impacts on victim-survivors' safety, health and wellbeing, meaning that substantial benefits experienced by victim-survivors may not be reflected in our findings. Moreover, our data sources may not have represented impacts with respect to groups of women who are most poorly served by health and social services, such as women who identify as Black or minority ethnic.

First, Health Pathfinder significantly increased the rate of cases discussed in MARACs. Specifically, we found a 10.9% increase in those sites where Health Pathfinder was implemented, which continued to significantly increase each quarter after implementation by 10.1%. Evidence of a significant increase followed by continued quarter-on-quarter change is a robust finding that reflects underlying system improvements across multiple stakeholders involved in Health Pathfinder.

Second, Health Pathfinder projects improved detection of domestic violence and abuse across a wider spectrum of risk. Specifically, Insights data from four Health Pathfinder sites offering data both before and after Health Pathfinder implementation, compared against other Insights-contributing services nationally, showed a significant 33.6% increase in the proportion of cases classified as standard risk, which remained constant quarter-on-quarter after implementation. One of the potential benefits of an improved whole health response to domestic violence and abuse is the ability to identify and refer victim-survivors to appropriate services before risk escalates.

Further evidence of an improved 'whole health response' is provided from data indicating a substantial, additional number of Health Pathfinder contacts with victim-survivors who were not yet ready to progress with linkage into specialist services, as well as the provision of specialist advice to health professionals regarding the management of domestic violence and abuse.

However, due to data limitations—namely, that we could not comprehensively include Insights data from services working in the most ethnically diverse implementation areas—analysis of MARAC and Insights data did not reflect consistent, robust changes in the proportion of cases where victim-survivors identified as Black or minority ethnic, LGBT, or having a disability, or where children were involved. Because of these data limitations, we suggest this is 'no evidence of effect' rather than 'evidence of no effect'. Further research should identify the extent and nature of Health Pathfinder impacts on identification and referral for victim-survivors most poorly served by health services.

What were the mechanisms that produced these changes?

A successful intervention such as Health Pathfinder must generate mechanisms that can effectively operate within variable and often challenging contexts in order to produce positive changes in the lives of victim-survivors. Analysis of the qualitative data revealed key mechanisms that together can account for the improved response to domestic violence and abuse in the Health Pathfinder sites. Analysis also underscored the importance of each of senior management, domestic violence and abuse coordinators and co-located experts in supporting Health Pathfinder's effectiveness as an ecological intervention. Many of these mechanisms also had important, parallel and plausible impacts on health inequities that accrue both to women generally as the vast majority of victim-survivors of domestic violence and abuse; and to women who experience disproportionate impacts arising from multiple forms of oppression. However, due to our sample size and recruitment challenges, we were unable to fully represent the voices and perspectives of women who are disproportionately impacted. Thus, we could not assess the degree to which our qualitative findings would generalise to groups who were not represented.

Awareness generation. There are two sides to this mechanism: generating victim-survivors' awareness about domestic violence and abuse and health-based opportunities to receive help; and generating health professionals' awareness of their role and responsibility in responding to domestic violence and abuse. Interviews with victim-survivors highlighted the importance of leaflets and posters to make visible both the problem of domestic violence and abuse and the avenues for help available. Interviews with healthcare professionals highlighted the importance of co-location and integration of the domestic violence and abuse service. Awareness generation is the foundation for a broader cultural shift that encourages health professionals to understand domestic violence and abuse as core to their professional role and supports its inclusion on the health agenda at all levels.

Expertise generation. Victim-survivors considered professional knowledge, skills and understanding to be crucial when it came to recognising domestic violence and abuse and facilitating safe enquiry, signposting and referrals to specialist support. Victim-survivors also emphasised the importance of health professionals' behaviour and attitude in routine appointments. Confident, sensitive and safe enquiry about domestic violence and abuse by health professionals requires a level of expertise that Health Pathfinder generated through formal training, informal training (coaching) and co-location.

Relationship generation. The extent and quality of pre-existing relationships between partner agencies influenced the extent to which Health Pathfinder generated new and/or enhanced effective working relationships. Interviews revealed that effective working relationships were generated through strong leadership within the NHS. This involved clear communication about domestic violence and abuse as a core aspect of professional practice generally as well as the aims and design of the Health Pathfinder projects specifically. Where relationships were successfully generated through the delivery of the intervention, many interviewees felt this created a shared sense of multi-agency responsibility and ownership for domestic violence and abuse.

Empowerment generation. Victim-survivors highlighted the importance of health professionals not only having the appropriate awareness, understanding and knowledge to recognise domestic violence and abuse but also the confidence and skills necessary to sensitively enquire and then to respond professionally to any disclosures made by their patients. Empowerment to act was generated via the presence, visibility and integration of domestic violence and abuse services as well as from the training and coaching they provided. Policy foundations, combined with other intervention components such as training and coaching, clear referral processes, and reassurance from the visible presence of a co-located domestic violence and abuse expert, create empowered health professionals who have the expertise to both 'ask' and 'act'.

Evidence generation. The extent to which the data collection processes implemented as part of Pathfinder were able to generate evidence were highly context-specific, depending on existing processes, information sharing and records access, perceived needs for different types of data and approaches to the collection of these data, and the possibilities a particular site's infrastructure and resources presented. In addition to quantifiable outcomes, evidence of positive change on 'softer' outcomes was important to victim-survivors and how they felt about the service they received.

What were the barriers and facilitators to successful implementation?

Drawing primarily on interviews with health professionals, we uncovered four key factors central to implementation: background commitment and history of addressing domestic violence and abuse in sites; professional and organisational preconceptions and stigma relating to domestic violence and abuse; the intersection of both of these categories in the perceived relevance of Health Pathfinder; and logistical factors relating to embedding Health Pathfinder roles in organisations.

Relating our findings to key Health Pathfinder outputs

Our independent evaluation of Health Pathfinder extends and complements the substantial body of research and evaluation generated by this project.

Survivor consultation. Between August 2018 and January 2020, AVA and Imkaan on behalf of the Health Pathfinder consortium led a survivor consultation, informed primarily by focus groups. A key strength of this consultation, especially as compared to our own sample of survivors, was that it was able to reach more Black and minority ethnic survivors and survivors living with a disability. Findings from the survivor consultation speak to the importance of culturally competent, patient-responsive enquiry and referral, both of which were important goals of Health Pathfinder, and which cut across the mechanisms we identified. However, where the consultation findings sound a note of caution is in corroborating our observation that the professionals' perceptions of the 'diversity' of patient populations can mask the true diversity in survivors who are unable to access services and thus do not appear in patient lists. These findings also support the importance of a whole health response that is not homogenising, including tailored services that are relevant to a range of groups and that are linked to consistent, appropriate and sensitive enquiry, response and referral.

Key findings report. This report demonstrates the impressive reach of Health Pathfinder. In total, 633 survivors took up domestic abuse services after referral from healthcare, including many survivors who would otherwise not have been identified by community-based services. This matches our finding that Health Pathfinder changed risk profiles of identified survivors. In addition, according to this report, 36% of survivors taking up services as a result of Health Pathfinder were Black or minority ethnic; 79% of these survivors were seen in London-based sites. Given that only 18.5% of survivors recorded in Insights nationally are Black or minority ethnic, the key findings report offers important evidence of the potential effectiveness of Health Pathfinder in reducing health inequities.

Recording and sharing information. Dheensa (2020) studied current practice relating to the recording and sharing of domestic violence and abuse in health settings, culminating in recommendations finalised via an expert panel. These speak to the importance of site-level domestic violence and abuse policies; of domestic violence and abuse coordination and senior management buy-in to support the implementation of these policies, including as they relate to the implementation of data collection and information sharing; and of evidence generation as a central mechanism by which Health Pathfinder supported victim-survivors' safety. Moreover, the situation described in this report also speaks directly to the insurmountable challenges we faced in acquiring meaningful health system data related to enquiry and disclosure.

Recommendations

Co-location. Reflecting the findings of prior work (e.g. SafeLives' 2016 report, *Cry for Health*), our research evidenced the value of co-location of services, especially when the necessary partnership agreements, protocols, and practical approvals were in place beforehand. This was central both to 'setting off' change mechanisms, and to effective implementation. Co-location should focus on services relevant to a wide range of victim-survivors, including those disproportionately impacted by poor health service responses, such as women who identify as Black or minority ethnic or as LGBT.

Coordination. However, co-location is not enough. Our research found that domestic violence and abuse coordination is both a central intervention function and a central implementation function. Where Health Pathfinder was most impactful, co-located services worked closely with a coordinator or champion with a specific remit to drive action on domestic violence and abuse.

Training combined with informal coaching. Formal training was necessary to increase health professionals' knowledge of the scale and nature of domestic violence and abuse, how to make sensitive enquiry, and how to follow this with appropriate and professional responses to any disclosures. However, most interviewees felt that health professionals needed additional support (e.g. coordination, co-location, integration) to develop skills and expertise.

Effective referral pathways. The upskilling of health professionals evidenced in the Health Pathfinder sites must be complemented with effective referral pathways to partner agencies that can provide victim-survivors with the necessary support (e.g. referring from mental health services to domestic violence and abuse). Without these in place, disclosures of domestic violence and abuse do not lead to the help required and thus can be not only counter-productive but also harmful. Referrals, again, should be to services relevant to victim-survivors.

Sustainable financial support for specialist services. Sustainability of Health Pathfinder was a key and recurring issue in our interviews. While there was a view that Health Pathfinder generated cultural and systemic shifts in the response to domestic violence and abuse, interviewees described the challenge of assembling 'business cases' to continue trust-led funding of Health Pathfinder posts, whether Advocate Educators, IDVAs or domestic violence and abuse coordinators.

Domestic violence and abuse policies in all NHS trusts. Domestic violence and abuse is the core business of the NHS and must be recognised thusly in policy documents across all specialisms in all NHS trusts. Policies should clearly communicate the role and responsibilities of partner agencies so that must underpin the initiation, support, and governance of Health Pathfinder specifically as well as the healthcare response to domestic violence and abuse more generally is clearly communicated.

Monitoring and information-sharing. Understanding the strengths and limitations of current practice in local areas is a necessary precursor for the successful implementation of any new initiatives, and should be sensitive to the needs of specific groups (e.g. migrant women, who may reasonably fear notification to the Home Office). Collecting the information necessary to understand whether, how and why new initiatives achieve their intended outcomes, or result in unintended consequences, should be seen as a central and shared responsibility across partner agencies.

A central concern for structural inequalities. Cutting across each of the previous recommendations, a concern for how structural inequalities affect victim-survivors, and the potential of the whole health response to meet and ameliorate these structural inequalities and thus impact health inequities, is important for a response that is effective in meeting the needs of all women who are victim-survivors of domestic violence and abuse. Greater recognition of diversity, both where this is represented in the population taking up services and where that diversity is 'masked' by barriers to uptake, is a central component of a whole-health response that works for all victim-survivors.

Conclusion

The Health Pathfinder projects evaluated here are truly complex interventions; they bring together a multitude of initiatives spanning sectors and agencies to achieve a range of ambitious outcomes. Health Pathfinder provided a safe context for people, mostly women, to disclose experiences of domestic violence and abuse, resulting in sensitive professional responses, and access to timely support from specialist agencies. In short, the research showed that Health Pathfinder helped more victim-survivors to safety, and sooner. The interventions that set off the mechanisms necessary for achieving these changes should be disseminated and implemented widely because domestic violence and abuse is the core business of the NHS. We owe it to *all* victim-survivors of domestic violence and abuse to help them to safety, no matter where they live.

Health Pathfinder: Full Technical Report

Introduction

The UK Government currently defines domestic violence and abuse as 'any incident or pattern of incidents 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 gender or sexuality. This can encompass but is not limited to the following types of abuse: psychological, physical, sexual, financial and/or emotional'.

There is a wealth of literature that has documented the detrimental physical and psychological health effects associated with experiencing domestic violence and abuse (Afifi et al., 2009; Boyle et al., 2006; Devries et al., 2013; Oram et al., 2017). The Department of Health has recognised that domestic violence and abuse has a harmful effect on health in adults and children (2009).

Every year an estimated 2.4 million adults aged 16 to 74 years in England and Wales experience some form of domestic violence and abuse (5.7% of the population). This includes 1.6 million women (7.5% of the population) and 786,000 men (3.8% of the population) (Office for National Statistics, 2019). Lifetime prevalence (experiencing any form of domestic violence and abuse since aged 16) equates to about 20% of the British population (ONS, 2019). Women are much more likely than men to be the victims of high risk or severe domestic violence and abuse, including domestic homicide (ONS, 2019). While research has shown that both men and women can perpetrate domestic violence and abuse (Herbert et al., 2020), the vast majority (95%) of those being referred to a Multi-Agency Risk Assessment Conference (MARAC) or accessing an Independent Domestic Violence Advocate (IDVA) or domestic abuse service are women.[1] Thus, it is manifestly clear that domestic violence and abuse constitute a gendered phenomenon that drives health inequities accruing to women, with particular intersectional impacts that disproportionately and inequitably accrue to women experiencing multiple forms of oppression. This disproportionate and inequitable burden, which has its basis in structural inequalities is reflected and refracted across a range of health conditions. For example, Black women die at a higher rate and at a younger age of breast cancer than white women (Barlow & Johnson, 2020), and pregnant women from Black and minority ethnic groups disproportionately experience poor outcomes in childbirth (Fernandez Turienzo et al., 2021). It is also manifestly clear that domestic violence and abuse drive a substantial and still-unmet need for health services that are both appropriate for and responsive to victim-survivors of domestic violence and abuse (Grady et al., 2019). Domestic violence and abuse is so prevalent in our society that NHS staff will be in contact with adult and child victim-survivors (and perpetrators) across the full range of health services.

Four out of five victim-survivors do not call the police, but almost all victim-survivors will use health services, especially victim-survivors with complex needs. Just under half a million victim-survivors accessed health services in relation to their abuse in 2016 alone. SafeLives' data shows that nearly a quarter (23%) of victim-survivors experiencing the highest risk of harm and one in ten victim-survivors experiencing medium risk of harm from domestic violence and abuse because of acute physical injuries in the last year. Nearly half (46%) of the victim-survivors experiencing high risk domestic violence and abuse visited their GP in the 12 months prior to receiving support from specialist services. According to research by Walby (2009), an estimated one in eight of all suicides

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[1] https://safelives.org.uk/practice-support/resources-MARAC-meetings/latest-MARAC-data

and suicide attempts by women in the UK are due to domestic violence and abuse. This equates to just under 200 women dying and nearly 10,000 attempting suicide each year because of domestic violence and abuse.

The mental and physical health consequences of domestic violence and abuse mean that the NHS spends more time dealing with the impact of domestic violence and abuse on women and children than almost any other sector, and is often the first point of contact for women who have experienced violence. The cost of domestic violence and abuse to health services has been calculated at £1.73 billion (with mental health costs estimated at an additional £176 million) so there is a pressing need to find cost effective and safe ways of supporting victim-survivors. Yet the response of health services to victim-survivors is variable and best practice is frequently short-term and dependent on individual practitioners.

The Health Pathfinder project was designed to transform healthcare's response to domestic violence and abuse by ensuring a coordinated and consistent approach across the health system including acute, mental health and primary care services. It was a three-year project running in eight sites from 2017 to 2020, with funding from the Department for Culture, Media and Sport and the Department for Health and Social Care. The project was developed and implemented through the strategic and operational direction provided by a consortium of five partners: Standing Together Against Domestic Violence, now Standing Together Against Domestic Abuse (STADV); SafeLives; Imkaan; Against Violence and Abuse (AVA); and Identification and Referral to Improve Safety (IRISi).

The Pathfinder Consortium was instigated to support each of the sites to develop new approaches to domestic violence and abuse within health and enhance any existing practice. This included resources to build new provision as well as ongoing support and access to expertise from Pathfinder partners. This intensive support was tailored to the needs of the site and focused on improving the response to a range of victim-survivors in health settings, including Black and minority ethnic, LGBT and disabled women and victims experiencing multiple disadvantages. Each Pathfinder Consortium partner has the following role:

- STADV had overall responsibility for managing the Health Pathfinder Project as the representative of the Lead Funder. It was also the lead partner for several Health Pathfinder sites.
- SafeLives' consultancy team provided a needs analysis of each Health Pathfinder site, and the SafeLives research team provided technical assistance relating to data collection and evidence gathering and assisted in the development of action planning. The SafeLives research team also provided scoping data for the evaluation partner.
- IRISi (Identification and Referral to Improve Safety) led on issues relating to primary care responses to domestic violence and abuse. It was also the lead partner for several Health Pathfinder sites.
- AVA led on issues related to mental health and substance misuse. It was also the lead partner for several Health Pathfinder sites.
- Imkaan led on interconnections between different forms of violence and intersectional analysis and approaches, with a particular focus on equity, diversity and intersectionality aspects of the domestic violence and abuse response in each site.

The Pathfinder Consortium commissioned a team of researchers to independently evaluate the effectiveness of the eight Health Pathfinder projects, all of which are located in England. The research involved the collection of qualitative and quantitative data in order to answer the primary research question:

> *What is the effectiveness of Health Pathfinder as a model for improving the healthcare response to domestic violence and abuse?*

Details of the research methodology are provided in the Appendix. This report contains the learning and recommendations from the research to enable best practice to be shared and consequently the healthcare response to domestic violence and abuse to be improved in other areas.

1. What is the Health Pathfinder intervention?

This chapter discusses the findings of our consultation exercise at the start of the evaluation. We represent our findings as a logic model, which describes the principles, components, mechanisms, and outcomes that Health Pathfinder was intended to include.

1.1 Overview

As described in its own documentation, “the Pathfinder intervention aims to bridge the implementation gap between knowledge and action through the following actions:

- Synthesising the evidence base;
- Codifying a domestic abuse mobilisation and maintenance methodology within a VAWG (Violence against women and girls) setting for each area of health: primary care, mental health trusts and acute health trusts;
- Supporting health services to implement, improve and maintain promising practice;
- Understanding and overcome the complexities of implantation, improvement and maintenance of promising practice; and,
- Sharing learning and the products that are developed.

The result of these actions are anticipated to result in a model response to domestic violence and abuse for health services, including recommendations on policy, procedure, training, governance and commissioning.”[2]

The crux of the Health Pathfinder intervention is to improve the awareness, knowledge and skills of health professionals and the systems within which these professionals work, in order to increase professionals’ ability to routinely and sensitively enquire about domestic violence and abuse and to increase system ability to support professionals in doing this work effectively and consistently, with the overarching aim of creating sustainable long-term changes in health services. This is expected to lead to improvements in the quality of their responses to disclosures from victim-survivors, through earlier identification and increased timely referrals to specialist services. It is also expected to increase the confidence of victim-survivors to disclose in health settings and perceive this to be a positive experience. The extent to which these expectations have been realised in the eight Health Pathfinder sites are the focus of this report.

Individuals experiencing domestic violence and abuse and presenting at one of the eight intervention sites were asked by trained healthcare professionals, including, where relevant, the named safeguarding lead, about whether they were experiencing domestic violence and abuse. The healthcare professional or safeguarding lead is then meant to refer this individual to the local specialist domestic abuse service, Independent Domestic Violence Advisor (IDVA) or Advocate Educator associated with that particular site following the intervention protocol. The provider then follows their standard operating procedures for managing referrals for domestic violence and abuse. “An IDVA is a named professional case worker for victims of domestic abuse, who works to address the safety of ‘high risk’ victims and their children. They assess the level of risk, discuss a range of suitable options and develop co-ordinated safety plans. These can include referral to the Multi-

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[2] Two publications providing additional information on Health Pathfinder are available at https://safelives.org.uk/health-pathfinder

Agency Risk Assessment Conference (MARAC), as well as sanctions and remedies available through the criminal and civil courts, housing options, and services available through other organisations" (Robinson, 2009; Cry for Health, SafeLives Report 2016).

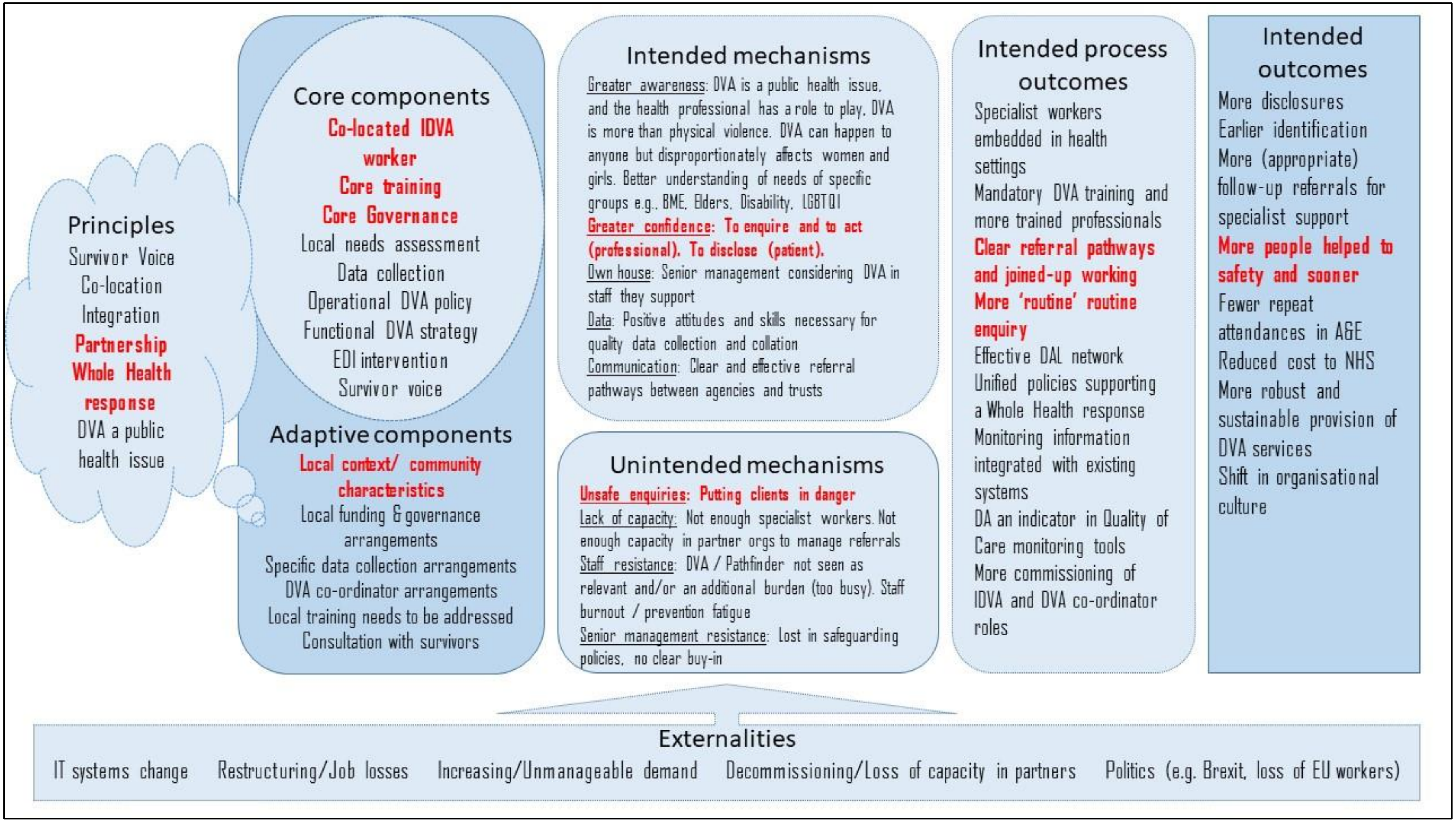
1.2 Logic Model

A logic model was developed to depict the relationships between the components of the Health Pathfinder intervention and its intended outcomes. It is meant to help communicate the nature of the program to people in a clear and concise way. The goals to be accomplished, and how this may be achieved, are thus made explicit to those working to deliver the intervention, its recipients, and outside stakeholders. The Health Pathfinder logic model was initially described from a review of documentation and then confirmed through a consultation event held with site leads as well as clinicians and victim-survivors. These consultation events included a range of activities designed to prompt discussion and agree answers to the following questions:

- Principles and values: Q: What makes the Health Pathfinder intervention different from existing systems of care for domestic violence and abuse victims?
- Core and adaptive components: Q: What needs to be kept the same across sites to be called a Health Pathfinder Intervention? Q: What could be different from site to site and still be a Health Pathfinder Intervention?
- Intended and Unintended mechanisms: Q: What will be different about the beliefs, attitudes or actions of people, triggered by the Health Pathfinder Intervention, so that it works? Q: What might be different about the beliefs, attitudes or actions of people, triggered by the Health Pathfinder Intervention, that means it will not work or is harmful?
- Intended and unintended intermediate outcomes: Q: What intended changes in processes should we measure to know that the Health Pathfinder Intervention is working? Q: What unintended changes in processes should we measure to check that the Health Pathfinder intervention is not harmful or ineffective?
- Long-term outcomes: What difference do we expect the Health Pathfinder Intervention to make to clients?

Each of the eight sites produced different proposals for achieving the overall goal of the Health Pathfinder intervention, which is to develop and embed a 'model response to domestic violence and abuse for health services' in each area. However, despite these differences in the nature and scope of the projects, all eight sites shared a set of underpinning principles, components, mechanisms and outcomes, which are visible in the graphic depiction of the Health Pathfinder logic model provided below.

Figure 1 Graphical depiction of the Health Pathfinder logic model



Principles

Survivor Voice
Co-location
Integration
Partnership
Whole Health response
DVA a public health issue

Core components

Co-located IDVA worker
Core training
Core Governance
Local needs assessment
Data collection
Operational DVA policy
Functional DVA strategy
EDI intervention
Survivor voice

Adaptive components

Local context/ community characteristics
Local funding & governance arrangements
Specific data collection arrangements
DVA co-ordinator arrangements
Local training needs to be addressed
Consultation with survivors

Intended mechanisms

Greater awareness: DVA is a public health issue, and the health professional has a role to play. DVA is more than physical violence. DVA can happen to anyone but disproportionately affects women and girls. Better understanding of needs of specific groups e.g., BME, Elders, Disability, LGBTQI

Greater confidence: To enquire and to act (professional). To disclose (patient).

Own house: Senior management considering DVA in staff they support

Data: Positive attitudes and skills necessary for quality data collection and collation

Communication: Clear and effective referral pathways between agencies and trusts

Unintended mechanisms

Unsafe enquiries: Putting clients in danger

Lack of capacity: Not enough specialist workers. Not enough capacity in partner orgs to manage referrals

Staff resistance: DVA / Pathfinder not seen as relevant and/or an additional burden (too busy). Staff burnout / prevention fatigue

Senior management resistance: lost in safeguarding policies, no clear buy-in

Intended process outcomes

Specialist workers embedded in health settings
Mandatory DVA training and more trained professionals
Clear referral pathways and joined-up working
More 'routine' routine enquiry
Effective DAL network
Unified policies supporting a Whole Health response
Monitoring information integrated with existing systems
DA an indicator in Quality of Care monitoring tools
More commissioning of IDVA and DVA co-ordinator roles

Intended outcomes

More disclosures
Earlier identification
More (appropriate) follow-up referrals for specialist support
More people helped to safety and sooner
Fewer repeat attendances in A&E
Reduced cost to NHS
More robust and sustainable provision of DVA services
Shift in organisational culture

Externalities

IT systems change
Restructuring/Job losses
Increasing/Unmanageable demand
Decommissioning/Loss of capacity in partners
Politics (e.g. Brexit, loss of EU workers)

1.2.1 Underpinning Principles

As depicted in the logic model, the Health Pathfinder intervention is underpinned by the following principles. These have been derived from knowledge of the extant research literature, practitioner and victim-survivor awareness of best practice, and frontline delivery of effective service provision in other settings:

- Survivor Voice: Any changes to the healthcare response to domestic violence and abuse should be designed in accordance with a robust understanding of what victim-survivor experiences have been and what their perspectives are about the priorities for change and how to best achieve lasting and meaningful improvements.
- Co-location and integration: The transfer of knowledge and expertise from domestic violence and abuse specialists to healthcare professionals is best achieved when they are working on-site as fully integrated team members.
- Partnership: Coordination and effective information sharing between partner agencies is essential for the delivery of support tailored to the particular needs of victim-survivors, particularly when they co-occur with physical and mental ill-health and other complex needs.
- Whole Health response: Professionals in all health settings must recognise domestic violence and abuse as a public health issue which is part of their core business. All healthcare professionals have a responsibility to provide an appropriate and effective response to domestic violence and abuse.

