

IRIS



Identification & Referral
to Improve Safety



IRIS Response to the COVID-19 Pandemic: A RAPID RESEARCH



Final Report

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Glossary

AE	Advocate educator - key member of a local IRIS team who delivers training and ongoing consultancy to general practice teams and supports patients affected by domestic abuse who are referred to her by general practice clinicians. The terms AE and advocate educator are used interchangeably throughout this document
CEO	Chief Executive Officer (or Director or Chief Executive) of an IRIS partner organisation
CL	Clinical lead – a local practicing clinician (usually a general practitioner) and a key member of a local IRIS team. The CL champions the IRIS programme amongst clinical peers and uses her/his contacts to engage practices with the IRIS programme, and co-delivers training with the AE. The terms CL and clinical lead are used interchangeably throughout this document
DVA	Domestic violence and abuse
GBV	Gender-based violence
Host organisation	The IRIS Partner organisation: the domestic abuse organisation that is hosting, supporting and managing the delivery of IRIS locally, including the hiring and line management of the AE(s)
IRIS	Identification and Referral to Improve Safety. The IRIS programme is an evidence based domestic violence and abuse training, support and referral programme developed to improve the general practice response to domestic abuse
IRISi	IRISi is a not-for-profit social enterprise established to improve the healthcare response to gender-based violence. IRISi works to sustain and expand the IRIS programme, and to collaborate with researchers to develop other evidence-based gender-based violence health interventions into commissionable models
IRIS network	The IRIS network refers to IRISi and the IRIS partners involved in delivering the IRIS service across different sites
IRIS partners	The host organisations delivering IRIS in their local areas
IRIS site	A defined geographical area in which the IRIS programme is delivered, e.g. 'Bristol', or 'Hackney'
IRIS team/local IRIS team	The key individuals involved in delivering the IRIS programme in an IRIS site, comprising of the advocate educator/s and clinical lead/s
Patient / service user (SU)	Woman identified in clinical practice as a victim of DVA supported by AE.
Service Manager	The individual within the IRIS partner organisation who is responsible for managing the IRIS service in that IRIS site and for line managing the advocate educator/s
VAWG	Violence against women and girls

Executive Summary

- **Identification and Referral to Improve Safety (IRIS)** is a programme of training and support to improve the response to domestic violence and abuse (DVA) in general practice, which has been proven effective and cost-effective in a cluster randomised controlled trial and in the real-world NHS. The IRIS programme provides in-house training for general practice teams, DVA health education materials and ongoing support for practice teams, and a direct referral pathway for patients who are victims and survivors of DVA to a named GP-practice-embedded advocate (called the advocate educator, or AE) based within a local, specialist DVA/VAWG service. Training is co-delivered by the AE and a clinical lead, who is a local clinician and a champion for IRIS within the practice. The IRIS Programme is commissioned across areas of England, Wales, the Channel Islands and Northern Ireland, where it is delivered by local IRIS teams.
- IRISi is a social enterprise established to promote and improve the health care response to gender based violence. A national, not-for profit organisation, IRISi provides areas with the IRIS model, training package, updates to the training, and support to commission, implement and maintain the programme. Until March 2020, all IRIS training, and much of the advocacy and support, was provided face-to-face.
- The imposition of a national lockdown in the UK in March 2020, and the need for social distancing thereafter, meant that the IRIS programme needed to move to remote training to primary care professionals and new ways of providing services to patients/service users. It also necessitated that the IRIS training sessions be rewritten to focus on training clinicians to safely identify, ask about and respond to DVA during telephone and online consultations.
- This rapid research addressed a concern around the lack of evidence in terms of desirability and acceptability of the IRIS programme under new remote ways of working. We have explored the perceptions of value of the IRIS programme under new ways of working, the acceptability and desirability of remote support to service users and the acceptability and desirability of online training for primary care clinicians.
- We ran four surveys and carried out 15 interviews between June and August 2020 to collect data, and analysed the data using the Lean Impact approach, which allows one to quickly evaluate innovation and the impact of social interventions. We have also carried

out a framework analysis of the interviews. While we have used multiple instruments for data collection, we acknowledge that the number of survey respondents and of stakeholders interviewed was relatively small.

- We found that the relevance of the IRIS programme has increased as a result of COVID-19 for three reasons: (1) an increased reporting and prevalence of domestic abuse, as a result of lockdown and social distancing; (2) the quick responsiveness in the adaptation of training and advocacy support to remote or online by IRISi and the local IRIS teams; and (3) the fact that the usual routes to support are more difficult to reach or access or are no longer available.
- We also found that all clinical leads and most clinicians feel at least as confident working over the phone and online, as compared to face-to-face, and that while there was an initial decline in referrals in March 2020, the level of referrals resumed to usual levels by July 2020. Since the new revised IRIS online training includes a specific section of the session to train clinicians to be able to identify, ask about DVA and refer to the IRIS programme during telephone/online consultations, one could expect the number of clinicians confident in identifying and responding to DVA to improve once more clinicians are trained online.
- There was a time-related effect in the adaptation and delivery of online training, with IRISi adapting the training in April and May and disseminating this to local IRIS teams in June, and AEs starting to deliver online training to clinical practices in July and August 2020.
- In general, clinicians and clinical leads felt online training fits better with their busy clinical schedule, as they are divided into smaller modules. In contrast, AEs and IRISi Regional Managers (RMs) were concerned about the difficulties imposed by the technology and in terms of engagement with training.
- Service users felt well supported remotely and attributed their good outcomes to the increased communication with AEs, and their quickness and responsiveness. Nearly two thirds of AEs started offering new forms of support, including text and WhatsApp messaging, as a response to social distancing restrictions.
- Technology was mentioned as the most frequently mentioned barrier to the change from face-to-face training and support to online training and remote support; the most frequently mentioned loss was the ability to read body language / facial expressions (during training / during consultations / during support sessions). The flexibility of the

programme and the responsiveness of IRISi and AEs, both in terms of increased frequency of communications as well as quicker responses, were considered the most important enablers of change. The availability of new forms of support and the ability to train clinicians from different practices jointly and with increased frequency were considered the main benefits of the IRIS online and remote programme.

