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HEALTH & WELLBEING BOARD

AGENDA

Wednesday August 13 2014
1.30 pm – 3.30 pm
Committee Room 2

1. **CHAIRMAN'S ANNOUNCEMENTS**

   The Chairman will announce details of the arrangements in case of fire or other events that might require the meeting room or building's evacuation.

2. **APOLOGIES FOR ABSENCE**

   (If any) – receive.

3. **DISCLOSURE OF PECUNIARY INTERESTS**

   Members are invited to disclose any pecuniary interest in any of the items on the agenda at this point of the meeting.

   Members may still disclose any pecuniary interest in any item at any time prior to the consideration of the matter.

4. **MINUTES** (Pages 1 - 10)

   To approve as a correct record the minutes of the Health and Wellbeing Board meeting held on 9 July 2014 and to authorise the Chairman to sign them.

5. **MATTERS ARISING**

   To consider any matters arising.

6. **HEALTHWATCH ANNUAL REPORT (**Pages 11 - 52)

   Report presented by Anne-Marie Dean.

7. **INTERMEDIATE CARE CONSULTATION** (Pages 53 - 78)

   Verbal update and presentation by Alan Steward.

8. **VIOLENCE AGAINST WOMEN** (Pages 79 - 172)

   Report presented by Cynthia Griffin.

9. **BETTER CARE FUND**

Verbal update by Barbara Nicholls.

10. **COMPLEX CARE**

Report to follow.

11. **DATE OF NEXT MEETING**

Board members are asked to note that the next Health and Wellbeing Board meeting will be held on Wednesday September 10 2014 at 1.30 pm.

MINUTES OF A MEETING OF THE
HEALTH & WELLBEING BOARD
Committee Room 2 - Town Hall
9 July 2014 (1.30 - 3.35 pm)

Present

Cllr. Steven Kelly (Chairman) Cabinet Member for Individuals, LBH
Dr Atul Aggarwal, Chair, Havering CCG
Cllr. Wendy Brice-Thompson, Cabinet Member for Health, LBH
Conor Burke, Chief Officer, BHR CCGs
Cheryl Coppell, Chief Executive, LBH
Anne-Marie Dean, Chair, Healthwatch
Cynthia Griffin, Group Director, Culture, Community and Economic Development, LBH
Alan Steward, Chief Operating Officer, Havering CCG

In Attendance

Phillipa Brent-Isherwood, Head of Business and Performance, LBH
Barbara Nicholls, Head of Adult Social Care, LBH
Lorraine Hunter-Brown, Committee Officer, LBH (Minutes)

Apologies

Mark Ansell, Consultant in Public Health, LBH
John Atherton, NHS England
Cllr. Meg Davis, Cabinet Member for Children & Young People's Services, LBH
Joy Hollister, Group Director, Social Care and Learning, LBH
Dr Gurdev Saini, Board Member, Havering CCG

1 **CHAIRMAN'S ANNOUNCEMENTS**

The Chairman announced details of the arrangements in the event of a fire or other event that would require evacuation of the meeting room.

2 **APOLOGIES FOR ABSENCE**

Apologies for absence were received and noted.

3 **DISCLOSURE OF PECUNIARY INTERESTS**

None declared.

4 MINUTES

The Board considered and agreed the minutes of the meeting held on 7 May 2014 and authorised the Chairman to sign them.

5 MATTERS ARISING

The Chairman thanked Board members for their hard work and commitment during the last twelve months in launching a number of successful initiatives aimed at improving the health outcomes for Havering residents.

The Chief Executive advised that all organisations within the local health economy had detailed management plans in place with committed project management teams to drive processes forward in the coming municipal year.

The Board discussed End of Life care with particular regard to people with dementia or people living on their own. It was agreed that the Clinical Commissioning Group representatives would provide an End of Life update at the October 2014 meeting.

6 COMMUNITY ENGAGEMENT IN LEARNING DISABILITIES AND DEMENTIA

The Board received a report from the Chairman of Havering Healthwatch that provided an update on a series of workshops held in the borough during February and March 2014. It was noted that the report had recently been presented at the National Commissioning Conference with Healthwatch England and at the last Board meeting at Queens Hospital where the Executive agreed to accept all the recommendations.

The purpose of the report was to investigate what services were available in Havering for people with dementia or a learning disability and what was needed to be done to secure improvements. Attendees to the workshop sessions included service users, carers, representatives from the voluntary sector, NHS organisations and Local Authority departments. The framework at each meeting and themes discussed were:

What is missing?
What would make a difference?
What have you experienced that is good?

The following conclusions were drawn from all the attendees sharing their knowledge and experience on both dementia and learning disabilities:

- Overall, services for people who have a learning disability or dementia appear adequate and there have been some good, innovative developments.

- Service planning over the years has taken account of the needs of people who have dementia; but much remains to be done, especially in early diagnosis.
- Services for people who have a learning disability appear to be less advanced. The challenges are across all the age groups, but many parents felt very strongly about the support and access to basics such as aids and equipment.
- A more contemporary and intuitive care model for learning disability and dementia, which addresses the inequity of service and access across the Borough, is needed.
- The feedback indicates that people who use services and carers need better means of communicating their views and a better understanding of how to seek the support and help that they need.
- That is not necessarily a criticism of the services – there was no suggestion that staff do not listen, or seek views, or try to tailor services to individual need. However, the statutory provisions under which services are provided tend to be aimed at common needs rather than individual circumstances.
- Personalised budgets will undoubtedly help people choose what they want rather than what is on offer. However, it may take time both to give people the confidence to make their own choices and for "the market" to develop service packages that are tailored to individual choice.
- People will need help and support in taking on this responsibility.
- Service users and carers appeared to be confused regarding the services on offer, the role of various voluntary sector organisations and who to contact and when.
- Service delivery problems are not confined to one sector: and there is evidence of joint planning and working across the agencies. However, from the comments given by users and carers, there is no doubting professional staff commitment and passion to achieve the best possible care standards for the residents in the Borough.

In response, Healthwatch had highlighted areas of concern and made a number of recommendations in each of which the main points were:

- Health checks – to review provision and monitoring of annual health checks and to consider a centralised service with expertise in dementia and learning disability.
- General Practice awareness – to ensure GPs had the necessary training and expertise and to eradicate delays in diagnosis and treatment.
- Communication and awareness – to develop borough information pack for learning disability and dementia.

- Staffing – to clarify the position in respect of Admiral Nurses and their future role in the borough.
- One Stop Shop – to provide all community services in one location so as to benefit service users and carers.
- JSNA – to improve the level of local detail about learning disabilities and dementia thus providing a better opportunity to plan and design care for the longer term.
- Reachability – to introduce "Reachability" as the new criteria for measuring access to services.

In conclusion, concerns were expressed about the regularity of annual health checks for people with a learning disability and also the delays in GPs diagnosing dementia.

