Violence and health and wellbeing boards

A practical guide for health and wellbeing boards

February 2014

Key points

- People affected by violence are far more likely to experience poor physical and mental health than the general population.
- Early intervention is the most effective way to tackle the negative health and wellbeing impacts of violence and save local healthcare costs.
- Coordination across local services is necessary to address the complex needs of those at risk of causing violence, at risk of experiencing violence, and victims of violence.
- Effective joint strategic working between health and wellbeing boards and community safety partnerships will support improved local commissioning to achieve better health outcomes for those affected by violence.

Violence is a major cause of ill health and poor wellbeing in local communities. As well as the personal cost, violent incidents, including gang and youth violence, violence against women and children, domestic violence, sexual violence and elder abuse, impose a considerable financial burden on local healthcare systems.

Significant health inequalities are experienced by people who are at risk of causing violence, at risk of experiencing violence, and victims of violence. Exposure to violence as a child has particularly negative impacts, not only increasing the risks of involvement in future violence but of substance abuse, poor mental health and chronic illness in later life. Furthermore, violence impacts on the wider wellbeing of local communities. Yet violence is preventable through appropriate targeted interventions, especially in childhood. There are specific violence-related indicators included in the Public Health Outcomes Framework.

At a glance

- **Audience**: This guide is aimed at all health and wellbeing board members, community safety partnerships and other local agencies working to address violence.
- **Purpose**: To provide practical information and guidance on the significant role health and wellbeing boards can play in preventing and tackling violence, in collaboration with community safety partnerships and other local partners.
- **Background**: This document was developed by a working group including the NHS Confederation, the Department of Health, the Home Office and Public Health England.

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Tackling violence effectively cannot be done through enforcement alone. It requires fully coordinated working across local agencies, including health organisations, with strong local leadership. Health and wellbeing boards, structured to bring all parts of the local health and care system together to improve commissioning and achieve better health outcomes, have a significant role to play. Recent changes to the health and care system present new opportunities for effective strategic collaboration at the local level between health and wellbeing boards, community safety partnerships and other local partners, to improve the health and wellbeing of those affected by violence.

Why should health and wellbeing boards give attention to the needs of people involved in or affected by violence?

Scale and cost

Each year there are more than two million violent incidents in England, including domestic violence, gang and youth violence, sexual violence, violence against women and children, and elder abuse. Furthermore, the impact of violence on the health and wellbeing of local communities and the costs it imposes on local healthcare systems are significant. The total cost of violence to local communities is an estimated £30 billion per year.[1]

Around half of all recorded violent incidents result in physical injury, often requiring health treatment and leading to high numbers of emergency department attendances and hospital admissions. People with mental health problems or learning disabilities, or older people, are particularly vulnerable to abuse. Many experiences of violence are, however, unreported. Violence also has a wide range of mental as well as physical health impacts. Forms of severe violence, such as male youth violence linked to gang membership, are significantly associated with high levels of psychiatric morbidity, post-traumatic stress disorder, anti-social personality disorder, psychosis, suicide attempts and anxiety disorders.[1,2,3,4]

Wider impacts

Violence has a serious detrimental impact on the health and wellbeing of the wider local community. It can negatively affect the emotional and mental wellbeing of people even if they are not directly victimised themselves. For example, young people living in communities affected by gang violence may constantly fear for their safety in public places. Fear of violence in the community can also limit use of parks and prevent parents taking their children to playground areas. Without safe and secure local environments, any measures designed to encourage people to exercise, socialise or adopt healthier, sustainable lifestyles are more likely to fail; people feel scared to spend time in public areas and unable to engage with local communities.[1] A recent review of the literature by the Early Intervention Foundation suggests that children witnessing violence are affected as if they have directly experienced it, showing increased fear, inhibited behaviour, depression, high levels of aggression and anti-social behaviour which can last into the teenage years and adulthood.[5]

Health inequalities

People affected by violence – those at risk of causing violence and those at risk of experiencing violence, as well as victims of violence – are far more likely to experience poor physical and mental health than the general population. There is also a strong link between violence and local inequalities. Differences between the low incidence of violence experienced in the most affluent neighbourhoods and the significantly higher levels experienced in the poorest communities, represent one of the most marked health-related inequalities.[1,6] Experiencing violence can also generate inequalities through the impact on life chances that may arise from consequential long-term illness.