Introduction

Identification and Referral to Improve Safety (IRIS) is a programme of training and support to improve the response to domestic violence and abuse (DVA) in general practice. The programme focuses on the identification of women patients affected by DVA, an appropriate initial response by clinicians, and referral for these patients to a specialist, named IRIS advocate educator based in a third sector DVA agency (an IRIS partner organisation), leading to increased safety and improvement in women's health and well-being. [IRISi](#) is the social enterprise established to improve the healthcare response to gender-based violence. The IRIS programme is IRISi's flagship intervention. IRISi works to support the local commissioning, implementation, maintenance and growth of the IRIS programme; collaborate with partners to develop innovative, evidence-based health interventions for those affected by gender-based violence; and provide expert advice and consultancy in the field of domestic violence and abuse (DVA) and health.

The IRIS programme is considered the gold standard in primary care responses to DVA [1-3], because IRIS was evaluated in a pragmatic cluster randomized control trial (RCT) and a post-trial evaluation. The RCT saw a six-fold increase in referrals to specialist DVA services by the IRIS-trained general practices [4], and demonstrated the intervention to be cost-effective [5] and acceptable to clinicians [6] and patients [7]. Post-trial evaluations of the implementation of IRIS for general practice in the real-world NHS showed that referral rates and acceptability remain consistent with the original trial [8, 9] and that the programme remains cost-effective [10].

The COVID-19 pandemic saw an increase in the global incidence of DVA [11] and an increase in reporting of DVA, alongside the need for social isolation and the imposition of a national lockdown. This resulted in the need to provide remote training to primary care professionals and new ways of providing services to patients referred into the IRIS programme [12]. While the IRIS programme has extensive evidence around its desirability and acceptability, the new ways of working imposed by the COVID-19 pandemic haven't been previously tested.

This rapid research was designed to provide initial evidence around the desirability and acceptability of the IRIS programme under new remote ways of working. We have explored the perceptions of value of the IRIS programme under new ways of working, the acceptability

and desirability of remote support to service users and the acceptability and desirability of online training for primary care clinicians.

Methods

The Lean Impact approach

This research was a timely response to adaptations that had to be made by both IRISi and also by IRIS partner organisations in response to the COVID-19 pandemic restrictions on social interaction. We have therefore used a Lean Impact approach, which is devised to quickly evaluate innovation and the impact of social interventions [13]. The Lean Impact approach encourages one to create three sets of hypotheses: (a) a value hypothesis, which tests whether an intervention is desirable and embraced by the relevant stakeholders; (b) a growth hypothesis, which tests whether the intervention is able to be upscaled and produce economies of scale and (c) an impact hypothesis, which tests the effectiveness of the intervention. In the Lean Impact approach, the process of hypothesis testing is defined in four steps: (1) identify assumptions; (2) generate a hypothesis based on assumptions, with pre-determined metrics for testing; (3) validate learning, allowing one to determine which assumptions are true and which are false, and therefore invest in the solutions shown to be most effective; and (4) pivot or persevere. This last step is based on the understanding that based on the learnings from step (3), the organisation can come closer to discovering the correct path for its value, growth and impact hypotheses. If this is the case, it should persevere. Otherwise, it should use its learnings to 'pivot' and attempt a new path.

In an attempt to understand the impact of the transition to remote IRIS support and training, we have explored four different hypotheses, which translate to four different workstreams. Workstream 1 explores the value proposition of IRISi's support to IRIS partner organisations and of the local IRIS teams being members of the IRIS network. Workstream 2 explores confidentiality of consultations in general practice, now, in large part, taking place over the phone or video, due to COVID-19 social distancing measures. Workstream 3 explores the desirability and acceptability of IRIS online training for advocate educators (AEs), clinical leads (CLs) and clinicians. Finally, workstream 4 explores the desirability and acceptability of remote/online/phone advocacy for patients/service users. Table 1 provides a summary of the assumptions and hypotheses for each workstream.

Framework analysis

As well as using a Lean Impact approach to test each of the four hypotheses defined in this research, we carried out a framework analysis to understand overarching patterns that combines findings from multiple stakeholders. It has been argued that the framework method provides a systematic and flexible approach to analysing qualitative data and is appropriate for use in research teams even where not all members have previous experience of conducting qualitative research, so long as there is some form of leadership from a more experienced researcher [14]. We have used a simple matrix as our analytical framework, and explored the themes “Barriers”, “Enablers”, “Losses” and “Benefits” when analysing interviews. All interviews were analysed by two independent researchers. Diagram 2 illustrates the simple analytical matrix used in the framework analysis.

Diagram 1. Analytical Framework matrix

Barriers	Enablers
Losses	Benefits

Table 2. Lean Impact approach: Assumptions, hypotheses and workstreams

	Assumptions: What must go right for IRIS to work?	Assumptions: What could go wrong and cause it to fail?	Generate a hypothesis	How to test this hypothesis
WS1	IRISi support and being part of IRIS network has a strong value proposition	IRISi support and being part of IRIS network is not seen as valuable	IRISi support/being part of IRIS network is perceived as valuable by key contacts in local sites	Satisfaction survey exploring perceived value of IRIS support and being part of IRIS network, followed by interviews
WS2	Assured confidentiality of consultations in general practice	Inability of clinicians in general practice to assure that consultations are confidential	Assured confidentiality of consultations is critical to substantially increasing number of identifications and number of referrals. It is harder to make referrals to IRIS post-lockdown restrictions.	Compare referral numbers pre and post the implementation of COVID-19 social distancing restrictions. Survey clinicians on their confidence and ability to discuss DVA during telephone consultations. Interview with patients on their confidence and ability to respond to questions about/raise DVA during telephone consultations.
WS3	Clinicians / AEs / CLs find online IRIS training effective and desirable	Online training is ineffective/undesirable	Clinicians / AEs / CLs find online IRIS training effective and desirable, although potentially less so than face to face training	Compare training evaluations from face to face training with online training. Survey followed by sample interview with clinicians, AEs and CLs
WS4	Patients/service users find online/phone advocacy effective and desirable	Online/phone advocacy is ineffective/undesirable	Patients find online/phone advocacy effective and desirable, although potentially less so than face to face advocacy	Compare patient/service user feedback from face to face advocacy with phone advocacy. Sample interviews with patients.