The Chairman of the CCG advised the Board that diagnosing dementia often took some considerable time as the Memory Clinic would only accept referrals on blood tests taken after three months.

The Healthwatch Chairman advised Board members that the organisation was planning to develop and train staff in Learning disabilities.

The Board welcomed the report and agreed the following actions:

A. The Chief Officer of the CCG would respond to a number of key points raised by the report and to investigate what services were being offered by current providers. A briefing would be available to the Health and Wellbeing Board in September 2014.

B. There should be a review of voluntary and community services relating to Learning disabilities and Dementia and that a mapping exercise should be carried out.

C. It was agreed that there should be a single source of up to date information which can be posted on a website. Information should also be simplified and easy to read and that leaflets for dementia and Learning disabilities should be merged. Advice and support on dementia and Learning disabilities was especially important when communicating with different cultures and ethnic groups.

D. There should be a review of Learning disability services in the borough.

E. It was agreed that the Chairman of Healthwatch should provide a report specifically on learning disabilities at a later meeting.

7 PRIME MINISTER'S CHALLENGE FUND UPDATE

The Board received an update from the Chief Operating Officer of the Clinical Commissioning Group (CCG) on the Prime Minister's Challenge Fund. The Challenge Fund of £5.6 million would be utilised to transform

Primary Care across Barking, Havering and Redbridge (BHR) over the next two years for the benefit of patient and to develop GP services. It was noted that there are three components in the Challenge Fund as follows:

- Access; extended hours, triage service, A&E support and care home and care professional support. Enhancing patient experience by providing improved access to emergency care, more responsive and flexible service covering evenings and weekends.

- Complex Care; tailored teams to meet patient's needs, patient support for reduction in reliance on hospital care, proactive planned care and Telehealth. Enhanced patient experience would include individually tailored care outside of hospital, proactive support, increases in capacity in Primary Care for others and reduced admissions.

- Software development; to enable all health providers to hold the very latest records and information. The computer system would be linked to extract information from various providers.

The CCGs were exploring the possibility of GP practices forming federations which could provide shared services or extended opening hours. It would be for the practices to plan the most effective delivery in how they could provide coverage from 8.00 am to 10.00 pm.

In total, there were 137 GP practices in BHR with 759,000 patients and there were already some clusters of GP practices working collaboratively to support combined lists of 50,000 patients. The Integrated Care Management team were currently supporting 3000 patients.

Complex Care would be supporting 1000 vulnerable patients across BHR. There were plans to link triage and the 111 service so as to provide support to A&E and provide an effective care home service.

The CCG advised the Board that they were considering co-commissioning Primary Care services with NHS England. Further briefings on this aspect would be brought to the Board at a later date.

The Board were advised that the CCG Communications Manager would advise about publicity for the Challenge Fund.

The Board agreed that the BHRUT Chief Officer would present a paper on the IT Software development at the October 2014 meeting.

The Board noted the update and that a more detailed report would be presented at the September 2014 meeting.

8 CARE ACT/BETTER CARE FUND - QUARTERLY UPDATE

Board members received an update on the Care Act and were asked to note the following:

The Care Act

The Care Bill had been given Royal Assent on 14 May 2014 and that the Act would become final in April 2015. Draft regulations and guidance had been issued for consultation and it was anticipated that the final version would be published in October 2014.

There was a lot of work being done nationally in order to understand the impact of the Care Act and ADASS was co-ordinating a national social care response on behalf of its membership.

There was also concern nationally as regards the affordability of the Care Act and its impact on the cost to Local Authorities in extending carers rights as set out in the legislation. The Group Director for Children, Adults and Housing had recently attended a meeting where this was discussed. Following a recent debate in the House of Lords, the government had committed an additional £69.4m funding via the BCF for 2015/2016 rising to £192.6 million in 2020 although it was not clear whether new money would be made available. It was noted that a grant of £125K would be given to Local Authorities for this financial year to cover implementation and a further £1.2 million next year.

With reference to preparations taking place in Havering, a Technical Hub had been established and was working to an agreed Programme Plan. A recent guidance and regulations workshop had proved productive outlining key issues pre and post April 2015 which were as follows:

- Implications to Social Work practice and changing the care management operationally
- Financial implications of additional cost pressures such as infrastructure and staff resources
- Focus on prevention in delaying the need for care and support
- Eligibility criteria
- Need to ensure that information, advice and signposting is robust and delivered by the right skill set.
- Emphasis on promoting resident independence and involving family and support networks
- Participation of NELFT

- To review in detail the end to end processes in order to design a new assessment support planning pathway fit for purpose.

Better Care Fund

The Board received an update on the Better Care Fund (BCF) and were asked to note the following:

- Plans would not be signed off as there were ministerial concerns regarding the robustness of financial modelling and provider engagement.

- Looking for a more detailed breakdown of planned investments and savings and how the BCF will impact on emergency admissions and the acute sector

- A key change had been recently announced in that £1 million of the £3.8 million would be held back for payment for the performance related element of BCF which was now linked to achievement of targets. ADASS had concerns about the impact on elements of the BCF that are specific to protecting Adult Social Care, therefore, a detailed analysis was currently underway

- The Health and Wellbeing Board would be asked to re-submit plans in the near future which would be subject to a revised assurance process

The Board noted the updates.

9 HEALTH AND WELLBEING FIVE YEAR STRATEGIC PLAN

The Health and Wellbeing Board received the final version of the Barking Havering and Redbridge Five Year Strategic Plan. The plan set out how the Strategic Planning Group would work collaboratively across the three boroughs in order to achieve a shared financially viable vision in meeting the expectations and improving outcomes for patients.

The Board noted and approved the plan.

10 FUTURE PRIORITIES, CHALLENGES AND OPPORTUNITIES FOR THE HAVERING HEALTH AND WELLBEING BOARD

Board members received a presentation on the priorities, challenges and opportunities for the Health and Wellbeing Board from 2014 to 2017. The current 8 priorities split into three thematic areas for 2012-2014 are as follows:

Prevention, keeping people healthy, early identification, early intervention and improving wellbeing

1 Early help for vulnerable people
2 Improved identification and support for people with dementia
3 Earlier detection of cancer
4 Tackling obesity

Integrated support for people most at risk

5 Better integrated care for the "frail elderly" population
6 Better integrated care for vulnerable children
7 Reducing avoidable hospital admissions

Quality of services and patient experience

8 Improve the quality of services to ensure that patient experiences and long term health outcomes are the best they can be

The Board were asked to consider the following as suggested priorities for 2014-2017 and to note that they were still grouped into 3 thematic areas:

Preventing, reducing and delaying the need for care and support through effective demand management strategies

1. Early help for vulnerable people
2. Improved identification and support for people with dementia
3. Improve the effectiveness of support for people with mental health conditions
4. Tackling obesity

Integrated support for people most at risk

5. Better integrated care for the "frail elderly" population
6. Better integrated care for children, young people and families
7. Reducing avoidable admissions and premature deaths

Quality of services and patient experience

8. Improve the quality of services to ensure that patient experiences and long term health outcomes are the best they can be

It was suggested that the above priorities should be subject to a longer timeframe than the one currently in place in order to impact on desired outcomes whilst recognising the need to keep the strategy current and the changing demography of the borough.