1.2.2 Core components

The Health Pathfinder intervention includes the following core components, which are considered to be essential regardless of the exact configuration and scope of any individual project:

- Co-located IDVA or Advocate Educator: The placement of a specialist ‘domestic violence and abuse expert’ within health settings will enable the transference of knowledge and the availability of on-site support and advice.
- Core training: The upskilling of healthcare professionals requires a dedicated and bespoke training package delivered by a specialist domestic violence and abuse expert.
- Core Governance: Steering groups representing key stakeholders must be implemented in order to (initially) specify and (continually) embed and facilitate the working arrangements across agencies necessary for an improved healthcare response.
- Local needs assessment: Necessary for the identification of deficiencies within local provision, understanding of the local organisational and geographical contexts, and shared agreement as to the priorities for producing positive change.
- Data collection: To enable the monitoring of activities (e.g., enquiries, disclosures, referrals, risk assessments, outcomes) in order to identify the extent and nature of changes resulting from the implementation of new initiatives.
- Operational domestic violence and abuse policy: Policies should clearly communicate the role and responsibilities of partner agencies to underpin the initiation, support, and

governance of Health Pathfinder specifically as well as the healthcare response to domestic violence and abuse more generally.

- Functional domestic violence and abuse strategy: The strategic aims of the intervention and how these will be achieved must be agreed and able to be routinely actioned by partner agencies.
- Equity, diversity and intersectionality intervention: victim-survivors from particular groups often face additional barriers when accessing services and those with intersecting identities may experience multiple forms of discrimination. For example, they may face barriers to services based on their disability and their ethnic background or sexual orientation. It is paramount that victim-survivors' diversity of experiences and access needs are at the forefront of the planning and delivery of services.
- Survivor voice: All intervention components must be designed and informed by on-going consultation with victim-survivors.

It was understood by those attending the logic model consultation event that the core components of the Health Pathfinder intervention will have to be adapted to the local context and the characteristics of the community served. For example, the level of pre-existing service provision for addressing domestic violence and abuse and the availability of local funding to complement and enhance the investment by the Health Pathfinder Consortium will affect the nature and scope of the project. The ability to collect monitoring data necessary for identifying whether and how intended outcomes are being achieved depend on the specific data collection arrangements already in place, and whether they are already sufficient or must be improved. The experience of the domestic violence and abuse coordinator within local partnership work must be harnessed in order to implement Health Pathfinder in a timely and effective manner. The extent and nature of local training needs must be understood so that the approach to upskilling healthcare professionals is suited to the local context.

1.2.3 Mechanisms

In order to understand how an intervention works, it is important to identify the mechanisms, or change processes, that are 'set off' to achieve specific outcomes. The list below contains the mechanisms considered to be essential for understanding how and why positive outcomes might be achieved in each of the eight Health Pathfinder projects.

Greater awareness. Change will occur because domestic violence and abuse will be recognised as a public health issue, and one in which every healthcare professional has an important role and responsibility to address. Also, they must be aware that domestic violence and abuse is multi-faceted, and may include physical violence as well as sexual violence, psychological and emotional abuse, coercive control, and financial abuse. Domestic violence and abuse can happen to anyone but disproportionately affects women and girls, and there needs to be a better understanding of needs of specific groups (e.g., Black and minority ethnic victim-survivors, older victim-survivors, victim-survivors living with a disability, and victim-survivors who identify as LGBT).

Greater confidence. Change will occur because healthcare professionals have the confidence and skills to enquire about domestic violence and abuse and to respond sensitively and professionally. Patients (survivors) must have confidence when attending health settings that those they encounter will have the necessary skills to identify and respond to their needs.

Own house. Greater awareness about the scale and nature of domestic violence and abuse, and how this affects their patients, must be extended to include NHS staff. Change will occur because senior management have awareness about how domestic violence and abuse can affect their own staff, both directly (as victim-survivors themselves) and indirectly (as healthcare professionals coming into contact with and supporting victim-survivors).

Data. Change will occur because key stakeholders hold the positive attitudes and skills required for quality data collection and collation, which are necessary for the effective monitoring of activities so their impacts can be evaluated.

Communication. Change will occur because clear and effective referral pathways between agencies and trusts have been established, communicated and understood by all partner agencies.

The intended mechanisms listed above are those that were confirmed in the consultation event as important for producing positive outcomes. However, it was also recognised that unintended mechanisms might arise, which could lead to negative outcomes. For example, these might include a lack of awareness or confidence resulting in unsafe enquiries, which could put victim-survivors in danger because they do not receive the support they require to stay safe and/or because they do not feel that receive a professional or sympathetic response to domestic violence and abuse within health settings and thus do not seek help in those settings again. A lack of capacity, especially in the provision of specialist services, could result in an inability to manage referrals, with victim-survivors not receiving timely access to the specialist support. Staff resistance to Health Pathfinder could arise due to the project being seen as not relevant (i.e., domestic violence and abuse is not a public health issue and therefore not the core business of the NHS) and/or an additional burden that cannot be managed on top of existing workloads. Staff burnout or 'prevention fatigue' might also hinder adherence to new protocols and ways of working. The discussion and identification of these sorts of unintended mechanisms was helpful for key stakeholders to share a common understanding of common pitfalls and why they must be avoided, helping to facilitate the successful implementation and delivery of Health Pathfinder.

1.2.4 Intended Process Outcomes

The intended mechanisms just described are expected to lead to several process outcomes in Health Pathfinder sites, which can be considered evidence of how the healthcare response to domestic violence and abuse has been changed.

- Specialist workers embedded in health settings: More domestic violence and abuse experts will be co-located and integrated into a greater number, and more types, of health settings. This will necessitate more commissioning of IDVA and domestic violence and abuse co-ordinator roles in local areas.
- Mandatory domestic violence and abuse training and more trained professionals: The provision of mandatory training will increase and a greater number and type of healthcare professionals will have competed it.
- Clear referral pathways and joined-up working: More health settings will have established referral pathways to agencies providing specialist support (e.g., domestic violence and abuse and mental health).

- More ‘routine’ routine enquiry: A greater number and type of healthcare professionals will, during the course of their interactions with patients, enquire about domestic violence and abuse.
- Unified policies supporting a Whole Health response: domestic violence and abuse policies will explicitly delineate the responsibilities of health practitioners within existing protocols, setting out both what they need to do and how to go about it.
- Monitoring information integrated with existing systems: To enable the collection and collation of data about domestic violence and abuse enquiries, signposting and referrals, and engagement with specialist support services.
- Domestic violence and abuse an indicator in Quality of Care monitoring tools: To communicate and reinforce that domestic violence and abuse is the core business of the NHS and performance will be monitored accordingly.

1.2.5 Intended Outcomes

The underpinning principles, core components and intended mechanisms of the Health Pathfinder intervention are expected to result in the following outcomes:

- Individual-level outcomes
    - More disclosures: Skilled and confident healthcare professionals will be more willing to enquire about domestic violence and abuse as part of their routine practice, resulting in a greater number of disclosures from patients.
    - Earlier identification: Patients experiencing domestic violence and abuse will be identified sooner because healthcare professionals have the interpersonal and professional skills necessary to enquire, identify and refer victim-survivors to support.
    - More (appropriate) follow-up referrals for specialist support: Patients disclosing domestic violence and abuse within health settings will be linked to agencies providing specialist support.
    - Fewer repeat attendances in A&E: Earlier identification, timely referrals and the provision of specialist support will reduce the number victim-survivors who repeatedly seek help for domestic violence and abuse within health settings such as A&E.
- System-level outcomes
    - Reduced cost to NHS: Better identification and response to domestic violence and abuse means that more people will be helped to safety and sooner, leading to a reduction in the overall costs associated with responding to domestic violence and abuse in the long-term.
    - More robust and sustainable provision of domestic violence and abuse services: More people helped to safety and sooner is dependent on specialist domestic violence and abuse services available to be co-located and/or working in partnership

with the NHS and therefore the provision of these services must be robust and sustainable.

- Shift in organisational culture: Skilled and confident healthcare professionals empowered to identify and respond to domestic violence and abuse, who understand the impact of their practice on victim-survivors, will generate changes in the underlying beliefs, assumptions, values and ways of interacting within their own health settings as well as partner agencies and the communities they serve.

1.3 Summary

This chapter has described the development of the Health Pathfinder logic model, which is a graphic depiction of the relationships between the components of the intervention, the contexts within which the intervention works and the mechanisms, or change processes, that are 'set off' in those contexts to achieve specific outcome. The logic model was derived from knowledge of the extant research literature, practitioner and victim-survivor awareness of best practice, and frontline delivery of effective service provision in other settings. The logic model was confirmed through a consultation event held with site leads as well as clinicians and victim-survivors, and provided an agreed basis from which to evaluate the 'context-mechanism-outcome configurations' in the eight Health Pathfinder sites.

2. What does the Health Pathfinder intervention achieve?

This chapter presents the findings of our effectiveness evaluation. We drew on national datasets to answer several interlinked questions:

- Did Health Pathfinder change the rate of high-risk referrals?
- Did Health Pathfinder change the risk profiles and abuse histories of victim-survivors referred to services?
- Did Health Pathfinder change the demographic characteristics of victim-survivors referred to services?

We also discuss key process outcomes that are relevant to a full understanding of Health Pathfinder's effectiveness.

2.1 Effectiveness of Health Pathfinder

To understand the effectiveness of Health Pathfinder, we analysed two key datasets. The first included data relating to MARAC cases. We analysed these data on a national level, taking police force area as our unit of analysis for ease of reference. We compared MARACs in police force areas including Health Pathfinder sites against MARACs in police force areas not including Health Pathfinder sites; and then a subset of these data focusing only on *specific* MARACs linked to sites where Health Pathfinder was implemented. MARACs are multi-agency in nature (i.e. not 'owned' by police forces), but we used police force areas in part due to availability of census data to standardise our analyses. The second included data from Insights, a monitoring database used to track the process and performance of domestic violence and abuse services, comparing IDVA contacts for four services from three Health Pathfinder sites against 18 other sites nationally. The timeframe for all analyses was 2018-2019, with time periods measured as quarters. Thus, eight quarters of data were included in the analysis.

Detailed information about the statistical methods used are available in the Appendix. In short, analyses took advantage of the longitudinal aspects of our data sources, comparing quarterly data before and after implementation in each site.

2.1.1 Some initial notes on data

Before presenting the results of analyses, it is important to note that the two data sources used have complementary strengths and limitations. An overarching limitation of the data available to us for analysis (rather than of the data collection methods themselves) is that we were only able to examine risk-related and diversity-related characteristics, instead of longer-term impacts on victim-survivors, both those who were able to take up services on referral and those who, for whatever reason, did not. This means that substantial benefits that accrued to victim-survivors—benefits such as improved psychological and physical safety, greater health and higher mental and physical wellbeing, and increased trust in health services—may not be reflected in our findings. We reflect these benefits, not all of which admit of quantification, in the subsequent chapter.

The key benefit of MARAC data is that these data are available nationally and with respect to well-defined geographical boundaries (in this case, police force areas), and thus rates of MARAC referral can be benchmarked against the adult (aged 16+) female population in each area. MARACs are multi-agency arrangements that have been established in local areas across the UK for many years.

They are the only such structure which enable robust comparisons to be made about system-level responses to domestic violence and abuse between different local areas. Thus, MARAC data provide the best available source of information for the identification of whether and to what extent changes in local multi-agency arrangements (e.g., with the implementation of Health Pathfinder), have significantly improved the overall response to those experiencing domestic violence and abuse. However, MARAC cases include only a proportion of those judged by practitioners across different agencies as both high-risk and appropriate for referral. Professional judgment in determining the MARAC caseload is necessary for managing resources. For example, all victim-survivors referred to MARAC should be offered independent support and representation from IDVAs to increase their immediate and long-term safety.

However, the application of professional judgment means that MARACs may differ in important ways that are not feasible to measure through existing routine monitoring. For example, although one of the principles of an effective MARAC is that it should reflect the diversity of the local population, the national dataset indicates this is not yet a reality. Yet, it is not possible to determine from the data provided the reasons behind any gaps in referrals for victims with specific vulnerabilities or protected characteristics. The data are compiled from submissions from individual MARACs on a quarterly basis and only include basic information about the cases discussed at each meeting (e.g., total number of cases, number of cases referred by a certain agency, number of cases where the victim-survivor has a disability, etc.). Thus, limited data are available for each case in each area, but taken together they provide the best available measure of broader detection and referral patterns in the areas where Health Pathfinder was implemented. Lastly, because the target of Health Pathfinder (acute trust, mental health trust, primary care settings) and pathways to MARAC referral varied by site, it is challenging to attribute changes in MARAC referral patterns to the *specific* channels that Health Pathfinder would have impacted. This is why our analysis does not seek to disaggregate changes by specific combinations of components or types of NHS bodies involved in each Health Pathfinder site.

A second data source was analysed to complement the MARAC findings thereby extending and deepening our understanding of the impact of Health Pathfinder in local areas. Insights is another routinely collected and widely available source of data, which is gathered from services working directly with victim-survivors and their children across the UK. These data most directly relate to contacts that would have been generated via Health Pathfinder, and provide more granular data as to the nature of cases that were seen by IDVAs as a result of Health Pathfinder. However, the contacts captured in this analysis only formed part of the larger activity in Health Pathfinder, and could not include the most direct impacts of IRIS programmes. In addition, we were only able to analyse Insights data from the four services that had sufficient data before and after implementation of Health Pathfinder in their sites. Thus, this data source also has certain strengths and limitations that should be borne in mind when interpreting the findings.

Finally, we note that our evaluation commenced with a different data source approach. In our original plan, we sought to analyse Insights data from before and after the implementation of Health Pathfinder, using other services not involved in Health Pathfinder as a ‘natural history’ control to capture trends. We then also intended to develop an analysis based on NHS records before and after implementation. However, it became clear early on in the analysis programme that data from NHS records would not provide the clear and consistent source of data needed to attribute an impact to Health Pathfinder in terms of improved enquiry, disclosure and referral. Our subsequent plan, developed in conjunction with SafeLives, focused on using targeted audit data from NHS sites to examine enquiry and disclosure patterns before and after Health Pathfinder implementation. While we were able to progress this plan, the advent of lockdowns in March 2020 meant that access to NHS data systems was appreciably restricted. Because we believe that domestic violence and abuse are part of the core business of the NHS, we reflect more on how our 'data journey' speaks to the findings of colleagues (e.g. Dheensa, 2020) regarding suboptimal data collection on domestic violence and abuse in a later chapter. Ultimately, our choice of MARAC and Insights data was a pragmatic one, seeking to triangulate across several data sources to develop a picture of Health Pathfinder's effectiveness.

2.1.2 Did Health Pathfinder change the rate of high-risk referrals? Analysis of MARAC data

We examined how the rate of cases discussed in MARACs changed by quarter as a result of implementation of Health Pathfinder. We defined the rate of cases as the number of cases discussed in each quarter divided by the adult female population from the last census. Our analysis used national MARAC data provided by SafeLives and organised by police force area for ease of reference, strengthening our conclusions by using a comparator group to capture trends working 'in the background'. Put otherwise, we use *police force area* as a geographical unit, not to refer to police involvement in MARACs or in Health Pathfinder.

Comparing police force areas where Health Pathfinder was implemented against police force areas without Health Pathfinder, we found that in the quarter of implementation, the rate of cases discussed in police force areas that included implementation of Health Pathfinder increased on average by 10.9%. This finding was statistically significant. We also found that in each quarter after implementation, the rate of cases discussed increased on average by 10.1%. This finding was also statistically significant. This increase is best interpreted as a quarter-on-quarter change; that is, in police force areas where Health Pathfinder was implemented, each quarter saw a 10.1% increase in the rate of cases over the last quarter.

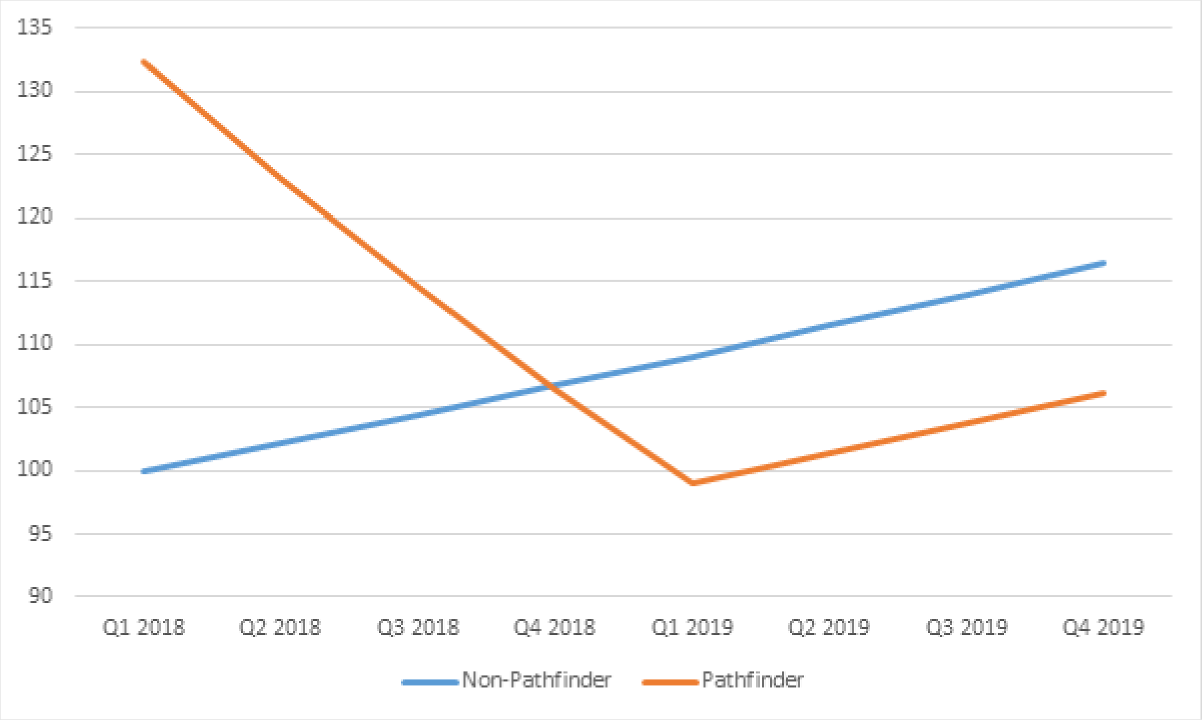
One challenge in this analysis was that MARACs in London dwarfed other MARACs in terms of size of adult female population covered. In addition, the Metropolitan London MARAC included several Health Pathfinder sites, with different quarters of implementation. To ensure our findings were robust, we dropped MARAC data from London and re-ran our analyses. Our finding relating to quarter-on-quarter increases was robust; however, in this analysis, we did not find any evidence of a step change in rate of referrals. That is, changes were best described as quarter-on-quarter following implementation rather than coincident with implementation. Each quarter after implementation saw a change in rate of referrals of 10.0%. This was also statistically significant.

The below figure models a MARAC in a **hypothetical** police force area where Health Pathfinder was implemented in the first quarter of 2019, and excludes London data. Because a limited number of police force areas contained specialist services and NHS trusts involved in Health Pathfinder and to avoid presenting disclosive data, we do not present service-level estimates. We use a standardised rate of 100 for non-Pathfinder sites as the starting point for our model. Inspection of the figure reveals several trends:

- In the time period before implementation, police force areas with Pathfinder sites initially had a much higher rate of MARAC cases, but this decreased over time.
- In contrast, MARAC case rates increased steadily in non-Health Pathfinder police force areas.
- However, the implementation of Pathfinder, shown as the 'elbow' in the curve for Health Pathfinder sites in below figure, suggests a steep reversal in trend.

It is this reversal, which represents quarter-on-quarter gains in the rate of MARAC cases following implementation, that is the evidence of Health Pathfinder's effectiveness, as these quarter-on-quarter gains outpaced those in non-Health Pathfinder MARACs. This is an important finding indicating the positive impact of Health Pathfinder in improving referral patterns in local areas, enabling more victim-survivors to receive the specialist support they need to achieve safety. We ascertain the extent to which these outcomes differ for victim-survivors who have specific vulnerabilities or protected characteristics in a subsequent section (e.g., was there an equivalent improvement in the referral of women at high risk who were also Black and minority ethnic to MARAC as a result of Health Pathfinder).

Figure 2 Trajectories of MARAC referrals in a hypothetical Health Pathfinder site



2.1.3 Did Health Pathfinder change the risk profiles and abuse histories of victim-survivors referred to services? Analysis of Insights data

We examined Insights data nationally, including four participating services in three Health Pathfinder sites, to understand the composition of cases being seen by IDVAs in Health Pathfinder-involved services. Again, our use of national data strengthened our conclusions by using a comparator group to capture trends working 'in the background'.

To understand risk profiles, we considered the proportion of cases classified as standard risk on intake (i.e., not classified as medium or high-risk based on professional judgment of the worker completing the DASH for the case, or based on not meeting the actuarial threshold of 14 ticks on the DASH); the average number of ticks on the DASH for each case at intake; the proportion of cases reporting physical abuse, reporting sexual abuse, reporting harassment, or reporting coercive control; and the proportion of cases reporting more than one of these forms of abuse.

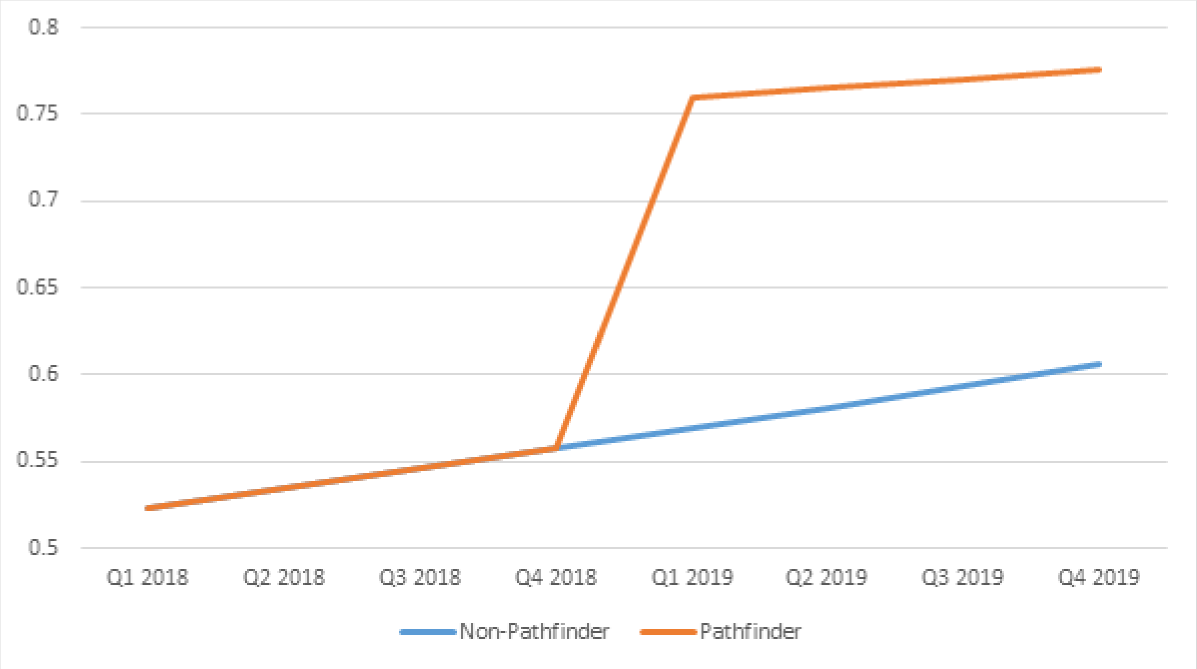
Cases classified as standard risk and average number of ticks on the DASH. We found that from the quarter of implementation onwards, participating services were more likely to see a higher proportion of cases classified as standard risk. This was associated with a 33.6% increase in the likelihood of cases seen by IDVAs as being of standard risk, and was statistically significant. This estimate remained constant; that is, there was no statistical evidence of quarter-on-quarter change after implementation.

The below figure models a **hypothetical** service where Health Pathfinder was implemented in the first quarter of 2019. Because a limited number of services involved in Health Pathfinder contributed to this analysis and to avoid presenting disclosive data, we do not present service-level estimates. We use the proportion of cases identified as standard risk in the first quarter of 2018 (52.4%) as the starting point for our model. Inspection of the figure reveals several trends:

- Across all services, there was a general quarter-on-quarter increase in the proportion of cases identified that were standard risk.
- However, it is clear that for a **hypothetical** service involved in implementing Health Pathfinder in Q1 2019, a step change in the proportion of cases identified as being of standard risk would be expected.

It is this step change that is the evidence of the effectiveness of Health Pathfinder in changing the 'mix' of cases seen by IDVAs. This is an important finding indicating the positive impact of Health Pathfinder in improving the detection of victim-survivors at standard risk. Earlier identification and more (appropriate) follow-up referrals for specialist support are intended outcomes of the Health Pathfinder intervention. We ascertain the extent to which these outcomes differ for victim-survivors who have specific vulnerabilities or protected characteristics in the next section (e.g., was there an equivalent improvement in the identification of women who were Black and minority ethnic as a result of Health Pathfinder).

Figure 3 Trajectories of standard-risk cases recorded in Insights data from a hypothetical Health Pathfinder site



Analysis of the number of ticks on the DASH at intake for cases seen by IDVAs did not suggest any statistical evidence of change as a result of Health Pathfinder; however, this analysis is likely to be less probative than an analysis focusing on professional or actuarial judgment, such as the risk classifications made by IDVAs. In addition, this analysis does not account for later ‘revisions’ to risk classifications as a result of IDVA or Advocate Educator expertise.

Proportion of cases reporting physical abuse. Analysis of the proportion of cases reporting physical abuse did not suggest any statistical evidence of change as a result of Health Pathfinder.

Proportion of cases reporting sexual abuse. Analysis of the proportion of cases reporting sexual abuse did not find statistical evidence of a change in the quarter of implementation. However, the likelihood of cases reporting sexual abuse decreased by 6.7% quarter-on-quarter after implementation in services participating in Health Pathfinder. This was statistically significant.

Proportion of cases reporting harassment. Analysis of the proportion of cases reporting harassment did not suggest any statistical evidence of change as a result of Health Pathfinder.

Proportion of cases reporting coercive control. Analysis of the proportion of cases reporting coercive control did not suggest any statistical evidence of change as a result of Health Pathfinder.

Proportion of cases reporting multiple forms of abuse. Analysis of the proportion of cases reporting multiple forms of abuse did not find statistical evidence of a change in the quarter of implementation of Health Pathfinder. However, the likelihood of cases reporting multiple forms of abuse decreased by 2.9% quarter-on-quarter after implementation in services participating in Health Pathfinder.

Taken together, these findings demonstrate that Health Pathfinder enables the improved identification of standard risk cases. Significant differences in the abusive histories of victim-survivors were not clearly observable, indicating either that their risk profiles differed in other ways or that the limited data available could not yield statistical detection of these differences. Further research is recommended to explore the extent and nature of changes to the profile of victim-survivors identified and referred for specialist support due to the implementation of Health Pathfinder.

2.1.4 Did Health Pathfinder change the demographic characteristics of victim-survivors referred to services? Analysis of Insights and MARAC data

Because one of the goals of Health Pathfinder was to embed an equity perspective in the health response to domestic violence and abuse, we analysed how Health Pathfinder was associated with changes in cases seen by IDVAs in participating services and in cases discussed at MARACs. Our analysis of Insights drew on the same national dataset as above; however, we restricted our MARAC data to those MARACs most closely linked to Health Pathfinder sites. As a result, the denominator in our MARAC analyses is not the adult female population as above, but the number of cases discussed in a quarter.

The goal of these analyses was to understand how the composition of cases in MARACs most closely linked to Health Pathfinder, and in services participating in Health Pathfinder where Insights data were available both before and after intervention implementation, changed as a result of Health Pathfinder. A positive, significant result in these analyses would provide evidence that Health Pathfinder enabled better access to services for victim-survivors who are traditionally underserved by domestic violence and abuse services. These analyses answer a similar question to analyses that would disaggregate data by victim-survivor characteristics; however, their interpretation is compositional with respect to cases (were victim-survivors with specific characteristics better represented in case data following Health Pathfinder?) rather than absolute with respect to the population (were a greater number of victim-survivors with a characteristic from the target population detected following Health Pathfinder?).

Ideally, we would present both forms of analysis. However, this was precluded by several factors that we discovered while feasibility testing for these analyses. First, we did not have reliable estimates of populations from census data to serve as denominators for our MARAC analyses. Second, stratifying our analyses of Insights data by victim-survivor characteristics would have led to unstable and uninterpretable estimates. Third, stratifying analyses with either source of data would have created a potential risk for deductive disclosure. This was an ethical risk we were particularly mindful of given the ongoing threats to their safety that many victim-survivors face.