Data collection: surveys and interviews

In order to be able to triangulate findings, each of the workstreams relied on more than one method for data collection. Workstream 1 focused on a satisfaction survey which was circulated to the IRIS network and explored the perception of value and relevance of the IRIS programme in the interviews. Workstream 2 relied on quantitative (referral) data analysis before and after the UK went into national lockdown, exploring the period between January and July 2020. It also relied on a survey with clinicians in IRIS-trained practices and interviews with patients/service users to understand their confidence and ability to discuss and/or disclose DVA in remote settings. Workstream 3, in turn, used multiple surveys to collect data around the acceptability and desirability of online training, including, a survey with advocate educators, a survey with clinical leads and a survey with clinicians. Furthermore, in the interviews, it explored the perceptions of the regional managers at IRISi, advocate educators, clinical leads and clinicians around both the training for general practices as well as the train-the-trainers training. Finally, workstream 4 relied on feedback from service users, both given to AEs in feedback forms or orally as well as in interviews directly with service users.

In terms of the interviews, we defined a convenience sample of 15 individuals (5 AEs, 3 CLs, 3 clinicians and 4 service users), as well as the IRISi regional managers. The participation of IRISi regional managers (RMs) was voluntary, and all interviews with RMs were carried out by a single member of the research team to ensure anonymity within the small IRISi team. AEs, CLs and clinicians were asked in the survey whether they wanted to participate in the interviews, and those who volunteered were selected based on perception mix. The research team attempted to balance new/longstanding sites, rural/urban location and recurrent involvement with IRISi projects, so that there was a multiplicity of views. While the number of volunteers was larger than the target sample size for AEs, CLS and clinicians, we only had 4 service users volunteer in the two-week window of recruitment, so all service users who volunteered were interviewed. We recognised that while the target sample size is relatively small, it would provide enough data for the application of the Lean Impact method and the framework analysis.

Results

Workstream 1: the perceived value of the IRIS programme, the IRIS network, and IRISi work and support

The satisfaction survey was completed by 56 respondents (out of 187 invited to respond): 26 AEs, 12 CLs, 6 commissioners, 6 service managers and 6 others (including safeguarding leads). Just under half of the respondents (48%) work in areas where the IRIS programme has been commissioned for more than five years, 26% had the IRIS programme commissioned in their area between two and four years, and 21% for less than two years. This provides an interesting mix of perceptions between new IRIS sites and more longstanding sites.

When asked to rank attributes of the IRIS programme in terms of their importance, 53% of the respondents responded that “Knowing you are commissioning/managing/delivering an intervention that is proven to be effective” was the most important attribute of the IRIS programme; 35% of respondents choose this attribute as the second most important. In turn, 35% of respondents chose “Having a model that encompasses a tailored training programme, referral pathways, ongoing advice for staff at participating practices, and advocacy and support for patients [this is ‘the IRIS model’]” as the most important attribute of the programme, and 37% chose this attribute as the second most important. The third best ranked attribute of the IRIS programme was its cost-effectiveness, with 5% and 17% of the respondents choosing this attribute as most and second most important features of IRIS, respectively.

The value survey also enquired about the continued commissioning of the IRIS programme, and 91% of respondents said they would like to see IRIS commissioned in their area in the middle term (2 to 3 years) and 94% would like it commissioned in their area in the long term (beyond 5 years), although 75% of the respondents did not have roles involving direct work to obtain funding for the IRIS programme locally.

Regarding the work of IRISi, 58% of respondents said its most important feature is to provide the evidence-based IRIS model, with another 19% choosing this attribute as the second most important for the work of IRISi. The second highest ranked component of IRISi’s work was “Initial training and support to set up IRIS in the area and recruit and train the new team”, with 19% of respondents choosing this attribute as most important and 28% choosing this feature as second most important.

When asked about what action by IRISi would add value to their experience, 30% of respondents said that they were satisfied with IRISi and the support it provides should remain as is, 28% believed IRISi could add value by offering “more or different links with academic research collaborations exploring IRIS-type interventions” and 23% believed IRISi could add value by offering “more or different updates to training materials and guidance”.

The survey also explored perceptions around the value of the IRIS network, and 77% responded that they feel a part of the network. In the exercise of ranking the most valuable attributes of the network, “feeling part of a shared network with shared vision/mission to improve clinical practice and improve patients’ access to specialist support” was the highest ranked attribute, followed by “having credibility of a national brand to support the work” and “increased opportunities to share good practice and learnings with other localities”.

Finally, regarding the IRIS network, 41% of respondents want more or different communication from IRISi (including newsletter), 38% want more opportunities to engage in developments and improvements to the IRIS programme and 36% want other means to link with the network.

Turning to the interviews, they explored more in depth the relevance of the IRIS programme in a COVID-19-existing world. All interviewees believed the relevance of the IRIS programme had increased as a result of COVID. This was justified using three important and different arguments: (1) lockdown and social distancing resulted in an increase in the incidence and prevalence of domestic abuse, which in turn, resulted in the IRIS programme becoming more relevant; (2) IRISi and the IRIS programme had been quick and responsive in the adaptation of training and advocacy support to remote or online; (3) lockdown and social distancing measures mean that the usual routes to support are more difficult or no longer available, particularly with regards to support from family and friends. Therefore, general practices may be one of the only possible routes to support. The quotes illustrate:

“It has made the IRIS programme more relevant, we definitely heard [this] from sites and being on national calls towards the beginning of lockdown. I think more so than ever, we were seeing again, the GP surgery was still the only safe place that someone could visit in person.”

IRISi Regional Manager

“I think the pandemic has made it [the IRIS programme] more important. More important that we get the IRIS service back at the forefront

of people's minds.”

IRIS Clinical Lead

“I think it's become even more relevant because obviously with the lockdown and people together, I think the level of abuse is likely to have gone up.”