Several areas had been identified as immediate priorities such as improved identification and support for people with dementia, improving the effectiveness of support for people with mental health conditions, tackling obesity, reducing avoidable admissions and premature deaths and improving patient experience and service quality.

Members agreed that data and performance indicators should be reported to the Board on a regular basis in order to monitor progress against the agreed priorities. The Board agreed to refresh the Joint Health and Wellbeing Strategy and accompanying action plan, and that the document is presented at the Health and Wellbeing Board meeting in October 2014.

11 ANY OTHER BUSINESS

It was noted that the CCG were currently undertaking consultations relating to Intermediate Care in Barking, Dagenham, Havering and Redbridge and that there would be a further update at the next Health and Wellbeing Board meeting. The Board were advised that the proposals would be presented by the Chief Officer to the Health Overview & Scrutiny Committee.

Members of the Board were advised that the CCG had been holding discussions with NHS England regarding future plans for the St Georges Hospital site. It had been proposed that medical facilities would be built on 10%-15% of the land. The Group Director of Culture, Community and Economic Development had recently held a productive meeting with the CCG and planners.

The Board gave their approval for the CCG to proceed with the proposal.

12 DATE OF NEXT MEETING

Members of the Board were asked to note that the next meeting would be held on Wednesday 13 August 2014 at 1.30 pm.

Chairman

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healthwatch Havering

ANNUAL REPORT, 2013/14

Making a difference…

Presented in accordance with
"The Matters to be Addressed in Local Healthwatch Annual Reports Directions, 2013"

Healthwatch Havering is the operating name of
Havering Healthwatch Limited
A company limited by guarantee
Registered in England and Wales
No. 08416383

What is Healthwatch Havering?

Healthwatch Havering is your new consumer local champion for both health and social care. Our aim is to give local citizens and communities a stronger voice to influence and challenge how health and social care services are provided for all individuals locally.

We are an independent organisation, established by the Health and Social Care Act 2012, and are able to employ our own staff and involve lay people/volunteers so that we can become the influential and effective voice of the public.

Healthwatch Havering is a Company Limited by Guarantee, managed by three part-time directors, including the Chairman and the Company Secretary. There is also a full-time Manager, who co-ordinates all Healthwatch Havering activity.

Why is this important to you and your family and friends?

Following the public inquiry into the failings at Mid-Staffordshire Hospital, the Francis report reinforces the importance of the voices of patients and their relatives within the health and social care system.

Healthwatch England is the national organisation which enables the collective views of the people who use NHS and social services to influence national policy, advice and guidance.

Healthwatch Havering is your local organisation, enabling you on behalf of yourself, your family and your friends to ensure views and concerns about the local health and social services are understood.

Your contribution will be vital in helping to build a picture of where services are doing well and where they need to be improved. This will help and support the Clinical Commissioning Groups and the Local Authority to make sure their services really are designed to meet citizens' needs.

'You make a living by what you get,
but you make a life by what you give.'
Winston Churchill

CONTENTS

We will be sending copies of this Annual Report to the statutory recipients (including the British Library) and circulating it widely to local health and social care organisations. Printed copies will be available for the public. It will also be available on our website, www.healthwatchhavering.co.uk .

Foreword

Anne-Marie Dean, Chairman, Healthwatch Havering

It is a pleasure to welcome you to our first annual report.

Firstly, I would like to begin by thanking our volunteers, staff and the statutory and voluntary organisations that have supported us in becoming established within Havering. With their help and advice we have become part of the Havering network of health and social care organisations.

Healthwatch Havering is part of a new national concept which gives every individual, in every community, their own local independent consumer champion for health and care. Our umbrella body is **Healthwatch England**, which is part of the Care Quality Commission.

Our job is to champion the needs of children, young people and adults. We know that if we can make things better for the most vulnerable in our communities, we will all benefit. We work for everyone, not just those who shout the loudest.

During the year patients, service users, carers and concerned members of the public have shared with us a number of matters. Our approach is always to listen carefully, build up a detailed

picture gaining a clear understanding of what is important to each individual.

Although we work in partnership with the health and care sector, voluntary and community sector; we are independent, and so we can, and do, when required, speak loudly on behalf of all individuals in Havering and we are not afraid to point out when things have gone wrong.

The strength of our work is entirely based in the strength of our volunteer team. They lead and set the priorities and objectives, based on personal knowledge and the experiences that people and organisations share with us and the national and local agenda. Within our Annual Report we share with you examples of their work and achievements.

We have had a busy and successful year and thank you for your part in helping us to achieve this.

1 Making a difference: working with local partner organisations to improve services

The launch of Healthwatch both nationally and in Havering in April 2013 coincided with emerging public concern about standards of care in health and social care settings - the scandals of Mid-Staffordshire Hospital and the Winterbourne House care home were just the two most remarked-upon examples of a series of failings that attracted the attention of the media and other commentators.

Safeguarding is at the heart of all we are doing in the Borough. It is often more effective to work informally in the background than stridently to produce formal reports and recommendations.

Locally, concerns arose following a series of adverse Care Quality Commission (CQC) and other reports about care in Queen's Hospital, Romford and in several residential care homes. Our contacts with the Barking, Havering & Redbridge University Hospitals Trust (BHRUT) and with several care home proprietors have received positive responses.

In late 2013, Queen's Hospital was one of the first in England to be subjected to a new inspection regime by the CQC, as a result of which the hospital was placed in "special measures". Although not directly involved in that decision, we submitted preliminary evidence to the inspection team and we were present by invitation at the meeting at which the CQC announced the findings of the inspection team.

Our Social Care team has been paying close attention to the Borough's care homes and, in particular, those identified by the CQC as being in need of significant improvement. We have not needed to make formal recommendations or representations to the CQC so far but our close working relationship with them both has led to the development of mutual trust and respect that enables us to be informally influential.

More recently, we have worked on services for people with Dementia and for people with a Learning Disability – both areas of growing concern nationally as well as locally. We are developing strong links with both statutory and voluntary agencies operating in those areas, enabling us to be influential without necessarily having to take formal action. We have recently submitted a series of recommendations to commissioners and providers of health and social care services for people with Dementia or for people with a Learning Disability, based on what people who live or work in the Borough have told us through our **"Have your say…"** events on Learning Disability and Dementia.