We considered several key equality-related characteristics: the proportion of cases where victim-survivors identified as Black or minority ethnic; the proportion of cases where victim-survivors identified as LGBT; the proportion of cases where victim-survivors reported a disability; and cases where children were involved.

Proportion of cases where victim-survivors identified as Black or minority ethnic. Analysis of Insights data did not suggest change in the proportion of cases where victim-survivors identified as Black or minority ethnic as a result of Health Pathfinder. Analysis of MARAC data also did not suggest change in the proportion of cases discussed where victim-survivors identified as Black or minority ethnic as a result of Health Pathfinder.

Proportion of cases where victim-survivors identified as LGBT. Analysis of Insights data did not suggest change in the proportion of cases where victim-survivors identified as LGBT as a result of Health Pathfinder. Analysis of MARAC data also did not conclusively suggest change in the proportion of cases where victim-survivors identified as LGBT as a result of Health Pathfinder. However, there was some marginal evidence of a quarter-on-quarter increase of 15.6% following implementation in the proportion of cases discussed at MARACs where victim-survivors identified as LGBT; this estimate was marginally significant. Further research with a larger sample is necessary to substantiate this finding.

Proportion of cases where victim-survivors reported a disability. Analysis of Insights data did not suggest change in the proportion of cases where victim-survivors reported a disability as a result of Health Pathfinder. Analysis of MARAC data also did not suggest change in the proportion of cases discussed where victim-survivors reported a disability as a result of Health Pathfinder.

Cases where children were involved. Analysis of Insights data did not suggest change in the rate of child involvement in cases as a result of Health Pathfinder. However, analysis of MARAC data suggested that while there was not a change in the rate of child involvement in the quarter of implementation, the rate of child involvement increased quarter-on-quarter by 5.5% in each quarter following implementation.

Again, because significant differences in the demographic characteristics of victim-survivors were not clearly observable, further research is recommended to explore the extent and nature of the profile of victim-survivors identified and referred for specialist support due to the implementation of Health Pathfinder.

2.2 Outputs of Health Pathfinder: a focused look

As part of data collection during the period of Health Pathfinder, sites collected extensive data regarding domestic violence and abuse cases handled through Safeguarding teams in a range of contexts, through IRIS programmes in GP surgeries, and through IDVA contacts in participating services, some of which were reported through Insights and analysed above. For many sites, detailed discussion of the cases reported would be disclosive due to small numbers of cases in any one category (e.g., of abuse experienced, or by ethnicity). In addition, Safeguarding data, while providing a meaningful and powerful record of how teams working in hospital contexts supported victim-survivors, were inconsistently formatted across sites (as would be expected) and were thus not amenable to inferential testing to detect changes in practice over time. A cross-cutting look at the characteristics of contacts and cases generated by Health Pathfinder is presented in the Pathfinder Key Findings Report published by SafeLives, and should be read in conjunction with this report. We discuss this further in a later chapter.

In this section, we describe two key types of contacts that are important to evidence the ways of working Pathfinder generated but that were not able to be included in our analysis above: IRIS contacts and other contacts.

IRIS contacts. A total of six sites reported IRIS contacts. In two sites, Blackpool and Tri-Borough, roles funded as part of Pathfinder related principally to IRIS. In Blackpool, which began implementation of Health Pathfinder in June 2019, a total of 29 referrals were received in the third quarter of 2019, an additional 29 referrals were received in the fourth quarter of 2019, and 36 referrals were received in the first quarter of 2020. These generated a total of five referrals to MARAC. A total of 18 GP practices were trained over these three quarters, with 10 practice meetings attended starting in the second quarter of 2019. In the Tri-Borough site, a total of one referral was recorded for the fourth quarter of 2019. However, 14 referrals were recorded in the first quarter of 2020, generating two referrals to MARAC.

Other contacts. In some sites, ‘other contacts’ constituted an important part of the work undertaken, as these included contacts with victim-survivors who were not yet ready to progress with linkage into services, and provision of advice to health professionals regarding their support and management of patients experiencing domestic violence and abuse. (We discuss the importance of these ‘other contacts’ in the subsequent chapters relating the findings of our qualitative research.) For example, over the study period, the specialist service in the Camden and Islington site, Camden Safety Net, recorded 141 ‘other contacts’. Of these, 120 contacts related to case consultations, which often included information sharing to support health professionals and Safeguarding staff in supporting victim-survivors. Splitz, one of the specialist services in the Devon and Exeter site, recorded 68 ‘other contacts’ over the study period, summing up to 245 hours of support, the majority of which was indirect (i.e., case consultations) rather than direct. Half of these contacts included information sharing, and 20 of these contacts related to supporting the safety of victim-survivors.

2.3 Summary

Collectively, our analyses suggest that Health Pathfinder had a meaningful impact in a) improving the implementation chain for domestic abuse and b) identifying and referring victim-survivors at what might be an earlier stage in abusive relationships, alongside generating a meaningful pattern of contacts to support referrals and clinical management of victim-survivors of domestic violence and abuse. However, our analyses did not present clear evidence that Health Pathfinder changed the composition of cases according to key diversity-relevant characteristics. We note now that this is not the same as ‘evidence of no effect’, and discuss this further below. A key limitation underlying our quantitative analyses is that the data we were able to analyse meaningfully, and in a comparative fashion, focused on measurement of risk, meaning that we were unable to test in a comparative fashion—similar to our analysis of e.g. changing risk profiles—for the full range of potential benefits Health Pathfinder might offer victim-survivors. To do this, we would have needed longer-term data on health and needs, for example through record linkage with NHS data.

Putting findings from MARAC and Insights analyses together. While it may appear at first glance to be contradictory that more high-risk cases were detected (i.e., cases discussed at relevant MARACs) and also that risk profiles shifted to include a wider spectrum of risks (i.e., victim-survivors classified as standard risk), these findings are not necessarily at odds. As we noted earlier, a strength of the MARAC data as we used it in our first set of analyses is that these analyses are with respect to the population in that area. Because of this, the population rate of high-risk cases discussed at MARACs can be viewed as a proxy for general system-wide capacity to support enquiry, disclosure and referral. Thus, the most likely interpretation of our findings relating to the rate of cases discussed at MARACs are that these reflect underlying system improvements across multiple stakeholders involved in Health Pathfinder. At the same time, Health Pathfinder improved detection of domestic violence and abuse across a wider spectrum of risks as demonstrated by the cases recorded in Insights data from participating services. This is, by definition, a narrower scope of activity than the activity reflected in data relating to MARAC referrals, and with respect to a narrower population. One of the potential benefits of an improved whole health response is the ability to detect domestic abuse across the risk spectrum and, importantly, refer victim-survivors before risk escalates.

These twin features of our quantitative analysis—improved system response and improved response across a broader spectrum of risk—closely reflect the Health Pathfinder logic model developed in consultation. In particular, the combination of victim-survivor-level and system-level impacts suggests that key mechanisms and outcomes of more disclosures, earlier identification, more and more appropriate referrals for specialist support, more people helped to safety and sooner, and shifts in organisational culture and response to domestic violence and abuse were achieved.

Equity, diversity and intersectionality: a key limitation of our data. Our analysis of Insights and MARAC data did not show evidence of a change in the composition of cases discussed with respect to diversity-relevant characteristics. We regarded that this was ‘no evidence of effect’ rather than ‘evidence of no effect’. Insights data would be expected to be more probative than MARAC in this regard as it relates to contacts arising specifically as a result of Health Pathfinder. However, we were only able to include four Health Pathfinder-involved services, only one of which was located in an area that would be expected to serve a more ethnically diverse population based on census characteristics. Three sites served mixed urban-rural areas in which access to services was not characterised by, for example, ethnic diversity, and thus improvements in respect of this characteristic would be difficult to evidence.

To properly test for the impact of Health Pathfinder on equity-relevant characteristics, we would have needed data covering the breadth of Health Pathfinder activity nationally. In this respect, our analysis was unable to evidence aspects of the logic model relating to equity and diversity; specifically, greater system awareness and responsiveness to the needs of victim-survivors who belong to groups that are underserved by health services, including victim-survivors who identify as Black or minority ethnic, identify as LGBT, or live with a disability. Further research is recommended to identify the extent and nature of changes to detection and referral patterns for victim-survivors with specific vulnerabilities or protected characteristics due to the implementation of Health Pathfinder. We also consider in the subsequent chapter how the mechanisms by which Health Pathfinder achieved its effect could also be understood to improve health equity both for women experiencing domestic violence and abuse and particularly for women experiencing multiple forms of oppression. While our compositional analyses accomplished a similar goal as analyses that stratified by victim-survivor characteristics (i.e. disaggregated analyses), we would have preferred to present both types of analysis.

Breadth of components assessed. Finally, we note that we were unable to formally test the impact of Health Pathfinder with respect to IRIS, despite the importance of IRIS to implementation of Health Pathfinder across multiple sites. This was due to the lack of availability of data for many sites prior to Health Pathfinder. This is a limitation of our analysis but also an inherent feature of the Health Pathfinder intervention, which in several sites sought to establish and expand the provision of IRIS. We were also unable to undertake an economic evaluation, whereby the benefits of Health Pathfinder would be formally quantified in terms of the costs expended to generate those benefits. Future research should seek to consider how the manifest benefits of a whole health response to domestic violence and abuse represent 'value for money', both in terms of cost-effectiveness against NHS standards and in terms of system-level cost savings through earlier identification and referral.

3. How did the Health Pathfinder intervention work?

In this chapter, we present findings from our qualitative interviews with both victim-survivors and professionals. Our analysis of these interviews helped answer the question: *how did Health Pathfinder achieve its goals?* That is, this chapter is an explanatory counterpart to the prior chapter, helping in understanding how system-level and victim-survivor-level impacts were achieved.

The characteristics of our sample are described in the Appendix. In short, we interviewed 20 victim-survivors and 27 professionals. This was an increase in our planned sample size of about 50%. We take this opportunity to acknowledge with gratitude the work of site leads from the organisations that were part of the Health Pathfinder consortium in facilitating recruitment for health professional interviews; the work of the IDVAs and Advocate Educators who collaborated with the study team to identify victim-survivors; the health professionals who gave their time to share their perspectives with us; and, most importantly, the victim-survivors who shared their experiences and stories with us. We were inspired by their courage and learned a great deal from our interviews with them.

To describe how the Health Pathfinder intervention worked, we first describe a key insight that arose in our analysis; namely, that Health Pathfinder is an ecological intervention. We then use a tool known as ‘context-mechanism-outcome configurations’. What we mean by this is that in order to understand how an intervention works, it is important to understand the contexts within which the intervention works and the mechanisms, or change processes, that are ‘set off’ in those contexts to achieve specific outcomes. Our analysis of the qualitative data revealed five mechanisms that together can account for the improved response to domestic violence and abuse in the Health Pathfinder sites. These are described below as step-changes in the nature and scope of (1) awareness, (2) expertise, (3) relationships, (4) empowerment and (5) evidence across the sites. As we demonstrate, these mechanisms formed a sequential and iterative chain by which Health Pathfinder achieved its goals. A key insight that emerged during consultation on our findings was that Health Pathfinder can be understood—or rather, must be understood—as an intervention that both operates in a context of health inequities that impact women, and that disproportionately impact certain groups of women along axes of oppression such as ethnic minority status, disability and sexual and gender identity. Thus, throughout this chapter, we highlight how these mechanisms ‘set off’ by Health Pathfinder can be viewed as supporting action on these health inequities. We regard this analysis as particularly important in exploring the impact of Health Pathfinder for marginalised victim-survivors given the data sources we were able to analyse in the previous chapter were not able to shed light on these inequities (i.e., ‘no evidence of effect’). This is discussed as well in a subsequent chapter that integrates findings from the Health Pathfinder survivor consultation.

3.1 Prologue: Health Pathfinder as an ecological intervention

One of the most important insights that arose from our analysis of Health Pathfinder is that rather than understanding it as a ‘simple’ intervention that is the sum of several components, it is essential to start from the position that Health Pathfinder is an *ecological intervention*. When we say ‘ecological’, what we mean is that the effectiveness of Health Pathfinder occurs at multiple levels, drawing on multiple roles, that each achieve multiple functions.

We believe this insight is important for several reasons:

- first, it is essential to an understanding of how Health Pathfinder unlocked mechanisms that led to the most directly observable evidence of effectiveness;

- second, and by corollary, it is critical to understanding how the intervention components and roles worked together to unlock this effectiveness; and
- third, it underlines how the work of an effective whole health response does not end with a successful contact between a victim-survivor and domestic violence and abuse services.

3.1.1 How Health Pathfinder unlocked mechanisms

Even though one of the ways in which the effectiveness of Health Pathfinder was most directly 'felt' was via more, more effective and more timely contacts between victim-survivors and domestic violence and abuse services, achieving this meant a range of people working together and across multiple domains of health sites. For example, the power of compassionate enquiry and effective follow-through was one of the key concepts that was most clearly evidenced in our interviews with victim-survivors. While this was most *manifestly* facilitated by co-location of IDVAs and Advocate Educators, successful co-location required successful domestic violence and abuse coordination, which in turn was closely linked to senior management support. This domestic violence and abuse coordination work occurred in many cases behind the scenes of patient contacts, but this makes it no less important. Domestic violence and abuse coordinators primed health professionals to engage with, and be empowered in, the work of appropriate enquiry and referral; worked to embed the principles of Health Pathfinder in trust policies; and organised training for health professionals. In addition, a range of components that extended beyond co-location and coordination and that may be less immediately linked to the outcome—such as technical assistance and training around trust and practice policies, data collection and evidence generation, and responding to the needs of groups of victim-survivors that have traditionally been marginalised—played a central role in the generation of positive outcomes.

Put otherwise, a reductive understanding of Health Pathfinder would solely prioritise increasing resource for IDVAs and Advocate Educators, assuming that the fact of these experts' existence would be enough to engender the positive effects of Health Pathfinder. This would be a mistake, because central to the success of Health Pathfinder was working across roles and domains that were fuzzier, and fruitfully so, than 'external domestic violence and abuse expert/internal health professionals'. It would also be a mistake because it would prioritise a surface-level understanding of the diverse needs and challenges that groups of victim-survivors face, and that a one-size-fits-all approach would not meet. Because one of the goals of Health Pathfinder was the amelioration of structural inequalities in the whole-health response to domestic violence and abuse, any analysis of its effectiveness needs to consider meaningfully the structural pathways (i.e. beyond individual provider change or action) through which the Health Pathfinder generated its effect.

3.1.2 How intervention components and roles worked together to unlock effectiveness

The second reason this insight is important is closely related to the first reason: it throws into relief the value of multilevel buy-in, including domestic violence and abuse coordination that was visible and that championed the work of Health Pathfinder alongside a clear senior management commitment to developing an effective health response to domestic violence and abuse. The fact of colocation is not enough; for the whole health response to be effective, multiple levels of the organisation needed to be involved. Our findings below should thus be read with a view towards how each of the mechanisms described were activated over a range of levels, from patient contacts to ward-level or service-level relationships to structural and cultural characteristics of health sites where Health Pathfinder was implemented. Our findings should also be read with a view towards the way in with site-specific responses drew on a range of components and activities, even where these components, like improved data collection, might be seen as somewhat distal or indirect to the ultimate goals of Health Pathfinder in improving the whole health response to victim-survivors of domestic violence and abuse.

3.1.3 How the work of an effective whole health response does not end with a successful referral

The third and final reason this insight is important is that it acknowledges that the work of Health Pathfinder does not conclude with effective enquiry or even victim-survivor uptake of services. Rather, the work of Health Pathfinder encompasses the need to 'close the circle' of organisational improvement through supporting empowerment and developing the evidence needed to continue improving the quality of, and justifying the need for, a whole health response. This is especially prominent in the mechanisms we describe below of Health Pathfinder as an 'evidence generating' intervention, where the value of improved data collection and technical assistance was experienced in several sites. Data collection in particular was useful not just to evaluate services, but to monitor reach, understand needs and identify where groups of victim-survivors were being underserved by existing services. This work is essential to create a whole-health response that addresses the needs of victim-survivors while addressing the structural inequalities that particular groups of victim-survivors, including Black and minority ethnic women, LGBT women and women with disabilities, in receiving appropriate services.

3.2 Intervention contexts

Our analysis begins by describing the contextual factors necessary to understand mechanisms. Our discussion of context foregrounds victim-survivor voices and the contextual factors in their own lives and experiences that they 'brought' to their encounters with the health system. We then consider the organisational and community contexts within which Health Pathfinder worked, drawing as well on interviews with professionals.

3.2.1 The victim-survivor context

Findings from victim-survivor narratives revealed that there were key contextual factors in which intervention mechanisms appeared to operate: the nature and impact of domestic violence and abuse experienced by victim-survivors; the co-occurrence of domestic violence and abuse and poor mental health and wellbeing in victim-survivors' lives; and how ready victim-survivors were to engage with services, which we describe with reference to stages of change theory; and, as a positive counterbalance, the presence of trusting relationships with health professionals.

Nature and impact of domestic violence and abuse. A significant but perhaps unsurprising contextual factor was associated with the hidden nature and impact of domestic violence and abuse on victim-survivors. The systematic patterns of abusive behaviour, used to establish and maintain power and control over victim-survivors, perpetuated expressions of inherent fear. Over half of the victim-survivors interviewed described a reluctance to disclose or reveal domestic violence and abuse, due to complex and diverse accounts of fear. These encompassed: fear of losing their children due to involvement of professionals or services; fear of not being believed by professionals;

fear and concerns that the perpetrator would find out resulting in further domestic violence and abuse; fear of being disempowered in decisions and fear of the future:

> You worry about somebody else getting involved and you might lose your kids. (S11)
>
> When it was all sort of happening it was like, they're not going to believe me. (S9)
>
> You could ask for help and then it's the fear of them (the perpetrator) finding out and then it getting worse. (S10)
>
> They're going to be telling me what to do in my life, or what not to do and stuff. (S7)
>
> You just don't know what's out there and what's going to happen to you. (S6)

However, the most prevalent expression of fear amongst victim-survivors was the fear of judgement and reprove from health professionals, highlighting the importance of sensitive and compassionate responses:

> I felt that they're going to be like, you know, judgmental and stuff. (S1)
>
> Largely the feeling of people sort of going "why the hell have you stayed in this relationship". (S6).

Victim-survivors' comments on the impact of domestic violence and abuse in their lives underscored the gendered nature inherent to domestic violence and abuse; in particular patriarchal beliefs, especially on the part of health professionals, about the dynamics present in abusive relationships As victim-survivor perspectives made clear, these preconceptions and the perceived unwelcoming and disbelieving nature of the healthcare response to domestic violence and abuse were central to the creation of health inequities arising from domestic violence and abuse.

Victim-survivor concerns of potential stigmatisation seemed to be linked to their own internal dialogue around shame and self-blame, which was reflected in their discourses around humiliation, embarrassment and personal failure when it comes to disclosing domestic violence and abuse:

> I was ashamed, I was embarrassed. (S11).
>
> It's like a failure in your life that's happening and you actually allow it to happen. (S1)

Co-occurrence of domestic violence and abuse and poor mental health. These incidents of power and control were also manifest where perpetrators' emotional abuse impacted victim-survivors' mental health, further perpetuating feelings of shame and self-blame and thus non-disclosure:

> And I believed him. And thought I was the worst person in the world. (S3)

Attributing their suffering to depression or anxiety meant victim-survivors often presented to health services with mental health symptoms, with no further context about their experiences or possible causes underlying their depression or anxiety:

> The abuse I was getting erm ... the ... the, the life I was living ... I thought ... I thought I was just depressed. (S3)
>
> When it's more mentally as well, you've got someone telling you that it's all in your head. (S7)

A significant number of victim-survivors described situations where this co-occurrence resulted in missed opportunities, where health professionals focused only on treating mental health, by prescribing or signposting to mental health services. This validated victim-survivors' views that their feelings and experiences were solely relevant to their mental health rather than to perpetrators' abuse. Interviews where victim-survivors readily disclosed domestic violence and abuse, revealed further missed opportunities, where they continued to be signposted or referred to mental health services, but without any access to specialist services. This is another way in which health inequities were both generated and perpetuated by the experience of domestic violence and abuse in these victim-survivors' lives.

Readiness to engage and stages of change. Inextricably linked to both of the above factors was the victim-survivors' journey through the stages of change; that is, identifying, recognising, signposting and referring victim-survivors appeared to take place within 'windows of opportunity'. These windows depended on where victim-survivors were within their readiness to engage with services.

Victim-survivors who recognised that they were experiencing domestic violence and abuse, were more likely to display help-seeking behaviour, attending health settings with the intention to disclose:

> I knew that I was in a relationship with a really, really wrong guy. (S1)
>
> I just decided I'd go to doctors and just say, "I need help because my ex-partner's mentally abusing me". (S8)

Other victim-survivors advised that they had not recognised the abuse and had assigned experiences and feelings around domestic violence and abuse to their mental health, linking to the co-occurrence of mental health and domestic violence and abuse and presenting in health-based settings.

Victim-survivors identified and signposted to specialist support from A&E health settings, disclosed having experienced a significant assault, which appeared to serve as an impetus for action, highlighting the 'window of opportunity' that can be held by health professionals and their settings. This motivation to action was described by one victim-survivor:

> You know, it does take time, but I think something will happen and it could be a big thing or a little thing, but I think that's when you know, enough is enough. (S11)

This emphasises the importance of identifying victim-survivors within this 'window of opportunity', working with victim-survivors within the stage of change they are in and supporting, signposting and referring victim-survivors who are ready for change and seeking support.

Trusting, established relationships with health professionals. Identification of domestic violence and abuse was therefore particularly successful if the victim-survivor had an established or trusting relationship with a health professional. Victim-survivors talked about having developed a rapport with certain professionals (e.g., GP, mental health provider), cultivating trusting relationships whereby they felt able to talk to them and open up. Availability of health professionals with the appropriate knowledge, understanding and skills, together with the provision of safe spaces, offered reassurance around the inherent fear and self-blame experienced by victim-survivors. Victim-survivors thus identified a willingness to disclose when they felt comfortable with a professional who had communicated empathy and care, and with whom they felt they could trust. Victim-survivors who were eventually identified in mental health settings often advised that they had had the time and space to talk about their relationships and therefore felt they could be 'open' with their mental health provider, resulting in signposting or referral to a specialist domestic violence and abuse service. A few victim-survivors also advised that they felt comfortable disclosing within primary care, due to safe, confidential spaces and familiarity with the health-based setting and their GP. As will be seen later on, trusting, established relationships were also fostered by Health Pathfinder, reinforcing the importance of this factor to understanding more generally the effectiveness of health system interventions for domestic violence and abuse, including for a range of women who are particularly poorly served by more ‘traditional’ health system responses.

3.2.2 The organisational context

Our analysis of the organisational (that is, NHS-level) contexts within which Health Pathfinder worked suggested three important factors: funding environments; health sector readiness and environmental characteristics conducive to the effectiveness of Health Pathfinder; and domestic violence and abuse ‘cultures’ that shaped professional and management attitudes to the relevance and importance of domestic violence and abuse and, by extension, Health Pathfinder.

Funding environments. The Health Pathfinder intervention was clearly tailored to the unique structures and sectors of each participating site. Initially, adaptation was necessary due to the funding environment in each site, with negotiations between the Consortium and the individual health sites in relation to how the funds would be spent. This meant in some sites decisions were made about each site’s ‘gaps’ and the best use of the funds. These funds were allocated in diverse ways. Sites implemented some combination of a full time co-located IDVA, a part-time co-located IDVA, an Advocate Educator as part of IRIS, a domestic violence and abuse coordinator post, or training and policy improvement work alongside efforts to improve the quality and scale of data collection around domestic violence and abuse. Therefore, the ‘needs’ of each site were different, allowing the intervention components to be flexibly implemented according to what each site’s perceived gaps in provision:

> Because we already had um a lot of what was on offer from Pathfinder, we were very keen to go ahead with IRIS so, and that’s where we are. (P3)

Therefore, at the outset, a consensus needed to be reached between health, third sector and consortium partners in relation to the allocation of funds. Sites were at different ‘starting points’ in relation to their existing policies and practices, and therefore had different desires in relation to Pathfinder’s input. In some sites, the originally agreed provision was changed as the intervention was implemented, with partners having different ideas about what would be most effective. Therefore, consensus or conflict within the sites in relation to the roles and components funded was an important organisational context in terms of not only *what* was implemented (discussed in the next chapter), but *how* the intended mechanisms worked in that site:

> It’s just been a constant work in progress really, in trying to adapt to the needs of not only the NHS trust that I’ve working within, but also the clinical commissioning group, the domestic abuse services, and Pathfinder itself… Trying to consolidate lots of different organisations, views and expectations really of what the role is going to involve. (P4)

Funding arrangements were highlighted as a difficulty across all sites; however, some NHS trusts appeared to have more ‘ripe’ funding environments than others and had allocated some funds to tackling domestic violence and abuse. Where a joint funding approach exists, it was seen to promote effective partnership working and a shared sense of ownership of the issue:

> We had, um, our, the, so some of the funding comes through out Office of Police and Crime Commissioners, and the Commissioner has met um and been in our hospitals. So those are conversations that are happening regularly. (P3)

> I suppose one of the challenges, and, you know, it’s what I’m talking about is there’s an expectation from our partners that the local authority will step in… So, the local authority in many [places] fund most of the activities around domestic abuse… and I think there’s something about health or the acute Trust, the [clinical commissioning groups], taking it a bit more seriously and my experience is that if you’re not… you know if you’re not funding it then you don’t take it as seriously. (P17)

Health sectors and environmental characteristics. Some health sectors, such as A&E, maternity and primary care, are now quite commonly the site of co-located services or partnership interventions which are evidenced as effective (for example, IRIS). However, some of the NHS sectors involved in Health Pathfinder were treading relatively new ground in terms of domestic abuse and health interventions, such as mental health and dentistry:

> Erm, and I must say it has also, erm, raised the profile of, erm, dentistry, er, across the system ‘cause it’s that now I’m invited to attend…the Domestic Abuse Commissioning and Development Board. (P21)

Furthermore, the different health sectors were described by participants as each having their own unique ‘culture’ that the intervention needed to fit into. For example, A&E was described as a chaotic environment where clinicians faced significant time and workload pressures, and where most IDVAs reported struggling to find private space to talk with patients:

> …you know certainly in ED for example, you know the... time is very pressured and they don't... you know they were... they hadn’t got time to complete a referral form. (P14)
>
> They were a little bit more tricky and resistant, um, partly because of the volume of their work and the sense that well this is just one other thing and we can’t, it’s very hard to get privacy in an Emergency Department, so this just isn’t gonna work you know. (P15)

Other health sectors, including primary care (where IRIS was a key intervention) and mental health, seemed to lend themselves well to not only partnership working but also co-working on individual cases. For instance, several IDVAs based in mental health described how the environment of mental health was conducive to this, and how this worked to the benefit of patients:

> I tend to have a lot more joint meetings, so that means, me meeting with the client, together with the mental health practitioner, we do a lot more joint working and that’s because of sort of the clients to that service, their mental health support needs and how it’s better to try and meet with them as a three way. (P28)

Domestic abuse ‘cultures’. Regardless of the health sector, another key contextual factor to understanding intervention effectiveness relates to the ‘readiness’ of the sites in terms of their investment in a changed response to domestic violence and abuse. Receptiveness to the intervention (and associated costs) from NHS management across multiple levels was seen as vital in establishing the infrastructure to support the various intervention components, particularly co-location. Management investment was also considered to create a local ‘culture’ in relation to tackling domestic violence and abuse that filtered down to staff, and won hearts and minds in a context where many other health issues are competing for professionals’ time and attention:

> As a provider we have a duty and a responsibility to respond to the recommendations coming in from the Department of Health and that is about the improvement of identification, assessments and response of patients affected by domestic abuse and I genuinely don’t feel that that can be influenced by an external provider, but that needs to be owned by health and

> that's driven through their systems and processes and also from a quality assurance point of view…so I think that's where the, the providers' responsibility is. (P9)
>
> It's probably because we have a really dedicated safeguarding team, and we have some really enthusiastic workers who domestic abuse is a specialist area of theirs…we do have lots of different areas that we work on but domestic abuse is part of our work plan. (P19)

Conversely, it was apparent from some interviewees that where resistance was present at any level of the NHS, the implementation of the intervention faced particular challenges:

> In my experience, it was being just "it's not our responsibility" and at one point, I think the old safeguarding lead…did actually say to me when I raised it "it's not our responsibility, refer on to domestic abuse services, we have nothing to do with it". And I was met with that kind of a response for many years until I then met with my old Ward Manager who was as enthusiastic as I was, really, about trying to improve our knowledge and responses. (P25)
>
> The mental health service wasn't there to really start off with, you know. They weren't doing routine enquiry, they don't have it, I don't even know if they have it specifically on their assessment forms. They don't have it and there's no training. They don't have enough training, so actually… I'm thinking like in hindsight, you know, I can see now that the structures aren't in place. (P10)
>
> Then maybe in a year, or two years' time, it will be written into the NHS contract to say "You need to do better and do more about domestic abuse" … But until it's done it becomes something people do because they're enthusiastic or they believe it's the right thing to do (P15)
>
> Much of the response of the health service or health sector can depend on the, the commitment of individuals. We have some fantastic individuals [here] who really promote the work around domestic abuse. I'm not sure it is taken as seriously at a higher and strategic level. It is a health issue. I'm not sure it is regarded as a health issue at a strategic and I probably am going to say here where there are those who make the decisions about funding. (P17)

In this respect, Health Pathfinder had an important role to play in working to change these 'cultures'. Embedding domestic violence and abuse as part of the core work of sites, whether acute trusts, mental health trusts or primary care, was an important way in which Health Pathfinder could be seen to address the health inequities that accrues to women experiencing domestic violence and abuse.