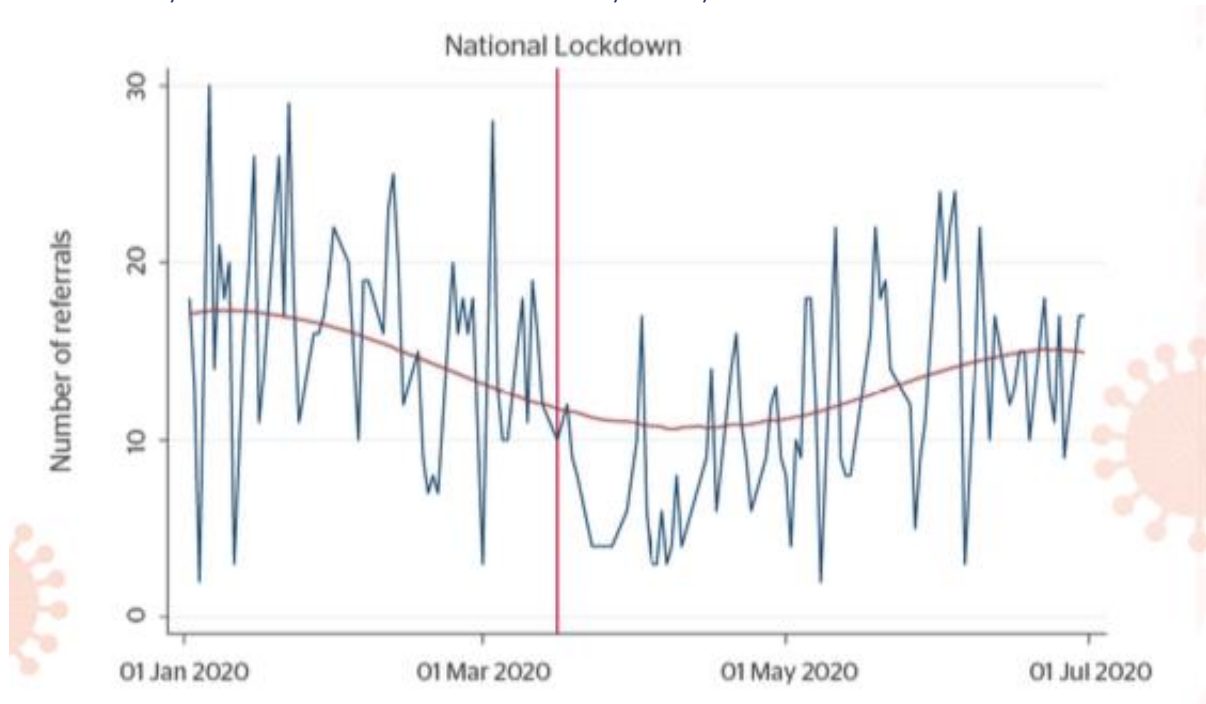
IRIS-trained clinician

Workstream 2: confidentiality of remote or online consultations

Workstream 2 explored potential difficulties in terms of confidentiality in the move from face-to-face identification and referral to online or remote identification and referral through phone and/or video consultations. In theory, with the exception of the first few weeks when all general practices were closed and not holding any type of consultations, GPs could continue to address the issue of domestic abuse in their consultations (regardless of the method of consultation). However, in practice, moving from face-to-face to online or telephone consultations brings an array of safety concerns. There is the possibility that the patient is not alone in the room, that they are locked in with the perpetrator, not to mention the lack of body language cues when using technology as the interface.

In order to understand the impact of moving to remote consultation, we first compared daily referrals from January 2020 to July 2020. After an initial decline in referrals in late March / early April, which could be an effect of closed practices as well as reduced confidence in referring, referrals started to increase again in late April 2020. By July, the level of referrals post-lockdown had already resumed to the pre-COVID level, with later anecdotal evidence of increases in referrals beyond this. IRIS referral data is reported to IRISi on a quarterly basis. At the time of writing, the last quarter for which we have full data is Quarter 1 2020-21 (1st April 2020 – 30th June 2020). Unfortunately, this means we cannot yet extend the quantitative analysis of daily referrals to October 2020, thus the reported increase in referrals remains tentative for the time being. Chart 3 shows the daily referrals from January to July 2020.

Chart 3. Daily referrals to IRIS services – January to July 2020



In the surveys with clinicians and CLs, we explored how they felt about identifying and asking about abuse in phone/video consultations and how this compared to their confidence level of identifying when asking face-to-face. Our survey with clinical leads had 25 responses, and 36% of CLs feel very confident identifying and asking about domestic abuse in phone/video consultations, 40% feel confident and only 4% said they don't feel confident, the remainder feeling neither confident nor unconfident. When comparing to their confidence level in face-to-face consultations, 88% said they feel at least as confident during phone/video consultations as they feel in face-to-face consultations.

Chart 4. Confidence level in identifying and asking about DVA in phone/video consultations – Clinical leads

Very confident	9
Somewhat confident	11
Neither confident nor unconfi...	4
Somewhat unconfident	1
Very unconfident	0



Our survey with clinicians had 115 responses. When asked the same set of questions, the responses we had from clinicians were 14% feel very confident identifying and asking about domestic abuse in phone/video consultations, 49% feel confident and only 16% said they don't feel confident or feel very unconfident, the remainder feeling neither confident nor unconfident. Although this implies room for improvement, 94.8% of clinicians said they feel at least as confident identifying and asking about domestic abuse in phone/video consultations compared to face-to-face consultations.

Chart 5. Confidence level in identifying and asking about DVA in phone/video consultations – Clinicians

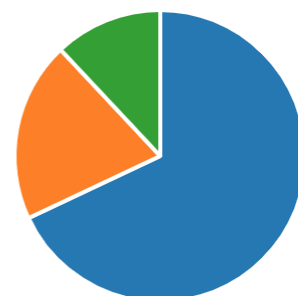
Very confident	16
Somewhat confident	56
Neither confident nor unconfi...	25
Somewhat unconfident	17
Very unconfident	1



We wanted to differentiate between actively asking about DVA and responding to a disclosure. Therefore, the surveys also asked CLs and clinicians about their level of confidence in responding to disclosures in a phone/video setting. 88% of CLs felt confident or very confident in responding to disclosures in remote consultation, with none saying they were not confident or very unconfident. Furthermore, 100% felt at least as confident in responding to the disclosure in phone/video consultations compared to face-to-face.

Chart 6. Confidence level in responding to disclosures of DVA in phone/video consultations – Clinical leads

Very confident	17
Somewhat confident	5
Neither confident nor unconfi...	3
Somewhat unconfident	0
Very unconfident	0



In turn, 71% of clinicians felt confident or very confident in responding to disclosures in remote consultation, although 10% said they were not confident and 1% very unconfident. When compared to face-to-face consultations, 99.1% felt at least as confident in responding to the disclosure in phone/video consultations.