2 Making a difference: working for local people

Although Healthwatch Havering has no direct remit to represent, or act as advocate for, individuals or to investigate individual complaints, people in distress do not always appreciate exactly whom to approach for help and contact Healthwatch Havering "because we are here". We have taken the view that we have a general duty of care to help those in distress.

Generally, we carry out that duty by referring people on to those best placed to help them but, occasionally, a more detailed intervention may be needed. Moreover, of course, an approach from a person in distress may be symptomatic of some underlying systemic failure that *is* within our remit.

An example of possible systemic failure emerged with difficulties in getting appointments at Queen's Hospital:

- a patient who had a life-threatening illness, who needed further medical attention was having trouble getting an appointment
- another was distressed because he had been told by Queen's Hospital that he had only a limited time to contact them to make an appointment for treatment for a respiratory problem but was unable to get though on the telephone, and was concerned that he would miss the slot
- one patient's paperwork for the pain clinic was lost and, despite being in agonising pain, she was told that she would have to go to the back of the queue

In each case, we made representations on the patient's behalf and appointments were promptly arranged for them.

In another case, a patient contacted us having taken her two young sons to be vaccinated at her GP practice – while there, she had a disagreement with the nurse and felt awkward about returning to the practice; she was very worried about not having a GP. We told her to contact NHS England, and we later learned that she had been allocated to another GP within a couple of days.

One man rang the office – his mother had been refused a stair lift on the ground that she lacked mental capacity to use it safely, even though the son was living with her. We referred him to the appropriate staff in Adult Social Care and he later told us that his mother had received her stair lift – his thanks were profuse!

3 Making a difference: influencing official bodies and others

Healthwatch Havering is a statutory member of the Havering Health & Wellbeing Board. We are also formally represented at meetings of Havering Council's Health, Individuals and Children's Services Overview & Scrutiny Committees and a wide range of other relevant bodies, both local and regional to North and East London.

A fuller list of the organisations etc. with which we are involved is set out in ***Appendix 1***.

Informal meetings are regularly held with senior managers of Havering Adult Social Care, BHRUT and Havering Clinical Commissioning Group (CCG). A good working relationship has been established with the local officers of the CQC Inspectorate responsible for health and social care facilities in Havering.

After a visit by our Social Care team to a particular, rather large care home, it transpired that their residents shared 8 or 9 GPs: as such a large number could have led to confusion over which GP was responsible for which residents, we contacted the CCG and suggested there should be fewer, designated GPs. As a result, the CCG has designated a single GP for the home instead. This case was recently cited to Healthwatch England as an example of the sort of change for the better that local Healthwatch can be instrumental in achieving[1].

In February, we undertook an announced "Enter & View" visit to a care home in Romford that had given the CQC cause for concern. Our team found that the home had made progress in dealing with the problems identified by the CQC but that there were still issues to be addressed. Our recommendations following the visit led to the home's proprietors employing an additional activities coordinator.

We have developed an ambitious work programme for 2014/15, which will include an investigation of patient-related activity at GP practices (see ***Chapter 8***).

[1] Comments to the Committee of Healthwatch England in February 2014 by Councillor Sir Merrick Cockell, Chairman of the Local Government Association and former Leader, Royal Borough of Kensington & Chelsea

Further details of our Enter & View activities are given in ***Appendix 2***. Some case studies of actions that have led to positive change are given in ***Appendix 3***.

Although strictly outside the scope of this Annual Report, we recently learned that BHRUT had welcomed as positive the feedback we have given them following an Enter & View visit to the Maternity Unit at Queen's Hospital. Their Chairman said, on the record at a Board meeting, that:

> "I am pleased to say that an independent review by Healthwatch into our maternity services was very complimentary. This is a reflection of the Journey of Improvement that has been carried out in BHRUT's maternity services"

Subsequently, BHRUT confirmed their acceptance of our recommendations for further improvement (details are on our website).

We have established a useful working relationship with Healthwatch England, both at national level and in London. During 2013/14, we had no occasion to make any suggestions or proposals to Healthwatch England on matters for investigation (though as publication of this annual report was nearing, we did agree to support a special inquiry proposed by Healthwatch England into hospital and other institutional discharge, based on local work about discharge already carried out – see ***Appendix 3***).

4 Making a difference: public consultation and participation

Healthwatch Havering is developing a role in consulting the public and encouraging their participation in health and social care issues.

In September, we commissioned the Film Unit of the Media Studies Group of Sixth Formers of a local School, the Coopers' Company & Coborn School, Upminster, to produce a short film of local peoples' thoughts about local health services. This film is available on **You Tube**.

In December, we held a workshop at which the CCG and North East London Foundation Health Trust (NELFT) were able to give presentations about their plans for improving home care services: **New Services Putting Care Closer to Home** was well-attended and generated valuable feedback for the CCG and NELFT in proceeding with their plans.

Over two weeks at the end of February and beginning of March, we held five **"Have your say…** on Learning Disability and Dementia services" events around the Borough. These gave health and social care professionals, service users and carers, and representatives of the voluntary sector an opportunity to discuss health and social care services for people who have Dementia or a Learning Disbaility. The information gathered in the course of those events has proved invaluable and the formal report is now on our website.

Some of our volunteers provided a stand at Havering's **National Women's Day** in March, at Havering College.

We are are represented at the monthly meetings of Havering's **Over-Fifties Forum**, giving us the opportunity to discuss health and social care issues with them on a regular basis.

We are planning to hold more **"Have your say…"** events in the course of 2014/15, probably in mid-summer, late autumn and spring; and we will also hold sessions to follow up the December event on **Putting Care Closer to Home** and the recent **"Have your say on…"** event about services available in Havering for people who have dementia or a learning disability. We have also arranged for the Nursing Director of Havering CCG to address a public meeting on the CCG's response to the Francis Report (about the Mid-Staffordshire Hospital scandal) and its implications for Havering.

5 Making a difference: Health and Wellbeing

Among the key provisions of the Health & Social Care 2012 was an obligation on local authorities to establish a new statutory executive committee, the Health & Wellbeing Board (HWB).

The HWB, uniquely in local government, includes as voting members representatives of the relevant CCG and the Chief Executive and chief officers responsible for Public Health, Adult Social Care and Children's Services as well as local Councillors. It is chaired by the Leader of the Council (or his nominee). Most significant, however, from the Healthwatch perspective, is the obligation to appoint a representative of the local Healthwatch to the HWB as a full voting member, since this gives us a key role within the principal health and social care planning and co-ordinating body for the borough.

Since April 2013, Healthwatch Havering has been represented at the Havering HWB by Anne-Marie Dean, its Chairman, who has attended every meeting of the Board, which meets on a monthly basis in the Town Hall, and the vast majority of all the work of the board is undertaken as an open public meeting. There is also a monthly preparation meeting to ensure that the most important issues are prioritised and reports are properly prepared for discussion. When required there are also special meetings where the board has additional development work needed to support main documents and papers such as the Better Care Fund. Healthwatch Havering is an active contributor at all of these meetings.

