

# DOMESTIC ABUSE AND THE NHS

10 ways the NHS 10 Year Plan can help halve  
violence against women and girls



# Introduction

The government has a manifesto commitment to half violence against women and girls (VAWG) in a decade. To achieve this ambitious goal every part of government will need to make a contribution. As the public service with the most contact with victims<sup>1</sup>, the NHS has an especially important role to play.

With the first of the ten years already gone, it is more important than ever for government to articulate a clear vision of how the NHS can play its role in halving VAWG and to ensure funding streams are available for this to happen.

The NHS 10 Year Plan was a missed opportunity to acknowledge the importance of the health system in achieving this key government goal. However, Ministerial intentions are clear. When launching the NHS 10 Year Plan, The Secretary of State for Health promised to “make sure that the NHS is playing its part in keeping women and girls safe, alive and well”.<sup>2</sup>

The existence of a long-term plan provides the context in which future domestic abuse related interventions will sit and in which that important Ministerial promise can be kept. The VAWG Strategy, due in September this year, DHSC guidance, NHSE’s upcoming 2026 guidance on training and NHS delivery plans must now lay out in more detail how the NHS will support the ten-year mission to halve VAWG.

This analysis seeks to inform those pieces of work, identifying the opportunities for domestic abuse interventions in the reformed NHS as well as the risks for survivors, so that these can be addressed. It makes ten recommendations that will help ensure the NHS contributes its full part in halving VAWG.

**About us:** Standing Together Against Domestic Abuse (STADA) has years of experience of working with health systems to improve the domestic abuse response, including the delivery of a series of pilots and research interventions funded by government over the last eight years. Our experience, along with a long history of designing, advising on and delivering coordinated community responses to domestic abuse, informs this analysis of the 10 Year Plan.

We also refer to the work of other specialist partners including IRISi and Respect with whom we have collaborated on the Crossing Pathways project. Thanks to these partnerships and others, there is now a wealth of research and evidence about what works in terms of improving health’s ability to identify and respond to domestic abuse (DA).

**Available research and practice covers:** effective policies, training, the importance of roles such as Domestic Abuse Coordinators, Health IDVAs, mental health IDVAS’s, IRISi interventions in general practice and sexual health clinics, and guidance and frameworks from Respect around responding to perpetrators within health settings. We encourage the DHSC and the NHS to make full use of this evidence along with our ten recommendations, as it implements the 10 Year Plan.

<sup>1</sup> Dheensa S, Feder G, ‘Sharing information about domestic violence and abuse in healthcare: an analysis of English guidance and recommendations for good practice’, *BMJ Open*, (2022).

<sup>2</sup> The Rt Hon Wes Streeting MP, *Hansard*, (3 July 2025).

# Summary

## The NHS 10 Year Plan is centred around three shifts:

### FIRST:

From hospital to community

### SECOND:

From analogue to digital

### THIRD:

From sickness to prevention

Whilst the plan itself only makes a passing mention of domestic abuse, each of these shifts hold significant potential for improvements to the NHS response to domestic abuse and other forms of violence against women and girls.

With regard to the first shift, if neighbourhood health teams are trained to recognise and respond to domestic abuse, DA coordinators are embedded in NHS settings and voluntary sector specialist provision is commissioned as part of the NHS's holistic response, then this could be a very positive model for DA survivors.

With regard to the second shift, from analogue to digital, we conclude it will be a positive thing if it goes alongside training for health care professionals to ensure safe and accurate recording of DA related data and if the various services and apps are designed with the needs of DA survivors in mind. We warn that there should be no assumption that a phone is a private place. If digital interactions become the norm but are not - for whatever reason - secure, then victims could be driven away from, rather than supported by health services.

The third shift, from sickness to prevention, is also welcome. The majority of women in an abusive relationship seek help from health services, usually GPs, at least once and this may be their first or only contact with professionals.<sup>3</sup>

Making the most of these contacts to get survivors the help they need as soon as possible is critical for the health and wellbeing outcomes of survivors and can represent significant cost savings to the NHS and other public services in future.<sup>4</sup>

However we note that there is little detail in the plan to point to the wider role the NHS can play in secondary prevention of domestic abuse, and we would like to see this in the forthcoming VAWG strategy. Given the high levels of mental ill health experienced by people affected by domestic abuse, plans to roll out more mental health support, especially for young people are a welcome part of this section of the plan.

These three shifts are underpinned by commitments on transparency and quality, workforce development, innovation and financial structures and incentives, which are also relevant. Our analysis touches on the importance of training; learning from what went wrong in Domestic Abuse Related Death Reviews through an effective oversight mechanism; and the importance of consistent data collection and data security. We also look at the opportunities to embed high quality DA responses through the adoption of an accreditation framework.

We hope that the new VAWG strategy will adopt the following ten recommendations that flow from this analysis of the NHS 10 Year Plan (hereafter referred to as 'the plan') along with recommendations contained in the letter from the [Domestic Abuse Health Leadership Group](#).

**The first and most important recommendation is that a detailed plan from the government is now needed - both as part of the VAWG strategy expected September 2025 and in NHS specific policy documents – to advise NHS commissioners on their role in responding to domestic abuse and ensure the right financial incentives and mechanisms are there for them to fulfil it.**

<sup>3</sup> Lewis NV, Dowrick A, Sohal A, Feder G, Griffiths C., 'Implementation of the Identification and Referral to Improve Safety programme for patients with experience of domestic violence and abuse: A theory-based mixed-method process evaluation.', (2019).