A significant aspect of the local domestic violence and abuse culture that was perceived to shape the intervention mechanisms was the site's pre-existing local partnerships and relationships with domestic violence and abuse services. Some sites described themselves as already having a strong base in relation to policy, practice and local partnership working; however, others had little existing relational infrastructure. Around half of the sites were able to point to the benefits of previous projects or pilots that helped create a local DV community and partnership culture that was regarded as beneficial to the effectiveness of Pathfinder:

> Pre Pathfinder I've been involved with another department domestic and sexual abuse project and that was to embed a cultural change in domestic and sexual abuse. So, we were still involved in that… which was awareness and response to domestic and sexual abuse and we had a network that I led on relating to domestic and sexual abuse and training and the rest of

> the sexual abuse policies, that kind of thing … so that was the groundwork that was kind of already there when … we were approached to sign up to the Pathfinder project. (P13)
>
> For ourselves we were already running to the model, not completely to the model but you know we already had - and when you bring in any service my feeling is it takes several years for it to become established and to run effectively. I mean I know speaking to colleagues in a different area where Pathfinder is funded, it is, you know they've had huge amounts of problems... that's where you know having it in place for 8 years or whatever, you know we've gone through those tricky, you know the points of establishing it. You know we have established it and it has worked very well. (P16)

Therefore, clear leadership and ownership of domestic violence and abuse from management within the NHS can support the creation of a local culture that shares responsibility for tackling domestic violence and abuse and is conducive to how the intervention components work in that context. Many of the sites were at different levels of readiness in this regard, which was in many ways shaped by the community context discussed below. Both the trust or practice's own domestic violence and abuse culture and an existing relational infrastructure with domestic violence and abuse services created fertile ground for the intervention components and mechanisms to work effectively.

3.2.3 The community context

Our analysis of the community contexts suggested two key but interlinked community characteristics were important to understand how Health Pathfinder mechanisms were 'set off': rurality and population demographics and perceived diversity of local populations, leading to the differential perceived relevance of different aspects of Health Pathfinder. These community contexts as they intersect with organisational contexts are important in understanding the potential success or failure of Health Pathfinder to generate a response that worked for all women.

Rurality and population demographics. Interviewees from over half of the sites felt that their population demographics or geographical location meant that the intervention operated differently in their site. Rurality and physical remoteness were considered to be a significant barrier in relation disclosure and working with clients:

> I think there is a challenge, a rural area, over a number of sites, I think presents a challenge. I think probably if you were in a city and you… perhaps you've got three or four healthcare providers in that city, or whatever, I think possibly geographically things are closer, and so you have a potential to perhaps meet face to face more often, or it may have its own challenges, I'm sure it has its own challenges. But the sheer distances and geography involved… in this area, pose challenges of their own. And you've got massive, massive differences… of demographics, and the ability of people to access services. You know… if you're 20 miles from the nearest hospital, then you're 20 miles from often the nearest domestic abuse service… and it does make a difference. (P12)
>
> We had a client where it takes two hours on a bus to get to her GP…but again it's still one of the only places that they can reach… you have to take geographics into account. There are additional factors with people being isolated, and that's all taken into account when you're working with victims, you know, in respect of safety planning because there's additional factors to include, differently than say in cities. (P14)

> So, in rural places it is, but I don't know if there’s, I know people are less willing to disclose what's going on because… the villages and little towns I work in are quite close knit and people know what's going on. Everyone knows everyone. (P20)

Therefore, in rural communities, integration of health and domestic violence and abuse services while victim-survivors were accessing healthcare was seen as possibly the only opportunity to engage victim-survivors who were otherwise isolated and difficult to engage. This is a key way in which Health Pathfinder could be understood as ameliorating structural inequities in access to services on the basis of place.

Relatedly, the population demographics of the area were also perceived to shape how the intervention worked, with a couple of sites indicating that health-based services were identifying older victim-survivors:

> What [it] highlighted was because we, once we rolled out training to all staff, it meant that our people working with older people, they were starting to uncover a lot more domestic abuse, and there was a pattern… they were uncovering a disproportionate compared to national stats, of older people, who are victims, so over sixty fives who were victims of domestic abuse… Certainly the stats we had… it was around, it was our younger women who appeared in the ED, with acute injuries, but there was a big group of older people, and probably not quite 50:50, but sort of 70:30, 60:40 of them, were men. (P15)

Perceived diversity of local populations. The Pathfinder intervention aimed to provide guidance to sites on how to engage with victim-survivors from a diverse range of backgrounds and protected characteristics to support equal access to services. However, a couple of sites felt that the composition of their local population lacked diversity and therefore were unable to fully implement this aspect of the intervention, or unable to fund some of the recommendations:

> I can think of an example as well when I was creating the posters and you know, it was recommended to have them in a certain amount of languages and obviously we didn’t have funding for that. (P31)
>
> To be honest [name of area] is not an ethnically diverse place… So, I can understand then that it would mean that we may not always be in tune with the BME population, or any other minority group, including sort of LGBT, as we should or could be, but it’s very hard to sort of think about how you tailor resources or response to meet that need, when the numbers are so small… And we don’t, we don’t have a large enough community of any one particular sort of ethnic group to sort of generate resources that are useful, and we tend to rely on what’s out there nationally and utilise those. (P15)

These comments revealed several aspects of perceptions that Health Pathfinder sought, directly or indirectly, to challenge and transform. The first is that all ‘diversity’ is visible to clinicians. This is unlikely to be the case when working with, for example, victim-survivors with invisible disabilities, who identify as LGBT, or who are members of minoritised and racialized groups. The second is that the ‘fact’ of perceived diversity in patient populations in fact reflects the need for those services. A goal of Health Pathfinder was to improve access to the whole-health response to domestic violence and abuse precisely for those victim-survivors who may not have had access before the intervention.

A couple of sites also felt that guidance on equity, diversity and intersectionality would have been more helpfully received at the beginning of the set-up phase rather than in the midpoint of intervention activity:

> Imkaan has been involved and kind of came to the foreground a little bit, well quite a bit later and kind of joined a couple of meetings to maybe look at things… but for me that came in a bit too late and I feel like we should have really, they should have been at the table from the word go really to really make sure that was, there was some key actions that had to be done in relation to them… not necessarily by them, but by us (P13)

One of the intended mechanisms of the intervention was to gain a better understanding of the needs of specific groups of women, particularly where these groups were ill-served by a homogenous and homogenising health response to domestic violence and abuse. The community context shaped the way in which this was able to be achieved in each site, with interviews revealing that many sites did not consider their local population diverse enough to be able to tailor the intervention to the needs of specific groups. Beyond protected characteristics, several sites in rural communities highlighted isolation as a significant contextual factor shaping the implementation of the intervention and the mechanism functioning.

3.3 Awareness Generation

The first and foundational mechanism by which Health Pathfinder achieved effectiveness was by generating awareness of domestic violence and abuse, with respect to both victim-survivors and professionals. In order to establish health services as a safe, effective and appropriate place for victim-survivors to access services, victim-survivors needed to be aware that health services can act as an entry point. This awareness emerged as an important way in which Health Pathfinder could act to reduce health inequities both from domestic violence and abuse as a whole and with respect to specific groups of women. In addition, in order to raise expertise and skills of health practitioners in relation to domestic violence and abuse, creating a basic level of awareness within health of domestic violence and abuse and their role and responsibilities is a necessary basis from which the other intervention mechanisms can be built. The creation of awareness is the foundation for a broader cultural shift in perspective within health that encourages health professionals to understand and consider domestic violence and abuse as a core aspect of their professional role and supports its inclusion on the health agenda at all levels.

Survivor awareness. A few of the victim-survivors interviewed were not initially aware of health’s role and responsibility in responding to domestic violence and abuse, highlighting the importance of visible services:

> But it was normal at the time and it was my problem, it's not the midwife’s problem what's going on with my boyfriend. But I think that would probably be something that I think should be done really, because I don't think anyone takes it seriously enough. (S12)

Importantly, victim-survivors who did disclose domestic violence and abuse, talked explicitly about wanting specialist support but advised they did not know where to seek this, or if it even existed:

> I knew… I wanted a support… I wanted some kind of support, or someone that could talk to about my… abusive relationship, and I didn’t feel… like even the counselling through NHS Wellbeing, I thought well that will help me with depression and anxiety, but… the counsellor isn’t a domestic abuse expert. (S6)
>
> To be honest with you, at first I didn’t even know there was such help available. (S11)

It is of note that in these responses, victim-survivors reflect the ‘traditional’ boundaries that exist in health services, for example between mental health and domestic violence and abuse services.

Integrating across these boundaries was one way in which Health Pathfinder increased access to services. Victim-survivors raised the issue of ensuring availability of services was more widely known, publicising what they do and how they help via leaflets and posters. A quarter of victim-survivors (over half identified within doctor's surgeries; i.e., substantially through IRIS implementation) mentioned, without prompting, visibility of services in health-based settings, communicating how powerful these can be to prompt earlier disclosure.

> So maybe something within the doctor's surgery then, before you go in the room so that they might be there for something else that day but then they might see the poster and then think well it says on there that they're here to help. (S10)

This indicates that increased victim-survivor awareness of health professionals' role and responsibility in addressing domestic violence and abuse, can increase health-based opportunities and inspire an increased willingness to disclose, which could ultimately lead to earlier referral and engagement to domestic violence and abuse services.

Additionally, victim-survivors highlighted the windows of opportunity that can arise in health settings, underscoring how creation of these windows was a central and foundational aspect of how Health Pathfinder achieved effectiveness. They pointed out that access to a health professional both without the perpetrator and within a safe, confidential space addresses the contextual nature and impact of domestic violence and abuse, which can prevent victim-survivors from disclosing:

> Yeah, but the doctors it's like you can absolute... it's somewhere where you can go to that appointment on your own, they don't have to be with you... And that's probably one of the best places you could go then to let someone know that there's something not quite right going on. And it's all confidential so you've not got to worry that it can then, you know... yeah definitely. It's a private room isn't it, no one can hear you. (S10)

This highlights the opportunities that can arise in health-based settings to respond to and address domestic violence and abuse and thus highlights the importance of professional awareness around their role and responsibility to utilise and maximise these opportunities to address domestic violence and abuse.

Visibility of domestic violence and abuse within health sector cultures. Professional interviews also highlighted that this basic awareness among health professionals was a powerful tool in increasing willingness to disclose:

> I think it's just raising awareness of it really and people taking it seriously, because sadly people don't take it seriously and it's not seen as, and I think especially for individuals who haven't experienced it themselves. So, it's something that they probably can't seem to get their head around or understand the extent and the seriousness of it and the fact that you know, people are dying as a result of domestic abuse… I think it's more just around raising the profile really of domestic abuse and the seriousness of it. (P31)
>
> And we're not suggesting it that after one hour they'll be experts in the matter but I think some awareness is better than ignorance really. (P21)

This awareness was generated not just by training, but also by the needs assessment that accompanied the introduction of Health Pathfinder, and the component of Health Pathfinder that included technical assistance in improving data collection and evidence gathering. Stressing that each of these components worked together to improve awareness, interviewees observed that this awareness creates an environment where open conversations about domestic violence and abuse become more common and part of the culture of an NHS trust or practice:

> So, it just really helped to be a point of contact and put a face to a service, and just be physically present there, we hope, that would encourage people to come over and talk to us and um, make talking about domestic abuse more open. (P29)

The organisational and community contexts shaped how the awareness-generating mechanism worked in each site, with some sites already having done much of the awareness-raising work among health professionals and patients (via campaigns and posters), and this being a core component of Pathfinder in others. However, across sites, awareness in respect of staff experiences of domestic violence and abuse was brought to the fore by Health Pathfinder and by the corresponding needs assessments and evidence gathering.

Even still, while formal training of health professionals contributes to generating awareness, most interviewees stressed the importance of co-location in creating and 'putting a face' to this change. Interviewees across all of the sites with co-located IDVAs felt that the physical presence of an IDVA was a talking point in itself which raised awareness across the trust, even if the IDVA was only co-located part-time:

> I think when you're physically present there, erm, then they're more like to think oh yeah this is something I can discuss with [IDVA] because I know she'll be in today. And they don't wait for me to come in anymore as well, like during the week they'll keep sending me emails saying I've just done an assessment. You know, I just want some advice around this client that I'm working with, can I give you a call? So, they're not waiting for me to come in it's done straightaway. (P28)

> And he even said that having me there kept the conversations of domestic abuse alive, because just by seeing me, people were triggered to think about domestic abuse and think about the cases they had. So that led to like more enquiries even when I'm not physically present there, which is what we had before… But it, I do think that the responsibility still does lie with literally having to physically be present. (P29)

Visibility of services. Therefore, the inclusion of a domestic violence and abuse specialist as a visible part of the health team was felt to be very important for generating (and maintaining) awareness of domestic violence and abuse in the local culture. As discussed in the next chapter as well, this visibility, and the attendant logistics of attaining that visibility, were important to smooth implementation of Health Pathfinder.

The integration of domestic violence and abuse specialists into health settings from organisations outside health was not, however, without challenges. Interviews highlighted how important visibility was to generating awareness, yet several services reported difficulties being 'noticed' within health settings due to lack of space:

> The logistics of the office means that I'm in a room at the end of the hallway, so in that situation, like people don't know I'm there and they don't physically see me, and I'm just in this room. So, I like to leave the door open and do as much as I can but it's so different to sitting in the team. (P29)

> I should say one other aspect that has been very difficult for us to manage is we have no other, we are in one room and we have no breakaway space at all. (P11)

> I come in and they have to find a desk space for me because, you know they're a big service that was running out of desks. I think they had me set up like somewhere so I was sitting with the admin team. Initially no one used to come and speak to me and I think emails were sent around reminding them that I am there for the day, and yeah no one was really kind of approaching or asking me questions. (P28)

Most IDVAs interviewed described other strategies they used to try and become more visible in order to generate awareness of their service, such as attending team meetings:

> Some team meetings have safeguarding discussions where…they bring up cases, where there are safeguarding concerns. So, our role in those meetings, was just to make sure that where there were safeguarding concerns and if there was domestic abuse data, we were able to input with our knowledge and expertise around sort of sending advice or how we could support that client, what more could be considered, sort of the questions to ask, to explore the risk a little bit more (P29)

Additionally, other practical issues inhibited the generation of 'visibility' around domestic violence and abuse: interviewees from most co-located sites highlighted challenges in relation to honorary contracts, access to health records, internet access and having an NHS email, all considered essential for generating the trust and buy-in between professionals that sits hand-in-hand with the visibility and integration of health and domestic violence and abuse services:

> I was allowed for example, even though I didn't get an honorary contract, I was allowed to sit within the team, but not having access to certain things because of the confidentiality. Even after the honorary contract came through, I don't still access to NHS email or any of their care notes. So, I rely on professionals there, asking them um to share certain information with me, because I don't, I still don't have access, although I should have had the access. (P30)

> And I think one of the issues, and it might sound silly but it's like technical things about logging into their network and everything is so highly secure nowadays. You can't log into any systems, or you know we take our equipment with us but I have to use my mobile phone data to login because I can't connect to their network. And I think it's those small things where the practical things can be quite sort of annoying, I think when it comes to the time to sort of embed. (P28)

The generation of awareness through presence and visibility creates the foundations for the downstream mechanisms of expertise, relationship and empowerment generation. For example, the presence and visibility of the IDVA or Advocate Educator not only generated basic awareness, but also provided health professionals with the security to identify domestic violence and abuse in their everyday practice, leading to an increase in referrals. Their visibility acted as a constant reminder of domestic violence and abuse to health professionals and was seen as a mechanism to increase referrals.

> Having the workers available, talking to them so having the flexibility of being the point of, having the point of contact to them to physically have help, instead of just finding information, so it's been very handy in that perspective having someone there you can just quickly go over and speak to them and call them and get advice. (P24)

> Our presence would be there, and um professionals will know that we are there. They will know where we sit, they will know where to come. (P3)

Awareness creating windows of opportunity. Professional interviewees from all sites acknowledged how increased awareness helped create the windows of opportunity highlighted as so important by victim-survivor accounts:

> The biggest benefit working in the hospital is often that's the only time the victim may be left alone by the perpetrator. Like if they're kept overnight, then they've got time to think, they can talk to the IDVA because the IDVA is onsite most of the time… the main difference is having qualified workers accessible to that support where needed. Because I do believe that a window of opportunity opened. (P14)
>
> Obviously, you know having someone on site, you know that delay in contacting a victim you know can be, make a huge difference between whether that person wants to engage or not. (P16)
>
> What we do know is that the referrals wouldn't have happened in many instances had the IDVA not been, you know, present with… in the co-locations when the client has come in to see her mental health worker for a different reason, or not been at the team meetings or safeguarding meetings where they can engender a referral. (P17)

Co-location creates visibility of domestic violence and abuse within health that enables patient-survivors to get in-time, same-visit access to the service internally without the delay of waiting for a referral. But for this co-location to be valuable, it needed to be supported by understanding, awareness and evidence, all of which were driven by the range of components and roles in Health Pathfinder.

The majority of interviewees felt that the visibility of domestic violence and abuse within health and as a health issue also helped generate trust with the patient because domestic violence and abuse specialists were not perceived as from a different service, culminating in improved engagement:

> Actually, being able to tell them that there is a specialised service that can manage this that it doesn't have to be that they're, they don't have to tie it together you know, they're two interlinked but separate issues. That they can get support for both. (P2)
>
> Any referral you make to someone outside of the organisation, you can see sometimes people have to weigh that up as to whether they want to engage, even though they might engage very well with you in the setting, at that time. You know, a referral onto another is the decision people have to make, and I think having an IDVA on site, who can then actually say "Well actually I'm both Health and the Specialist Service" is really, is very smooth. (P15)
>
> So, I think for service users knowing that they can access services at one place, and not go to 10 different places, and that's hugely, hugely beneficial, because they don't, also it's beneficial that they don't need to repeat their story so many times as well. And in that way, you know, will be traumatised as well. (P3)

The awareness created through coordination, integration and data collection raised the profile of domestic violence and abuse, creating possibilities for more open conversations about domestic violence and abuse through the visibility and presence of a dedicated service and creating the conditions for success of co-location. Interviews highlighted the importance of the service being fully integrated as part of the health team, not an 'outsider' in order to generate awareness. The creation of awareness is the foundation for a broader cultural shift in perspective within health that encourages professionals to consider domestic violence and abuse their 'responsibility' and supports its inclusion on the health agenda at all levels:

> I think it’s just opened up the dialogue and the conversation a lot more across the Trust, so, you know, when you, when you don’t offer these types of things we all just, not ignore it, but we all just, you know, carry on business as usual. (P19)

3.4 Expertise Generation

Though awareness generation was foundational to the effectiveness of Health Pathfinder, expertise generation was the mechanism that was most apparent to interviewees, and particularly to professionals. Expertise generation was also the mechanisms that was most closely linked to the stated activities of Health Pathfinder. Confident, sensitive and safe enquiry about domestic violence and abuse by health professionals requires a level of expertise that Health Pathfinder generated through formal training, informal training (coaching) and co-location. Importantly, expertise was generated through the multi-directional transfer of knowledge between subject-matter experts such as IDVAs and health professionals (i.e., up and down the chain as well as out to other health professionals). This expertise was made ‘necessary’ by the awareness of domestic violence and abuse that Health Pathfinder created.

The value of knowledgeable health professionals. Victim-survivors considered professional knowledge, skills and understanding to be crucial when it came to recognising domestic violence and abuse and facilitating safe enquiry, signposting and referrals.

When asked how professionals could facilitate disclosure, victim-survivors consistently described interpersonal and communication skills as essential in making them feel comfortable enough to disclose. Victim-survivors emphasised the importance of professionals’ behaviour and attitude in routine appointments, particularly when they had previous negative experiences of health:

> I didn’t like him, I didn’t go again. I told him I didn’t want to see him again, he was... er he was abrupt. (S4)

Another victim-survivor recalled a time where a health visitor witnessed verbal abuse from the perpetrator; disclosing that although a follow up phone call was conducted to ensure safety, the health visitor did not facilitate safe enquiry (due to presence of the perpetrator), or signpost to specialist services:

> Because the health visitor came round a few times and I think I'd have felt comfortable speaking to her but he was always present. (S11)

Moreover, a number of victim-survivors advised that referrals to mental health services, or provision of mental health treatment alone without regard to experience of domestic violence and abuse, validated and perpetuated victim-survivor self-blame:

> Just cos someone’s depressed it might be deeper than that. It’s not always, ‘Oh you’ve got depression. Shove tablets down your throat. You’ll be fine’. (S8)

In one interview, a victim-survivor noted being ‘told off’ for being late to the appointment; although she indicated a readiness to disclose, she wondered whether this could have been different:

> If she didn’t open this whole appointment like this I would have felt so much better. (S1)

Therefore, implied and expressed power dynamics—which, almost by definition, work along lines of structural oppression and marginalisation—and victim-survivors’ feelings of being reprimanded or inferior could mirror a victim-survivors’ experience of the abusive relationship. This could put victim-survivors off disclosing, and represents a way in which existing health responses to domestic violence and abuse exacerbate health inequities, including in women who experience multiple forms of oppression

This was felt especially acutely by victim-survivors who were earlier in the journey to disclosure and seeking help, or who had mistrust in professionals. Indeed, victim-survivors who felt that they trusted the professionals and were genuinely cared about, were more likely to disclose, highlighting the powerful impact interpersonal skills can have in encouraging disclosure amongst victim-survivors:

> Because I felt comfortable sitting with him and speaking to him… You can sort of open up to that person and say what's going on. (S10)

This highlights the importance of generating expertise among all professionals to recognise and identify victim-survivors, in order to facilitate safe enquiry, prompt disclosure and ultimately refer onto specialist support for victim-survivors. This expertise was factual (the nature and prevalence of domestic violence and abuse), professional (shaped by clinical expertise in diagnosis and history-taking) and relational (characterised by an empathy and ethic of care towards victim-survivors).

This professional and relational expertise was particularly evident in the experiences of victim-survivors who were identified in mental health contexts. Victim-survivors who were referred from mental health services expressed that having the opportunity to talk more in depth about their lives and relationships indicated the need for specialist support and ultimately led mental health professionals to signpost and refer to a domestic violence and abuse service:

> So, erm, yeah, I talked to [mental health provider] a lot, and she decided that yeah, I needed some… more support around that… you know, with the domestic abuse and things, because… I think sometimes as well you don’t realise it is just that, you know? And erm, so she was the one who rang. (S7)

In this representative case, although this victim-survivor’s experience of domestic violence and abuse was not identified upon initial presentation with mental health symptoms, domestic violence and abuse was revealed later in the victim-survivor’s journey, highlighting the importance of upskilling all professionals to identify victim-survivors as they encounter a range of health services.

In concordance with victim-survivors’ views, health professionals understood generating expertise as central to the effectiveness of Health Pathfinder. The Health Pathfinder intervention logic model identifies ‘greater awareness’ and ‘greater confidence’ of health professionals as one of the key intended mechanisms of the intervention by upskilling and providing a basic level of knowledge and expertise to health professionals. While generating awareness was still the first and foundational mechanism, it was generating expertise that was most obvious to professionals interviewed:

> I think that a lot of... Pathfinder is about trauma informing and educating health professionals. (P14)

There are several intervention components that interviewees highlighted as central to generating expertise and knowledge: formal training, informal training (coaching) and co-location. Furthermore, expertise generation was not a one-way transferral of knowledge from domestic abuse experts to health professionals, and knowledge was shared multi-directionally between health professionals and intervention partners. For example, health professionals were also noted to transfer knowledge both horizontally, to peer professionals, and vertically, both to direct reports and to higher levels of management. The intervention also worked to generate expertise among domestic abuse professionals through coordination and colocation of services, whereby health professionals transferred health knowledge and expertise to IDVAs and Advocate Educators.

Formal training. The delivery of the formal training component of the intervention unfolded differently across all the sites, fitting into the organisational contexts, what training already existed, and the local NHS policies about what training is or is not mandatory for health professionals. For example, a couple of sites felt that they already had effective training models in place, and therefore either didn't see value in the training component, or decided not to take it up:

> INT: Is there anything that hasn't been valuable as part of it to you, or hasn't made that much of a difference?
>
> RES: Um, probably the, the training, because we already had that in place. (P11)

This was both in respect of the offer of training and of the offer to expand capacity to provide training across NHS sites:

> We're planning to do a Train the Trainer internally ourselves. So, there was an offer from one of those organisations to do a Train the Trainer… and we decided not to take that up because we kind of knew what we thought we needed… erm, there was enough of us to do that, so we're going to do a Train the Trainer for all the network members… and so you know part of their role is to train in their area. (P13)

The formal training delivered by Health Pathfinder was given enhanced credibility in around half of the sites where it was delivered by a perceived 'expert' such as an IDVA. Several interviewees felt it was important that it was delivered by a specialist, rather than a 'train the trainer' model:

> *Yeah, absolutely and you know, the advantage of having experts in the room is that you know they really know what they're talking about, that is their bread and butter, it might come up for us every so often but it's not something that we specialise in. (P2)*

However, a couple of sites felt the train the trainer model was a sustainable way of delivering the training across a large trust:

> I know that the train the trainer training has been really well evaluated, the delegates that did that training found it really quite useful and they feel now quite empowered to be able to deliver that across the organisation so we're going to be having a sort of some events going on across the organisation where they're going to be delivering that to their teams. (P19)

There were also specific elements of the training that were highlighted as particularly useful: for example, half the sites mentioned the importance of the MARAC training, and a couple of interviewees highlighted the value of understanding the stages of change for their practice. The MARAC training was particularly mentioned by around a quarter of interviewees as directly linked to an increase in identification and referrals:

> I think the MARAC training was really relevant, we have a lot of referrals into MARAC, or we have a good proportion of referrals into MARAC so I think that was really useful for our champions to truly understand what that means when you're referring someone to MARAC and understand the workings of that and what the expectations will be when you've done MARAC or you've done a MARAC referral and what the expectations of the staff members are. (P19)

The majority of interviewees expressed the importance of mandatory domestic violence and abuse training for health professionals as a means of generating expertise:

> That would be a good idea to make it mandatory and I know that the educational person that I was talking to also agreed that it, ideally it would be better off if it was mandatory, that if people did have to go to it. (P25)

However, despite the support and consensus on the need for mandatory training, all professionals interviewed recognised that domestic violence and abuse training competes with many other issues for mandatory status. Thus, interviewees strongly and consistently expressed the view that the Health Pathfinder training needed to be more compressed due to time pressures and workloads of health professionals which limited capacity to attend training:

> I know the one thing is the training aspect, people being able to take time away from certain roles, because on a ward it’s very difficult to be able to always commit to your training that you’re having. (P25)

> Yeah, so, so I was probably a bit reluctant to expand the training beyond that one hour, because we, I had got the Exec Team to agree that all clinical staff were gonna have this one hour domestic abuse training, and err by the time I left last April it was about probably eighty per cent of all clinical staff, had had domestic abuse training. (P15)

> So we are planning and putting together, if you like, training that’s just an hour long, but you take it to a team and do it over handover or lunch time… so kind of team, just going to the teams because we’re so under resourced now it’s really hard to get to any training. (P13)

These findings are also discussed in relation to implementation of Health Pathfinder in the subsequent chapter.