We have presented an end of year report on our progress to the Board, which included our work plan for 2014/15 and is available on our website.

The Health and Wellbeing Board established 8 Priorities for 2013/14 and some of the key highlights from a Healthwatch perspective are:

- *The CQC inspection of Queens Hospital (Priority 7: Reducing avoidable hospital admissions)*

  From the local people's perspective, there had been a growing concern about care standards, the A&E, unsafe discharge of the frail and elderly and some complex concerning complaints.

  Healthwatch submitted a report to CQC on the evidence provided by local residents as part of the formal process. In addition, we worked with the HWB to ensure that it was at the heart of the discussions to support the Hospital to develop detailed integrated plans to help them move forward positively, such as the development of 7 day working and successful recruitment initiatives.

Particular focus has been placed by the HWB on the safer and more effective management of A&E, which reflects the CQC report. The focus is to develop more detailed integrated plans for reducing avoidable hospital admissions.

- Frail and Elderly Members of our community (Priority 5: Better integrated care for the 'frail elderly' population and Priority 1 Early help for vulnerable people)

  This work has ranged from the monitoring of patients admitted to A&E to discharge, developing detailed community plans which aim to ensure wherever possible hospital admissions are avoided.

  The HWB has overseen the development of the Tri-borough (Havering, Barking & Dagenham and Redbridge) Integrated Care Coalition which sets out plans for the shift of resources from acute to community services, detailed intermediate care plans for long term conditions and comprehensive rehabilitation services run by NELFT.

  We supported the work on the Frailty Audit undertaken in A&E by University College Hospital Partners and the outcomes from this audit have significantly influenced the development of services and the training of staff.

  As part of our **Have your say…** series of consultation events, we hosted an event at which the CCG and NELFT outlined their Integrated Care programme.

- The Better Care Fund ((Priority 8: Improvement the quality of services to ensure that patient experience and long-term health outcomes are the best they can be)

  The Better Care Fund sets out joint strategic aims and the plans to support the implementation of new care models. This is the first time that such an integrated financial joint community action plan has been developed.

  The proposed service plans addresses both health and social care and is developed and led by both the CCG and the Council. The total proposed value of the pooled budget for 2014/15 is £6,946,000 and for 2015/16 the budget increases to £18,914,000.

- The Care of Children in our Community (Priority 6: Better integrated care for vulnerable children)

  During the year the HWB has received a number of reports that look at the needs and the welfare of children in our community. These reports have included: Child Death Overview Panel, Looked after Children, Child Protection Processes, the Troubled Families report and the Serious Case Review reports.

  The Safeguarding Borough team have developed a highly effective Multi Agency Safeguarding Hub (MASH), which has gained recognition as a highly effective tool in safeguarding for children and young people across London.

  We in Healthwatch Havering work closely with the Safeguarding team, particularly on the safeguarding of vulnerable adults which is highlighted elsewhere in this Annual Report.

- Joint Strategic Needs Assessment (Supports the development of all the 8 priorities)

  Healthwatch Havering was consulted, and provided recommendations, on the JSNA. These included requesting more detailed data on

  - Carers – age group, area, health group and whether adult or children
  - Accommodation – residents maintained in care and nursing homes, enhanced sheltered accommodation and warden controlled.
  - How the needs of the increased number of residents on the Waterloo estate have their primary care needs met, so that there is not an increased burden on A&E
  - How is the predicted growth in the early year's group being addressed by primary, social and educational teams?
  - The training of health and social care providers in cultural needs and practices, given ethnicity is up from 8% in 2001 to 17% in 2011.
  - More lately, following our **Have your say…** sessions on Learning Disabilities and Dementia, we have requested more detailed information on individuals with learning disability and dementia.

- Dementia Strategy (Priority 2: Improved identification and support for people with dementia)

  The management of people who have dementia and their families has been a yearlong discussion item. The strategy has now been received and approved by the HWB with encouragement for this to be implemented as quickly as possible.

  Our Social Care Team is particularly involved in working with people with dementia in their work with Care Homes and their Enter & View programme.

- Children and Families Bill (Priority 1: Early help for vulnerable people)

  There have been regular updates to keep the HWB informed of the progress being made to develop the proposals expected once the Children and Families Bill has passed by Parliament.

  The Board has particularly focused on Special Educational Needs and Disability (SEND) Project The reports have outlined The Local Offer, Educational Health and Care Plans from 0-25, Joint commissioning and Personal Budgets.

  Our Learning Disability Team is working closely with the Council and local voluntary organisations, parents and schools.

  Our **Have your say…** sessions on Learning Disabilities and Dementia have supported both the Dementia Strategy and development of services for people with a Learning Disability by enabling people who use the services, carers and professionals to help inform the commissioning of services for these vulnerable groups.

- Specialist and Cardiovascular Services (Priority 3: Earlier detection of cancer)

  Throughout the year there have been detailed discussions regarding the provision of specialist cancer services. This has involved detailed presentations from senior clinicians and the clinical working parties tasked with reviewing and providing recommendations for change. The HWB was keen to reinforce support to keep the services, talents and abilities of key staff local to the Queen's Hospital. This work is still on going and is also being covered in detailed by the Havering Council Health Overview & Scrutiny Committee and the Outer London North East Joint Health Overview and Scrutiny Committee (which covers Barking & Dagenham, Havering, Redbridge and Waltham Forest), on both of which we are represented.

Healthwatch expressed the concerns on behalf of patients and their carers that

- Earlier detection was vital and better training of GPs and better public awareness campaigns were necessary
- No patient should have to travel to London for routine tests
- Proper transport arrangements should be made for patients and carers who have to travel to London for regular chemotherapy or other debilitating therapies
- Greatly improved communication/integration is needed between Queen's Hospital and the London hospitals' clinical teams, as patients had shared their concerns regarding 'being lost in the system' and losing valuable time in the treatment programme

- Childhood Obesity (Priority 4: Tackling obesity)

  The Public Health team produced a report and programme for the HWB which was well received. The HWB has requested a more comprehensive approach, which is to include looking at 'best in class' programmes where organisations/countries are able to demonstrate real sustained improvement in the management of childhood obesity.

As the first year began, a key priority for all members of the HWB was to establish a common base, an agreed understanding of what was happening, how it was happening and to whom, when and why: questions such as how does each member contribute to a positive culture and how do we agree priorities coming from such diverse starting points. These issues have all been discussed in an open and supportive way and, although it has been a challenging year for the Health and Wellbeing Board, a lot has been achieved.

6 Developing volunteer participation

The Directors decided early on that the differences of function between the former LINk and Healthwatch Havering meant that a new approach was needed.