<sup>4</sup> For example, Standing Together's Crossing Pathways' project included an analysis of five service users' journeys who engaged with the project. The five were identified for being at risk of serious harm. The analysis showed an average cost saving of £1.58m per survivor. The early intervention they received cost just £656. Source: Standing Together Against Domestic Abuse, Crossing Pathways Key Findings Report, (2025).

# Summary of Recommendations

1

Publish a detailed plan as part of the VAWG strategy expected in September 2025, DHSC guidance and in NHS specific policy documents - to advise NHS commissioners on their role in responding to domestic abuse and ensure the right financial incentives and mechanisms are there for them to fulfil it.

2

Ensure domestic abuse expertise is part of the local offer of Neighbourhood Health Centres, by funding and supporting specialist provision of domestic abuse services (including 'by and for' services and perpetrator responses) as required under the Duty to Collaborate.

3

There should be a Domestic Abuse Health Coordinator or a DA and Sexual Safety (DASS) Coordinator in every ICB – this would cost in the region of £2.66m per year, or less if as expected ICBs merge (current figure is based on 42 ICBs).

4

The care plans for people with complex needs should as standard consider whether domestic abuse is an issue for the patient.<sup>5</sup>

5

Include survivors and specialist domestic abuse services in the design and implementation of the full range of NHS apps under development, so that they can reflect the needs of survivors and not inadvertently expose them to extra risk.

<sup>5</sup> The NHS 10 Year Plan uses the term 'complex needs' to refer to people accessing healthcare systems who require a high level of support across various aspects of their daily lives due to a range of factors, including disability, illness, experience and life circumstances. Their needs may overlap, compound, and require support from a range of statutory and voluntary services such as health, social care, education, social services etc. Standing Together Against Domestic Abuse works within an intersectional and trauma-informed framework. We use the term multiple disadvantage to reflect the wide variety of systemic factors, structural inequalities and lived-experiences that can make people more at risk of experiencing domestic abuse and make it harder to seek support. These include but are not limited to race, religion, sex, gender, age, substance use, homelessness, immigration status and disability. Our recommendations and expertise relate to all victim-survivors of domestic abuse, including and not limited to child, male, elderly, criminalised, parent who experiences violence from a child or adolescent, disabled and black and minoritised victim-survivors. A public health strategy to tackle domestic abuse has the opportunity to address clear gaps, including those not recognised under the Domestic Abuse Bill (2021), specifically migrants and refugees. We have worked to ensure that these recommendations reflect the varied experiences of victim-survivors and it is imperative that a public health strategy to tackle domestic abuse and VAWG is trauma-informed, survivor-centred, intersectional and considers the needs, challenges and barriers faced by the most vulnerable and marginalised victim-survivors.

## Summary of Recommendations (cont'd)

6

There must be clear and robust national guidance on safeguarding and data protection related to domestic abuse; and local systems must ensure mechanisms are in place to ensure these are adhered to.

7

Government prioritises the work needed to identify what and how data will be collected on health IT systems around domestic abuse and VAWG.

8

Mental health professionals, including those in schools and colleges, and in the Young Futures Hubs, should be trained to recognise and enquire about domestic abuse and refer onto to specialist support services, such as mental health IDVAs. Similar provision should be made in Family Hubs.

9

A funded Domestic Abuse Death Review oversight mechanism - as called for by the Domestic Abuse Commissioner – is needed to ensure the NHS learns lessons from every domestic abuse related death.

10

Planned work with health professional regulators and educational institutions to overhaul education and training curricula over the next three years must draw on specialist VAWG sector expertise to enshrine an awareness and understanding of VAWG within syllabuses.

# 1

## **Recommendation:**

*Publish a detailed plan as part of the VAWG strategy expected in September 2025, DHSC guidance and in NHS specific policy documents - to advise NHS commissioners on their role in responding to domestic abuse and ensure the right financial incentives and mechanisms are there for them to fulfil it.*



# 2

## ***Recommendation:***

*Ensure domestic abuse expertise is part of the local offer of Neighbourhood Health Centres, by funding and supporting specialist provision of domestic abuse services (including 'by and for' services and perpetrator responses) as required under the Duty to Collaborate.*



# From Hospital to Community

The plan announces a shift from a reliance on care in acute settings towards community-based provision. This should support coordination of care and promote primary and secondary prevention of domestic abuse. This is welcome.

## What is the problem the plan is trying to address?

This problem statement in the plan will sound painfully familiar to many survivors of domestic abuse:

*“Too often, using the NHS means navigating a complex web of services; making many trips, at personal cost, to see different professionals on different days; or being forced to constantly repeat yourself to professionals who have not talked to each other, or had proper access to your medical records.”*

Domestic abuse is associated with a wide range of serious physical and mental health impacts, the treatment of which may involve many professionals.