Life course

Violence impacts on health and wellbeing outcomes across the life course. Exposure to violence in childhood can have particularly negative long-term health impacts. Childhood abuse not only increases

Violence has a significant impact on health inequalities and health costs

- Violence results in around 300,000 emergency department attendances and 35,000 emergency admissions into hospitals annually in England and Wales.
- Over 16,000 young people aged 13 to 24 years old are admitted to hospital each year for assault wounds.
- Emergency hospital admission rates for violence are around five times higher in the most deprived local communities in England than in the most affluent.
- There is a £1.2 billion direct cost to the NHS annually as a result of violence against women and girls; domestic abuse costs an additional £176 million for mental health services alone.
- Each rape costs over £76,000 to the NHS, the criminal justice system, and from lost output owing to long-term health issues faced by victims.
- Around 50 per cent of women who use mental health services have experienced violence and abuse.
- By the age of ten years, young people exposed to traumatic and abusive environments are 13 times more at risk of joining a gang.
- At least 750,000 children witness domestic violence annually, a key risk factor in these children themselves causing violence in later life.

Sources: HM Government (2011) *Ending gang and youth violence. A cross-government report including further evidence and good practice case studies;* HM Government (2012) *Ending gang and youth violence report: one year on;* Bellis MA, Hughes K, Perkins C, Bennett A. (2012) *Protecting people, promoting health: a public health approach to violence prevention for England* Department of Health/NHS England; Home Office (2013) *Ending violence against women and girls.*

the risk of being involved in violence in later life, but the risk of mental health difficulties, cancer, heart disease, sexually transmitted infections, alcohol and drug misuse, and a wide range of other health conditions. Many gang-affiliated young people have complex childhood abuse histories. They have also frequently suffered from poor attachment relationships in childhood, resulting in a high need to 'belong' and a strong propensity to gang membership.[1,7,8]

At the other end of the life course, there are significantly increasing numbers of older people experiencing violence and abuse.[1] Older people are vulnerable to abuse in their own homes as well as in acute and residential care; it remains a largely hidden form of violence as highlighted, for example, by the Francis Inquiry.[9] Some of the most vulnerable people are those with cognitive impairment such as Alzheimer's disease and other forms of dementia. Negative perceptions of community safety can restrict older people maintaining social activity and independence, thereby increasing isolation.

Women's health

Within every local community, women's health is affected by violence. More than a million women are the victim of domestic violence and abuse, 70,000 women are raped and a further 330,000 sexually assaulted in England each year. Sexual violence is also perpetrated through forced marriage and human trafficking.[1,10]

In 2007 it was estimated that 20,000 girls under the age of 15 in England and Wales were at risk of female genital mutilation (FGM) every year.[11] However, the actual figure may be higher. The Home Office has part funded a new study into the prevalence rates of FGM in England and Wales based on data from

the 2011 Census. The study is being undertaken by Equality Now and City University and the results are due to be published in the spring of 2014. From April 2014, hospitals will be given guidance on how to use new clinical codes to record if a patient has had FGM, if there is a family history of FGM and if an FGM-related procedure has been carried out on a woman (de-infibulation). From September 2014, all NHS acute hospitals will be required to report back to the Department of Health on a monthly basis information on how many patients they are treating who have had FGM. This is part of a programme of work that will see the Department of Health working across Government, the NHS and a range of agencies to deliver tangible change and improvement in the health response to FGM.

All forms of domestic abuse and sexual violence are however under-reported and often poorly recorded by local health and care services. Social attitudes to inter-personal violence can also inhibit people from seeking support. Women experiencing abuse or violence may not only have to contend with the direct physical health consequences but can suffer other negative health behaviours such as poor eating, disrupted sleep patterns, and use of alcohol or other drugs as a form of self-medication. The controlling and coercive aspects of domestic abuse, and its erosion of personal confidence and worth, can also cause life-long emotional harm. Post-traumatic stress, depression and anxiety disorders are also more likely. Moreover many of those who suffer physical or emotional injury will have to take time away from education or employment as a consequence and some may need to leave their own home.