Informal training. In addition to formal training, interviewees described how the co-location of IDVAs and Advocate Educators made a significant contribution to expertise generation. While some IDVAs and Advocate Educators were involved in formal training, most interviewees highlighted that informal coaching-style training occurred as a result of the IDVAs and Advocate Educators working *alongside* health professionals. The informal learning that takes place as a result of informal conversations, combined with raised awareness as a result of the IDVA’s everyday visibility, was regarded as incredibly valuable in upskilling health professionals. IDVAs and Advocate Educators were coaching health professionals step-by-step through cases, meaning they had the opportunity to learn by doing with the support of the IDVA or Advocate Educator. Around half of the professionals interviewed regarded this as more beneficial than formal training, because it was tailored to the scenario at hand.

> I’ve learnt more from what she’s done, and sometimes it’s that individual, where there’s been people who haven’t given consent to see [IDVA], she has had to train that individual up, she’s sort of had to wait there for an hour, and they’d go in and talk to the person themselves and then come back for some advice from [IDVA]… it’s coaching if you like really.(P11)

> She’ll try and put training around every intervention if you know what I mean? So, a ward calls her, they think this is going on, can she come, go onto the ward round and taking that opportunity to bring resources, do a bit of teaching, show people how to do a MARAC referral. (P13)

> Because I think also with training, every case is so, so different and training can be quite sort of general… and it's, you know impossible to cover every single scenario but I think… Because I

> think that's what's helped because it is very tailored, it is very individual, case to case, or even the advice and consultation is very different to professionals. (P28)
>
> But we haven't done kind of like specialist DV training with them or I haven't, myself did it with them. But I think most of it has been the kind of face-to-face consultations and I think I used that time to speak to them about like the dynamics of like abuse and I think just raising awareness in those situations…so yeah, I think it's been more like on one to one rather than like a group, group training. (P28)

Around a quarter of professionals highlighted that they felt successful informal coaching also created a level of trust between domestic abuse services and health professionals which gave those professionals the opportunity to become more independent in enquiring, referring and supporting around domestic violence and abuse, as well as encouraging joint working:

> I found that as soon as I worked with somebody on a case together, like if we jointly supported a client and so then they were familiar with who I am and the sort of support that we can find, how we can work together, then it, that continued to develop, and we continued to work together more frequently. (P29)

Colocation also generated expertise in a range of directions: between health professionals, domestic violence and abuse coordinators, and IDVAs and Advocate Educators. Several IDVAs and Advocate Educators underscored the value of this bidirectional, symbiotic expertise generation, resulting in improvements in IDVAs and Advocate Educators' own practice. This was particularly the case in relation to mental health settings:

> It was a total maze to me, mental health services, and by the way it was also a total maze to some of the people who worked in mental health services. So, what I… I understood the need for… I've understood more where our clients present at different stages of their journey. (P17)
>
> Mental health professionals are then able to also help the domestic abuse service, you know, and, and provide them with a bit of training as well. (P25)
>
> I thought that really, I'm there to sort of benefit them and I won't benefit much from it. But sitting with them has been eye opening because I think it's just having, or like being open to them about my cases and talking to them about certain things, about the way like clients respond to things and getting their sort of consultations as well. So, I went in thinking like okay I can be extra here, I'm here to sort of give the advice and they will come and see me but I've actually been using the space to improve my understanding as well of like how people are impacted and how I can work better with them. (P28)

This greater expertise acquired by domestic violence and abuse services reflects a pathway created by Health Pathfinder to reduced health inequities, in that domestic violence and abuse services were made more responsive to the needs of women with complex needs including mental health services.

Interviews with professionals involved with the intervention considered the upskilling of health professionals as one of the main successes of Health Pathfinder:

> But certainly, my understanding of the biggest impact that I've seen that Pathfinder has was really in the training. (P16)

This training, importantly, included not just factual aspects of domestic violence and abuse, but a range of topics relevant to meeting the needs of victim-survivors that have been historically marginalised by health system domestic violence and abuse responses, including women of Black and minority ethnic background, women with disabilities, and women who identify as LGBT.

Most interviewees placed significant value on the informal learning opportunities that were created by co-location and coordination for upskilling health professionals (and IDVAs). Therefore, it is combination of a time-sensitive formal training offer *and* the learning opportunities created by co-location and coordination which facilitate the generation of domestic violence and abuse knowledge and expertise within health settings:

> So actually, upskilling our practitioners to be able to identify symptoms but also having the support of people who're specialised in the subject is, is, well it works a lot better to be fair if there were more people involved and they have a sensitivity that we might not be able to demonstrate in practice. (P2)

This specialism was both on the part of co-located IDVAs and Advocate Educators and on the part of champions and coordinators, whose role was to generate knowledge and expertise, including through informal means, at a range of levels in trusts and other health sites, such as primary care.

3.5 Relationship Generation

Effective working relationships between colleagues and between partners were central to the effectiveness of Health Pathfinder. Though these relationships came into play at a later stage of the process after expertise and awareness, these were essential preconditions. Several sites benefited from strong pre-existing relationships; in other sites, these relationships were built up over the course of the intervention. Relationships generated and strengthened by Health Pathfinder were multifaceted, and manifested in a range of ways, including coordination-led spearheading; strategic networks; as passionate leadership and communication; and as buy-in across all levels, from senior management to frontline staff. While victim-survivors rarely discussed explicitly the value of professional relationships, their accounts of successful and unsuccessful encounters with health services pointed to the ways in which relationship generation improves the experience of these victim-survivors.

Pre-existing relationships. Pre-existing relationships between delivery partners played an important role in terms of the extent to which Pathfinder generated relationships between the delivery partners in the sites. Some sites had benefited from years of partnership working between the organisations involved in Pathfinder, and already had mutual understandings and agreement on roles and distribution of responsibilities between the partners. In these sites, a foundation of good communication had been built over many years, and any initial misunderstandings or sources of conflict around governance and operations were resolved long before Pathfinder was implemented:

> Probably the one thing I haven't said, which I think has been really key, is that we've got incredibly good relationship with [domestic abuse service] and historically we've worked really, really well together. Um, and that's so important isn't it? It's just that personal relationship with an organisation is so, so important. (P12)

> Where we're slightly different with our organisation is that we have been running it in conjunction with the hospital for a number of years and have that built-up relationship and those pathways already existing… (P16)

> So, it was very, I know from speaking to colleagues, part of the um, not barriers but you know, in getting the programmes off the ground in other areas within England, it's been getting into

> the surgeries in the first place. Well I think part of our success is because we'd already got that relationship. (P3)
>
> And like I say, those sorts of things take years to develop… I think it relies a lot on characters, you know who have respect for the other party and understand what the other party is doing and how they work. But like I say I think we all know that it does, you know having good working relationships does take time to build up. (P16)

The value of coordination in forming relationships. Coordination, whether by a named postholder, a chair or a group, was inextricably linked to generating relationships. This was most evident in the counterfactual: in sites where relationships were not generated as successfully by the intervention, interviewees felt it would have been helpful to have formed a steering group earlier in the process in order to build the relationship infrastructure between partners and put working agreements in place. Interviewees in these sites, specifically with few historic relationships between partners, emphasised the value of coordination:

> I think probably there's a bit of disjointedness, and I don't think that's anyone's fault necessarily. How would I do it differently if I was …? If you were asking if you were setting up a service and you wanted a steering group, I think you probably would need to start at the beginning, finding a chair who had a good understanding of the different um, the different areas where the health IDVAs were in place, so that best practice could be shared, and challenges could be sort of worked on as a group. (P12)
>
> I think we were a good year into Pathfinder if not longer, before we said "We ought to have a sort of Steering Group". And that's partly, I think because there was money left in the pot and we said "we ought to all get together and look at how this is gonna be spent"…Yeah, I think it was, um and we probably should have had one earlier. (P15)
>
> And uh it would have been really beneficial for, for me, and to have like everything ready and prepared when we start. Not you know, say you start, and then everything is in a process, and you wait for contracts, you wait for this. So, it's felt like um yeah, we couldn't have been as productive as, you know, this project, because it's a pilot it should have been everything ready, set, go. And I feel like lots of time has been wasted, and yeah in that regard. (P30)

Relationships as strategic networks. The higher-level strategic relationships that were created as a result of Health Pathfinder in some sites were highlighted as an important source of funding and support. People were no longer 'lone wolves' in the health service, and the chorus of support across other agencies willing to work with them gave them a 'hook' on which to hang their funding requests. These strategic networks were also seen as key to sustaining any changes in the future, and creating new roles and alliances beyond Pathfinder:

> It's certainly opened the window for us in an area we, we probably wouldn't have gone to for lack of confidence, not, you know, sure how to use the resources. It certainly gave us something to hang our requests on. So rather than a service coming, we'd like to do something about domestic violence in your service, it allowed us to say this is a consortium of people were trying to do something … so it gave us something to hang our demand on. (P17)
>
> Until Pathfinder came in, I kind of felt a little bit like a lone wolf who was trying to take everything and do it, so now Pathfinder's come in, it's good. (P25)

> [We've been] making links across [the county] and now there's going to be a domestic abuse lead at the CCG, which there hasn't been up 'til now, so that's a big positive and making those links. (P11)

Relationships as leadership and communication. Interviews revealed that relationships were generated through strong leadership within the NHS and clear communication. Most interviewees acknowledged that a key factor in building successful relationships was the personalities of those individuals involved. Having a key, invested, tenacious and passionate person *within* health to drive the intervention forward and influence senior management was vital to shaping how the intervention generated partnership relationships:

> Yeah, without blowing my... no I supposed it wouldn't have been, it did require someone to sort of be passionate about it and tenacious and to get other people on board. (P15)

This was both with regard to successfully embedding domestic violence and abuse experts, whether IDVAs or Advocate Educators, within health services:

> Being within a team is being familiar, I think really helped the practitioners to know who you are, know what service you've come from and help to develop that during partnership working. It really did help, but then a lot of that encouragement did come from management I found. (P29)

But the value of this senior leadership was also strongly felt with regard to shepherding improvements in data collection and evidence gathering, which was a particularly challenging component of Health Pathfinder to implement:

> I have… I'm at a level of senior… a senior in a local authority where I can make decisions about IT and about data sharing and yes, sorry. The seniority did help. (P17)

Several health professionals highlighted the need for domestic violence and abuse services to work flexibly and understand the restrictive infrastructure of the NHS, as there is little room for compromise on their side given contextual pressures and stringent governance procedures. These restrictions applied equally to co-location, coordination and changes to IT necessary to support improved data collection. About half of health professionals interviewed emphasised the need for honesty, openness, compromise and diplomacy in communication between partners, especially given that there are likely to be some implementation issues with respect to new clinical ways of working:

> Generally speaking, I would probably say that we need to get our communication right, especially because in cases of domestic abuse things can happen quite quickly. So just keeping that communication open and informing each other of what's going on I think is of the essence, so I, but I don't actually know if that's a problem I think I just know that in general, it's generally a problem. (P2)

> Decent, relationships, relationships and respect… To be able to have those honest conversations as well when something is not working to adapt it or you know change it slightly without you know worrying that you're going to upset the other person. (P16)

These relationships were especially valuable in the process of change management that Health Pathfinder often ushered in. This respondent emphasised that flexibility was especially key in handling the structural changes, including to data collection, that Health Pathfinder ushered in:

> INT: What would you say is the most helpful thing that they can do to work alongside health services to improve that response?
>
> RES: Work flexibly. And... understand the pressures. So, they're very small, you know, generally, and if we change something here, if we're changing it for nine thousand something people…And we can't do that overnight and there are governance processes, that we have to go through correctly, that is the right thing to do…and they don't have appreciation of that, and they lack patience. And understanding and flexibility. (P11)

Relationships built on trust. An underlying factor frequently highlighted by interviewees as shaping the generation of working relationships was trust between partners, something most interviewees felt needed to be built over time. Specifically, information sharing was raised as an issue in relation to trust in many of the sites, particularly if the co-located IDVA or Advocate Educator was external to the NHS:

> It felt like, to be able to have communication with mental health professionals, and them know that I'm internal, I think that makes a difference. Because I think they can be very um, I found it challenging being internal, so I can't even, you know, can't really imagine what it's like for somebody that's external trying to, trying to get some joint working with professionals. (P4)
>
> If they have an, an NHS email, it shows staff that they're part of the Trust and that they can be trusted. Because there is, you know, they worry about sharing information otherwise. (P11)

The continued, physical and visible presence of a co-located IDVA was a way in which trust was built to generate good partnership relationships, something the IDVAs themselves all described as an everyday process of interacting with health professionals to generate trust on the front line:

> [They would think] "so that really helped so I'll come again and speak to you about another case". So, I think being there physically helped to build that relationship (P28)

Relationships leading to domestic violence and abuse as shared responsibility and buy-in across levels. Many interviewees felt that where relationships were successfully generated through the delivery of Health Pathfinder components, this created a shared sense of multi-agency responsibility and ownership for domestic violence and abuse. In many sites, professionals were able to provide diverse examples where good relationships and shared responsibility had led to joint working of cases, capitalising on those windows of opportunity to provide support. Ultimately, professionals' accounts demonstrated how generating relationships that create true and equal partnership working can lead to improved levels of support for victim-survivors:

> I know that there's a sense of relief that this can be shared, that there, that there's somebody picking it up. (P2)
>
> So, a lot of sort of the…support that I would provide directly to the client, I'm actually providing *through* the Care Coordinator, so advising the Care Coordinator like, you know, tell the client to report to the police, if there are options, or tell the client, if the client was to get non-molestation… because you know, that those pockets of engagement are so sporadic, you don't know when you're gonna get them or what sort of position the client's gonna be in, and you really wanna ensure that you're, in those moments, being able to give the client all the information and advice that they can get, so. (P29)

> And we've done some work together where the people from [domestic abuse service] have come to the sessions, they've got involved with us, we've been able to do risk assessments and care plans together all three of us and, and it's worked so well. (P25)

Around half of the sites pointed out that senior management in the NHS were invested, which helped shape the quality of the relationships generated with the domestic violence and abuse service:

> And we're very fortunate that our Trust has always been quite committed to safeguarding and domestic abuse, and all the features within that. We're very fortunate in that. (P12)
>
> And really one of the consultant psychiatrists there… was really keen for her to come as the manager, so [the IDVA] was coming into a place that senior, two senior people really wanted her. (P13)

However, as discussed when illustrating the significant contextual factors around the intervention, shared responsibility for domestic violence and abuse can sometimes be absent at a senior level within the NHS:

> There was quite a lot of politics really. So, the trust in particular want to see… directors of safeguarding, and she I think maybe didn't see the, the point or the need for the CCG project, domestic abuse project lead post. She didn't really. (P10)
>
> There is some ignorance out there, at the top of the NHS, so one person that I spoke to sent me an email with a link to Refuge, which says they're open twenty-four hours a day and they will provide accommodation, and so therefore, we don't need an IDVA. (P11)

A health system response that culminates in 'we don't need an IDVA', as reported by this professional, is unlikely to be a health system where domestic violence and abuse is viewed as a core priority in addressing health inequities experienced by women; it is also unlikely to be a health system where the needs of women who experience additional forms of oppression are likely to be taken seriously.

While around half of health professionals interviewed highlighted current or previous resistance at a senior management level, interviews with domestic abuse services highlighted examples of where front-line staff resistance to changes impacted on the quality of the relationships generated. Interviews suggested that the onus is on the domestic violence and abuse service to build the relationships with health rather than the other way around:

> It wasn't easy. There was initially a reluctance and a resistance because of the possible change, also because many of the services we were pushing didn't, didn't necessarily know us… so there was… for example, when we started [in the team]… referrals were slow. There was, you know, it did take a lot of effort to build the relationship and once you built it with one person it started to flow from there. (P17)
>
> You can see the frustrations in some…you know fed up of it and I had one psychologist who said to me like, you know, I think she got quite annoyed with our service and she said, oh I feel like I'm doing your work. You know, why can't you guys focus on the safety but it's all embedded, like it is part of everyone's job. Like, you know I'm not sitting there like why am I doing therapeutic work with this client because, you know it's all... you can't separate, like you can't separate it. (P28)

One health professional also noted the difficulty of getting middle management, rather than senior management invested in the relationships:

> We’ve been doing this for about twelve months. It’s a very, very slow, making very slow progress. There is some resistance, cos we’re, we’re looking at change at a local level at the front door and that’s quite... that’s been quite a tough one. So, we have our seniors…on board but that kind of middle element is… it’s, it’s a job of work for me to do to bring others with me, to help them understand how we can help our survivors, victims, and their families in a much more efficient way, and that’s about risk reduction as well. (P17)

Therefore, building high quality relationships between intervention partners was shaped by the quality of relationships that pre-dated Pathfinder, and the buy-in or resistance to acceptance of domestic violence and abuse as a shared responsibility between all partners and across multiple levels. Interviewees highlighted the importance of leadership, communication and trust in generating high quality relationships at all levels. In particular, higher level strategic relationships were considered to be a potential lever in making the intervention sustainable.

Victim-survivors’ experiences and relationships between providers and partners. The majority of victim-survivors did not discuss or mention relationships between professionals improving their experiences or outcomes. Despite this lack of direct evidence, victim-survivors did discuss their experiences around disclosure and access to support, where it seemed that existing working relationships between health professionals and domestic violence and abuse services led to a quicker response and access to support. In this sense, the value of relationships between providers and partners is implicit as a ‘background’ factor to victim-survivors’ positive experiences. This was especially highlighted when they had been referred to a co-located IDVA or Advocate Educator, indicating that increased visibility of the IDVA or Advocate Educator facilitated the development of key working relationships and a shared responsibility of addressing domestic violence and abuse:

> Erm, so that's what I did and then the actual doctor rang me and said we've had this lady in, and she does this, this and this and I think you know you'd be really well to go and see her with everything that you're going through. And he made me an appointment with her and that was it, it went from there. (S10)

> And the doctor did it yeah, she said “I’m gonna put you in touch with somebody to speak to”. [The IDVA] phoned me and made an appointment to come, if I wouldn’t have had that... (S11)

These relationships were central to fast and decisive action to support safety when a victim-survivor was in crisis:

> I got referred erm via the mental health team and they were on the ball with it, they were quite quick, erm they got back to me very quickly and they did the assessment really quickly, erm so there was no like waiting round so that was quite good. (S16)

> IDVA came and met me at [an agreed location] and got me a place exactly the same day and I've been there ever since. (S17)

This was in contrast to no co-located services, where the specialist service was situated outside of the health setting and in the community. One victim-survivor advised they felt fearful of engaging, due to it being another service and not really understanding what they would do or how they would support her, whilst other victim-survivors advised that signposting alone, with no further information, put them off initially calling the service for support:

> Just I have to do it, I have to do it but then every time I'd pick up the phone I'd be like, I can't. (S9)

However, there was an example where one victim-survivor described evidence of partnership working, where there was no co-located IDVA or Advocate Educator:

> Yeah, so she rang [the IDVA] actually and erm … they … so quick, like told me what I needed to do, sent the email with the form to refer in, and erm … that … that my psychologist could help me fill that in... Obviously, it was hard coming to the house to talk to me... how they worked together was brilliant. So, [the IDVA] would come in and they would book a safe … you know, a room like this, and erm, they would … they would sit in and they would write notes for me … (S7)

Although this was a singular example, this demonstration of a person-centred, relationship-based approach appeared highly beneficial to the victim-survivor and increased their engagement with the IDVA. Additionally, there were victim-survivors who expressed their disappointment at simply being signposted to services, where there was a co-located IDVA:

> At first, I was just like, well, that was pointless. I've just geared myself up to come here … And then just be sent away with a load of numbers... I was like, well, I'm just phoning these numbers that I don't know what to say... And we had to talk to a stranger on the phone to say like, [quiet] oh I've been, you know, sexually abused... And I was like, just that daunting thinking that I'm going to have to tell a complete stranger... What if I'm judged, or what if they don't believe me, and…I was like, I don't want to do that but… My auntie was there and she phoned, so it was her that spoke to [the IDVA] first. And then I was passed over the phone when I'd calmed down a bit. (S9)

Consequently, although co-location can facilitate the development of those key working relationships, it does not completely guarantee this; nor is co-location unquestionably effective without the relationships co-location and coordination should cultivate. This reinforces the need to shape a whole-health response informed by coordination, clinical policies and evidence gathering to support the development of responsive services for victim-survivors. Victim-survivors described how these negative experiences of 'mere' signposting eroded trust in health services. This erosion of trust perpetuates health inequities along axes of oppression experienced by women, especially where victim-survivors have been let down by health services in the past.

Delays in receiving support, limited information about the service and signposting for self-referral could all impact on engagement with the specialist service. This emphasises the value in developing strong working relationships to promote multi-disciplinary working and shared responsibility to improve victim-survivor outcomes, regardless of co-location.

3.6 Empowerment Generation

Awareness and expertise are not enough; our analysis revealed that generating relationships led to generating empowerment, and that the generation of empowerment was a central mechanism for the effectiveness of Health Pathfinder. This empowerment was most keenly felt by victim-survivors in terms of the ways in which disclosure following enquiry was handled, with effective responses and confident referrals improving the victim-survivor experience, reducing the dehumanisation of having to disclose multiple times and supporting improved access to services with implications for health inequities. Professionals related that co-location of services, and the attendant relationships that co-location could cultivate, was important, but it was not enough. Clear and coherent policy and evidence foundations, generally driven by the work of domestic violence and abuse coordinators and steering groups, were critical to the empowerment of professionals to ask and act on disclosures of domestic abuse.

From expertise to empowerment. Victim-survivors highlighted the importance of professionals not only having the appropriate awareness, understanding and knowledge to recognise domestic violence and abuse but the ability for professionals to act, especially if they had willingly disclosed. Over half of the victim-survivors identified occasions in health-based settings where opportunities to conduct safe enquiry, signpost to specialist services or submit referrals had been overlooked. This is one way in which existing health system responses reinforce health inequities and erode trust in health services. Victim-survivors who presented with mental health recommended that professionals should feel empowered to questions about their relationships and home life, emphasising the acceptability of safe enquiry:

> Just making sure that if they do go to see their doctor and they're struggling with depression or whatever, just maybe probably ask a few more questions about relationships at home. (S4)

This ‘empowerment to enquire’ was reported by one victim-survivor, where attendance to primary care to acquire a sick note led to a referral to an Advocate Educator after enquiry prompted disclosure:

> Yeah, I think he sort of knew there was something not quite right, it wasn't just that I was wanting a sick note because I wasn't well. (S11)

Put otherwise, awareness and expertise to enquire are not enough; empowerment is essential as well. Sensitive questioning to establish any underlying causes of mental health presentation can provide more opportunities for disclosure, leading to earlier referral and thus engagement with domestic violence and abuse services, in addition to mental health services. This is especially important when considering persistent waiting lists to access mental health support or treatment. In relation to this, a few victim-survivors disclosed situations where they had reached a mental health crisis due to the trauma of domestic violence and abuse, because they had been consistently overlooked in health-based settings:

> And because of the relationship, I was very, very depressed ... tried to end my life once and nearly did it a second time. (S3)

Signposting to specialist services was recognised as helpful but only when combined with clear information about the service’s role and how they can help, ultimately providing reassurance about involvement of an additional service, especially considering the nature and impact of domestic violence and abuse and the inherent fear that victim-survivors can experience:

> I thought oh God, I thought the, they didn’t explain… she just said “I’m putting you through to somebody...” And I was panicking then I thought, that’s it now... I’m getting judged for things he’s done. (S11)

This fear may be especially experienced by victim-survivors who have low baseline trust in health services, particularly in situations and with respect to groups of women where health services have a pronounced history of structural and symbolic violence; for example, migrant women who may be in legally precarious situations. There is a clear role for training and clinical policies to engender this trust, to ensure that enquiry and referral following disclosure are sensitive to individual women’s circumstances, and thus to take positive action on health inequities

Professional referrals meant victim-survivors did not have to call the service themselves and repeat their story, which was important to victim-survivors due to the nature and impact of domestic violence and abuse preventing them from accessing specialist services:

> Because every single time I've spoken to somebody I've had to start again… repeating the whole story. (S12)

Therefore, victim-survivors wanted not only to be asked, but for something to be done about a disclosure. In this respect, Health Pathfinder appeared to empower professionals to ensure that disclosures were acted upon effectively.

Confident, professional and empowered enquiries. Interviews with professionals highlighted that the presence, visibility and awareness of the service, combined with knowledge and expertise from training and coaching, provided health professionals with the security not just to think about and identify domestic violence and abuse, but more importantly to act. Co-location means there was always an 'expert' on hand to seek advice from in the form of the IDVA or Advocate Educator, and most professional interviewees expressed how this empowered health professionals to enquire safely and sensitively. While several interviewees made clear the link between training and enquiry, most interviewees felt that health professionals need support beyond the formal training in *how* to ask patients about abuse. The informal coaching and presence of the IDVA or Advocate Educator as a form of support were central to this empowerment.

Some interviewees highlighted that knowledge of the signs of abuse could be harmful if health professionals were not empowered to act confidently and safely by knowing exactly *how* to respond to the answer:

> What I say to my staff, is that if you don't want to do something about the answer, don't ask the question. Because then you're setting someone up to fail. Worse, because the next time they won't disclose, because the person they disclosed to last time, ignored what they said… I would make sure that all my staff were um, absolutely confident about how to ask the key questions, and how to direct people to the most appropriate support. (P12)

Reflecting victim-survivors' comments, professionals noted that an empowered enquiry translates to one fewer time a victim-survivor needs to disclose, lessening the potential for dehumanisation of victim-survivors and decreasing the burden of health system-generated re-traumatisation of these victim-survivors:

> I think health care providers need to be empowered to be able to ask that question around, you know, domestic abuse, is someone, is someone hurting you, or are you scared of anyone, etc. … but the health care providers role is also to know how to respond to that… one of my big things is it's all very well to ask the question and feel confident to ask the question around domestic abuse but if you have nowhere to send that person, if you have no response for that, if you have no way to support them following that, it, it's not worth asking the question all. (P19)

> Like I said it's generally there's clumsiness sometimes you know… it's one thing to identify that somebody might be a victim of domestic abuse and then really knowing what to do with them once, once you've picked that up. So, it's been really nice to have the Pathfinder pilot trying to see, like sharing that, that responsibility with us really. (P2)

> I think that what we've probably seen is that people are, can perhaps accept about asking the question but then they're a bit worried about how do you deal with the response, depending

> on what someone’s said back to them in their, in their response… I think, certainly it is one of the areas that I’m looking at developing is a video to support other training but influenced by, you know, victims, survivors as well, and the charity to, to perhaps have some scenarios that they have of asking the question of somebody or a member of staff learning something of a patient and what do we do there, what do we say, you know, because I think people are sometimes a bit fearful. (P21)

Clear referral pathways and policies. Professional referral appeared to take place most often when referral pathways to the relevant domestic violence and abuse service were clear and effective, increasing the probability of a successful referral. This mostly appeared to happen when there was a co-located IDVA or Advocate Educator and a relationship had been developed. This meant that professionals knew of the presence of an expert on hand to help empower professionals to act. Victim-survivors talked about gratitude towards professionals who had referred them onto the service:

> So, I literally went in the other day and thanked him for referring me because I just said if you'd not done that for me, I'd have probably still been going through all this now and I don't know what I'd have done. (S10)

In mental health trusts in co-located sites, victim-survivors noted that they were referred sooner than they ordinarily would have been absent Health Pathfinder. Victim-survivors at an earlier stage of change advised that they were not looking to leave the relationship; however, the referral and access to specialist services meant that they now knew the service existed and where to get help and support:

> I’m not thinking of leaving my husband and stuff, so you know, so, erm, I see her like to talk about stuff. (S15)

> I know whichever way I go I’ve got that support that I need. (S7)

As a counterfactual, the effectiveness of victim-survivors’ self-referrals, in terms of leaving a relationship and achieving safety, appeared strongly linked in victim-survivor accounts to the victim-survivor’s own journey through readiness for change. In addition, the value of these contacts—even where a decision to leave the relationship was not taken—speaks to the additional impacts of Health Pathfinder on victim-survivors’ wellbeing.