## For example:

- 1 in 2 people who have experienced domestic abuse in England and Wales may be living with a brain injury. <sup>6</sup>
- Female victim-survivors of domestic violence and abuse are nearly three times as likely to develop mental illness, including severe conditions such as schizophrenia and bipolar disorder, compared with those who have not. <sup>7</sup>
- Physical health consequences also include a 50% to 70% increase in gynaecological, central nervous system and stress-related problems. <sup>8</sup>
- Violence in pregnancy also increases the risk of late entry into prenatal care, perinatal death, preterm birth and domestic abuse related death. <sup>9</sup>
- Domestic abuse can elevate the risk of deaths of its victims by 44 percent when compared to the general population. Domestic abuse survivors are more at risk of heart disease and type 2 diabetes. <sup>10</sup>
- Disabled women are twice as likely to experience domestic abuse as non-disabled women. <sup>11</sup>

Having to constantly repeat your experiences to a range of health professionals can be re-traumatising. And where domestic abuse hasn't been disclosed, failure of professionals to make the links with other professionals about symptoms that might suggest domestic abuse, and enquire sensitively, can represent fatal missed opportunities. It is vital that healthcare professionals can deliver a response that is holistic, recognises the wide range physical and mental health impacts of domestic abuse and ensures that patients receive effective support and informed care across health services and departments.

The plan explains that *“healthcare in this country is organised into multiple, fragmented siloes - across community care, primary care, mental healthcare, hospitals, social care providers, local government and the voluntary sector. If the NHS doesn't feel like a single, coordinated, patient-orientated service, that's for a simple reason: it isn't one.”*

This reflects our recent research into lessons for the NHS from Domestic Abuse Related Death Reviews. As part of the “Never again. Again.” study <sup>12</sup>, we talked to the mother (Phyllis Daly) of a victim (Jessica Laverack) of domestic abuse, who had taken her own life, who felt that siloed working in the NHS was one of the reasons why her daughter didn't get the help that could have saved her life.

Phyllis told us that, of the various professionals her daughter was in contact with, *“none were able to join the dots or form a bigger picture.”* They had *“institutionalised blinkers,”* concentrating only on their specialism and failing to spot the red flags and the danger she was in. <sup>13</sup>

Victim-survivors are badly affected not only by professional siloes within the NHS but also between the NHS and other services. Survivors and their children are often caught within system structures, unclear of how to navigate services to get the help they need. Coordinated, community-based services enable a ‘whole system’ response. Domestic Abuse Coordinators (DACs) or Domestic Abuse and Sexual Safety (DASS) Coordinators can help institute this.

# From Hospital to Community (cont'd)

## What are the proposed changes?

The plan envisages an NHS that is integrated with other services in the community – including the voluntary sector - and can respond holistically to a person's needs. These are things that we at STADA have been calling for over a long period and we welcome. This kind of collaboration also aligns with ICBs' legal 'Duty to Collaborate' under the Victims and Prisoners Act 2024, which will require local policing bodies, local authorities and ICBs to collaborate in the commissioning of community support services in England for victims of domestic abuse, sexual abuse, and serious violence.

## Neighbourhood Health Centres

The local integrated service will be most apparent in the form of Neighbourhood Health Centres in every community. According to the plan, these will:

*“Co-locate NHS, local authority and voluntary sector services, to help create an offer that meets population need holistically. That will mean NHCs will not only bring historically hospital-based services such as diagnostics, post-operative care and rehabilitation into the community, but they will also offer services like debt advice, employment support and smoking cessation or weight management services.”*

Given wide prevalence of domestic abuse and the importance of early identification there is an excellent opportunity to weave domestic abuse specialist responses – including services designed 'by and for' specific communities - into NHCs. The plan acknowledges that: *“women have faced particular difficulty with NHS fragmentation in the past”* and commits to *“women's health never again being ignored.”* Weaving in domestic abuse responses will help achieve this.

Recent patient survey analysis from a Women's Health Hub in Horsham showed that over 40% of respondents thought that the Hub should be a place where they could access domestic abuse support. This high percentage is particularly striking given there was no individual domestic abuse questions asked in the survey.<sup>14</sup>

Where STADA has commissioned the delivery of domestic abuse support in health settings and/or facilitated the training of healthcare professionals, the responses from survivors have been incredibly positive. These are quotes from a survivor-led review of our recent 'Crossing Pathways' project, which brought DA expertise into health settings:

*“The GP was incredible, and she made lots of calls out of hours to check that I was safe, they made so many safeguarding referrals.”<sup>15</sup>*

*“For somebody to name it is massive, or you know just to ask questions about me. How are you? What do you want? What do you need? You're important too, not just the children, or not just your husband, or not just what this medical form says.”<sup>16</sup>*

<sup>6</sup> Brainkind, Too Many To Count, (2024).

<sup>7</sup> British Medical Journal, 'Women who experience domestic abuse are three times as likely to develop mental illness', (2019).

<sup>8</sup> Campbell, Jacquelyn et al., 'Intimate partner violence and physical health consequences.', Archives of Internal Medicine vol. 162,10, (2002).

<sup>9</sup> Campbell, Jacquelyn et al.,

<sup>10</sup> Singh Chandan et al; 'Risk of Cardiometabolic Disease and All-Cause Mortality in Female Survivors of Domestic Abuse', Journal of the American Heart Association, (2020).

<sup>11</sup> SafeLives, Disabled Survivors Too, (2017).

<sup>12</sup> Ashton, A., Standing Together Against Domestic Abuse, Never Again, Again., (2024).