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Prevention: outcome and cost benefits

Violence is preventable. The Government has a national strategy through *Call to end violence against women and girls*, for which there have been successive action plans on International Women's Day (8 March) since 2011. This ambition reflects Millennium Development Goals 2020 on violence and also complements the UK Government's international work on supporting the elimination of violence overseas. In specific forms of violence, a range of interventions have been shown to reduce individuals' propensity to violence, restrict the likelihood of those involved in violence being involved again, and mitigate the risk of poor physical and mental health outcomes associated with violence. They also bring wider benefits in terms of educational achievement, employment prospects and wellbeing. Furthermore, evidence-based violence prevention programmes have demonstrated considerable savings in local healthcare costs[1,4,10,12] and there is economic evidence of significant cost benefits from childhood interventions to prevent violence and abuse. More evaluations are being undertaken on standards for domestic abuse perpetrator programme by the National Institute for Health Service Research.

Given the complex needs of people associated with violence, prevention and intervention requires highly coordinated, joined-up partnership working across a range of services, including health, children's services, early years services including children's centres, social care, youth justice, safeguarding, education, schools, voluntary sector services, policing and youth services. Health and wellbeing boards can play a significant role in leading effective joint working to improve partnerships' prioritisation of violence and commissioning to improve health outcomes of local communities affected by violence, working in strategic collaboration with community safety partnerships and other key partners such as police and crime commissioners, clinical commissioning groups (CCGs) and local authorities.

Working in partnership to prevent and address violence locally

Health and wellbeing boards bring together NHS, local government and local Healthwatch representatives to improve the health and wellbeing of their local populations. The model relies on strong productive partnerships. Health and wellbeing boards and community safety partnerships, working together in collaboration with other relevant agencies, including police and crime commissioners, will be a powerful combination to prevent and tackle violence and the associated health issues that affect local communities.

Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies

The Joint Strategic Needs Assessment (JSNA) and Joint Health and Wellbeing Strategy (JHWS) process provides an ongoing local mechanism for development of integrated multi-agency approaches to tackle violence. Local authorities and CCGs have statutory duties to develop JSNAs and JHWSs to be discharged through the health and wellbeing board. The aim of the JSNA is to assess the needs and assets of the local population in order to improve the physical and mental health and wellbeing of communities and to reduce health inequalities within and between communities. Incorporating women's health needs within JSNAs and JHWSs will be an important part of each process.[18] Since research evidence shows significant health and wellbeing inequalities are experienced by local communities where there are high levels of violence, it is important a local needs assessment for people who are at risk of causing violence, at risk of experiencing violence, and victims of violence, be incorporated in the JSNA.

JSNAs will underpin JHWSs and together these will drive local commissioning priorities, policies and practices. Whilst JHWSs are strategies to meet the needs identified in JSNAs they should not seek to cover everything but prioritise areas where the board members can take collective action and make the biggest impact. JSNAs and JHWSs are the key

Community safety partnerships

- Community safety partnerships (CSPs) are made up of five 'responsible authorities' – police, local authority, fire and rescue service, probation trust, and the clinical commissioning group (CCG) – convened by a chair elected by the CSP membership.
- They are statutorily responsible for reducing crime and disorder, and substance misuse and re-offending in each single and lower-tier local authority area. County councils host 'county strategy groups' which in two-tier areas often take responsibility for commissioning services such as domestic violence, offender management and drug and alcohol services on behalf of district CSPs.
- Responsible authorities on CSPs share joint responsibility for developing a local strategy to reduce crime and disorder, underpinned by a strategic assessment. Since the CSP will be commissioning services to address violence, there will be benefits in aligning the strategic assessment and strategy with the JSNA and JHWS.
- Partnership structures and operational boundaries will affect division of these responsibilities. For example, in some two-tier areas, strategic assessments and partnership plans will be completed at county level with CSPs contributing, although the strategic assessments and strategies will be published at district CSP level. In other areas partners may choose to develop a strategic assessment and partnership plan for each CSP.

For more information, see:
www.gov.uk/government/policies/reducing-and-preventing-crime--2/supporting-pages/community-safety-partnerships
or **www.local.gov.uk**

mechanisms by which health and wellbeing boards will engage with their local partners and hold each other to account for actions agreed in relation to violence.