Indeed, most professional interviewees highlighted that the relational context between delivery partners was strongly shaped by having clear referral processes and governance processes in place, providing unambiguous divisions in terms of roles and responsibilities of different practitioners. Where these were not already in place before the implementation of the service, the intervention did not function as efficiently:

> It was a very slow burner, like even to get... they've got like a, what do you call it, a one-click system for referral forms. It took several months before that went on and then they've asked for amendments and again it's still several months and it's not been amended. So, there's been huge delays, it's like there seems to be a lot of bureaucracy maybe. (P14)

> Well, I think things have to be, have to be informed about what they’re supposed to do when they refer the cases… there should be clearer information about that I believe… Yeah, so there are, so the sort of referral pathway including that data that’s needed. (P3)

Having clear referral processes and responsibilities in place was also considered to empower healthcare professionals to act. This is particularly the case where there was a co-located service physically present and visible:

> It means I think the staff are more confident at bringing something up… you know a hunch about something because somebody's there to talk to as opposed to now I have to make a referral to another service and making a referral is a whole process (laughs) and you're not sure about something, so having the person actually there and you don't need to make a referral, they're already there. (P13)
>
> And I think having the IDVA over there made a big difference to the confidence staff feel about… it's okay to be, to not go for that kind of belt and braces response, that they believe MARAC referral will be. (P15)

Health professionals were also empowered to act through having clear policy frameworks adopted by the trust. Development of these policies was most often the work of domestic violence and abuse coordinators or steering groups in intervention sites, and required a higher-level coordination function than could be achieved by co-location of services alone. Most Health Pathfinder sites did not adopt routine enquiry, instead adopting selective, targeted enquiry in most areas. However, it was clear that top-down, trust-wide policies in relation to enquiry were considered important contextual factors supporting consistent, safe enquiry:

> So, we have targeted questions for some professionals, but others, it, it works, its um like admission, in-patient admissions, people should be asking this of patients, so and giving them a chance to disclose. (P11)
>
> And um and then getting them to start asking around sort of… we weren't rigid about a routine enquiry, but there were certain areas, we said actually about Midwives and how um, err, sort of Pre-Operative Assessment Team, could pretty much ask everyone because they have that time and privacy to do that at some point in that patient's journey, but we recognise that Emergency Department it was very unrealistic to say "You should ask everybody about domestic abuse". So that was more sort of targeted clinical enquiry. (P15)
>
> I don't actually know whether people do always routinely enquire about domestic violence…very kind of important in kind of instilling that, you know, how important it is and, I think the Trust needs to continue to invest some time and effort into making sure future colleagues kind of understand about it as well. (P7)

Though professionals interviewed did not focus on this, it was clear from interviews that a key point of improvement arising from policy development was improved recognition and referral pathways for staff experiencing domestic violence and abuse. This was important for clinical sites to support their own staff who may themselves experience domestic violence and abuse. Inclusion of domestic violence and abuse and guidance in trust or practice policy supports the empowerment of health professionals to ask patients about domestic abuse, because the approach to enquiry is clear and validated from senior management. Together, policy foundations, training and coaching, clear referral processes, and the reassurance of the visible presence of a co-located IDVA or Advocate Educator leading to strong relationships, can cultivate health professionals who are not only aware and expert, but also empowered.

3.7 Evidence Generation

The final mechanism, evidence generation, came after awareness, expertise, empowerment and relationships. This is for several reasons: first, the ability to generate evidence was often the last mechanism to be unlocked by Health Pathfinder; second, this mechanism was the most unevenly evidenced across sites; and third, interviewees—professionals and victim-survivors alike—raised a number of questions about the relevance of evidence that an outputs-led and measurement-led approach would most directly suggest. It was the case in most sites that Health Pathfinder, even where it was unable to transform evidence generation, was able to highlight the need for better data capture and collection. An important way whereby this mechanism was 'set off' was via the technical assistance and practical support provided by Health Pathfinder to sites in the development and improvement of methods for data collection and evidence gathering and generation. However, we note here that while improving data collection methods was an important part of Health Pathfinder, our view of what constitutes 'evidence generation' is necessarily more expansive, including clinical and professional knowledge, evidence of effectiveness and breadth of impacts on victim-survivors, and the communication to professional peers of this knowledge and evidence.

The extent to which the data collection processes implemented as part of Pathfinder were able to generate evidence were highly context-specific, depending on existing processes, information sharing and records access, perceived needs for different types of data (e.g. recording enquiry, disclosure, referral and uptake of services vs equity-focused monitoring of victim-survivor characteristics) and approaches to the collection of these data, and the possibilities a particular site's infrastructure and resources presented. While poor existing systems created extra burden on services, it also began a process of improving those systems in some sites. IDVAs, Advocate Educators and victim-survivors alike argued that the evidence generated should focus on less readily quantifiable outcomes around victim-survivor confidence and emotional safety and should accurately represent the referrals and workload of health-based IDVAs and Advocate Educators. This is linked to the value of understanding impacts on victim-survivors beyond reductions in risk, as important as these reductions are to victim-survivors' safety.

Adoption and improvement of evidence generation. One of the intended mechanisms of the logic model was to create an evidence base from which future decisions about funding of services could be made; needs could be assessed; and reach could be monitored. These data are particularly important to support action on health inequities, either in access to the whole-health response or in onward referral by professionals and uptake of services by victim-survivors. The extent to which this mechanism was activated was variable across the sites. This variability was primarily characterised by the processes of data collection that pre-existed Health Pathfinder; the recognition at multiple levels, from senior management to clinician, of the points of sufficiency and insufficiency of these pre-existing systems; and the degree to which these two points combined to shape the Trust's capacity or willingness to adopt new systems where theirs was insufficient.

Most of the sites included an interview where a professional mentioned data collection, and the majority of these highlighted poor data capture systems in sites. In two sites, however, this did mean that action was taken to create better systems:

> I mean what's, what may have lacked is our kind of poor systems for collecting data… and how we extrapolate the data and how, you know so colleagues from [the consortium] or from possibly you guys, anyone who's wanted to kind of interface with any of our systems to get any data about benchmarking… how, it's really almost impossible… I think the senior management have utilised the fact we're doing the Pathfinder… and somebody who's just

> been appointed to really look at all of that and improve our systems. So, you know there's no-one I can kind of go to somehow and say can you pull out some of our incident forms. (P13)
>
> We've changed our… the good side of it is that the Insights, the data collection system used by Pathfinder, has helped us develop our [patient information system] to be more meaningful, to capture more data, which that, that would be the really good thing, but we've had an extra level of, um, bureaucracy in providing Pathfinders with the data. (P17)

In both cases, professionals held the technical assistance provided through Health Pathfinder in high regard, finding it relevant. It is also evident in these professionals' views that their sites' ability to engage with the evidence generation mechanism was supported by the preceding mechanisms, characterised by senior management support and close working relationships.

It is of note that one of these professionals commented on the 'bureaucracy' that reporting these data centrally created. Central data reporting serves several important functions, including national monitoring and quality improvement, though these may not be perceived by local sites. This was not, however, a universal view. One site included interviewees who felt they were able to easily generate the data needed:

> Yeah, we're kind of comparing to the [other] team, they have been having lots of difficulties in terms of collecting data, because they have different system. Our system we use, it allows us to kind of easily collect data. (P30)

A couple of interviewees, reflecting several sites, also felt that where the intervention implementation had highlighted suboptimal data capture systems, the demand to use other tools was too resource-intensive:

> It doesn't… it's not compatible with what Pathfinder wanted, and they've been brilliant so … when we went we had some training on it so there was an extra demand for us to use Insights. Now we thought we could…just carry over everything from Mosaic…and that hasn't happened. So, it is an extra burden on us. (P17)
>
> The data collection side of things was really challenging, because we have a system in the council that we use to sort of gather all our data, where we view all our casework on, but it's not a system that's been specifically made for us, as a domestic abuse service, it's a council-wide database and the reporting outcomes from that, I couldn't get, which was specific around like mental health, to like a demographic, and the referral numbers from certain teams and things so, I had to do quite a lot of that manually over a spreadsheet, like to like found the referral numbers. (P29)

Even where technical assistance, which was widely viewed as valuable, flagged the need for improvement, it may have been outwith the power of professionals involved in Health Pathfinder to create the necessary changes to data collection.

Another IDVA started a bespoke database to record the outcomes to satisfy both Pathfinder data collection needs and the IDVA's own requirements on measuring abuse and outcomes:

> I was wanting to have some form of recording database as well. So, I sort of combined the information that I wanted to keep with the information that they wanted, so that I'm not having to record different things in different places. So, I've just made one great big, one great big information database, and had that approved by the person in Safe Lives. So, it's collecting

> all of the information they want, you know, it's let me now see the outcomes and the types of different abuses. (P4)

Related to the issues around information sharing previously highlighted, one IDVA also raised concerns about the appropriateness of where data was recorded in their site, as the database for capturing data about a patient's domestic violence and abuse was within medical records:

> Personally, I feel as though there would needed to have been a completely separate database that perhaps only safeguarding, the safeguarding service could access, so that nobody else in the trust could access it. It just doesn't feel comfortable with so many people having open access to it and it forming part of a medical record. You know, it could be accessed by insurance and prospective employers. (P4)

In two sites, interviewees felt that the time period of the intervention was too short to generate sufficient evidence. In one of these sites, delivery of the intervention had been significantly delayed:

> From my perspective I don't think that we have long enough really to implement the intervention and then evaluate its impact to then be able to look at how we're going to take it forward, going forward really. (P21)

> I can't really give you anything to evidence change at this moment post-Pathfinder cause as I say in this, in this time period that we've been working with Pathfinder which is a relatively short cycle, it seemed very much about actually getting the infrastructure and the foundation right so that we, we can measure those things going forwards, so that we can quality assure against their best practice recommendations. I just don't think we're in that position at the moment. (P9)

Appropriateness and relevance of evidence generation. Three of the sites also highlighted that the types of evidence generated by the intervention did not accurately capture or measure the work of domestic violence and abuse services or the softer outcomes for victim-survivors.

Many interviewees felt that often victim-survivors identified within healthcare settings are more likely to be at an earlier point in readiness to leave a relationship or take up services, and may present with additional complex needs. In particular, IDVAs voiced their frustration that evidence of their work was not accurately captured through the data collection processes of the intervention:

> And because of the way that I've had to end up taking referrals in domestic violence internally, I'm not sure if in terms of quantitative data what you would find from that. I'm not sure it would look as though there's been a huge impact. It's probably more the qualitative that would demonstrate more. (P4)

> I mean we'll hear from sort of top management that you're saying you're very busy, you're overwhelmed, and, you know, but your stats, you know don't show all these outcomes. And because with a lot of the clients that we work with actually a lot of them are not at that stage where they want to move and they want to take this ... it's such a long process. Sometimes they can be with the service for a year and all you're doing is talking to them and empowering them. And those are the things that are not being recognised or acknowledged or captured. (P28)

Both of these views reflect that the positive effects of Health Pathfinder may not be readily quantifiable in terms of increased disclosures; but rather, in wider access, improved wellbeing and greater readiness to take up services for victim-survivors, and for health services, in greater system readiness and responsiveness to the needs of victim-survivors. All of these are important outcomes that are of central relevance to taking action on health inequities. As one professional described, the amount of supporting and consulting work, particularly for victim-survivors with complex needs, was not readily captured by data collection systems:

> It would have been good if we were able to also look at, cos that's only looking at the number of referrals we receive from mental health teams. It's not looking at the whole number of clients we support, who are not with mental health but not necessarily from a mental health team. It's not entirely representative of the number of clients we support, with a mental health support need… [With some cases] I've done a lot of work, working directly with the care coordinators, or managed to see a client once, like that might have taken ages, and taken a lot of time. Or you might be doing a lot of work behind the scenes, that doesn't necessarily get caught on these systems. So, a way forward, might be actually to record the amount of time you spend, on calls, or through how many consultations and things like that, that might help to record how much work you do. (P29)

In our impact evaluation, we acknowledge this work as key outputs and contacts that go beyond specific IDVA or Advocate Educator cases recorded.

In support of these findings, many victim-survivors highlighted the importance of the IDVA or Advocate Educator's role in improving their emotional wellbeing; providing information, advice and tools to increase their confidence, autonomy, empowerment and self-esteem.

> Probably I would still be depressed and stuff but with her, and her assistance, erm, I felt so much safer and, er, better and, erm more confident that I can make it without hi'. (S1)

> Yeah, and just someone to talk to on the end of the phone is a massive thing as well. Erm, because I could be going into panic mode one minute, and then, as long as I've got someone to speak to, and just reassure me that I'm doing the right thing and it's all going to be okay, I come off the phone in a completely different mood and I'm strong again. (S10)

Victim-survivors presenting at an earlier stage of change pointed out that although domestic violence and abuse service involvement did not result in leaving the relationship, the support and help they received was beneficial and generated improved trust in health services. One spoke about the importance of having the space to discuss different options, as this was fundamental in helping them to increase their confidence and self-belief, ultimately empowering them to make decisions that were right for them, whereas another indicated that the IDVA provided all the right support, information and access to other groups but the victim-survivor was simply not ready to take this up.

> And knowing I could ask questions with [the IDVA] and … because you really don't know what… other than… to me it was either you stay or you leave, which isn't always the easy thing… you know, so you won't know all your options and different things… It's given me the confidence to say you know, I deserve better… It's not just about your safety and things, another thing is… is confidence and that, and to believe in yourself. (S7)

> I have my emails and message that she has text, she has sent the link but you know, I have to be honest, I haven't attended any of them. It's not her fault… giving you information about what's out there, it's up to me if I, if I go or not, yeah, yeah. Yeah, like it's not their fault, I think they're doing their job perfect I would say. (S15)

Therefore, in addition to quantifiable outputs and outcomes, evidence around process and victim-survivor experience would have more accurately captured the range of impacts on victim-survivors.

This supports the findings from the professional interviews, indicating that the evidence generated could be adapted, expanded or improved to recognise and acknowledge that the IDVA and Advocate Educator role encompasses more than practical, quantifiable outcomes. It also highlights the importance of generating an evidence base which accurately reflects how the IDVA or Advocate Educator role is person-centred in its approach, meeting individual victim-survivors' needs based upon their individual context.

Victim-survivors value evidence generation. All of the victim-survivors interviewed communicated value in the service they had received, emphasising how beneficial and worthwhile the support had been in addressing domestic violence and abuse and helping them to change their lives:

> It was amazing, this help it was just amazing. (S1)
>
> So, she's helped me sort of change my life really. (S10)
>
> Yes, she was absolutely brilliant, she was absolutely fantastic, she really was. She really was, like I say she saved my life. (S17)

Some victim-survivors pointed out that without access to the service through health they would not have received the important help they needed, emphasising the essential role that a whole health response can play in supporting action on health inequities by increasing access to help:

> Yeah, because if I hadn't of spoke to her about it, she wouldn't have told me about this place and stuff. (S4)
>
> It was really to the GP that kind of helped me find my way. (S6)

In addition, some victim-survivors indicated that more could be done to improve health responses:

> More training definitely needs to be given the doctors and … professionals and stuff like that. (S9)
>
> Everyone should have training. (S12)

Victim-survivors acknowledged that evidence was needed in order to sustain these specialist domestic violence and abuse services, recognising that services were mostly charity based and reliant on funding:

> They should be supported by government and they should be having lots of money for them to do their work from government, this is my point of view. But it's all down to money. (S3)
>
> There's a big thing with funding. And… and that, you know, believe it or not, that… that's a worry to people like me who depend on services on a daily basis, because you panic that one day what would you do if they weren't … you know? (S7)
>
> Erm but I do think there's... there's... there's more that can be done, a lot more. (S3)

3.8 Health Pathfinder roles and change mechanisms

As we noted at the start of this chapter, one of the ways in which victim-survivors most directly experienced the effectiveness of Health Pathfinder was via more, more effective and more timely contacts between victim-survivors and health professionals in relation to domestic violence and abuse, leading to an improved referral pathway to domestic violence and abuse services. We also noted ways in which these mechanisms might serve to address health inequities experienced by women and particularly women who experience marginalisation by health services. We stressed that because Health Pathfinder is an ecological intervention, requiring multiple roles and multiple functions over multiple levels, the intervention's effectiveness cannot be reduced to a single component. To further illustrate this, we turn our attention to how three key roles in Health Pathfinder relate to the mechanisms just presented.

3.8.1 Senior management teams

The role of senior management teams in the mechanisms by which Health Pathfinder was effective was most directly evidenced in the context of **relationship generation**, where these teams' cultivation of relationships as strategic networks and ensuring buy-in across all levels was critical to the cultural change that empowerment generation created. However, leadership by senior management was central to unlocking the preceding mechanisms:

- Senior management sign-off and 'centring' of domestic violence and abuse as a trust priority were both part and precondition of **awareness generation**.
- Relatedly, prioritisation by senior management of the key activities linked with **expertise generation**—including the value of domestic violence and abuse training—were central to the perceived relevance of this part of the Health Pathfinder offer.

Leadership by senior management was also central to the succeeding mechanisms:

- Ratification and approval of trust policies and pathways relating to domestic violence and abuse comprise a critical senior management function. These policies and pathways were central to **empowerment generation**.
- Uptake of evidence generated through audit and feedback, an important part of **evidence generation**, is also a critical senior management function. So is approval of the adoption and implementation of improved evidence generation and data collection systems. Without acknowledgement of the need to continuously improve the whole health response, the work of Health Pathfinder in local sites would never evolve.

3.8.2 Domestic violence and abuse coordinators

Domestic violence and abuse coordinators were, in a sense, the unsung heroes of Health Pathfinder's effectiveness. Though they may or may not have had roles in direct contact with victim-survivors, the range of functions that they took up over multiple levels in local sites were central to facilitating not only the activation of mechanisms, but also the evolution of each site in unlocking each subsequent mechanism.

- Even though it is proper to senior management's role to set domestic violence and abuse as a priority, coordinators were essential in health sites to championing domestic violence and abuse as a priority and to making visible domestic violence and abuse. This was a central part of **awareness generation**.
- Domestic violence and abuse coordinators played a central role in organising training in local health sites. In this respect, domestic violence and abuse coordinators facilitated **expertise generation**.

- Domestic violence and abuse coordinators were the glue in the strategic networks formed through **relationship generation**. As the point people for domestic violence and abuse, coordinators' leadership alongside senior management supported the development of relationships that embedded a whole health response in local sites.
- Development of the clear trust policies and pathways that are central to **empowerment generation** was a key aspect of domestic violence and abuse coordinators' role.
- Finally, spearheading the development or improvement of data collection systems, integrating learning from the technical assistance provided as part of Health Pathfinder, and deriving key insights from data to support programme improvement, were collectively central functions for domestic violence and abuse coordinators and the basis of **evidence generation**.

3.8.3 Co-located IDVAs and Advocate Educators

Finally, co-located IDVAs and Advocate Educators had a clear role across each mechanism.

- Co-located IDVAs and Advocate Educators helped to make visible domestic violence and abuse as a trust priority through their presence and participation in health settings, which was key to **awareness generation**.
- Co-located IDVAs and Advocate Educators were also central to the informal coaching that was so highly valued as part of **expertise generating**.
- As essential partners in the whole health response, co-located IDVAs and Advocate Educators were central to the **relationship generation** that sustained and evolved the whole health response.
- As these relationships deepened and the Health Pathfinder intervention became further embedded, co-located IDVAs and Advocate Educators were essential to **empowerment generation**.
- Finally, IDVAs and Advocate Educators in some cases suggested valuable ways to support **evidence generation**.

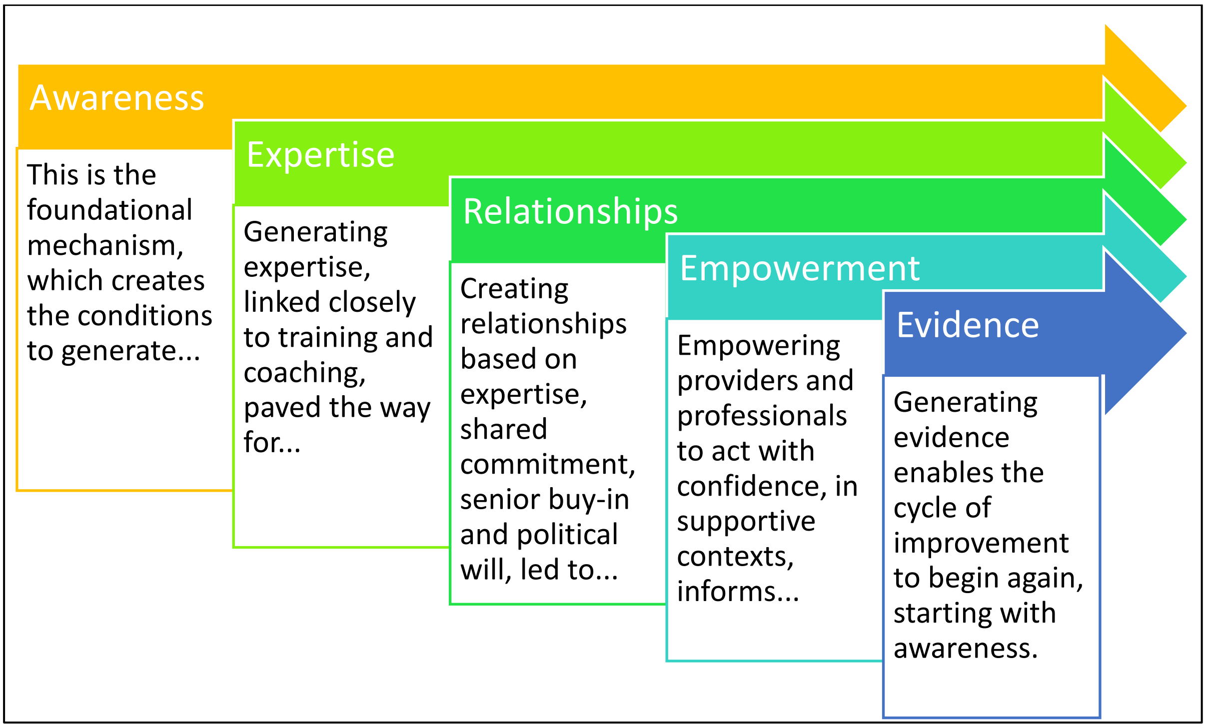
3.9 Summary

Our analysis suggested that Health Pathfinder achieved its goals as an ecological intervention through five mechanisms, each of required multiple roles working across multiple levels of health systems. These mechanisms unfolded sequentially. Each mechanism paved the way for the subsequent one, with early successes forming the context and backdrop for subsequent changes. A recurring phrase in our analysis of these mechanisms is that one mechanism alone is 'not enough'. We believe it is important to underscore that all the components and roles in the Health Pathfinder ecological intervention worked together to transform health system responses to domestic violence and abuse, with potentially critical pathways to reducing health inequities experienced by women and particularly by women who experience multiple forms of oppression. These provide context and plausibility to the impacts of Health Pathfinder on these inequities where our quantitative analysis could not.

Even where victim-survivors could not speak directly to individual mechanisms (e.g., relationship generation, which focused on linkages between professionals), it was clear from their accounts how positive progress in respect of each mechanism had meaningful impacts on victim-survivor experiences of enquiry, disclosure and uptake of services, and had the potential to meaningfully impact health inequities. Though our model suggests gradual unfolding of mechanisms, we also found that there was significant bidirectional movement between adjacent mechanisms. For example, awareness informed expertise, which then increased awareness through diffusion of knowledge through organisations. In addition, in sites health professionals felt empowered to ask and act about domestic violence and abuse, this empowerment improved relationships with domestic violence and abuse services.

Health Pathfinder sites, each working in a different set of contexts, started the journey at a different point in the change process. Similarly, at the conclusion of the project, sites were at different stages of the process, with some sites planning for evidence creation stage and others still focusing on building and sustaining relationships. The mechanisms that emerged in our analysis are depicted sequentially below.

Figure 4 Mechanisms of change in Health Pathfinder



Awareness

This is the foundational mechanism, which creates the conditions to generate...

Expertise

Generating expertise, linked closely to training and coaching, paved the way for...

Relationships

Creating relationships based on expertise, shared commitment, senior buy-in and political will, led to...

Empowerment

Empowering providers and professionals to act with confidence, in supportive contexts, informs...

Evidence

Generating evidence enables the cycle of improvement to begin again, starting with awareness.

4. How was the Health Pathfinder intervention implemented?

In this chapter, we discuss findings of our analysis of barriers and facilitators of Health Pathfinder. Our goal was to understand the factors that supported or hindered the implementation of Health Pathfinder, drawing primarily on the interviews that we undertook with staff and professionals. Unlike the previous chapter, which focuses on *how Health Pathfinder achieved its goals*, we focus here on *how Health Pathfinder was rolled out in participating sites*.

We focused on the experiences of staff and professionals in this section as they were principally responsible, together with site leads from the organisations who led Health Pathfinder, for the implementation of the intervention. We note as well that while findings relating to implementation echo several of the findings we described in the chapter on intervention mechanisms, they have a substantially different tenor and feel, in many cases appearing as the ‘view from 30,000 feet’. There are several reasons for this.

First, while our analyses of mechanisms were driven by the key principles, roles and functions of the Health Pathfinder approach, analyses of implementation necessarily deal with the ‘fact’ of what was implemented. Components and activities implemented were variable across Health Pathfinder sites. As a result, our analysis focused less on the implementation of any one component and more on recurrent themes that were encountered across the range of Health Pathfinder components, though we principally relate our findings to co-location of services; domestic violence and abuse coordination; training and technical assistance including where this focused on equity, diversity and intersectionality; and technical assistance relating to data collection.

Second, and by corollary, our sample size of professional interviews, and the limitations of our ability to sample within any one site, mean that findings about any one component in any one site would have been undersaturated (that is, without enough ‘information power’ to draw firm conclusions).

Third, presenting detailed findings by site would risk deductive disclosure, which we regarded was an unacceptable ethical risk. This is also why, despite our efforts throughout the analysis process to draw on the range of viewpoints that contributed to our dataset of interviews, we do not attribute specific quotes to individual respondents as we did in the previous chapter.

We discuss the implementation of Health Pathfinder using several categories: the background commitment and history of addressing domestic abuse in Health Pathfinder sites; preconceptions and stigma relating to domestic abuse at both professional and organisational levels; the intersection of both of these categories in the perceived relevance of Health Pathfinder; and logistical factors relating to the embedding of Health Pathfinder roles in organisations. Analysis suggested that logistical factors were an important manifestation both of background commitment and history and of preconceptions and stigma.

4.1 Background commitment and history of addressing domestic abuse

Participants reflected that each site’s background of addressing domestic abuse influenced implementation of Pathfinder in several ways. For example, sites that previously did not have a strong history of policy action and coordination on domestic abuse were starting from a very different place than sites where domestic abuse was a policy priority. This required embedding domestic abuse into settings where perceptions of time pressures precluded previous attempts to address domestic abuse, such as emergency departments.

One professional described that solutions could include reframing domestic abuse using quantitative evidence, explicitly medical language (e.g. symptoms), duty of care to patients, and reframing training to be part of Safeguarding rather than 'just another training'. These solutions would ideally be championed by a domestic violence and abuse coordinator. Another professional noted that linking the presence of a co-located IDVA or Advocate Educator to obligations, both legal and moral, to patients was central to messaging and implementation:

> No, it would be risk, as I said it would be a risk to our other statutory obligations. Because a lot of the domestic abuse that we get, whether a staff or a patient, is urgent.

A cost-effectiveness rationale, both in preventing staff absence and in preventing patient need to re-engage with health services, was also useful in developing the initial hook needed to get professionals onside:

> …part of the work that I've had to do, is prove that actually it is cost effective, because [the IDVA] has kept people at work. [The IDVA] has prevented re-attendance… whether that be for an overdose or falls, or whatever.

This lack of background history was a double-edged phenomenon in that it also meant that in some contexts where sites did not have a strong history of policy actions, healthcare professionals were receptive to training. Three participants observed that Health Pathfinder was able to engage groups of healthcare professionals who had previously not been meaningfully reached, such as dentists, and individual healthcare providers noted that training and co-location of IDVAs 'opened eyes' to the challenges of domestic abuse, including among colleagues and peers in the workplace who disclosed their own victimisation.

The role of background history also meant that according to some professionals, where Pathfinder-suggested ways of working clashed with existing structures that were perceived to be successful, integrating Pathfinder was not seen to add specific value. One participant noted that due to previous experience working with IDVAs in health settings, the inclusion of Pathfinder did not seem to have obvious value:

> I mean to be honest from a practical note, Pathfinder has done very little for us because we already have those established links, we had those processes in place.

Nevertheless, this participant made positive comments regarding the training:

> Any training that can be delivered is always a bonus… I am a big advocate for training staff.

This finding was surprising in that it reflected an 'incremental' understanding of Health Pathfinder; that is, an understanding of the intervention as just one or two components (co-location, training) rather than an ecological intervention that included, for example, support for domestic violence and abuse coordination, technical assistance in developing evidence and data collection methods, and a focus on intersectional and transformative action for victim-survivors who are often marginalised.