<sup>13</sup> Opher, Dr. S., Henry-Leach, C., 'The NHS needs a domestic abuse strategy.', British Medical Journal, (2025).

<sup>14</sup> Berry, C., Woodcock, E., NHS Sussex, Park and Orchard PCN, Horsham District Women's Health Survey Report: Access to Health Care for Women, (2025).

<sup>15</sup> Standing Together Against Domestic Abuse, Centring the Survivor Voice: Phase Two, (2024).

i. As part of the Crossing Pathways Project, Standing Together delivered thirty services across England. These roles included Domestic Abuse Coordinators (DACs), Mental Health Independent Domestic Violence Advocates (IDVAs) and Health, Disability and Specialist IDVAs. These roles were delivered in collaboration with the Home Office, NHS Trusts, ICBs, 'By and For' services and with sector partners, including IRISi, Respect and SafeLives. We are grateful for the expertise, support and collaboration.

ii. The Survivor Voice Network surveyed and supported a number of survivors who had engaged with the services provided by the Crossing Pathways Project. In the interests of their privacy, safety and wellbeing, their testimonies and journeys have been anonymised.

<sup>16</sup> Standing Together Against Domestic Abuse, Centring the Survivor Voice: Phase Two, (2024).

# 3

## ***Recommendation:***

*There should be a Domestic Abuse Health Coordinator or a DA and Sexual Safety (DASS) Coordinator in every ICB – this would cost in the region of £2.66m per year, or less if as expected ICBs merge (current figure is based on 42 ICBs).*



# From Hospital to Community (cont'd)

## Coordination between NHS Services and Beyond

The neighbourhood health service will *“convene professionals into patient-centred teams.”* The plan notes that *“More integrated working within the NHS – and between the NHS, local government and voluntary sector - can deliver large efficiencies. A recent systematic review showed a 6% reduction in costs and a 6% improvement in patient outcomes from integrated care.”*<sup>17</sup>

This accords with our experience. Services delivered or supported by Standing Together have demonstrated the impact that dedicated Domestic Abuse Coordinator roles can have, particularly in facilitating efficient and cost-effective multi-agency working and referral.<sup>18</sup>

*“The mental health person I saw in hospital referred me to [A domestic abuse service], and they also referred me to social services, wrote to my GP told them I needed to be referred to the community mental health team psychologist.”*<sup>19</sup>

A Domestic Abuse Coordinator (DAC) or Domestic Abuse and Sexual Safety (DASS) Coordinator at every ICB would complement and accelerate effective local coordination. DACs or DASSs could enable the embedding of the range of best practice as laid out in the Pathways to Safety Accreditation Framework.<sup>20</sup>

They would ensure key departments and frontline professionals across the whole health system, from acute care to Neighbourhood Health Centres, understand and implement the benefits of robust policies, clear training frameworks and requirements. They will bring knowledge and good relationships with key local specialist partners as well as being able to deliver training and share specialist tools, guidance and resources. Investments in specialist DA coordination can reduce costs (financial and impact on patients) associated with not identifying and responding effectively first time to domestic abuse.

ICB based Domestic Abuse Coordinators (DAC) / Domestic Abuse and Sexual Safety (DASS) Coordinators will also be able to advise and support the ICB-wide coordination and domestic abuse related skills of nurse leads in the new neighbourhood health services. These are referred to in the plan as: “neighbourhood nursing and midwifery leads who will act across multiple neighbourhoods to coordinate local strategy, convene partners and represent the community’s voice.”

<sup>17</sup> Rocks, S., Berntson, D., Gil-Salmerón, A., Kadu, M., Ehrenberg, N., Stein, V., Tsiachristas, A. , ‘Cost and Effects of Integrated Care: A Systematic Literature Review and Meta-Analysis’ The European Journal of Health Economics, (2020).

<sup>18</sup> Standing Together Against Domestic Abuse, Crossing Pathways Key Findings Report, (2025).

<sup>19</sup> Standing Together Against Domestic Abuse, Centring the Survivor Voice: Phase Two, (2024).

<sup>20</sup> Standing Together Against Domestic Abuse, Crossing Pathways Key Findings Report, (2025).

# 4

## ***Recommendation:***

*The care plans for people with complex needs should as standard consider whether domestic abuse is an issue for the patient.*





## From Hospital to Community (cont'd)

### Care Plans

As part of its commitment to delivering holistic responses the plan commits that: *“by 2027, 95% of people with complex needs will have an agreed care plan. We will expect all care plans to be co-created with patients and cover their holistic needs, not just their treatment.”*

This is likely to be very welcome for the many survivors who find themselves having to navigate a range of services in crisis mode rather than having a clear ongoing plan of support.<sup>21</sup>

Those drawing up care plans must be able to deliver robust screening for domestic abuse and risk assessment and be aware of local referral pathways to specialist support.

Such specialist support must in turn be available to meet the needs of victims of domestic abuse and perpetrators.