Accessing and sharing local level evidence

Different types of evidence from a wide range of sources and partner agencies will be needed to build an accurate picture of assets, needs and priorities of people who are at risk of causing violence, at risk of experiencing violence, and victims of violence.

Every health and wellbeing board will need to consider inclusive ways of engaging with people affected by violence; recognising it is crucial to hear views first-hand if their health and care needs are to be successfully addressed by commissioners. Yet these seldom heard groups are often difficult to access and engage. Local voluntary and community organisations often have good connections with such groups. Boards will also benefit from working closely with community safety partnerships and other

Case study: Reducing the health and wellbeing consequences of domestic violence as a JHWS priority in Bath and NE Somerset

Reducing the health and wellbeing consequences of domestic violence is a key strategic objective in the JHWS developed by the health and wellbeing board in Bath and NE Somerset. It details how domestic abuse represents a significant proportion of crime within the local area, with wide-reaching health and wellbeing consequences, including physical harm and disability, depression, low self-esteem, drug and alcohol abuse, child abuse, poverty, social exclusion and homelessness.

The JHWS states that the board will 'work with health, social care and police to promote early, swift and prompt intervention to make sure victims of domestic abuse get the care and support they deserve.' Also that health services are often the first point of contact for people who have experienced domestic abuse and therefore they can play an important role in preventing violence by intervening early, providing treatment and referring victims on to other services.

Set out in the JHWS are examples of how the priority will be delivered, aligned with existing local plans:

- Children and young people to be provided with a safe environment, including empowering them to recognise risks of violence (Children and Young People's Plan).
- Protect children and young people from violence, maltreatment, neglect and sexual exploitation (Children and Young People's Plan).
- Tackle domestic and sexual violence, particularly towards women and children (Avon and Somerset Police and Crime Plan).
- Provide support, advice and refuge to victims of domestic abuse in partnership with commissioned service providers (Housing Services).
- Implementation of Violence Against Women and Girls Action Plan (Interpersonal Violence and Abuse Strategic Partnership).

For more information, contact Councillor Simon Allen, cabinet member for wellbeing and chair, health and wellbeing board,
simon.allen@bathnes.gov.uk
or **www.bathnes.gov.uk/sites/default/files/joint_health_wellbeing_strategy.pdf**

partners such as police and crime commissioners, schools, community youth teams, children's services, safeguarding boards and troubled families coordinators to reach a thorough understanding of local needs and priorities. Equally useful will be guidance on making use of community assets, for example utilising the skills, knowledge and experience of former gang members.

Effective commissioning to prevent violence also requires data on the local communities most at risk, and evidence of the efficiency and effectiveness of services and interventions, especially 'what works' locally. Collation and sharing of local level multi-agency information is critical since relevant and useful data will be held by a range of different services including health, police, schools, criminal justice agencies, child protection, victim support and advocacy. Data sharing between agencies has been shown to make a significant contribution to local efforts to tackle violence. For example, recording information on people with stabbings and gunshot wounds attending A&E units and linking this with data on gang membership held by community safety partnerships, has led to a marked reduction in violent assaults and better child safeguarding in some local areas. Multi-Agency Safeguarding Hubs (MASH)

Case study: Partnership working through the Multi-Agency Safeguarding Hub in Salford

Salford has a significant problem with organised criminal gangs heavily involved in criminal offences such as the importation, production and sale of drugs, robberies, use of firearms and extortion. Recognising that enforcement alone is insufficient to address the problem, the Multi-Agency Safeguarding Hub (MASH) was established in 2012, using funding from the government's Ending Gang and Youth Violence programme.

From the outset the strategic focus of MASH has been on safeguarding as well as long-term measures to identify and target those who aspire to be future gang members. The emphasis is on partnership working to prevent young people becoming involved in violence in the first place, and providing pathways for young people out of violence and the gang culture; with punishment and enforcement being used to suppress the violence of those refusing to exit violent lifestyles.