Chart 7. Confidence level in responding to disclosures of DVA in phone/video consultations – Clinicians



Another topic covered in the survey with clinicians was whether they had actively asked about domestic abuse in phone/video consultations, with 61.7% of clinicians responding yes. The survey with clinicians also found that 48.7% of respondents had responded to a disclosure and 33.6% had made a referral to an IRIS advocate educator during a phone/video consultation. Interviews with service users revealed that they also felt confident in being referred and/or asked on the phone/video.

“I think it's easier sometimes to do it on the phone because you wouldn't hug a doctor when you're crying anyway. I don't mind it so much on the phone, the doctors.”

IRIS Service User

Workstream 3: desirability and acceptability of IRIS online training

Workstream 3 explored the desirability and acceptability of IRIS online training. While clinicians responded to questions around online training for clinical practice, AEs, CLs and RMs were asked about both the train-the-trainers (T4T) online training as well as the training of general practices. Our surveys and interviews focused on the planning and delivery of training. Unfortunately, by August 2020, only 4.3% of clinicians had received IRIS (general practice) training online.

In the interviews, the IRISi regional managers appeared to be very focused on the technological aspect of online training and on how IRISi could support IRIS sites in the transition to online training. This concern resulted in the development of components within training sessions focusing on technology and engagement using technology.

“I think it's never going to be ideal online because either it's spread over so long that you're taking up chunks of people's time on lots of different days, or it's not covering everything.”

IRISi Regional Manager

While AEs in general were also concerned with the technological aspect of online training, their responses focused more on its desirability and acceptability for clinicians. Our survey with AEs revealed mixed perceptions around online training. Around half of the respondents (48.7%) feel that clinicians will take more from IRIS training in its online form, while the other half (48.7%)¹ are concerned about difficulties in concentration, engagement or IT/technological difficulties in online delivery of training. Perceptions around the planning for online training are also mixed. In interviews, some have highlighted the decrease in admin work required for delivery of online training, while others have expressed the opposite view, stating that preparing for online training is more time consuming. 59% of the AEs who responded to the survey had not yet delivered any training online, and 50% of these were looking forward to delivering it online, while 30.4% are not looking forward to delivering training online.

The same mixed perceptions around online training were not shared by CLs. In the survey with clinical leads, 72% of the respondents preferred online training to face-to-face. In the interviews, clinical leads explained their preference for online justifying that blocking out full days is very difficult for clinicians and that shorter more frequent training, as being done online, appears to fit in better with clinicians' diaries and commitments. Furthermore, the CLs interviewed all highlighted that online training enables IRIS to train multiple practices at different locations at the same time. They also reinforced that online training enables training to happen more often, which would be desirable given that every so often new guidance comes along. The following quotes from clinical leads illustrate:

¹ In this question, AEs could select multiple options from a list. Thus, the total sum is not necessarily 100%.

“We can offer an online meeting for anybody else across the other 60 practices or even the 90, who wants to come and just do an hour or an hour and a half update about IRIS in COVID-19. Actually, having done that, we should go on doing it year after year, because there are about 10 things that have changed in the last six months.”

IRIS Clinical Lead

“The benefit of online is that we can offer, as well as the update training rollout program, and the mop up sessions for people who've never done IRIS training.”

IRIS Clinical Lead

“During the pandemic, practices are more interested in getting the IRIS training.”

IRIS Clinical Lead

Although there was a concern from the AEs around engagement of clinicians, clinicians themselves have responded that they were able to engage and absorb online training well. In our survey with clinicians, 100% said they were able to find a quiet place to do the training, they didn't have any technical difficulties, they managed to have dedicated time for training with no distractions and they found it straightforward to access materials before and after the training. In the interviews, clinicians acknowledged the difficulties in moving the IRIS service to remote and praised the programme for its responsiveness. Furthermore, clinicians said they felt comfortable with online training and believed that in the near future no face-to-face trainings would be possible.

“I'm just trying to make sure that the program is still running in the best ability that it can be with lockdown and the use of the tele-communications but I think it's also just to make sure that the online training still goes ahead for the GPs”

IRIS trained clinician

“One of my patients I spoke to recently and she said, even though there wasn't face-to-face support, she has been supported well over the telephone, and she was one of our older patients.”

IRIS trained clinician

Finally, in the interviews, AEs, CLs, RMs and clinicians seemed to agree that the downside of online training relates to the difficulties that technology imposes in terms of reading facial expressions and body language. While RMs and AEs appeared to be more concerned with the impact of the near absence of body cues in the training, which might prevent them from being

able to provide bespoke support to clinicians who might have felt uneasy during training, CLs and clinicians were more concerned with similar difficulties when in consultation with patients. 25.6% of AEs who responded to the survey believed clinicians who were trained online would not have the same level of understanding of DVA as they do in face-to-face IRIS training, but only 5.1% thought that this would result in clinicians referring less to IRIS programmes.

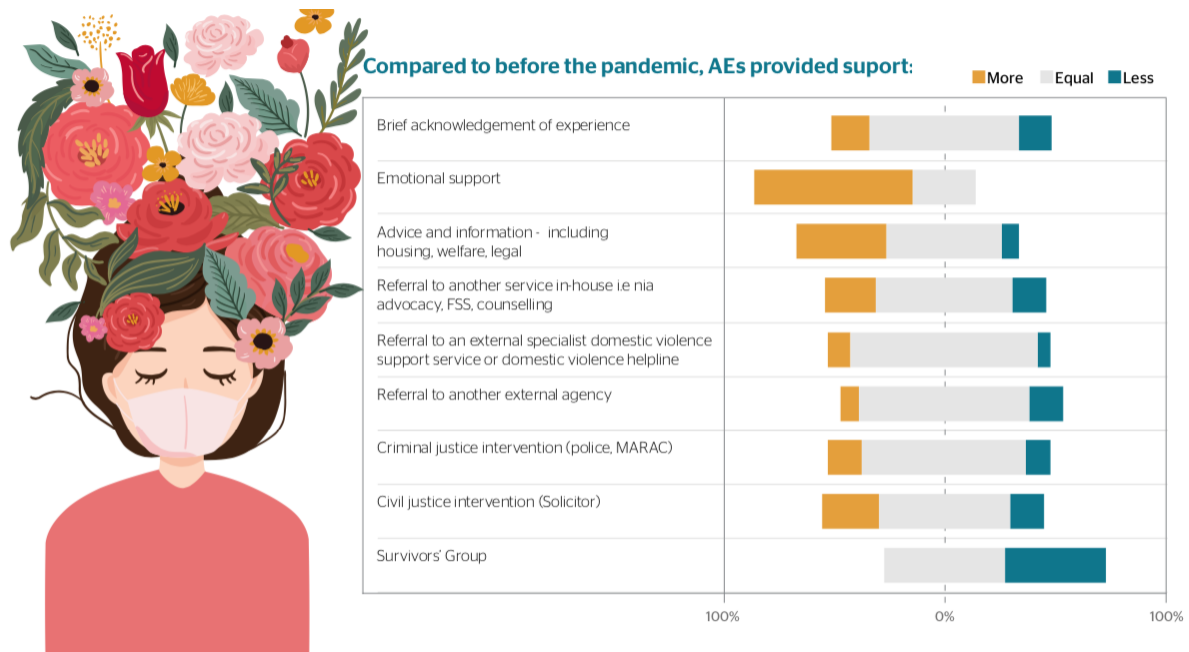
“It's different when you're in the room with someone. I think when it's a screen, people are slightly more shut off, and sometimes even when you're face-to-face you're struggling to, ‘Come on, somebody talk to me.’”