<sup>21</sup> The NHS 10 Year Plan uses the term 'complex needs' to refer to people accessing healthcare systems who require a high level of support across various aspects of their daily lives due to a range of factors, including disability, illness, experience and life circumstances. Their needs may overlap, compound, and require support from a range of statutory and voluntary services such as health, social care, education, social services etc. Standing Together Against Domestic Abuse works within an intersectional and trauma-informed framework. We use the term multiple disadvantage to reflect the wide variety of systemic factors, structural inequalities and lived-experiences that can make people more at risk of experiencing domestic abuse and make it harder to seek support. These include but are not limited to race, religion, sex, gender, age, substance use, homelessness, immigration status and disability. Our recommendations and expertise relate to all victim-survivors of domestic abuse, including and not limited to child, male, elderly, criminalised, parent who experiences violence from a child or adolescent, disabled and black and minoritised victim-survivors. A public health strategy to tackle domestic abuse has the opportunity to address clear gaps, including those not recognised under the Domestic Abuse Bill (2021), specifically migrants and refugees. We have worked to ensure that these recommendations reflect the varied experiences of victim-survivors and it is imperative that a public health strategy to tackle domestic abuse and VAWG is trauma-informed, survivor-centred, intersectional and considers the needs, challenges and barriers faced by the most vulnerable and marginalised victim-survivors.

# From Hospital to Community (cont'd)

## Making the ambition to improve 'life course outcomes' a reality.

In the financial section of the plan there is a commitment to incentivise a holistic approach as follows: *“Providers will be rewarded based on how well they both improve the life course outcomes of each individual, as well as how well they involve them in the design of their care, rather than solely on whether they provide episodic instances of care on demand.”*

New funding mechanisms will support this shift from hospital into the community. The plan notes that:

*“under current funding mechanisms the cost of new more efficient community-based services will be in one part of the NHS, whilst the savings are in another, typically hospitals.”* In other words, there's been no financial incentives to keep patients' away from A+E, by caring for them better locally. To fix this, the government will create *“new funding flows and payment mechanisms that connect the savings from improved quality of care with the investment in new services in the community.”*

This is welcome, because treating the physical and mental impacts of domestic abuse episodically, rather than identifying the domestic abuse itself and supporting the victim in a more holistic way, makes it more likely that harm will continue for longer, sometimes with fatal consequences. By working alongside specialist domestic abuse agencies and implementing evidence informed interventions the NHS can improve outcomes for patient safety, health and wellbeing.<sup>22</sup>

## Assessment of impact of the shift to community for victim-survivors.

If neighbourhood health teams are trained to recognise and respond to domestic abuse including with appropriate referrals, DA coordinators are embedded in NHS settings and voluntary sector specialist provision is commissioned as part of the NHS's holistic response, then this could be a very positive model for DA survivors.

<sup>22</sup> Standing Together's Crossing Pathways' project included an analysis of five service users' journeys who engaged with the project. The five were identified for being at risk of serious harm. The analysis showed an average cost saving of £1.58m per survivor. The early intervention they received cost just £656. Source: Standing Together Against Domestic Abuse, Crossing Pathways Key Findings Report, (2025).

# 5

## ***Recommendation:***

*Include survivors and specialist domestic abuse services in the design and implementation of the full range of NHS apps under development, so that they can reflect their needs and not inadvertently expose them to extra risk.*



# From Analogue to Digital

The shift from analogue to digital is designed to achieve several positive outcomes: making health support more accessible like a 'doctor in your pocket', enabling you to book appointments through apps, access reminders and health records and facilitating feedback.

The ambition is for it to free up clinical time – for example by automating note taking – so that doctors can see more patients or have more time for each patient. The idea of a single patient record should also make services better connected which could reduce the trauma of having to explain a problem time and time again. This would also aid in the multi-agency collaboration needed to manage and reduce risk related to domestic abuse.

Whilst there is a lot here that could be helpful for survivors of domestic abuse, there are also risks which need to be considered. These include risks related to confidentiality and ensuring services and access remain inclusive and risks related to technology enabled abuse. We know that perpetrators can control victims' phones, so security measures will be very important as will options to opt out of the app system (and have viable alternatives) if victim-survivors feel there is no safe way to keep information they want private.

## App Development

There are several apps being developed. Of particular relevance to domestic abuse survivors will be apps called:

### MY CARE

This is *"For those who need more intensive support, such as people with long-term conditions or other complex needs"*. The plan recognises that *"managing healthcare can feel more like a full-time job than a service."*

We expect that many people who fall into the *"complex needs"* category will be or have been affected by domestic abuse.

The app is described as *"each patient's one stop shop for managing their care. It will be where patients can find and review their care plan. It will be where they can book and manage appointments, enrol in a clinical trial and access their Single Patient Record. Over time, My Care will increasingly link to services outside the NHS - in the voluntary sector, from social enterprises, social care, community groups or local government. It will be a digital social prescriber."*

### MY COMPANION

This has the potential to be useful for survivors who face linguistic barriers to support and those who would like to raise the issue of domestic abuse they are facing with doctors but do not feel able to do so in person. The plans says:

*"My Companion will help them [patients] articulate their health needs and preferences confidently.... It will support translation, so that everyone can engage with their healthcare in their first language. It will support patients to ask questions, including any they may have forgotten about or felt too embarrassed to raise at an in-person appointment."*

### MY CARER

This will *"allow people to securely prove they are providing care, often for an older family member, and gain access to the App on their behalf. It will help unpaid carers book appointments and communicate with their loved one's care team. For carers, this will streamline their care responsibilities significantly, while giving them a means to seek advice or reassurance directly from a range of professionals when they need it."*

We know that relationships that are supposed to be caring can also be abusive. STADA's recent research on Domestic Abuse Related Death Reviews found that in 28% of the reviews, either the victim or the perpetrator of a domestic abuse related death was a carer.<sup>23</sup>

This app will have to be very carefully managed to avoid it becoming a tool for perpetrators.