MASH partners include social workers, health visitors, domestic abuse support services, schools, Salford city council, the youth offending team, housing, as well as the police. A recent example of partnership work in action concerned an organised criminal gang dealing drugs from a local home. Initially, a 22-year-old gang member was arrested at the property, after which the property was inspected by housing officers, social workers and fraud investigators. The occupant of the house was found to be suffering mental health problems and had stopped taking prescribed medicine in favour of the Class A drugs available at her home. Following a strategy meeting with MASH, she was supported by health and care workers to ensure she continued taking her correct medication and empowered to better resist the influence of gang members, reducing her chances of re-offending. Additionally, her 15-year-old son was referred to a mentoring project run by Salford Foundation; the intervention led to his improved attendance and behaviour at school and he is now participating in a local sports programme.

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co-locate police and other protection agencies, making it easier to share information, cut bureaucracy and agree actions. A new national Information Standard is also being developed to enable A&E departments to collect data on violent assault and share this with third party organisations.

Violence indicator profiles, available by local authority area, can provide useful information. They also include helpful data summaries on the effectiveness of different violence prevention strategies (Violence Indicator Profiles for England: www.eviper.org.uk).

A life course approach focused on early intervention

Commissioning services to effectively tackle violence requires a life course approach that emphasises primary prevention. Early identification of risk factors and proactive intervention in childhood not only prevents individuals developing a propensity for violence, but benefits their long-term health outcomes, educational performance and employment prospects. The National Institute for Health and Care Excellence (NICE) standards and guidelines can be helpful.[13] Guidance on identifying and preventing domestic violence and abuse will be published in 2014.

Case study: Using a shared pathway to support vulnerable young people in Sheffield

A systematic partnership approach based around a shared pathway is working effectively to address the health and wellbeing issues of vulnerable 16 and 17-year-olds presenting at A&E in Sheffield. The pathway has been developed and signed up to by the Northern General Hospital Emergency Department (A&E), the Paediatric Liaison Service based at the Northern General Hospital, and Community Youth Teams (CYT) – a partnership of Sheffield City Council, South Yorkshire Police, Sheffield Futures and specialist health staff. A memorandum of understanding has been drawn up between the partners, clearly defining the roles and responsibilities of each agency as well as information sharing and consent processes.

The pathway involves appropriate multi-agency support being offered at the point of discharge to young people aged 16 to 17 years presenting at A&E, where assessment by A&E staff has identified any of the following risks:

- involved in gang activity or crime
- involved in anti-social behaviour
- at risk of or involved in sexual exploitation
- misusing drugs and/or alcohol.

Between February and May 2013, there were 592 presentations at A&E by 16 and 17-year-olds, of whom 29 were assessed as vulnerable; of these 15 were referred for support to CYT and seven to social care. Key to success has been the training provided to A&E staff by CYT to ensure awareness and understanding of the pathway, and having a named contact in A&E who staff can go to for advice and support. There are now plans to extend and develop this pathway with the Sheffield Children's NHS FT Hospital, ensuring all vulnerable young people that present at A&E have access to appropriate support.

For more information, contact Gail Gibbons, service manager, community youth teams, **Gail.Gibbons@sheffield.gov.uk**

Particular attention should be given to addressing abuse in childhood. Health visitors, for example, can play a crucial role in identifying struggling families where there are signs of domestic abuse and violence and helping parents to access evidence-based parenting support interventions.[14] The Family Nurse Partnership programme for first-time parents under 20 years also provides early interventions to encourage supportive parenting, including promoting parent-child attachment. High risk victims of domestic abuse can be referred to a Multi-Agency Risk Assessment Conference where, based on shared information, statutory and voluntary agencies can produce a coordinated action plan focused on increasing the victim's safety.

School nurses who work with children and young people aged 5 to 19 provide early help and universal public health services. Children transition from being supported by the health visiting service to the school nursing service at the age of 5[15] and subsequently transition into adult services at 19. School based interventions can be effective in targeting and supporting children at risk of being violent. For example, the Good Behaviour Game programme is a relatively low cost intervention shown to reduce levels of aggression, particularly among more aggressive males.

Seamless integrated support between commissioned services and across age groups is needed to stop people who are at risk of causing or experiencing violence slipping through the net. Effective transition planning is also necessary, especially when children move to adult services.

Shared outcomes

Identifying a common set of local outcome measures is a powerful way of delivering effective joint working on violence. These outcomes can be used as the basis for identifying where shared and integrated commissioning is necessary. They can also be used for measuring local progress on tackling violence.