IRIS AE

Workstream 4: desirability and acceptability of IRIS remote advocacy and support

Workstream 4 explored the effectiveness and desirability of IRIS remote advocacy and support. In the survey with AEs (39 responses), 100% of the respondents stated that they were able to transfer support from face-to-face to remote, as appropriate. All the AEs have also said that service users were happy to transfer to remote support, and 63% of AEs changed the method of support for SUs, with text and WhatsApp messaging as the new most common methods of support. 71.8% of AEs believed the change from face-to-face to remote did not impact outcomes for service users, that is, service users were just as positive about the support provided remotely as they normally are. This perception may have been a result of additional support provided. 71.8% of AEs reported providing additional emotional support to service users, and 41% provided additional advice and information on legal, welfare and housing services. However, national lockdown and social distancing restrictions meant that some offered services became (partially) unavailable during the pandemic, with 46.2% of AEs reporting a decrease in access to survivor’s groups, which initially had to be paused as a result of the pandemic. At the time of writing of this report, some DVA-specialist partner organisations had already resumed survivors’ groups in online or blended form, whilst others remained paused. Chart 8 shows differences in types of support provided before and during the pandemic.

Chart 8. Differences in type of support provided by AEs to SUs.



In interviews, both service users and AEs emphasised the quickness and responsiveness of AEs to service users as a mechanism for coping with the newly imposed restrictions. By providing more frequent contact and working into the evening, AEs managed to provide the support needed by SUs. The AEs have taken it upon themselves to ensure service users feel supported under stressful circumstances by working longer hours and being available via text and WhatsApp. The quotes illustrate:

“We have phone calls every week, and if I think if I wanted a phone call twice a week, three times a week, she'd accommodate it.”

IRIS Service User

“We do a video call once a week. If I got something to say or she's got a reminder for me she'll WhatsApp me with the reminder.”

IRIS Service User

“After we've had our phone call, she's giving me a time and a date and if I needed to get hold of her, all I'd have to do was text and she answers really quick.”

IRIS Service User

In interviews, service users also reiterated that they felt adequately supported by AEs during / after lockdown.

“She's done the referrals for social services. She got me on the Freedom Program. She did my legal aid for my solicitor, she helped him with his statements for court. She does do anything she can do remote. She does get it done. Then once a week, she sends me weekly reminders of things to do which is nice. It's really cool, actually. We have some actions for the week which I really enjoy actually.”

IRIS Service User

“She's absolutely brilliant. Like I said, it's even to the point where she's kind of, 'If you need to speak to me then give me a text message and I'll schedule you in.' Even just little things like, 'Let me know when you've got the court date.' [...] I feel like she's on my side if you know what I mean?”

IRIS Service User

“I wouldn't say there's anything that she hasn't helped me with, to be honest. Even if she's not been able to answer a question, she's given me her kind of opinion or she's based it on past experiences she's come across and how they've worked out in the end.”

IRIS Service User

When asked during the interviews whether they preferred face-to-face or remote support, 2 service users expressed a preference for face-to-face, while the other 2 preferred remote support. There was a difference between service users who had engaged with services prior to lockdown and those referred after the national lockdown. Service users before lockdown, when face-to-face support was still available were more likely to prefer face-to-face than service users who started the support after lockdown, when face-to-face was no longer available. This suggests that women who were never offered face-to-face do not seem to have a preference for it, with some thinking that remote support is more convenient and ultimately better.

“I know if remote wasn't going on and it wasn't available, I would just be missing an appointment because I don't fancy going outside that day. I'm just in a low mood.”

IRIS Service User

“It was good because my problem could be solved over the phone.”

For other people, I don't know. For me, it worked."

IRIS Service User

Finally, service users acknowledge the fact that it's sometimes easier to hide their emotions in video or over the phone. However, their perception around this was mixed. Some thought this is the downside of receiving remote support, others thought this was actually a good thing, since it can be overwhelming to be taken over by emotions face-to-face. This difference in perception may be interpreted as a not-one-size-fits-all approach in terms of support provision by the IRIS programme going forward.

Framework Analysis results

We carried out a Framework analysis of the interviews focusing on barriers, enablers, benefits and losses [15, 16], as an alternative method of analysis, to understand communalities and differences between advocate educators, clinical leads, clinicians and service users. Based on the analyses of the interviews, we produced a matrix of emerging findings for each of the relevant groups of stakeholders in this research. Matrixes 9 – 12 summarise the findings.

In general, technology was the most frequently mentioned barrier across all stakeholders. While AEs considered the technology a barrier in the delivery of training, CLs and clinicians mentioned technology as a barrier for identification of DVA. AEs and SUs also mentioned that technology could create a barrier in advocacy and support. The fact that lockdown and social distancing meant women were often restricted at home, and possibly locked in with their perpetrator(s) was also frequently mentioned as a barrier. AEs, CLs and clinicians agreed that this meant that it was less safe to identify and potentially contact these women, which in turn made support more difficult to provide. The other frequently mentioned barrier related to training and managing discussions and promoting engagement with the training. While this barrier was not directly raised by clinicians, AEs and CLs all mentioned the need to improve and enable engagement similar to that obtained in face-to-face training.