We were clear that we would be looking for particular levels of commitment and participation (which had to be developed, rather than taken for granted) and that time would be needed to achieve that: we also wanted to encourage people who had never been involved in the former LINk to join us.

We therefore took time to develop a model of involvement that we felt would suit our vision for Healthwatch Havering. Although there will always be a place for new members, our structure is designed to make the most of the talents, abilities and experiences of those who have volunteered to join us.

Currently, four Lead Members are in post, and fourteen Active Members have been appointed; in addition, a total of 147 Supporters, including local organisations as well as individuals, are on our mailing list. We are really pleased with the progress that we, as effectively a start-up organisation, have been able to make. Although there remain a number of Lead Member vacancies, those already appointed have begun work on a variety of issues:

* The Social Care Lead Member and members of her team have met the managers and/or proprietors of care homes that have fallen short in CQC report. The team have also written to those care homes that have received good reviews in recent CQC reports
* The Hospital Lead Member and her team have met the Chief Executive and/or other senior managers of BHRUT
* We have participated in a survey on the use of A&E
* Following comments from members of the public, we have begun to review a number of aspects of services provided by or through GP practices
* The newly-appointed Lead Member for people who have a Learning Disability has begun work, particularly in relation to services for young people.

All of our current volunteers have now received, or are due shortly to receive, training about "Enter & View", safeguarding (both adults and children), mental capacity and deprivation of liberty.

Our volunteers have taken leading roles in the **"Have your say…"** sessions, acting as facilitators to lead discussion as well as acting as hosts.

Profiles of our Directors, Staff and Members are shown in ***Appendix 6***.

7 Governance, finance and business support

Statutory responsibility for the conduct of the legal, financial and business affairs of the Company rests upon the three Directors in accordance with the Articles of Association.

The Directors are clear that it is essential for the volunteers who comprise Healthwatch Havering to play an active role in the direction of the organisation's affairs. As a result, all volunteers wishing to play an active role in Healthwatch Havering are (after providing satisfactory references, completing a Disclosure & Barring Service (DBS, formerly CRB) check and undergoing appropriate training) admitted to membership of the Company; and those members designated as Lead Members serve on the Strategy, Assurance and Governance Board.

Greater detail of the governance arrangements is given in ***Appendix 4***.

Finance

Healthwatch Havering is funded principally by grant from Havering Council in accordance with section 221 of the Local Government & Public Involvement in Health Act 2007, as amended. The Council has a statutory obligation to secure provision of a Healthwatch service and receives specific funds from the Government for that purpose.

It is understood that the Council has passed the bulk of the available finance to Healthwatch Havering.

An abstract from the Annual Accounts is set out in ***Appendix 5***.

Business support: resilience

It became clear during summer 2013 that the amount of effort required of Healthwatch was, unexpectedly, significantly greater than had been the case with the former Local Involvement Network (LINk). Not only were the commitments expected by official bodies much greater than ever required of the LINk – including statutory membership of the Health & Wellbeing Board and close consultation with the CQC over a range of regulatory functions – but the "back office" functions of running a business required more attention than anticipated, largely because the previous contractor for supporting the LINk had dealt with such issues from its central office, in effect hidden from sight, whereas Healthwatch Havering has to deal with all such matters itself. The financial and other penalties that can be incurred as a result of failure to comply with the statutory requirements of Her Majesty's Revenue & Customs, Companies

House and other regulatory bodies can be considerable and demand constant attention.

In consequence, the time required of the Chairman and Company Secretary was much greater than anticipated; accordingly, both are now engaged for 21 hours per week and remunerated accordingly (see ***Appendix 4***). Moreover, the workload of the volunteer Lead Members has grown; as volunteers, their time is more limited and, to ease the pressure on them, two part-time posts, of Administrative Assistant and Community Support Assistant, reporting to the Manager, have been created to ensure that the Members are given the support they need to be effective.

Short profiles of the Directors, Staff and Lead Members are given in ***Appendix 6***.

Business support: office accommodation and equipment

Initially, office accommodation for the Manager was provided at the CarePoint premises in High Street, Romford. Unfortunately, that arrangement proved disappointing as no permanent base could be made available there and the facilities that could be used were very limited. A possibility of accommodation in the Harold Wood Polyclinic was pursued but proved impossible to achieve in a realistic timescale. An office was therefore taken on commercial terms in Morland House, Romford. The room initially available there proved inadequate for our needs but in November we were able to move to a much larger room, ideal for our purposes, but an unforeseen additional expense.

As an entirely new organisation, Healthwatch Havering had to acquire new office equipment. Equipment transferred from the LINk proved to be obsolete and inadequate for our purposes, and had to be replaced. In addition, it was necessary to obtain a range of IT services, including a website, email system, land-line telephone system, mobile telephones, PCs, printers, wireless local network and a photocopier.

8 Looking forward…

An Annual Report inevitably looks back upon the year past. We do, however, have ambitious plans for the coming year and feel it appropriate to give a flavour of them here.

Our Key Priorities for 2014/2015

We have identified 6 key priorities for 2014/15, reflecting areas where we have been alerted to concerns or there are changes in service provision, and which will support the overall health and wellbeing of people.

- End of Life Care
- Frail and Elderly Care within the Emergency department
- Access to Primary Care
- Access to Health checks and immunisation
- Continue the programme of Care Home visits
- To identify a project working with Young People

How we will approach the Key Priorities

We have been developing dedicated programmes of work to enable us to get a comprehensive understanding of

- Ways in which we can jointly measure and define good care,
- The rights of people and how these are supported
- The challenges and opportunities within the health and social care environment
- Joint approach to collecting and sharing information and overall provision

We will manage the process by

- Setting priorities for six months ahead;
- Reviewing them on a monthly basis, adjusting as necessary to accommodate any new issues or concerns e.g. feedback from public forums
- Sharing evidence and information with our partners

- Where appropriate, making immediate contact to ensure urgent concerns are shared and known.