There is an indicator for domestic abuse and three specific violence-related indicators in the Public Health Outcomes Framework 2013–16:

- violent crime, including age-standardised rate of emergency hospital admissions for violence
- rate of violence against the person offences
- sexual violence.

(Department of Health (2013) *Public Health Outcomes Framework for England 2013 to 2016: Part 1B* www.gov.uk).

Local authorities, police and crime commissioners, CCGs and other crime prevention partners can look at local indicators based on the level of police reported crime, how their local authority compare nationally, in order to improve dialogue on what needs to be done: http://www.phoutcomes.info/

The Adult Social Care and Outcomes Framework 2014–15 includes a broader but relevant indicator: safeguarding adults whose circumstances make them vulnerable and protecting them from avoidable harm (Department of Health (2013) *Adult Social Care Outcomes Framework* 2014–15 www.gov.uk).

The Department of Health has commissioned NICE to develop a health and social care quality standard for child maltreatment with a focus on the recognition of and response to concerns about abuse. This will also include evidence on effective interventions.

Alignment of commissioning plans

Aligning the commissioning priorities and plans of different partner agencies is an important task for health and wellbeing boards, ensuring better coordinated commissioning. There should be alignment between any violence-related needs and priorities in the JSNA and JHWS, and other relevant local commissioning plans and arrangements such as community safety partnership commission plans, police and crime commissioners' commissioning

Addressing violence in partnership with police and crime commissioners (PCCs)

- Directly elected PCCs in England and Wales have responsibility for holding police forces to account on behalf of the local community. They have a remit to cut crime, along with the commissioning powers and funding to enable them to deliver on this. In London, the Mayor has responsibility for the PCC role through the Mayor's Office for Policing and Crime and the London Assembly.
- A key statutory duty of PCCs is to set out a five-year Police and Crime Plan based on local priorities.
- Health and wellbeing boards are key partners given their responsibility for JSNAs and JHWSs that inform the commissioning of any violence-related local health and care services. Since PCCs commission services to prevent and address violence, there are benefits in aligning the needs and priorities in the Police and Crime Plan with JSNAs and JHWSs in local areas.
- PCCs and CSPs could also consider each other's priorities when drawing up the Police and Crime Plan and community safety strategic assessment respectively.
- From October 2014, it is intended that the majority of emotional and practical support services for victims of crime, including criminal violence, will be commissioned locally by PCCs. Grant funding for the commissioning of services for victims will be provided by the Ministry of Justice.
- The Government is taking forward legislation to give PCCs clear powers to provide or commission a wide range of services for victims of crime, witnesses and others affected by offences, or anti-social behaviour not caused by a criminal offence. A revised Victim's Code was published in October 2013[16] which gives victims clearer entitlements from criminal justice agencies and better tailored services to individual need.

For more information, see:
www.gov.uk/police-and-crime-commissioners
www.local.gov.uk/pcc
www.policecrimecommissioner.co.uk

plans, community safety strategic assessments, safeguarding for adults and children, child poverty strategies, and mental wellbeing impact assessments. Health and wellbeing boards will need to take into consideration the commissioning cycles and timelines of community safety partnerships which may differ from those of local authorities and CCGs.

Pooling budgets

There is potential to pool or align budgets to address the violence agenda across health and wellbeing board and community safety partnership member organisations. Boards should be seeking how best to use collective spend to deliver any violence-related strategic priorities. This provides the opportunity not only to improve the health outcomes of people affected by violence, but to reduce duplication of effort and improve cost efficiencies for all organisations involved. In this respect there is value in using learning from the community budget pilots, particularly those focused on tackling violence. This shows the benefits of aligning resources, reducing duplication and sharing information to deliver better outcomes, as well as realising substantial financial savings.[17]

Top tips for health and wellbeing boards on building positive partnership working with community safety partnerships