<sup>23</sup> Ashton, A., Standing Together Against Domestic Abuse, Never Again, Again., (2025).

# 6

## ***Recommendation:***

*There must be clear and robust national guidance on safeguarding and data protection related to domestic abuse; and local systems must ensure mechanisms are in place to ensure these are adhered to.*



# From Analogue to Digital (cont'd)

## Giving clinicians greater context

The digitisation of the NHS may give clinicians greater context when they see a patient, which could facilitate more appropriate care. As the plan says:

*“Since clinicians do not currently have access to patient records from different care settings, they often see patients without knowing enough about their context. For example, they often do not know their patient’s housing status, level of digital exclusion or caring responsibilities. The introduction of the Single Patient Record will change that, by making information visible across different care settings. It will also enable clinicians to better understand contextual as well as clinical information.”*

This is welcome, however preserving the security of data being held not only across the NHS but across other agencies will be critical. Staff will need to be trained on how to safely and appropriately record DA in a patient’s medical record to ensure information is clear to other professionals accessing the record, and that any mention of DA is hidden from online access so it is not viewable within the NHS app in case perpetrators are accessing this.

Recommendations on data privacy and patient confidentiality made by survivors as part of Standing Together’s Survivor Voice Report included:

- Offer alternative secure communication methods to protect victim-survivors.
- Record and honour victim-survivor communication preferences.
- Develop a centralised system for sharing victim-survivor data across care settings.
- Use flagging systems on victim-survivor records for prioritised care.
- Avoid compromising safety by disclosing sensitive information in public areas. (This is in line with NICE Quality Statement).

## Personalised social risk assessments

There are plans for the Single Patient Record to be strengthened with the introduction of **“tested and validated personalised social risk assessments, to more consistently capture non-clinical risk factors for ill health, so that care can be tailored and co-ordinated to improve patient outcomes and reduce health inequalities.”**

We know that domestic abuse is a risk factor for ill health, and it should be considered in any such assessment.

A system of personalised social risk assessments could be transformational for the domestic abuse response – helping coordination and the capacity challenges which hinder agency participation. Multi-agency forums such as safeguarding meetings, MARAC, DRIVE panels and MATAC that manage and reduce risk are an integral part of the coordinated community response. Streamlining this coordination and offering it to more people could save lives.

STADA’s analysis of Domestic Abuse Related Death Reviews published in 2024 showed 35% called for better coordination between services.<sup>24</sup>

However, again, there are risks. With one in 5 people experiencing domestic abuse in their lifetimes, the data set will be huge and some of those on it may be facing threats to their life. Widening access to data across agencies, means data security must be tight.

<sup>24</sup> Ashton, A., Standing Together Against Domestic Abuse, Never Again, Again., (2025).

# 7

## ***Recommendation:***

*Government prioritises the work needed to identify what and how data will be collected on health IT systems around domestic abuse and VAWG.*



# From Analogue to Digital (cont'd)

## The Opportunity of Better National Data

Current national data sets on domestic abuse are heavily criminal justice focussed. We know that this underrepresents the number of people facing abuse each year and paints a context-thin picture. If the Single Patient Record and the validated personalised social risk assessments are done carefully and well, there is the opportunity to build a much deeper and more nuanced picture of the state of domestic abuse in England and Wales than currently exists. This picture can inform work on health inequalities and future service planning and delivery.

Consistent coding of domestic abuse will be key – the data set will only be as good as the data going into it. As part of its work with the Royal Colleges, DHSC must ensure that guidance on recording and coding of domestic abuse is updated and aligned across disciplines.

## Innovation

The section of the plan on innovation talks about the *“untapped potential of NHS datasets”*.

Responses to domestic abuse are being hampered by inadequate criminal justice focussed data sets. This plan has the potential to change that. But data analysis will only be as good as the data entered into systems.

The new *“actuarial approach to health funding”* which allocates money on the basis of anonymised health-care data, makes it even more important to get this right. What gets measured is more likely to get funded.

## Assessment of impact of the shift to digital for victim-survivors

The shift from analogue to digital will be a positive thing if it goes alongside training for health care professionals to ensure safe and accurate recording of domestic abuse related data and if the various services and apps are designed with the needs of domestic abuse victim-survivors in mind.

There should be no assumption that a phone is a private place. If digital interactions become the norm but are not for whatever reason secure, then victim-survivors could be driven away from, rather than supported by health services.