In terms of losses, there were three that resonated across the different types of interviewees. Firstly, remote training and support is perceived as less personable for both training and support. This correlates with the previously discussed barrier of technology, in the sense that the screen or telephone makes it easier for someone to hide their emotions and/or facial expressions. Secondly, the loss of embedded status of the IRIS service, where the AEs can use

space in the general practice and hold face-to-face meetings with clinicians, and IRIS AE within general practices was mentioned frequently by CLs and AEs, and on occasion by some clinicians, as another important loss from moving to online training and support². Finally, AEs and CLs state there has been a loss in networking opportunities, such as IRIS network days, although they acknowledged the effort by IRISi to try and replace those with online network days and access to a member's area on its website³.

If we turn to the enablers of change, four attributes were often mentioned during interviews. First, AEs, clinicians and SUs mentioned that the IRIS programme remained effective, desirable and relevant due to the increased contact and communication, be it between IRISi and sites, AEs and general practices or AEs and service users. Furthermore, the quick responsiveness of all involved with the IRIS programme has also been considered an enabler of change, as has flexibility, both in terms of support and training. The final enabler was the increase in relevance of the IRIS programme, justified mostly by the increase in the incidence and prevalence of domestic abuse and by the fact that the usual routes to support are more difficult or no longer available.

Finally, the move from face-to-face support and training to online training and remote support also has produced benefits. For CLs and AEs, the most frequently mentioned benefit was the reduction of administrative work, such as booking rooms or printing materials ahead of training, and reduction of time spent travelling. The second type of benefit mentioned, particularly by AEs and SUs, were the new forms of support (e.g. via WhatsApp, or via video call) that increased in uptake as a result of the pandemic. Many AEs mentioned that going forward, even when face-to-face advocacy can take place, a more flexible range of methods of support should be made available for SUs.

There were also benefits in terms of training. Clinical leads and clinicians mentioned that online training split into several smaller sessions is much easier to fit into a busy clinical diary, and that they felt comfortable being trained online. Finally, a technology-based training enables multiple people from different general practices, and indeed different parts of the

² Prior to March 2020, AEs would provide the majority of their support to patients at the general practice where that patient is registered, and so became regular visitors who became embedded within the IRIS-trained practices in the local area.

³ Prior to March 2020, IRISi held face to face 'IRIS Network and Development Days' approximately every six months, to which all AEs and CLs were invited.

country, to come together at the same time. This last benefit can potentially increase exchange between clinicians, which would be a desirable feature for the IRIS programme. Quickly comparing matrixes 9-12 highlights how AEs and CLs more frequently discussed the barriers and enablers of the change from face-to-face to online/remote training and support, while clinicians and SUs focused more on the enablers of change.

Matrix 9. Framework analysis of interviews – Advocate educators

<p>Barriers</p> <p><i>Advocacy:</i> SU's restrictions at home (perpetrator more often present in house Perpetrator using lockdown as a control/isolation tactic); SU's mental ill health; More time consuming Other organisations (i.e. solicitors, social care) being slow to respond;</p> <p><i>Engaging with practices and delivering training:</i> More difficult to get evaluation forms completed; Difficult to get (extra) time commitment from practice staff (communications with practices via email are easier for them to ignore); Technological difficulties – platforms not always working, difficulties dealing with chat while delivering training; Online training is more intense and requires more alertness;</p>	<p>Enablers</p> <p><i>Advocacy:</i> Adapting work and 'offer' alongside other organisations adapting; New ways of working – text and WhatsApp messages; AEs more accessible</p> <p><i>Engaging with practices and delivering training:</i> More accessible for attendees; Seeing the AE 'live' during training - 'Live' nature of online delivery is crucial to building relationships; Additional awareness raising sessions; Success breeds success – clinicians (and patients) having a positive perception of the IRIS service increases the usage of the IRIS service; Flexibility around training times / to edit/adapt training materials; Online training enables dispersed clinicians to attend;</p> <p><i>General</i> Support from CCG contact promoting IRIS programme via bulletins; Support from IRISi;</p>
<p>Losses</p> <p><i>Advocacy:</i> Lessened ability to be present to accompany SUs to appointments; Lessened ability to deal with multiple queries in one go; Less 'value' from AE time; Not seeing body language, hearing tone of voice;</p> <p><i>Engaging with practices and delivering training:</i> Ability to build relationships/network diminished, esp. if remote delivery is long term; Pre-recorded training would remove personal relationship; Informal opportunities for relationship building diminished; Minority of practices have refused online training in preference of waiting for f2f.</p>	<p>Benefits</p> <p><i>Advocacy:</i> Increased referrals New package of advocacy support specific to pandemic Good case outcomes 'no waste of time' – increased productivity, measured quantifiably (advocacy and training)</p> <p><i>Engaging with practices and delivering training:</i> Easier to gather practice staff for training at same time; Practices have requested online training.</p>

Matrix 10. Framework analysis of interviews – Clinical leads

<p>Barriers</p> <p>Set ways in clinical practice; Engagement and attention of clinicians during online training (and its reflexion on referrals); Confusion about referrals; Uncertain whether patient is alone for a phone consultation; Not necessarily knowing the patient (if it's a telephone consultation); Backlog of training; Technical difficulties with technology -different organisations use different platforms and it's not always easy to adapt; Sharing views and perceptions with other members of the team; Lack of confidence from GPs in dealing with/responding to DV remotely.</p>	<p>Enablers</p> <p>Quick responsiveness from AEs to referrals; Regular check-ins with the audience during training; Practices being pro-active and putting info on their website; Practices more interested in getting IRIS training; Getting professional training to use online platforms; COVID-19 guidance on telephone consultations; IRISi online training - made it look smooth and possible; Online training demonstrates role play, video and telephone consultations High quality materials developed for online training and support; Good connection between AEs and practices; Creative response from clinicians.</p>
<p>Losses</p> <p>Not seeing body language, hearing tone of voice; Ability to hold space for people struggling with training; Attending training alone from your home – loss of opportunity to share experience, thoughts, feelings with other trainees; Ability to see patients at the GP practice (temporary).</p>	<p>Benefits</p> <p>Help women responding to their needs Improve peer-to-peer relationships; No travel time; Fosters collaborative working; Getting people from different practices in the same space; More regular updates possible; Linking different sites (with and without IRIS) in the same region possible; Remote support empowers women to be safer.</p>