- Build on and strengthen relationships that already exist at local level between health and wellbeing board member organisations and community safety partnerships, included shared membership.
- Recognise that among some community safety partnership members there may be frustration at difficulties faced and slow progress over recent years in engaging health partners in working jointly on the violence agenda.
- Recognise that community safety partnerships often have detailed insights and understanding of the individual health and care needs of people who are at risk of causing violence, at risk of experiencing violence, or victims of violence. Consider how best this information can be shared and used.
- Understand the prevention of violence benefits that can result from health members of the health and wellbeing board sharing key non-patient specific data on victims of violence with community safety partnerships.
- Ensure there is active engagement and involvement with key local community groups in contact with the community safety partnership, including people who are at risk of causing violence, those at risk of experiencing violence, as well as victims of violence.
- Utilise the knowledge that community safety partnerships have of local evidence-based

Case study: Using a community budget to address domestic abuse in West Cheshire

In West Cheshire a range of partners, including the council, health providers, police, probation service, and independent providers, are using a community budget to pilot a radical approach which will address the health and wellbeing problems associated with domestic abuse. The cost of domestic abuse to local public services is estimated to be £20 million annually, with 98 per cent of the cost associated with reactive services. Whilst over 9,000 women in the local area are estimated to be affected by domestic abuse, the majority (87 per cent) are not engaging with the criminal justice system.

Using the experiences of domestic abuse victims and perpetrators, and a cost-benefit analysis developed with HM Treasury, new ways to deliver services are being implemented. It is estimated that around £7.6 million net savings can be generated over five years. The new approach to addressing domestic abuse is based around a shared partnership delivery model, Integrated Early Support, that also supports troubled families and children with multiple needs, and incorporates:

- three multi-agency case management teams
- a single point of access for information, advice and guidance
- a common set of desired outcomes and measurable objectives
- shared investment based on a clear map of costs and benefits across local public sector organisations
- a coordinated, consistent and evidence-based common assessment and planning framework
- a suite of evidence-based interventions to support both victims and perpetrators of domestic abuse.

For more information, contact Laurence Ainsworth, head of change management service, **laurence.ainsworth@cheshirewestandchester.gov.uk**

interventions that deliver the most successful and cost-effective health and wellbeing outcomes for those at risk of causing violence, at risk of experiencing violence, or victims of violence.

- Give attention to integrating care services commissioned by health and wellbeing board member organisations, the community safety partnership and other partner agencies, around the needs of people affected by violence.
- Be brave and consider innovative solutions to resource alignment that can potentially save costs or prevent additional costs.
- Utilise new opportunities for collaborative working using pooled resources, for example community budgets.
- Establish boundaries of responsibility for different agencies' funding streams in terms of their relative contributions to commissioning services to deliver any violence-linked strategic priorities.

Case study: An innovative local partnership approach supporting victims of domestic and sexual abuse in West Sussex

A strategic multi-agency partnership arrangement between health organisations, the local authority, and criminal justice agencies is successfully supporting victims of domestic and sexual abuse in West Sussex. The domestic and sexual violence strategic board works to a remit from the West Sussex CSP and both strategic bodies have representation at senior level from public health and criminal justice agency partners, as well as health and wellbeing board members. A county-wide domestic violence strategy, developed by the domestic and sexual violence board, is underpinned by joint funding from the local authority's public health and safeguarding directorates. This incorporates a single referral pathway for all domestic violence services and shared case-management to support cross-team working.

Support services for victims of domestic and sexual abuse are focused on a network of independent domestic violence advisors (IDVAs) co-located in four hospitals across three NHS hospital trusts. The IDVAs are employed directly by the local authority with each hospital trust providing free accommodation and use of facilities to support their work. In addition, there are IDVAs based with the children's social care team, probation agency and police, working in partnership with the health-located IDVAs to provide seamless support for the highest risk, most vulnerable victims. A network of community outreach workers support victims experiencing abuse of a lower risk level.

Evidence from Insights, an outcome measurement scheme developed by Coordinated Action Against Domestic Abuse (CAADA), indicates this innovative partnership approach is proving effective. As Trish Harrison explains: 'Victims engage earlier with services co-located in health settings and as a result, the average length of the abusive relationships they experience is consequently lower. We think this is because health agencies are available 24 hours a day, making them more accessible and they are a much safer and less contested space than criminal justice agencies. Victims feel more comfortable about accepting support in a health environment and as a result, they are disclosing at an earlier stage of their relationship. The profile of the victims we support in the co-located services is also different – victims hidden from criminal justice agencies, for example the young and those with complex needs.'