Social Care Work stream

Developing networks across the Borough

- Bi-monthly Borough Safeguarding Meetings since January 2014
- Three-weekly Borough Quality Assurance Team meetings since November 2013
- Regular meetings with Care Home Providers commenced in August 2013
- Quarterly meetings with local CQC team

Enter and View programme for Care Homes

- Number of homes visited from December to March 2014 = 3 1 Enter & View, 2 informal)
- Number planned for April 2014 to September 2014 = 15 (5 every two months)

Extending this role 2014/15

- Discuss and develop locally the CQC's work on 'End of Life' care
- More extensive training on Dementia
- Establish a better understanding of 'Domiciliary Care'

Hospital Services Work stream

Developing networks across the Borough

- Meetings with the Deputy Director of Nursing at Queen's hospital
- Member of St. Francis Hospice board
- Key high profile meetings – CQC, Coroner Reports
- Attendance at the Outer North East London Health Joint Overview & Scrutiny Committee on Acute Service reconfiguration in respect of Cardiac and Cancer services

Enter and View programme for Hospital Services

- Visits to Queen's Hospital will commence once the Trust has published its proposals to respond to the 'Special Measures' position
- Queen's Hospital Maternity Unit visit in early April

Extending this Role for 2014/2015

- Care of the Frail and Elderly in the Emergency Department
- Discharge processes once the new joint Borough arrangements have been in place for 6 months
- Alcohol and Drug recovery programme
- End of Life Pathway
- Review of the waiting times for Chemotherapy services

Learning Disabilities Work stream (*this role began in February 2014****)***

Developing Networks across the Borough

- Member of the Learning Disability Health Pathway Group at BHRUT
- Member of the Learning Disability Partnership board
- Member of the Children with Disabilities and Special needs forum

Enter and View programme for Learning Disability services

- Planned visits will commence in Autumn 2014
- There will be joint visits undertaken between the Learning Disabilities team and the Social Care team, with a particular emphasis on Dementia

Extending this role in 2014/2015

- To 'shadow' the key members of the Boroughs Learning Disabilities team
- To visit as many providers/users and organisations as possible to enable us to map the provision
- Determine the level of provision and consultation with users, carers and families by and with NELFT
- Investigate issues which are raised by people about the health and social care provision e.g. the provision of yearly health checks

Other work streams

We will be developing other work streams during the year as and when the opportunity arises. For example, we are in the process of setting up a team to visit GP surgeries.

Knowing the patch…

The London Borough of Havering is one of the largest of the London Boroughs – see the profile in ***Appendix 7***. This profile has informed, and will continue to inform, our work priorities and programmes.

Appendix 1: Involvement with other organisations

Healthwatch Havering is a member of, or is represented at meetings of, a range of local, regional and national bodies, both statutory and voluntary.

Healthwatch Havering is a statutory member of the Havering Health & Wellbeing Board.

We are also formally represented at meetings of Havering's Overview & Scrutiny Committees: Health; Individuals; and Children's Services. We also have a co-opted member on the Outer North East London Joint Health Overview & Scrutiny Committee (which brings together the Health OSCs of Havering, Barking & Dagenham, Redbridge and Waltham Forest, and is also attended by representatives of the Healthwatches of those boroughs).

In addition, Healthwatch Havering is a member of, or is represented at meetings of:

* Barking, Havering & Redbridge University Hospital Trust Learning Disability Health Pathway
* Children with Disabilities and Special Needs Strategy Group
* CQC Dementia Advisory Group (a national body)
* Havering Adult Services Quality Assurance Team
* Havering CCG Voluntary and Community Sector Health and Social Care Forum
* Havering Dementia Action Alliance
* Havering Safeguarding Adults Board
* Havering Winterbourne Steering Group
* Local Government Association (LGA) Healthwatch Local Peers meetings
* NHS England (London)'s pan-London Quality Surveillance Group (representing North East London)
* North East London Quality Surveillance Group
* PLACE Inspection Teams for Queen's Hospital and King George Hospital, Chadwell Heath
* St Francis Hospice Clinical Governance Group
* St George's Hospital Site Steering Group (currently in abeyance)
* University College Hospital Partners – developing services for frailty in North East London
* Urgent Care Board for Barking & Dagenham, Havering and Redbridge (which also includes the three CCGs, Boroughs, BHRUT and NHS England)

Informal meetings are regularly held with senior managers of the Adult Social Care Quality & Assessment Team, BHRUT and CCG on a regular basis and a good working relationship has been established with the local officers of the CQC Inspectorate responsible for health and social care facilities in Havering, with regular meetings programmed to discuss matters of mutual interest (including discussion about care homes that are cause for concern); and we attended the CQC Quality Summit at Queen's Hospital, prior to the publication of the CQC report on their Autumn 2013 inspection of BHRUT (which led to the hospital being placed in special measures).

We have developed a network of strong working relationships with health and social care providers and commissioners. Using those networks has enabled us to obtain relevant information without the need to resort to use of statutory powers.

Our Lead Member for Dementia represented Healthwatch nationally on an Advisory Group set up by the CQC in respect of proposed changes in the way that they inspect care homes providing for people with dementia.

Appendix 2: Enter and View

The power to carry out "Enter and View" visits to health and social care premises is the most powerful tool available to local Healthwatch organisations. The law allows entry to almost all premises where publicly-funded health or social care is provided, including not only hospitals and residential care homes, but also GP surgeries, pharmacies, dental surgeries and opticians' practices. Enter and view visits may be both announced and unannounced. Reports of all our Enter & View visits are checked for factual accuracy with the management of the establishment visited and published on our website.

Healthwatch Havering considers that, to be effective, the power to enter and view should be:

- Used appropriately – neither as mere routine nor as a last resort, nor as a licence for simple curiosity or nosiness;
- Used sparingly: in particular, unannounced visits should be made only where there are serious concerns about a particular establishment; and
- Exercised only by Healthwatch members who have acquired essential skills by undergoing training in safeguarding, mental capacity and deprivation of liberty.

We recognise too that Enter and View visits can be disruptive of an establishment's proper routine and, potentially, a source of anxiety for management, staff and residents or patients.

For all those reasons, in the year under review, only one enter and view visit was undertaken, as it took time to ensure that all those members undertaking such visits had been properly trained.

Date of visit	Establishment visited		Reason for visit	Announced or unannounced?
	Name	Type		
17/2/14	Barleycroft	Residential care	Concerns raised by CQC	Announced

In addition to formal Enter & View visits, several informal visits were made in the course of the year to residential care homes in order to discuss particular issues. As the year closed, a similar informal visit had been arranged to a GP practice in the borough about which members of the public had raised concerns with us.

Since the year end, we have carried out a number of Enter & View visits, details of which are available on our website.

Appendix 3: Case studies

The following "case studies" are examples of the sort of activity that we have carried out during the year, with the aim of making a difference…

Care Homes:

- Following our "Enter & View" visit to Barleycroft, one of our recommendations was that they improve their activities arrangements for residents. The Manager has told us that they now have two activity co-ordinators.

- We carried an informal visit to a care home and learned that 8 or 9 GPs were assigned to the home, each dealing with a handful of residents, a clearly unsatisfactory and inefficient situation. We contacted the CCG (which responded promptly) and, as a result, there is now a single GP caring for all of the residents, holding a surgery there weekly.

Queen's Hospital:

- Following the inquest into the death of a pregnant woman in the Maternity Unit at Queen's Hospital as a result of inappropriate surgical intervention, we met senior representatives of BHRUT and asked a number of questions, most importantly, why there was no process in place for the supervision of the junior medical staff. BHRUT has now put measures in place to avoid a recurrence of the problems that had arisen in that case and the Trust had welcomed our feedback.