Matrix 11. Framework analysis of interviews – Clinicians

<p>Barriers</p> <p>Uncertainty around the foreseeable future; Not knowing remotely if it's safe to ask; GPs can forget parts of the training if they don't apply it (so refreshers needed); Patient/SU's restrictions at home (perpetrator more often present in house / Perpetrator using lockdown as a control/isolation tactic).</p>	<p>Enablers</p> <p>Concise and informative training on DVA; Easy and quick process to get support for patients; Ability to bring women to practice if unsure they are safe; Non-confrontational approach to DVA; Systematic training (including refreshers); Embedded AE; Ensuring IRIS programme is running to best of its ability in current circumstances; Structured way of asking about DVA.</p>
<p>Losses</p> <p>Women can no longer walk-in to the practice and see the worker; Lack of human contact; Missing women who it's not safe to support now; Not seeing body language, hearing tone of voice.</p>	<p>Benefits</p> <p>Patients feel benefit from phone support; IRIS programme provides named AE for direct referrals (benefit across the board); GPs are better able to deal with cases of DVA (remote and face-to-face)</p>

Matrix 12. Framework analysis of interviews – Service Users

<p>Barriers</p> <p>No transition when support ends; Difficulty believing to be in an abusive relationship; Technical difficulties with online support program (Freedom Programme); No link between the IRIS programme and the police.</p>	<p>Enablers</p> <p>Clinician recognising DVA; Quick access to AE; Using text and WhatsApp; Health visitor linked with IRIS worker; Access to multiple forms of support; Easy access to online support AE very responsive; More frequent contact since lockdown</p>
<p>Losses</p> <p>Clinicians and AEs lose ability to read body language and facial expression; Physical contact with AE; Some services not available in online form.</p>	<p>Benefits</p> <p>Less personal (remote) – easier; Easier not to miss appointments if in low mood (as they are remote)</p>

Discussion

This rapid research was a first attempt to collate evidence for the IRIS programme in its online and remote form of delivery. We have carried out 4 surveys and 15 interviews, in which we explored perceptions around the value of the IRIS programme and desirability and acceptability of online training and remote support for patients/service users, clinicians, clinical leads and advocate educators.

We have found that, overall, respondents found that the relevance of the IRIS programme has increased as a result of COVID-19 for three reasons: (1) an increased incidence and prevalence of domestic abuse, as a result of lockdown and social distancing; (2) the quick responsiveness in the adaptation of training and advocacy support to remote or online by IRISi and the IRIS programme; and (3) the fact that the usual routes to support are more difficult or no longer available, particularly with regards to support from family and friends. Furthermore, nearly 95% of the respondents to the IRIS satisfaction survey (56 respondents) wanted the programme to be commissioned in their area in the long term (5 years or more). In terms of confidentiality and ability to identify, ask about DVA and refer to the IRIS programme, we have found that nearly all clinical leads and most clinicians feel at least as confident working over the phone and online, as compared with face-to-face. While 16.7% of clinicians who responded to our survey said they felt less confident, this could be explained by the fact that as of August 2020 only 4.3% of clinicians who responded to the survey had attended some form of IRIS online training. Since the new revised IRIS online training includes a dedicated section of the session to train clinicians to be able to identify, ask about DVA and refer to the IRIS programme during telephone/online consultations, and also provides COVID-19 relevant information throughout trainings, this number would be expected to improve once more clinicians are trained online.

There were mixed perceptions of online training. While AEs and RMs were more concerned with the barriers imposed by technology and difficulties in terms of engagement during training, this perception was not shared by clinical leads and clinicians, who in general felt that online training fits better with their clinical schedule, as the sessions are shorter. This must be explored further with clinicians, as our sample sizes for the surveys and the interviews were relatively small.

Quantitatively, we found that there was a decline in referrals immediately after lockdown in March 2020, but the level of referrals returned to that observed pre-COVID by July 2020. Finally, service users felt well supported by the IRIS programme throughout the pandemic, considering their good outcomes to be a direct reflexion of the increased communication with AEs, and their quickness and responsiveness.

In the Framework analysis, we found that the most frequently mentioned barrier to change from face-to-face training and support to online training and remote support was the technology, although there seemed to be a difference between younger and older stakeholders in terms of their concern with the technology. This could be partially explained by the fact that younger stakeholders seemed to be more willing to embrace new technologies, given they are already more used to using a technological interface in their private life. The ability to read body language / facial expressions during training, during consultations and during support sessions was the most important loss. The most important enabler of change was the flexibility of the programme and the responsiveness and increased communication from IRISi and AEs, and the main benefit of the new ways of working for the IRIS programme was the offer of new forms of support and the ability to train clinicians from different practices jointly and more often.

The findings from this research are in line with other findings regarding online and phone consultations, and provision of remote support. Murphy and colleagues have observed a decline in general practice consultations in March and April 2020, and by July 2020 90% of all consultations were taking place over video or phone [17]. The reduction in consultations immediately after lockdown could partially explain the reduction in referrals to the IRIS programmes. Furthermore, a report by the Health Foundation highlighted that many health and care services had to adapt as a result of the pandemic and move towards a remote mode of working. They have also highlighted that, in general, services that managed to adapt well relied on quickness and responsiveness as enablers of change [18].

There are a number of limitations to this study. Firstly, while we have used multiple instruments for data collection, we acknowledge that the number of survey respondents and of stakeholders interviewed is not large. Furthermore, while all advocate educators (81), clinical leads (36), clinicians (circa 400) and other members of the IRIS network (70) were invited to respond, we understand that there is some degree of self-selection that that the respondents across all categories, but particularly clinicians, may be those who are more likely

to engage with the IRIS programme. This is even more relevant if we consider that interviewees were selected from a subsample of survey respondents.

Another limitation of this rapid research relates to the time. Given that one of the objectives of this study was to produce timely evidence around the effectiveness and acceptability of the IRIS programme in its new format, the surveys were closed in early August and the interviews took place in August, meaning that by the time of writing, further changes, in particular more online training of general practices, is likely to have taken place.

Contributions

This rapid research was conceived by Lucy Downes. It was designed and carried out by Lucy Downes and Estela Barbosa. The manuscript was a joint effort by Lucy Downes, Estela Barbosa, Annie Howell and Medina Johnson.

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Any errors or omissions are the responsibility of the research team and not of the research participants.

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