However, this perspective was not uniform. In one site that has previously experimented with co-locating domestic abuse services, working with the Health Pathfinder site lead "really stepped up a pace" in terms of trust action on domestic abuse. This is another way in which coordination is central to the success of a whole health response. Similar to findings related to relationship generation, this was, in another site, credited to an energetic and enthusiastic site lead as a key facilitator working with, or against, background commitment and history. As one Safeguarding lead said:

> One of the challenges with Pathfinder was that we really didn't get going with the project, partly because there was not much of a drive, until [the site lead] took over. Since [the site lead] has taken over the project has absolutely flown.

In this site, implementation of Health Pathfinder more readily embraced the whole-health approach, including the range of components and roles described above.

In other contexts, strong and pre-existing background in addressing domestic abuse meant that sites were in some cases ready to take action and make full use of Health Pathfinder. This manifested in sites actively seeking out funding opportunities to advance work related to domestic abuse; sites already seeking to develop strong domestic violence and abuse coordination mechanisms, and partner with IDVAs; sites aiming to coordinate improved action on identifying domestic violence and abuse in victim-survivors of greater diversity than were previously identified; trusts including domestic abuse as part of their strategic work plan; and senior management buy-in, all also relevant contextual or mechanism-related factors as well. Participants observed as well that pre-existing implementation of other domestic abuse interventions in the 'health ecosystem', such as IRIS, also served to prime sites for ramping up to successful implementation of Health Pathfinder. As one participant noted, in respect of the expansion of work beyond co-located services:

> …there was no harm in having more support to carry on embedding things.

This strong and pre-existing background also meant that work relating to domestic abuse was highly regarded. In these situations, engagement with Health Pathfinder was viewed as offering important career benefits for those who engaged. One professional who participated in train-the-trainer sessions and cascaded that learning back to their sites said:

> At the end somebody from NHS England, came up to me and said that the presentation was good, and they were going to be writing a policy for staff victims, of domestic abuse, so would I join that group? So, I now go up to London once a month and we've been writing a policy for National.

In sum, background commitment and history played a multifaceted role as both a barrier and a facilitator of the *implementation* of Health Pathfinder, in the same way as it played a key role in *how* Health Pathfinder achieved its goals, particularly with respect to relationship generation. In sites without previous history of policy action and coordination, Health Pathfinder both needed to address organisational barriers that may have precluded that action from taking place and benefited from substantial gains and 'aha' moments. In sites with strong previous history, Health Pathfinder both needed to engage with existing and possibly very successful ways of working while also benefiting from the strong buy-in from multiple stakeholders and extending the work of those sites to areas that may previously have been 'blind spots', such as supporting identification of domestic violence and abuse in women who may not have been well-served by existing support mechanisms.

4.2 Preconceptions and stigma

Existing preconceptions and stigma as to what domestic abuse 'looks like', or how it 'presents' in patients, was a barrier to Health Pathfinder's implementation, in the same way as it was an important part of the organisational context of 'domestic abuse cultures'. This presented in several ways, each of which has important implications for an understanding of how Health Pathfinder's implementation was challenged by structural inequalities as well as for an understanding of how the gendered aspects of domestic violence and abuse continue to challenge a meaningful whole-health response to domestic violence and abuse.

First, two participants observed that health professionals espoused ‘traditional’ views relating to domestic abuse victimisation, such as ‘Why don’t victims just leave?’ This is an axiomatic finding with respect to health professional responses to domestic violence and abuse, reflecting a patriarchal understanding of domestic violence and abuse and well as a simplistic view of the challenges and dangers of ‘just leaving’ an abusive relationship. However, these views posed a particular block to the implementation of Health Pathfinder in that they questioned the need for domestic violence and abuse to be part of the core business of the NHS, and thus the need for Health Pathfinder or a whole-health response at all.

Second, five participants noted that a challenge to implementing improved enquiry and disclosure was a preconception as to what a victim or a perpetrator might look like. As one participant observed about what a ‘standard’ victim might look like:

> Yeah, and I think the presentation of the victim victim-survivor, you know, she, we were only talking about it today. She, she’s very, quite loud and quite... she’s just, I suppose a professional might see her and think well you’re fine, because of the way she is.

This professional elaborated, noting that perpetrators may not look the same as what might be expected.

> Because I think, you know, people are still looking for that obviously aggressive person, when in fact it may look like somebody who’s very caring and attentive.

Participants noted that these preconceptions were especially difficult to shift at the individual level. It is important to note that these preconceptions are an important driver at individual and structural levels of persisting inequalities in the health response to domestic violence and abuse across a range of axes of oppression, including ethnicity and minority status, disability and LGBT identity. In this respect, a barrier to the implementation of Health Pathfinder was also an objective of the Health Pathfinder approach, underscoring the value of intersectional action on domestic violence and abuse that was an important part of the intervention.

These preconceptions also intersected with stigma relating to patients in specific health-related groups, especially groups in which Health Pathfinder sought to improve engagement: patients with specific mental health conditions or multiple complex needs. One participant noted that where these patients were difficult to engage (e.g., through repeatedly missing appointments), healthcare professionals viewed it as harder or less important to keep trying to address domestic abuse in these patients’ lives. This ultimately made this professional’s role more challenging:

> …there was an understanding that perhaps somebody that was experiencing those three difficulties combined might not be in a position to engage with our community IDVA function, you know, in terms of wanting to address their safety immediately. So, my understanding is that what my role would be would be doing some longer-term work with people affected by those combination of difficulties, to perhaps just help them get to the stage where they were identifying with their experience of abuse…

Instead, what this IDVA ended up working on was higher-level organisational issues, which she described as:

> trying to consolidate lots of different organisations, views and expectations really of what the role is going to involve.

In the situation this IDVA described, it is clear that victim-survivors experiencing multiple oppressions and health challenges would be especially poorly served by the existing NHS response to domestic violence and abuse; indeed, survivors did frequently describe fears of being judged by health services (see e.g., victim-survivor views in 3.5 Relationship Generation). Moreover, at an organisational level, these preconceptions also meant that embedding domestic abuse was not seen as part of health professionals' core work. Three participants noted that this manifested in difficulties linking domestic abuse within a range of specialisms; difficulties generating domestic abuse referrals from specialisms where domestic abuse was not seen as central; and poor training provision and engagement. Each of these difficulties could be seen to 'layer on' additional barriers to an effective whole-health response for those victim-survivors already most poorly served by the NHS. This organisational and structural resistance to acknowledging the importance of domestic abuse as core to the work of all health professionals posed a major challenge to the acceptability and uptake of training. As one health professional described,

> I felt like it was important that…all staff treated DA like a preventable disease… I don't want this [domestic abuse] to be a specialised thing. I think the IDVAs have got an absolutely crucial role, but they need to be used as specialist resource, rather than doing what I believe is everyone's job.

Five participants observed that in the context of crushing clinical schedules and short-staffed units, it was challenging both to undertake the training as well as, in situations where training was provided by other professionals, to find enough time to prepare and provide it.

Finally, an important way in which preconceptions formed a barrier to the work of Health Pathfinder was in respect of equality and diversity aspects of both sites and Health Pathfinder, discussed below.

4.3 Intersections between background commitment and preconceptions: relevance of Health Pathfinder

An important category of barriers and facilitators that sits at the intersection of the previous two factors is the perceived relevance of Health Pathfinder, either with respect to specific components of the intervention or with respect to the intervention's applicability to different roles.

Equality and diversity was, in several sites, a signal indicator of this category. In at least one site, equality and diversity leads did not see the value of engaging with Health Pathfinder. A professional interviewed said that the local equality and diversity lead did not see the value of training offered by Health Pathfinder. This professional commented that the relevant lead's "thinking is very much away from domestic abuse". In another site, a health professional did not see the importance of the equality and diversity strand of Health Pathfinder, given the perceived characteristics of their local catchment:

> It's very hard to sort of think about how you tailor resources or response to meet that need, when the numbers are so small… It's not like we've got a large sort of Somali population, you go okay let's get some resources, that will be for that group…

This barrier to implementation, again, served to perpetuate the structural inequalities that Health Pathfinder sought to address. Despite the range of training offered as part of Health Pathfinder and the multifaceted resources deployed to support work on equity, diversity and intersectionality, some participants focused on an understanding of equity and diversity as primarily relating to ethnicity. This is important as well because these perceptions were based on the status of the patient population as it currently existed, rather than the patient population as it would appear if all patients had fair and equal access to health services in a particular context.

This finding was not uniform, however. In several sites, however, the acknowledgement that Black and minority ethnic victim-survivors of domestic abuse were not being reached by existing services heightened the perceived relevance of Health Pathfinder. In two sites, this meant that training offered was seen as especially valuable; for example, in one site, training provided by a Pathfinder consortium partner including domestic abuse in LGBT and Black and minority ethnic populations was well received. Professionals interviewed in this site also observed that having expertise relating to domestic abuse from local domestic abuse services was particularly welcome.

Another signal indicator of this category was the role of data collection. In several sites, data collection was viewed as onerous and unrealistic, despite the extensive technical assistance offered by Health Pathfinder organisations in developing evidence generation methods. Similar to key challenges reflected above in the evidence generation mechanism, Health Pathfinder-related data collection processes in some cases conflicted with existing trust-level or service-level data collection requirements and systems. One professional commented that data collection as designed may not have captured where the work was being done especially where this related to consultation or support for healthcare professionals:

> You don't always get like those standard outcomes, but you have done so much.

This perceived relevance also intersected with ethical issues of data collection for one participant:

> And I did, I have raised this several times, I really have raised that I'm deeply deeply unhappy about recording domestic violence specific information on somebody's mental health record, which forms part of their official medical record.

A strong domestic violence and abuse coordination function, which includes data collection, would thus be central to the successful implementation of Health Pathfinder.

However, in one site, this mismatch between data collection requirements from Health Pathfinder and existing procedures was a prompt to change, indicating that there was room for data collection and evidence generation to form an important part of the whole-health response in some sites. One professional working in specialist domestic abuse services noted that Health Pathfinder's implementation underscored the need to improve and formalise how domestic abuse data are collected, leading to innovation at the service level. Three interviewees noted that data collection systems had improved as a result of Health Pathfinder, with implications for evidencing and justifying the role of domestic abuse services and coordination with trusts.

4.4 Logistical factors

Logistical factors were primarily demonstrated in three respects: co-location of IDVAs and Advocate Educators, scheduling of domestic violence and abuse training and sustainability of the intervention. Because we interviewed participants over the range of Health Pathfinder's implementation, we were unable to systematically analyse exit plans for the intervention, which were in various stages of development over the course of the interview period.

Clearly established arrangements and provision for the new roles and ways of working that Health Pathfinder created facilitated the intervention's successful implementation. Visually establishing IDVAs and Advocate Educators as part of the healthcare professional team was an important part of this. For example, allocating IDVAs and Advocate Educators private spaces to see patients and to discuss how to support specific victim-survivors of domestic abuse with professionals was noted by a range of professionals as an important step. Providing IDVAs and Advocate Educators with NHS emails also improved communication with colleagues in hospital contexts. As one IDVA noted, ironing out these logistical factors smoothed the path to co-location:

> So, it's just really helped to be a point of contact and put a face to a service, and just be physically present there, we hope, that would encourage people to come over to us and make talking about DA more open.

Equally, where these factors were not in place, these were barriers to the successful integration of IDVAs and Advocate Educators in health contexts. Six participants noted that absence of dedicated space, emails, logins to access medical records or a phone line each made it more difficult for IDVAs and Advocate Educators to undertake their work. Delays to contracting and budgetary limitations in two sites also meant that IDVAs had less time and fewer resources to make the most of their roles in health contexts. In one site, reallocation of funds non-recruitment to an IDVA post following the reallocation of the previous postholder meant that the site went without an IDVA for the majority of Health Pathfinder's duration.

These logistical factors also had a real supporting or hindering consequence on the structural and organisational innovation in ways of working that Health Pathfinder sought to engender. For example, several participants from different professional groups described that sorting out issues relating to employment, contracting and pay as well as line management created difficulties for IDVAs and Advocate Educators in undertaking their roles, or in domestic abuse coordinators finding the time to allocate to their duties.

IDVAs, Advocate Educators and professionals described a variety of ways for working around these barriers. One IDVA described actively seeking out to establish her presence within health settings as an important step in overcoming logistical barriers. Senior management support at the trust or clinical commissioning group for co-located IDVAs and Advocate Educators was also key to overcoming logistical barriers, through 'vouching' for these experts, modelling the importance of the co-located role, and securing appropriate training for IDVAs and Advocate Educators in IT systems and accessing health records.

The second logistical factor related to scheduling of training. As noted above, participants observed that the strenuous clinical schedules of health professionals and linked challenges of understaffing across clinical services meant that organising training at a time that was convenient was challenging. Given that a substantial part of the training offer related to supporting equity, diversity and intersectionality, these logistical factors, together with the preconceptions and stigma described above, may have served to reinforce structural inequalities that accrue to victim-survivors.

Another related logistical factor related to the sustainability of the Health Pathfinder intervention. Where systems and processes were in place that nurtured longer-term implementation of changes arising from Health Pathfinder, implementation was facilitated. In contrast, circumstances of high staff turnover and shifting budgets (such as the situation described above) challenged the sustainability of Health Pathfinder. This barrier was multiplied by the general shortage of qualified IDVAs nationally. One site described that keeping an IDVA in post was challenging, leading to redistribution of the work of that role to other colleagues and inducing overwork.

At their core, these logistical factors were manifestations, albeit consequential and practical ones, of background history and organisational preconceptions relating to domestic abuse. As one participant said:

> It is really important I think for there to be a structure in place to enable the IDVA to actually be integrated, embedded in the system. And that can only be done when you have Trusts that recognise and believe that DA is their core business.

4.5 Summary

Our analysis reflected that many of the contextual factors that were relevant to understanding how Health Pathfinder worked were also relevant to understanding how Health Pathfinder was implemented, albeit working in different ways and extending to cover a range of the activities and components that were implemented in participating sites. For example, while the background commitment and history of addressing domestic abuse in Health Pathfinder sites was important as part of the organisational context for intervention effectiveness, it also shaped how the intervention was rolled out, both in terms of acceptability of the intervention and in terms of how readily different aspects of Health Pathfinder were embedded into health settings.

Specifically, our analysis of implementation showed that intersections between background history of action on domestic violence and abuse and preconceptions of domestic violence and abuse by health professionals played an important role in the perceived relevance of Health Pathfinder, either supporting or hindering the intervention's implementation, and with particular impact on the ability of Health Pathfinder to support meaningful action on structural inequalities through the whole health response. This meaningful action was both hindered by preconceptions and also sought to meet them to create a whole-health response that worked for all victim-survivors. Finally, our analysis underscored the role of domestic violence and abuse coordination as a central component not only to support achieving change but also to facilitate successful implementation.

5. Relating our analysis to key Health Pathfinder outputs

Our independent evaluation of Health Pathfinder extends and complements the substantial body of research and evaluation generated by this project. In an effort to link and extend our findings, we consider here three key aspects of work supported by the Health Pathfinder project:

- the survivor consultation, which provides key insight into experiences of women that we were unable to explore in depth in our sample;
- the report of outputs and reach of Health Pathfinder, which provides additional context to the work of Health Pathfinder, particularly in sites that were poorly served by pre-existing data collection systems (and for which implementation of Insights was an important part of Health Pathfinder); and
- the work of Dheensa (2020) in cataloguing the significant challenges to domestic violence and abuse-related data collection in NHS IT systems, which provides essential insight into the substantial challenges both to our quantitative evaluation and to the technical assistance, data collection and evidence generation aspects of Health Pathfinder.

5.1 Survivor consultation

Between August 2018 and January 2020, AVA and Imkaan on behalf of the Health Pathfinder consortium led a survivor consultation, informed primarily by focus groups.[3] A key strength of this consultation, especially as compared to our own sample of survivors, was that it was able to reach more Black and minority ethnic survivors (roughly a third of the total sample of participants) and survivors living with a disability (28% of those providing information on this respect). In addition, this consultation reached Deaf survivors, which our sample could not include. However, the consultation was unable to reach a substantial number of LGBT survivors, nor was it able to construct focus groups of survivors living with physical disabilities or of older survivors. Nevertheless, findings from this survivor consultation are helpful in corroborating many of our hypothesised mechanisms by which Health Pathfinder can work to reduce health inequities that accrue to women, and particularly women who experience multiple forms of oppression.

5.1.1 Health systems and processes; service delivery

Key messages from survivors in this consultation reflected the importance of information sharing between and within health services; the value of effective processes in ensuring follow-up after disclosure of abuse; and the importance of sensitive, careful, and respectful management of mental health challenges. Survivors also observed that trust and a relationship with a health professional were both important to their own safety and wellbeing. These findings reflect and extend our own identified mechanisms in several ways. For example, these findings echo the comments of survivors in our own sample, who observed consistently that a sensitive, empowered and appropriate enquiry supported by a referral that did not ‘go nowhere’ were *jointly* important to understanding the effectiveness of Health Pathfinder. This also corroborates our finding of one mechanism, or one component, not being enough to achieve meaningful change.

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[3] The findings of the survivor consultation can be accessed at https://safelives.org.uk/sites/default/files/resources/Pathfinder%20Survivor%20Consultation%20Report_Final.pdf

Comments by survivors in this consultation also speak to the importance of a trauma-informed approach, particularly in mental health contexts. This matches closely the views of survivors we interviewed on the value of a mental health response to domestic violence and abuse that is joined-up, respectful and appropriate, and speaks to another of the pathways to effectiveness that Health Pathfinder 'set off'.

5.1.2 Professional knowledge

Survivors in the consultation also stressed the value of professional knowledge, including in terms of clinical presentation and with regard to the dynamics of abuse. This included, importantly, the avoidance of preconceptions and stigma attached to domestic violence and abuse, and the need to be prepared to support safe disclosure upon enquiry. Again, these findings match closely our own findings based on the value survivors placed on appropriate and empowered enquiry supported by clinical expertise. This is another way in which Health Pathfinder achieved its effects.

5.1.3 Impacts relating to equity, diversity and intersectionality

As noted above, the key way in which this consultation extends our findings is by providing rich information relating to the experiences of survivors who experience disproportionate barriers to access arising from ethnicity, disability and sexuality. For example, Black and minority ethnic women described in this consultation that they 'were not taken seriously as a result of their ethnicity'.[4] Women who were asylum seekers were turned away and spoken down to by health professionals, and women who were Deaf noted that the lack of availability of interpreters meant that they were often unable to access services. Black and minority ethnic women specifically observed that health professionals did not understand their specific experiences, and that cultural stereotypes led to health professionals 'normalised the abuse they were suffering'; for example by assuming that domestic violence and abuse were just part of survivors' 'culture'.[5] LGBT survivors described that health professionals frequently acted with heteronormative assumptions; and Black and minority ethnic women who also identified as LGBT particularly described 'assumptions that [Black and minority ethnic] women are heterosexual'.[6]

These findings both chime with our own conclusions from interviews with survivors, but also sound a meaningful note of caution. In our description of how Health Pathfinder achieved its effects, we stressed the plausibility of awareness generation, expertise generation, empowerment generation and evidence generation as mechanisms that could work against health inequities that disproportionately accrue to specific groups of women. Findings from the survivor consultation speak to the importance of culturally competent, patient-responsive enquiry and referral, both of which were important goals of Health Pathfinder, and which cut across the mechanisms we identified. However, where the consultation findings sound a note of caution is in corroborating our observation that the perceived 'diversity' of patient populations can mask diversity in survivors who are unable to access services and thus do not appear in patient lists. These findings also underscore the importance of a whole health response that is not homogenising, including tailored services that are relevant to a range of groups and that are linked to consistent, appropriate and sensitive enquiry, response and referral. Put otherwise, the conclusion that Health Pathfinder has helped

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[4] p. 30
[5] p. 34
[6] p. 36

women experiencing domestic violence and abuse *on average* does not mean that Health Pathfinder has helped all women equally. We honour these survivors' perspectives by underscoring the importance of relevant, co-created services that meet the needs of all women.

5.2 Pathfinder key findings report

This report describes many of the outputs and reach of the Health Pathfinder project across the eight sites.[7] This analysis did not seek to 'test' for effectiveness, and thus its comparative power is limited. However, an important strength of this report is that it includes data from all sites reporting Insights during the implementation period. Because our own effectiveness analysis only considered Insights data from sites where these data were available before and after implementation, we could not include all Insights data collected in the course of Health Pathfinder. In addition, this report includes data from OnTrack, which is a data collection service supported by Women's Aid. We did not have access to the national OnTrack dataset for our analyses.

This report demonstrates the impressive reach of Health Pathfinder. In total, 633 survivors took up domestic abuse services after referral from a healthcare setting, including many survivors who would otherwise not have been identified by community-based services. This matches our own finding in respect of the implementation of Health Pathfinder changing the risk profile of identified survivors. According to this report, 36% of survivors taking up services as a result of Health Pathfinder were Black or minority ethnic, of which 79% of these survivors were seen in London-based sites. Given that only 18.5% of survivors recorded in Insights nationally are Black or minority ethnic, this is important evidence of the potential effectiveness of Health Pathfinder in supporting action on health inequities. We note that none of the Health Pathfinder sites represented in our own analysis of Insights were based in London, supporting our conclusion that the non-significant effect demonstrated in our analysis was 'no evidence of effect' rather than 'evidence of no effect'.

This report also demonstrates that survivors who exited services reported meaningful impact on their lives: 91% reported increased feeling of safety, and 95% reported that their wellbeing improved. Of survivors reporting physical abuse, 82% reported that abuse reduced or stopped.

5.3 Report on recording and sharing information about domestic violence and abuse

Dheensa (2020), in a project funded by the Health Pathfinder consortium, studied current practice relating to the recording and sharing of domestic violence and abuse in health settings, culminating in recommendations finalised via an expert panel. Dheensa's work is an important and rigorous contribution to the whole health response. It is particularly valuable to this report both in terms of supporting the relevance of evidence generation as a mechanism central to Health Pathfinder's effectiveness, and in contextualising the major challenges we experienced in securing relevant data for our quantitative evaluation.

Dheensa (2020) found that key professional groups (e.g. Royal Colleges) provide inconsistent guidelines relating to recording information, and considerably more variable guidelines relating to the sharing of information. This is important because, as Dheensa notes, domestic homicide reviews consistently reflect poor information recording practices in primary care as a factor in failure to prevent harm. This extended to failure to notice key risks; failure to refer victim-survivors; and failure to transfer information between practices. A range of studies reflect under-recording of

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[7] https://safelives.org.uk/sites/default/files/resources/Pathfinder%20Key%20Findings%20Report_Final.pdf

domestic violence and abuse in primary care settings, with similar issues in handoff noted in A&E; Dheensa notes as well that research in this area relating to maternity settings is especially scant. Recording and reporting of domestic violence and abuse data are remarkably inconsistent across each of these settings, as they are in mental health, sexual health and home and paediatrics. Many health visitors can no longer access relevant GP records. Health IT systems also vary considerably in the consistency and detail to which domestic violence and abuse are recorded and flagged; with perpetrator information especially inconsistent. This suggests an exceptionally fragmented record-keeping system in which victim-survivors of domestic violence and abuse are retraumatised by repeated disclosures or 'fall through the cracks', leading to significant risk of harm. This fragmentation is compounded by the fact that information sharing can be used against specific, structurally vulnerable groups of women. For example, fear of notification to the Home Office can preclude migrant women from accessing health services, and thus from disclosing domestic violence and abuse.

The recommendations contained in Dheensa (2020) speak to the importance of site-level domestic violence and abuse policies; of domestic violence and abuse coordination and senior management buy-in to support the implementation of these policies, including as they relate to the implementation of data collection and information sharing; and of evidence generation as a central mechanism by which Health Pathfinder supported victim-survivors' safety. For example, our analyses found that domestic violence and abuse coordinators and senior management in acute trusts had an important role to play in ushering in new data collection systems that would support victim-survivor safety. Even though evidence generation was the last mechanism to be activated, it remains a central one not only for evaluation and monitoring but also for survivor safety. Indeed, implementation of the recommendations in Dheensa's (2020) report would be a major step towards activating this mechanism.

Health Pathfinder sites that implemented new data collection systems reported this as one of the most challenging aspects of intervention roll-out, a finding that is corroborated by the significant issues in health IT interoperability highlighted by Dheensa (2020). Moreover, the situation described in this report also speaks directly to the insurmountable challenges we faced in acquiring meaningful health system data related to enquiry and disclosure. This was disappointing as trust-wide or practice-wide data from even a limited number of sites both before and after implementation would have constituted the most direct and optimally powered test of the effectiveness of Health Pathfinder. The failure of IT systems and the trusts and practice that operate them to consistently record information relating to enquiry and disclosure of domestic violence and abuse meant that these data could not be consistently reported or shared. While we are confident that our analyses of Insights and MARAC data provide good evidence of Health Pathfinder's overall effectiveness, trust-level or practice-level analyses undertaken using the same statistical methods as we used elsewhere in our evaluation would have been nearly conclusive.

6. Sustaining a Whole Health approach to domestic violence and abuse

In this chapter, we discuss the key recommendations that emerged from our research for commissioners and implementers of the Health Pathfinder model, including for those who seek to continue their ongoing implementation. Our recommendations also touch briefly on unanswered questions that future research should address to continue generating the evidence needed for a whole health response that is both effective and optimised. We relate each recommendation to the need for an approach that recognises structural inequalities arising from the intersection of race and ethnicity, sexual orientation and gender identity, and disability, recognising how each of these factors multiply with each other to shape, limit and diminish the quality of access to health services and to specialist services for domestic violence and abuse. We then provide an overview of the strengths and limitations of our evaluation approach before presenting some concluding thoughts.

6.1 Co-location

Our research clearly evidenced the value of co-location of services, especially when the necessary partnership agreements, protocols, delineation of responsibilities and practical approvals were in place beforehand. This was central to ‘setting off’ many of the mechanisms described above, and was central to effective implementation. The importance of effective, rather than tokenistic, co-location is a well-known finding in the organisation of domestic abuse services. For example, SafeLives’ (2016) report *Cry for Health* documented the challenges of half-hearted or poorly conceived attempts of co-location of IDVA services in healthcare settings.

Our analysis also named several key barriers to co-location, including with respect to logistical factors and the need to meet clinical sites where they are on their journey to an effective whole health response. It was also unclear from our interview data if co-location effectively met the needs of women who are often ‘erased’ in discussions around provision of domestic violence and abuse services; for example, Black and minority ethnic women, women living with disabilities or queer women. A clear plan for information-sharing, for space and support, and for integration into clinical settings will be essential to the success of co-location when this is defined as embedded and integrated working; however, to ensure the effectiveness of co-location where co-location is defined as health setting-based access for *all* women who need to access domestic violence and abuse services, co-location will require the provision of services that are co-created by and thus specifically meet the needs of these women.

6.2 Coordination

As important as co-location, however, is the coordinating role that Health Pathfinder-funded staff played in sites. That is, the Health Pathfinder intervention is not reducible to simply funding an additional key worker or IDVA. Where Health Pathfinder was perceived by interviewees to be most impactful, co-located services worked closely with a coordinator or champion with a specific remit to drive action on domestic violence and abuse. Moreover, where Health Pathfinder was most successfully implemented, domestic violence and abuse coordinators were central to intervention rollout. This suggests that domestic violence and abuse coordination is both a central intervention function and a central implementation function. It also suggests that sites should seek clear and concrete senior management buy-in; identify a passionate, highly visible champion; and strongly consider allocation of resources to a named domestic violence and abuse coordinator to support multilevel action—both at the bedside and in the boardroom—on domestic violence and abuse. Domestic violence and abuse coordinators also have an important and underexplored role to play in supporting action on domestic violence and abuse that meets the needs of all women and that transforms the whole-health response into a tool to address structural inequalities. Domestic violence and abuse coordinators we interviewed primarily understood their roles to do with system-level coordination, as opposed to system-level transformation. Linking the coordinator role to include a success metric of access and not just of implementation and identification of victim-survivors can ensure that coordinator-driven change leads to improved access for all women.

6.3 Training combined with informal coaching

Formal training was necessary to increase the knowledge of health professionals as to the scale and nature of domestic violence and abuse, how to make sensitive enquiries with patients, and how to follow this with an appropriate and professional response to any disclosures of domestic violence and abuse. ‘Bite-size’ chunks rather than long training programmes were preferred. Furthermore, most interviewees felt that health professionals needed support beyond the formal training in order to develop their skills and expertise. This was best achieved via the co-location and integration of domestic violence and abuse experts into healthcare teams so that advice and informal coaching was readily available on a daily basis.