# 8

## ***Recommendation:***

*Mental health professionals, including those in schools and colleges, and in the Young Futures Hubs, should be trained to recognise and enquire about domestic abuse and refer onto to specialist support services, such as mental health IDVAs. Similar provision should be made in Family Hubs.*



# From Sickness to Prevention

The 10 Year Plan says: *“Until now, government strategy has been defined by a mix of government striking out alone on primary prevention, often without cohesion or real strategy – while the NHS has avoided taking its responsibility seriously on secondary prevention.”*

This is a picture we recognise and want to help change. The NHS has great potential in secondary prevention of domestic abuse and all its health impacts. The majority of women in an abusive relationship seek help from health services, usually GPs, at least once and this may be their first or only contact with professionals.<sup>25</sup>

Making the most of these contacts to get survivors the help they need as soon as possible is critical for the health and wellbeing outcomes of survivors and can represent significant cost savings to the NHS and other public services in future harms avoided.<sup>26</sup>

Standing Together’s Crossing Pathways Project showed that 89% of victim-survivors were supported by the project to get support for their additional, and often overlapping, health needs as well as access specialist domestic abuse services. 78% were supported by the project to access additional needs, including support from community care and additional statutory services such as police, social services and education.<sup>27</sup>

The plan focuses its preventive efforts mainly on obesity, air pollution, alcohol, good work and mental health. Of these, mental health is particularly relevant for domestic abuse survivors. Research indicates domestic abuse results in long-term negative impacts on both physical and mental wellbeing, resulting in a high correlation between domestic abuse and suicide.<sup>28</sup>

Suicide has now overtaken homicide as the primary cause of domestic abuse related deaths.<sup>29</sup>

## Mental Health

It is therefore important that mental health professionals are trained to recognise and enquire about domestic abuse and take appropriate action.

<sup>25</sup> Lewis NV, Dowrick A, Sohal A, Feder G, Griffiths C., 'Implementation of the Identification and Referral to Improve Safety programme for patients with experience of domestic violence and abuse: A theory-based mixed-method process evaluation.', (2019).

<sup>26</sup> Standing Together Against Domestic Abuse, Crossing Pathways Key Findings Report, (2025).

As part of the Crossing Pathways Project, Standing Together was able to identify an average cost-saving of £1.58m per survivor. This average was taken across the cost breakdown of five survivor journeys who engaged with the project. The cost of early intervention was £656 per survivor.

<sup>27</sup> Standing Together Against Domestic Abuse, Crossing Pathways Key Findings Report, (2025).

<sup>28</sup> Aitken, R., Munro, V., 'Domestic abuse and suicide: exploring the links with Refuge's client base and work force.', (2018).

<sup>29</sup> Hoeger, K., Gutierrez-Munoz, C., Sadullah, A., Whitaker, A., College of Policing, Home Office, National Police Chiefs' Council, Vulnerability Knowledge and Practice Programme, Domestic Homicides and Suspected Victim Suicides 2020-2024 Year 4 Report, (2025).

# From Sickness to Prevention (cont'd)

## The Mental Health Needs of Children and Young People

We hope that the National Youth Strategy due soon from the Department for Culture, Media and Sport will align with September's VAWG strategy in proposing interventions that address the importance of healthy relationships and ensure appropriate referral routes for young people already affected by abuse.

The plan promises that *"Health services will also do more to play their part in child safeguarding. We will work in partnership with the Department for Education to implement a single unique identifier for every child, to enable proactive, preventative and joined-up care across different public services. Dependent on successful piloting, the NHS number will become the single unique identifier for children."*

Like the digital risk assessment tools in adults, there is real potential in this proposal to support and protect children from domestic abuse, if the risks around data management are given the right consideration.

The focus on young people's mental health and wellbeing is also welcome. Children are now legally recognised as victims of domestic abuse and children living in homes where there is abuse need their own specialist responses.

Family hubs can help identify domestic abuse and refer pre-school children for specialist support. Young Futures Hubs and school-based mental health support should also develop referral pathways to specialist domestic abuse support services.

### Assessment of impact of shift to prevention for victim-survivors

Given the high levels of mental ill health experienced by people affected by domestic abuse, plans to roll out more mental health support, especially for young people are welcome. However, there is little detail in the plan to point to the wider role the NHS can play in secondary prevention of domestic abuse and we look forward to hearing more in the forthcoming Violence Against Women and Girls Strategy.



# 9

## ***Recommendation:***

*A funded Domestic Abuse Related Death Review oversight mechanism, as called for by the Domestic Abuse Commissioner, is needed to ensure the NHS learns lessons from every domestic abuse related death.*



# Underpinning Commitments to Support the Three Shifts

The plan is underpinned by commitments on:

NHS structure | Quality and transparency | Workforce development | Innovation | Financial Foundations

## Structure

We note that the plan is essentially to shrink the centre and devolve decision making. There will be fewer bigger ICBs, and where possible, these will match the boundaries of the new combined local authorities. One advantage of this could be improved coordination between health and local government in support of victim-survivors much easier. Planning will operate in the following way:

*“a neighbourhood health plan will be drawn up by local government, the NHS and its partners at single or upper tier authority level under the leadership of the Health and Wellbeing Board, incorporating public health, social care, and the Better Care Fund. The ICB will bring together these local neighbourhood health plans into a population health improvement plan for their footprint and use it to inform commissioning decisions.”*

This looks likely to support the ‘Duty to Collaborate’ under the Victims and Prisoners Act and could be helpful. ICBs will be *“empowered to commission neighbourhood health services from a diverse range of providers, both within and beyond the NHS”*.