For more information, contact Trish Harrison, principal manager for domestic abuse and sexual violence, **trish.harrison@westsussex.gov.uk**

Top tips for community safety partnerships on engaging with health and wellbeing boards

- Be proactive in engaging with health and wellbeing boards since they are still relatively newly formed bodies, open to working in new and different ways with partners.
- Realise 'this isn't like before' and be willing to collaborate irrespective of any earlier frustrations over working with health partners; understanding that over the last two years the local NHS has undergone major structural change at all levels, making it a demanding time for health colleagues and disrupting working relationships.
- Recognise a strong evidence base will be needed to encourage upstream investments to prevent violence and associated health inequalities. Clarify what data is needed and how it can best be shared. Marshal the available evidence and cost effectiveness of 'what works' in relation to local interventions and initiatives that can be used to support commissioning decisions.
- Ensure the health and wellbeing board has a clear overview of what resources are available to address the violence agenda, and where in the system, so the board can better align spending with priorities.
- Develop structured partnership links with local Healthwatch (who have a seat on the health and wellbeing board), to ensure there is active engagement with local communities affected by violence, and encourage their engagement with local Healthwatch.
- Ensure there is a local needs assessment incorporated into the JSNA that identifies the health and wellbeing assets, needs and priorities of people who are at risk of causing violence, at risk of experiencing violence, and victims of violence.
- Take into consideration that health and wellbeing boards are seeking to make a significant difference locally and in ways that will achieve recognisably better local health and wellbeing outcomes. They will align with but avoid duplication of existing local strategies that impact on the health of the local population.
- Recognise whilst the JHWS will build on evidence of local assets, needs and priorities identified in the JSNA, it will focus on only a small number of strategic priorities that add value locally. The health and wellbeing board will likely use a prioritisation framework to assist the prioritisation process, working in close collaboration with local communities.
- Examine neighbouring community safety partnerships for potential partnership links with health and wellbeing boards for delivering on the same or similar violence priorities.
- Consider working with the independent local authority overview and scrutiny function, if other approaches have been insufficient, to assist boards to understand better the health and care needs of vulnerable people affected by violence, and ensure health inequalities experienced by them are being reduced, and health and care services integrated around their needs.

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16. Ministry of Justice (2013) *Code of Practice for Victims of Crime.* **www.justice.gov.uk**
17. HM Government/Local Government Association (2013) *Local Public Service Transformation. A Guide to Whole Place Community Budgets.* Local Government Association. **www.local.gov.uk**
18. Women's Health & Equality Consortium, *Better health for women: how to incorporate women's health needs into Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies.*

Additional resources

Catch 22/MHP Communications (2013) *Violence prevention, health promotion: a public health approach to tackling youth violence.*

Department of Health (2013) *Statutory guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies.* **www.gov.uk**

Local Government Association (2013) *Adult safeguarding and domestic abuse. A guide to support practitioners and managers.* **www.local.gov.uk**

Local Government Association (2013) *Community safety partnerships. A guide for clinical commissioning groups.* **www.local.gov.uk**

London School of Economics/Kids Company (2013) *Kids Company. A diagnosis of the organisation and its interventions. Final Report.* **www.lse.ac.uk**

NHS Confederation (2012) *Operating principles for Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies.* **www.nhsconfed.org**

NHS Confederation (2013) *Good practice in joint health and wellbeing strategies: a self-evaluation tool for health and wellbeing boards.* **www.nhsconfed.org**

Taskforce on the Health Aspects of Violence Against Women and Children (2010) *Report from the Sexual Violence Against Women sub-group. Responding to violence against women and children – the role of the NHS.*

The Adverse Childhood Experiences (ACE) Study: linking childhood trauma to long-term health and social consequences. **http://acestudy.org**

The Office of the Children's Commissioner's Inquiry into Child Exploitation in Gangs and Groups (2013) *I thought I was the only one. The only one in the world. Interim Report.* **www.childrenscommissioner.gov.uk**

Additional health and wellbeing board resources can be found at:

https://knowledgehub.local.gov.uk/group/hwbs_resources

http://www.nhsconfed.org/Publications/Pages/lresources-health-wellbeing-boards.aspx

Further information

www.nhsconfed.org/hwb

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