While training is clearly central to setting off early mechanisms relating to awareness, expertise and empowerment, it is important that training offers are locally relevant. This relevance unfolds in several ways: acknowledging where trusts already have significant records of action on domestic violence and abuse; supporting sites with ‘blind spots’ such as Black and minority ethnic, LGBT or disabled victim-survivors while accounting for the perceived demographics of local catchments; and using health-facing rationales for the importance of domestic violence and abuse to frontline clinical practice. These are all central roles for domestic violence and abuse coordinators.

Some interviewees did not perceive that training and policy development with reference to the diverse characteristics of victim-survivors was relevant or useful due to their perceptions of the diversity of their local catchment. In these circumstances, training that sensitises and acknowledges professionals to the multiplicity of forms of diversity is especially important. Latent in these interviewees’ responses was a lack of understanding and appreciation of the diversity that they might not be seeing in their practice, due to barriers to access to health services generally and for victim-survivors of domestic violence and abuse.

6.4 Effective referral pathways

The upskilling of health professionals evidenced in the Health Pathfinder sites must be complemented with effective referral pathways to partner agencies that can provide victim-survivors with the necessary support (e.g., domestic violence and abuse and mental health services, including services with specialist focus for victim-survivors whose needs are often unmet by generalist services, such as Black and minority ethnic women). Without these in place, disclosures of domestic violence and abuse do not lead to the help required. Victim-survivor interviews clearly evidenced that the feeling of being left hanging can be not only counter-productive but also harmful, precluding uptake of services and damaging relationships with providers. Outcomes of referrals should be conveyed to health professionals to provide feedback on their practice and help generate future referrals.

6.5 Sustainable financial support for specialist services

Sustainability of Health Pathfinder was a key and recurring issue in our interviews. While there was a view that Health Pathfinder generated cultural and systemic shifts in the response to domestic violence and abuse, interviewees described the challenge of assembling 'business cases' to continue trust-led funding of Health Pathfinder posts, whether Advocate Educators, IDVAs or domestic violence and abuse coordinators. Because our interviews spanned the breadth of the implementation period, it was beyond the scope of this work to consider each site's exit strategy for Health Pathfinder work. While interviewees were generally optimistic about culture change, it was clear that many sites were facing the challenge of locating longer-term support for Health Pathfinder work.

6.6 Domestic violence and abuse policies in all NHS trusts

Domestic violence and abuse is part of the core business of the NHS and must be recognised thusly in policy documents across all specialisms in all NHS trusts. Policies must underpin the initiation, support, and governance of Health Pathfinder specifically as well as the healthcare response to domestic violence and abuse more generally. Domestic violence and abuse policies also have a central role to play in identifying, acknowledging and supporting staff who are themselves victim-survivors.

Policies need to be clearly directive and contextually relevant and support the development of working relationships between service delivery partners. These should be practical documents, which explicitly delineate the responsibilities of health practitioners within existing protocols, setting out both what they need to do and how to go about it. Domestic violence and abuse policies should also be regularly reviewed and audited for equity impacts across those groups who experience barriers to access, defined broadly (i.e., beyond minority ethnic status). Because domestic violence and abuse policies are a structural intervention (i.e., an intervention that seeks to improve the contexts within which health is produced and reproduced), they have the potential to address systemic barriers to the identification of victim-survivors who may not otherwise be identified, alongside systemic barriers to access to health services and domestic violence and abuse specialist services. This is an area in need of further evaluation.

6.7 Monitoring and information-sharing

Understanding the strengths and limitations of current practice in local areas is a necessary precursor for the successful implementation of any new initiatives. Collecting the information necessary to understand whether, how and why the implementation of any new initiatives achieve their intended outcomes, or result in unintended consequences, should be seen as a central and shared responsibility across partner agencies. For example, ongoing monitoring of IDVA caseloads is needed to ensure that changes to the volume of referrals does not prevent the timely delivery of support to victim-survivors. Data are also central to the monitoring of reach and identification of needs. An important component of Health Pathfinder was the provision of technical assistance to sites to improve data collection. While it was difficult to evaluate this specific component of Health Pathfinder, it is clear that improved evidence use arising from successful evidence generation—one of the key mechanisms of change our evaluation identified—is central to developing and embedding a whole health response that works for all victim-survivors. Finally, evidence generation needs to encompass the full range of impacts on victim-survivors of service provision for domestic violence and abuse, and should be sensitive to the needs of specific groups (e.g. migrant women, who may reasonably fear notification to the Home Office). This is important not only to acknowledge, evaluate and improve the full range of benefits accruing to victim-survivors that an improved whole health response can offer, but also to ensure that a whole health response to domestic violence and abuse centres the experiences, perspectives and needs of victim-survivors of domestic violence and abuse, no matter where they are in their journeys.

6.8 Generating the evidence needed to optimise the whole health response

Following on from the previous recommendation, improved data collection, monitoring and information sharing is essential to audit and identify populations, including Black and minority ethnic victim-survivors, LGBT victim-survivors, victim-survivors with disabilities and older adult victim-survivors, for which the whole health response remains suboptimal. That is to say, data collection and monitoring should have specific regard for equity-relevant characteristics of victim-survivors, as data can be used to understand where, how and to what degree barriers to access that reflect structural inequalities exist. This is essential not only to avoid exacerbating inequities, but to close the gaps that already exist. Challenges with data collection and reporting across sites meant that this evaluation could not evidence equity and disparity impacts of Health Pathfinder. In addition, and building on previous economic evaluations of domestic abuse services (e.g. *Cry for Health*, which suggested that IDVA services were cost-saving to the public purse), future research should seek to establish the cost effectiveness of Health Pathfinder, drawing on real-world evidence to understand how much money is spent to accrue the potentially considerable long-term health benefits of the whole health response to domestic violence and abuse.

6.9 A central concern with structural inequalities

Cutting across each of the previous recommendations, a concern for how structural inequalities affect victim-survivors, and the potential of the whole health response to meet and ameliorate these structural inequalities, is important for a response that is effective in meeting the needs of all women who are victim-survivors of domestic violence and abuse. Our findings generated a range of plausible mechanisms by which Health Pathfinder could also impact health inequities that accrue to women, and specifically inequities that accrue to women who experience multiple forms of oppression. We describe these findings as ‘plausible’ because, as we reflect below in the strengths and limitations of our evaluation, we were unable to systematically identify a sample of victim-survivors to interview that captured the full diversity of experiences and perspectives including with regard to factors relevant for understanding structural inequalities. However, our findings dovetailed significantly with evidence from the Health Pathfinder survivor consultation of the challenges that specific groups of women, many of whom are at the intersection of multiple structural inequalities, face in receiving an effective, appropriate and safe response from health services and domestic violence and abuse specialist services. Greater recognition of diversity, both where that diversity is represented in the population taking up services and where that diversity is ‘masked’ by barriers to uptake, is a central component of a whole-health response that works for all victim-survivors.

6.10 Strengths and limitations of our evaluation

We already discuss the strengths and limitations of our quantitative evaluation in the relevant chapter. In sum, while our analysis drew on existing data that reflected strong, policy-relevant and population-level indicators of the system-level and service-level impacts of Health Pathfinder, we were limited by the inability to engage directly with all relevant domestic violence and abuse services. For example, we could not include Insights data from services working with victim-survivors in the most ethnically diverse Health Pathfinder sites as these services did not report Insights data prior to Health Pathfinder implementation. We were also unable to disaggregate data by, for example, ethnic group due to small numbers; the high and ethically unacceptable risk of deductive disclosure; and, in the case of the all-MARAC analysis, the lack of provided census data to standardise estimates by the relevant population of adult women. This mean that analyses seeking to understand the impacts of Health Pathfinder were limited in their ability to understand the impact of Health Pathfinder on structural inequalities.

Key strengths of our qualitative data collection included a sample size that was ultimately 50% larger than originally targeted. However, the scope of our evaluation meant that our study only reached victim-survivors who were contacted in the context of Health Pathfinder interventions. This could limit the generalisability of our findings in respect of whole-health responses generally. While we were able to oversample health professionals and victim-survivors in some areas, we were unable to recruit a consistent number across all sites due to local difficulties and due to delays in ethical approval arising from the number of NHS stakeholders involved.

In addition, an ethical strength of our evaluation was that our consent process, especially for victim-survivors, was co-produced with site leads and with the IDVAs and Advocate Educators who worked with the women we sought to interview. The key limitation arising from this, however, was that we were limited in our ability to purposively sample across the characteristics of women who came into contact with the whole-health response at Health Pathfinder sites. In conjunction with our limited sample size, this meant that our analysis was less able to reflect the structural inequalities and specific challenges that minoritised, disabled and LGBT women face when encountering services. Future research should seek to understand these perspectives as a priority to shape a whole-health response that works for all victim-survivors.

6.11 Conclusion

The Health Pathfinder projects running in each of the eight sites evaluated here are truly complex interventions; they bring together a multitude of initiatives spanning sectors and agencies to achieve a range of ambitious outcomes. Most importantly, the research showed that each of these projects did in fact help more people to safety, and sooner, though we were unable to ascertain the degree to which these benefits were equitably distributed with respect to the women who face the greatest barriers to access. Those who came into contact with Health Pathfinder, mostly women, were unlikely to have had the specialist assistance required to deal with domestic violence and abuse and its harmful consequences on their physical and mental health without Health Pathfinder. Those we interviewed recounted their experiences with health professionals prior to the implementation of Health Pathfinder. These seemed to be uninformed as to the scale and nature of domestic violence and abuse, and were often characterised as lacking both the interpersonal and professional skills necessary for an effective response. For some women, these negative and ineffective interactions went on for years, during which time additional harms accrued, significantly impacting their health over the long-term. In contrast, Health Pathfinder provided a safe context for people, mostly women, to disclose their experiences of domestic violence and abuse, resulting in a professional and sensitive response from clinicians, and access to timely support from specialist agencies.

The implementation of Health Pathfinder involved the foresight, agreement, and participation of a number of individuals and agencies operating in concert. Much time and effort, as well as new financial resource, were invested to make this possible. Notwithstanding their differing professional and organisational contexts, funding environments and local infrastructures, these individuals came together and took responsibility for producing essential and long-awaited change. The interventions and mechanisms necessary for achieving these changes have been identified in this report. These should be disseminated and then implemented in other areas because domestic violence and abuse is the core business of the NHS. Victim-survivors of domestic violence and abuse should be helped to safety, and sooner, no matter where they live.

Appendix: Methodology

Overall goals and research questions

The overarching aim of the research was to independently evaluate the Health Pathfinder in eight sites (in acute hospital trusts, mental health trusts and community-based IRIS programmes in GP Practices).

This research assessed the effectiveness of the interventions by evaluating overall change created, and the barriers and facilitators of implementation. It also assessed the overall systemic change in referral pathways. The evaluation brought together four inter-related work packages (WP) to answer this primary research question:

> *What is the effectiveness of Health Pathfinder as a model for improving the health service response to domestic violence and abuse?*

WP1 involved the development of a logic model. This WP marked the starting point for the evaluation. It used a review of documentation and consultation with key stakeholders to answer the following research questions:

- RQ1. What is a plausible, generalizable model for how the intervention works, in which contexts, for which individuals, and with respect to which outcomes?
- RQ2. What are priority areas and uncertainties for understanding the implementation and effectiveness of the intervention?

WP2 consisted of a process evaluation, which involved stakeholder interviews across all eight project sites to address the following research questions:

- RQ3. What is the acceptability and feasibility of different intervention components included as part of Health Pathfinder?
- RQ4. How do stakeholders' perceptions of acceptability and feasibility change over time?
- RQ5. How do interventions implemented in Health Pathfinder sites achieve proposed outcomes, and where does this relate to contextual characteristics?
- RQ6. Are there any unintended causal pathways or unexpected outcomes that should be added to the logic model?

WP3 was designed to evaluate the impact of interventions, providing answers to the following research questions:

- RQ7. What is the effectiveness of Health Pathfinder as a model in improving intended programme outcomes?
- RQ8. What is the effectiveness of individual interventions included in Health Pathfinder?

WP4 was the final WP, which was focussed on an economic evaluation of Health Pathfinder, and sought to answer the following research questions:

- RQ9. What is the cost-effectiveness of different intervention components, principally understood as cost per additional case of domestic violence and abuse identified?

Due to considerable limitations in available data, we did not undertake WP4. Instead, we reallocated resources to support expanded qualitative data collection and analysis.

Research design

WP1 - Logic Model

As part of an initial consultation phase, the research team co-developed a logic model through the following activities: 1) in person consultation with key stakeholders from the consortium partners (SafeLives, STADV, AVA, Imkaan, IRISi), 2) drawing upon evidence from prior evaluations (e.g., previous Insights reports) and 3) examining governance documentation from the Health Pathfinder project as part of a review of strategic and operational governance.

WP2 - Process Evaluation

The research included a process evaluation of the Health Pathfinder intervention using semi-structured interviews with health professionals and victim-survivors of domestic violence and abuse to explore the acceptability and feasibility of the intervention components, the mechanisms of change, implementation, reach and recruitment and any unintended causal pathways or outcomes.

Setting and target population

The project is set in acute health, mental health and primary care settings within the eight different Health Pathfinder locations:

- Blackpool
- Exeter and North Devon
- Haringey & Enfield
- Somerset
- London Tri-Borough
- Camden and Islington
- North Staffordshire
- Southampton

Service users (victim-survivors of domestic violence and abuse) must have had recent experience of service use in Health Pathfinder areas following the initiation of the Health Pathfinder intervention in that area (i.e., the service use period of interest should not relate to a period before the initiation of Health Pathfinder).

Site staff (health professionals) must have been involved in development and/or provision of Health Pathfinder in the included sites to take part in the interview.

Sample and recruitment

Qualitative semi-structured interviews were conducted with victim-survivors and health professionals within the eight Health Pathfinder sites across England. Training in victim-survivor recruitment processes was provided to IDVAs/DAS providers in each individual site and a recruitment guidance document was compiled to outline these processes. Victim-survivors were not excluded on the basis of current risk level, instead we worked with IDVAs/DAS providers, as recognised experts of domestic violence and abuse, to interview only those participants who in their professional judgement could safely participate (i.e., excluded if participating posed a significant risk to wellbeing, or did not have capacity to consent). To ensure all victim-survivors working with the services were given the opportunity to participate, services were instructed that if they felt it was too unsafe for a client to participate, services could ask them further into their journey if risk sufficiently reduced.

IDVAs/domestic abuse service providers were asked to approach Victim-survivors using the information sheet (timing of the approach was left to services' professional judgement) and to complete a consent to contact form for each victim-survivor, regardless of whether they consented or declined to be contacted. This was to collate information on demographics and characteristics, ensuring a varied sample according to age, ethnicity and abuse experiences in light of the client groups each service was working with. However, contact details were only received for victim-survivors who agreed to be contacted about taking part in the research. Services provided as much detail as possible about safety information relevant to contacting the victim-survivor for the research team. A member of the research team then contacted these victim-survivors and invited them to take part in an interview. The researcher would only attempt contact twice before consent was considered withdrawn and the service was asked to re-establish consent to contact with the victim-survivor.

Each Pathfinder site had an original recruitment target of 2-3 victim-survivors (n=16). However, we were unable to meet the recruitment targets in some sites, while in other sites we were able to interview several more victim-survivors than expected. The table below illustrates the numbers of victim-survivors interviewed from each of the Health Pathfinder sites.

Table 1 Interviews with victim-survivors

Site Name	**Number of consent to contact forms received**	**Number of interviews conducted**
Three Councils	3	0
Southampton	2	1
Blackpool	0	6
Somerset	1	0
Exeter and North Devon	3	3
Camden and Islington	2	2
Haringey and Enfield	5	4
North Staffordshire	0	5
Total number across all sites		20

A total of 19 female victim-survivors and one male victim-survivor were interviewed. Type of abuse experienced included emotional, psychological, stalking, coercive control, physical, sexual, isolation and financial abuse. Length of abuse ranged from 3 weeks to 30 years, entering the service with low to high-risk needs. Thirteen participants identified as White British, four as Eastern European, one as Asian British, one as Kurdish and one as Black African. Eighteen out of the twenty participants identified as heterosexual and two participants identified as bisexual, and participants' age ranged from 19 to 63.

While we were hoping to ensure maximum variation in the sample based on these characteristics by asking services to focus recruitment efforts on particular groups of victim-survivors as recruitment progressed, this was unable to be achieved due to small numbers of victim-survivors that were approached by services, and the lack of demographic data provided by services for service users that were ineligible or did not consent to be contacted.

Site leads identified health professionals involved in the Pathfinder intervention who may wish to take part in an interview, including staff who had received the intervention, strategy group members or leads and IDVAs/DAS providers. Those who expressed an interest were emailed to arrange a mutually convenient interview date and time, along with the information sheet and consent form. Each Pathfinder site had a recruitment target of 2-3 professionals per site (n=16-20). However, we were able to interview a considerably higher number of professionals across sites. The table below illustrates the numbers of professionals interviewed in each of the Health Pathfinder sites.

Table 2 Interviews with professionals

Site Name	**Pathfinder Health Setting**	**Number of professional interviews**
Three Councils	Primary Care	2
Southampton	Mental Health Trust and Dentistry	2
Blackpool	Primary Care	1
Somerset	Acute Trust	4
Exeter and North Devon	Acute Trust	5
Camden and Islington	Mental Health Trust	6
Haringey and Enfield	Acute Trust	3
North Staffordshire	Mental Health Trust	4
Total number across all sites		**27**

Ethics and safety

Ethical approval was provided by Wales Research Ethical Committee 3 on 21st August 2019. Both victim-survivor and health professional participants were provided with information about the study in advance of data collection, detailing confidentiality, anonymity and the process of informed consent. This information was discussed with the participant, ensuring any questions or uncertainties were addressed, prior to providing consent.

Written informed consent was obtained for all face-to-face interviews. For the victim-survivor telephone interviews, each consent statement was read out to the victim-survivor to check their understanding and agreement, which was audio-recorded and then quality checked by another member of the research team for final sign off prior to transcription. Victim-survivors were offered a £20 shopping voucher to acknowledge and thank them for their contribution to the study. Researchers conducting the interviews with victim-survivors were experienced domestic violence and abuse researchers and ensured that victim-survivors were comfortable and happy to continue throughout the interview. They also ensured that participants were aware they could stop the interview at any time.

Health professionals participating in telephone interviews provided electronic written consent. Data were recorded with an encrypted audio-recorder, before being transferred to the secure University network. All participants were offered to provide their own pseudonym, or ascribed one at random. Data are retained and archived in accordance with Cardiff University's retention schedule. Due to the sensitive nature of the topic, both victim-survivors and professionals were provided with a list of resources relating to domestic violence and abuse in the information sheet.

A safety data collection document guided processes for both researcher and participant adverse consequences. At the end of the victim-survivor interviews, participants were advised they would receive a follow up safety telephone call from their IDVA/DAS provider, approximately three days following the interview. IDVAs/DAS providers were instructed to check for any adverse consequences resulting from the interview and to inform us for pharmacovigilance reporting processes. Adverse Events relating to the research were recorded as a Serious Adverse Event (SAE) on the corresponding SAE form and signed off by a senior member of the research team. We experienced one SAE, where an interview was ended early out of concern for participant safety. The participant was fully informed of the reasons why the interview needed to end, reassuring them that their safety was of utmost importance and informing them their IDVA would be informed. Safety processes were followed as per protocol and signed off by a senior member of the research team.

Qualitative data collection

Semi-structured interviews were undertaken with participants. Forty-seven participants took part in interviews. Eleven victim-survivor interviews took place face-to-face, whilst the remaining nine took place over the telephone. All interviews with health professionals took place over the telephone.

Victim-survivor interview topic guides were developed by the study team in consultation with the consortium partners and informed by the logic model constructed in collaboration with representatives from the sites. Topics explored in the victim-survivor interviews included previous use of any services in relation to domestic violence and abuse, disclosure of domestic violence and abuse to health professionals, referral and receipt of services and service improvement. Professional interview topics varied based on their role, or specific involvement in the intervention. Topics explored were professional role, experience, training, reflections on implementation, impact on practice and high-level strategy implementation (additional topic for strategy group leads).

Interviews were conducted between December 2019 – April 2020. The majority were conducted by BP, an experienced qualitative researcher and former IDVA, whilst the remainder were conducted by KB an experienced qualitative researcher, AR a professor specialising in domestic violence and abuse research and Co-Chief Investigator of the study, and GJMT a professor of epidemiology and Co-Chief Investigator of the study. These ranged in length from 28 minutes to 83 minutes. The victim-survivor interviews were only facilitated by female researchers. All interviews were audio-recorded and transcribed verbatim by a professional transcription service. Interviews continued until we reached our target sample size; however, as discussed above, not all sites individually were able to recruit their target number.

We also observed steering group and strategy meetings in each of the sites. Consent was obtained by the chair from all of the members of the group, with the chair signing a consent form on behalf of the group where there were no objections. Where a member of the group objected to the meeting observation, the meeting was not observed. Researchers were able to dial into the meetings on the phone and make notes relating to the relevant operational and strategic issues in each site. This contextual data helped researchers to probe in the professional interviews, and understand more about the models of delivery being implemented in each site. However, these data are not explicitly represented in the report of the analysis (e.g. by quotes) to prevent disclosure of sensitive information.

Analysis

We checked all transcripts for errors by listening back to the audio-recording and reading the transcripts simultaneously. Using the framework method, we took a combined approach to analysis, enabling themes to be developed both inductively, from research participants' narratives and deductively from the logic model. Coding of the data was undertaken using the software NVivo. Analysis was a collaborative process amongst all members of the research team, cross-checking interpretation and developing the framework for analysis together.

The analytic framework paid attention to the diversity of interventions implemented and sought to understand how the context in which the intervention is delivered informs acceptability and feasibility. Our approach was informed by the existing Medical Research Council guidance on process evaluations (Moore et al., 2015). It was important to understand acceptability and feasibility separately from intervention functioning. They relate to how 'well-liked' the interventions are and how readily they might be scaled up and out in the future, rather than how the intervention generated a specific outcome; for example, did victim-survivors value contact with IDVAs vs. how did contact with IDVAs improve uptake of specialist referrals?

To understand implementation issues (acceptability, feasibility and stakeholder perceptions' change over time), we used the framework proposed by Tanahashi (1978): understanding interventions' feasibility in terms of how available interventions are, how accessible they are, and how acceptable they are. We organised the different factors described according to their ecological level (individual/victim-survivor; victim-survivor-clinician; institutional/systemic; social/structural), and described contextual influences using cross-case analysis (Miles, Huberman & Saldana, 2014) with findings from different sites. Our analysis then consolidated across several categories used to describe factors relevant to understanding implementation.

We analysed intervention functioning using constant comparative analysis from grounded theory (Corbin & Strauss, 2015) to identify how the interventions implemented functioned. We sought to identify generalities across sites, but also highlighted findings that suggest *what works in what context*. The outcome of this analysis was a set of context-mechanism-outcome configurations that related salient contextual factors, key mechanisms that drove intervention impacts, and the outcomes these mechanisms produced in different contexts.

Qualitative study limitations

The recruitment period varied between sites as a result of delays in local approvals. Therefore, not all sites had the same amount of time to recruit clients and professionals to the study. As the tables above indicate, there was variation in the number of both health professionals and victim-survivor interviews between the sites, with some sites meeting or exceeding recruitment targets, and other sites unable to recruit professionals or victim-survivors. Therefore, each of the eight Health Pathfinder sites is not equally represented in the qualitative data. As highlighted above, not all services completed the consent to contact form for all clients, providing demographic and abuse profile information of all clients they were working with in order to guide our purposive sampling and ensure diversity in the victim-survivor voices included in the research. Therefore, we were not able to purposively sample according to the strategy laid out in our protocol, and are therefore unable to ascertain the representativeness of our participant sample, in relation to the clients each service supports. Furthermore, in sites where victim-survivor interviews were conducted face-to-face, services did not complete consent to contact forms: as a result, demographic and abuse type data were collected retrospectively but were not collected at the start of the interview process.

WP3 - Impact Evaluation of Interventions

As described above, our analysis drew on MARAC data as well as Insights data from Q1 2018 through Q4 2019. The framework for analysis was generalised linear mixed-effects models in the context of an interrupted time series design.

MARAC data: comparing referral rates

Our analysis unfolded in several steps. First, we inspected general time trends in non-Health Pathfinder police force areas and established the plausibility of a linear time trend, and compared this to time trends in Health Pathfinder police force areas pre-implementation. This suggested that different time trends were in operation. Second, we generated two variables: one capturing quarters with data that included Health Pathfinder implementation and one capturing the number of quarters following implementation in Health Pathfinder sites. Third, we estimated a multilevel Poisson regression with random intercepts, police force areas at level 2, and quarters at level 1, and with number of cases standardised by the female population aged 16+ from the last census. This analysis included variables for whether sites were Health Pathfinder sites; time measured in quarters; the interaction between time and whether sites were Health Pathfinder sites to capture different pre-implementation time trends; quarters in Health Pathfinder sites that included implementation; and the number of quarters post-implementation in Health Pathfinder sites.

Because one police force area (Metropolitan London) included several Health Pathfinder sites with staggered implementation and because London MARACs were outliers in terms of population size in catchment, we reran analyses without London police force areas for robustness. This confirmed the existence of a change over time in Health Pathfinder sites that was significantly greater than in non-Health Pathfinder sites.

MARAC data: comparing composition of referrals

Our analysis was restricted only to those MARACs corresponding to where Health Pathfinder was implemented. As before, we generated two variables: one capturing quarters with data that included Health Pathfinder implementation and one capturing the number of quarters following implementation in Health Pathfinder sites. We then estimated a multilevel Poisson regression with random intercepts, with MARACs at level 2 and quarters at level 1, and with number of cases with a specific characteristic (e.g., Black or minority ethnic victim-survivor) standardised by the total number of cases discussed that quarter. This analysis included variables for time measured in quarters; quarters in Health Pathfinder sites that included implementation; and the number of quarters post-implementation in Health Pathfinder sites.

Insights data: comparing composition of referrals

Our analysis was restricted to 22 services with sufficient Insights data over the eight quarters in the analysis, and included four services participating in Health Pathfinder. First, we inspected general time trends in non-Health Pathfinder services and established the plausibility of a linear time trend, and compared this to time trends in Health Pathfinder services pre-implementation. This suggested that time trends were similar. Second, we generated two variables: one capturing quarters with data that included Health Pathfinder implementation and one capturing the number of quarters following implementation in Health Pathfinder sites. Third, we estimated a multilevel Poisson regression with random intercepts, services at level 2, and individual contacts at level 1. This analysis included variables for time measured in quarters; quarters in Health Pathfinder sites that included implementation; and the number of quarters post-implementation in Health Pathfinder sites.

Voice groups

We worked with SafeLives, partner agencies and project sites to identify key clinician and victim-survivor representative from each project site and thus assembled a victim-survivor voice group. We undertook a series of one-to-one consultations with our victim-survivor voice group to inform our logic model and to generate key concepts that sensitised our analysis. This group was facilitated by co-I Heather Trickey with support from co-Is Honor Young and, Kelly Buckley and Bethan Pell. We used standard incentives of £20 per session for each participant. Additional consultation with professionals at the start of the project generated key messages to inform the evaluation.

While we aimed to undertake multiple rounds of co-production, the challenges of identifying a suitable group for co-production and, in the second half of the project, the imposition of lockdown meant that sustained voice group activities were infeasible. This was particularly clear with respect to the inability to guarantee safe participation for victim-survivors, and the challenge and ethical dilemma of consuming clinician and professional time in the context of a major public health emergency.

Acknowledgements

Undertaking an independent evaluation of this scale is always a team effort, including between researchers and implementers. We are grateful to the consortium partners, including Standing Together Against Domestic Abuse, SafeLives, IRISs, Imkaan and AVA, for working with us throughout the course of this evaluation. We specifically acknowledge the work of the site leads from each organisation, which was highly valued both by the evaluation team and the healthcare organisations that were also Health Pathfinder sites. Site leads played a particularly instrumental role in recruiting professionals to our interview sample.

Recruitment for our sample of victim-survivors was primarily led by IDVAs and Advocate Educators. We thank them for their close collaboration. They worked closely with us to co-produce an ethical and acceptable consent process, and then supported us in working with victim-survivors to understand their experiences in Health Pathfinder sites.

Finally, we acknowledge with gratitude the contributions of health professionals and victim-survivors who took the time to speak with us and share their journeys. It was a privilege to work with them, and we hope our work has done justice to their experiences.

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