## Quality and transparency

The section on quality and transparency talks about what happens when things go wrong. It states that this is the part of the plan that can best help reduce *“the number of lives lost to the biggest killers, including cancer, cardiovascular disease (CVD), and suicide.”*

Recognition of *“failure to learn from mistakes”* is welcome as is the commitment to *“put patient choice, voice and feedback at the heart of how we define and measure quality”*. STADA research into domestic abuse related death reviews published in 2024 suggests that lessons are not being learnt by the NHS when domestic abuse victims take their own lives.<sup>30</sup>

However, there is no detail in the 10 Year Plan that gives us confidence that this will change yet. A domestic abuse related death review (DARDR) oversight mechanism – as proposed by the Domestic Abuse Commissioner - will make a major contribution to ensuring the learning from every domestic abuse related death is shared more widely across the health system.

There is also now an accreditation framework which health systems can deploy to ensure the quality of their responses to domestic abuse, called ‘Pathways to Safety’.<sup>31</sup>

It has been developed in partnership with health service pilot areas, IRISi, Respect and includes learning from the voices of survivors. This offers local commissioners a mechanism by which to adopt and embed these best practice models, offering cost benefits and improved outcomes for victim-survivors and perpetrators of domestic abuse.

<sup>30</sup> Ashton, A., Standing Together Against Domestic Abuse, Never Again, Again., (2025)

<sup>31</sup> Standing Together Against Domestic Abuse, Crossing Pathways Key Findings Report, (2025).

# 10

## ***Recommendation:***

*Planned work with health professional regulators and educational institutions to overhaul education and training curricula over the next three years must draw on specialist VAWG sector expertise to enshrine an awareness and understanding of VAWG within syllabuses.*



# Underpinning Commitments to Support the Three Shifts (cont'd)

The section of the plan on workforce development points to risks as well as opportunities for those looking to support domestic abuse survivors.

## Workforce Development

There is a commitment to have completely reformed mandatory training by April 2026 and

*“reverse the accumulation of centrally dictated training requirements, which irritate staff and add unnecessary burdens to their working day. It is often repetitive, irrelevant to the work that staff do and has little or no impact on the quality of care that patients receive.”*

We agree that training must be effective and relevant, however we do not agree that staff need less of it.

The need for more training was the single most often repeated recommendations for the NHS in the Domestic Abuse Related Death Reviews studied by STADA in its ‘Never again. Again’ report.<sup>32</sup>

Our experience is that health professionals welcome quality, stand-alone, domestic abuse training.

As part of Standing Together’s Crossing Pathway’s Project, 8960 healthcare professionals received dedicated domestic abuse training. These healthcare professionals were working across a range of specialties and departments, across primary, secondary and community care.

Of those surveyed:<sup>33</sup>

- 98% responded that they had a better understanding of domestic abuse.
- 97% responded that they felt confident in recognising indicators of domestic abuse.
- 95% responded that they felt confident to respond to disclosures.

Given the very wide prevalence of domestic abuse, we think that there should be a requirement for all frontline health workers to receive domestic abuse awareness training and without this we doubt very much the government will be able to meet its halving VAWG target. ICB Domestic Abuse Coordinators can play an important role in delivering locally tailored training and ensuring learning is ongoing and embedded, and research and updates are disseminated. They have a key role in collaboration with sector specialists to ensure this.

## Education and training

The new training will *“promote acquisition and retention of generalist skills required for the Neighbourhood Health Service”* and there is a strong argument for domestic abuse training to be included in this category and complemented by additional specialist training.

As covered earlier in this document, training on the use of digital tools will be very important for the safe use of sensitive data, and we welcome a proposed focus of training on this.

We expect more details in the revised NHS workforce plan due out in the summer.

<sup>32</sup> Ashton, A., Standing Together Against Domestic Abuse, Never Again, Again., (2025).

<sup>33</sup> Standing Together Against Domestic Abuse, Crossing Pathways Key Findings Report, (2025).



## Underpinning Commitments to Support the Three Shifts (cont'd)

### Financial Foundations, Fit for the Future

The NHS 10 Year Plan recognises that *“The NHS’ financial future depends on people getting a good education, on safe streets, on strong local government, clean air and better housing.”*

This is the only place where the Safer Streets mission – under which the halving violence against women and girls’ commitment sits – is mentioned in the plan. 2019 Home Office figures show that domestic abuse costs the NHS £2.3billion each year.<sup>34</sup>

That figure is likely to be significantly higher now following inflation. Investments in domestic abuse prevention are therefore also investments in the future viability of the NHS. Cross government working between the Home Office, which leads the Safer Streets mission and the Department for Health and Social Care, which leads the NHS mission, is essential.

We hope that this document shows how implementing the NHS 10-year plan in a domestic-abuse-informed manner represents an investment in health outcomes for individuals now and builds an NHS fit for the future.

<sup>34</sup> Home Office, The economic and social costs of domestic abuse, (2019).

# Conclusions

There is much to welcome in the 10 Year Plan, particularly the shift from acute care towards community-based provision. The shift to digital must be carried out with input from domestic abuse victim-survivors and solid training on data protection for data users.

However, much more detail is needed to show how government will use the opportunity of the 10 Year Plan to progress its goals on reducing violence against women and girls (VAWG), which we hope to see in the new VAWG strategy.

We urge the government to consider the 10 recommendations in this plan to help build an NHS fit for the future that never again neglects girls and women's needs.

**STANDING  
TOGETHER**  
against domestic abuse

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