Annual Health Checks:

- We learned at one of our **"Have your say…"** sessions that many people with a Learning Disability were finding it hard to have an annual health check. This was mentioned at a later session attended by a GP representative of the CCG, who undertook to look into the issue. The CCG subsequently wrote to all GPs in the borough reminding them that these checks should be undertaken and offering training; and suggesting that "a hub" could be set up where such checks could be dealt with in a single location.

One-Stop Shop for Learning Disability

- During discussion at another **"Have your say…"** session, it transpired that NELFT were looking for a site for a "one stop shop" for people with a Learning Disability; a senior officer from Adult Social Care, hitherto unaware of this need, was able to facilitate investigation of a suitable site.

Dementia services

- At another **"Have your say…"** session, members of the Age Concern dementia team expressed concern that, although they had been in the past, they were no longer being invited to some meetings that NELFT held about dementia patients. Representatives of NELFT who were present said that they would look into this and, if possible, reinstate the Age Concern attendance.
- As a result of what we learned during the **"Have your say…"** sessions, we have recommended that NELFT review the provision of Admiral Nurses, with a view to increasing their cover, and that the CCG ensure that all GPs have the right level of training and expertise to treat appropriately their patients who have dementia or a learning disability.
- Subsequently, we have become members of the Havering Dementia Action Alliance, and intend to use our activities, such as Enter & View visits, to ensure that due recognition is given to the needs of people who have dementia.

Orchard Village Medical Centre

- The Centre was closed as it had been flooded but local people complained that information was available about alternative facilities only by actually visiting the Centre. We contacted the CCG which then arranged to put up a notice on its website indicating that the Centre was closed and that patients should contact the Harold Wood Polyclinic.

Appendix 4: Governance arrangements

Healthwatch Havering is, in legal terms, a company limited by guarantee called Havering Healthwatch Limited[2]. As a company limited by guarantee, it has no shareholders and is prohibited by law from distributing any financial surplus (or profit) generated in the course of its business to individuals.

This form of business entity satisfies the requirements of the Local Government & Public Involvement in Health Act 2007, as amended by the Health & Social Care Act 2012, and various orders and regulations made under those Acts (all referred to here as "the governing legislation"), which is the legal basis for Healthwatch nationally.

Havering Healthwatch Limited was incorporated in February 2013, having been set up by Havering Council, which then invited the three individuals who are now the directors to take over the company and to move it forward in forming Healthwatch Havering. The legal and business affairs of Havering Healthwatch Limited are directed by the Management Board of the three directors (see below). This is the statutory Board of Havering Healthwatch Limited.

Membership of Havering Healthwatch Limited is open to anyone resident or working in Havering who has satisfied the Board that they are qualified for admission.

"Qualified for admission" means obtaining a satisfactory Disclosure & Barring Service certificate and satisfactorily completing a series of relevant training sessions. Membership of the company confers rights of voting at general meetings as provided for in the Company's Articles of Association. Members guarantee to contribute £1 in the event of the Company being wound up with outstanding debt.

There is also a Strategy, Governance and Assurance Board, comprising the directors, the Manager and those members of the Company who have been designated Lead Members. This Board oversees the work of Healthwatch Havering, deciding the strategic direction of its activities and holding the Management Board to account for its stewardship of the Company's resources.

Lead and Active Members

The governing legislation envisages that the bulk of Healthwatch activity will be undertaken by volunteers, both those who work as healthcare professionals (legally termed "volunteers") and members of the public who have an interest in health and social care issues (legally termed "lay persons"), supported by professional administrators. Across England, different Local Healthwatch organisations have adopted different approaches to ensuring that volunteers and lay persons are engaged directly in the governance of their organisation as well as undertaking Healthwatch activity generally. Havering Healthwatch has chosen not to distinguish

[2] Healthwatch Havering is the operating name of Havering Healthwatch Limited, a company limited by guarantee, registered in England and Wales under No. 08416383. The Registered Office is Morland House, 12-16 Eastern Road, Romford RM1 3PJ

between the different types of voluntary effort and so terms all who participate in its activities as "Members"

Healthwatch Havering decided early on to give its Members a stake in the organisation by admitting them as members of the company.

There are two categories of member (but all are members of the Company):

> **Lead Members** who commit on average at least five hours a week to Healthwatch activity. Each is responsible for a discrete area of activity, and either leads a team of volunteers or has an over-arching responsibility for facilitating issues common to several, or all, teams.
>
> **Active Members** who commit on average at least two hours a week to Healthwatch activity. They are the members of the teams (and may, if they wish, belong to more than one team) and undertake the majority of Healthwatch activity.

Supporters

Healthwatch Havering recognise that there are many people who have an interest in health and social care matters who, for one reason or another, do not wish to, or cannot, commit to giving regular time but are able to respond to enquiries, give information and occasionally help out at events.

Such people are not regarded as volunteers and are not members of the company but are termed "supporters". They play no part in the governance of the organisation.

The Management Board

The Management Board comprises the three Directors who, acting collectively as the statutory Board, are responsible for ensuring the company's compliance with the various legal requirements for running a business, including company law, taxation (income and corporation), accountancy, health & safety and, of course, the legal framework for Healthwatch (including authorising members to undertake enter and view visits). In accordance with arrangements made by Havering Council, each Director is paid a basic fee of £5,000 per annum, in return for which they commit to a minimum of five hours per week, supervising the organisation generally. Two of the Directors also have executive responsibility as Chairman and Company Secretary respectively, for which they are additionally remunerated; the third Director is non-executive.

The Directors are supported by the (full time) Manager, Community Support Assistant and an Administrative Assistant (both part time), all of whom are salaried employees.

The Strategy, Governance and Assurance Board

The Strategy, Governance and Assurance Board brings together the Management Board and the Lead Members and is responsible for setting the broad policy direction for the organisation. Active Members may be invited to attend Board meetings from time to time.

Among other issues, the Board receives monthly finance updates and reports about the numerous meetings at which Healthwatch Havering is represented.

The Board not only holds the Management Board to account for its stewardship of the Company's resources but considers matters such as the Work Programme, reports of Teams' activities and publication of the Annual Report.

Policies and standard operating procedures

The Management Board decided early on that it was important that Healthwatch Havering should have a series of agreed policies and operating procedures to guide its activities and to ensure that volunteers were aware of the scope – and the constraints – of its activities.

The following policies have been formally adopted:

- **Attendance at conferences and events outside London**
- **Complaints Procedure**
- **Declaration of Interests Guidance**
- **Equality & Diversity**
- **Escalation Procedure for complaints**
- **Expenses**
- **Health and Safety**
- **Safeguarding**
- **Use of IT**
- **Volunteer**
- **Whistle Blowing**

A comprehensive handbook for volunteers has been produced.

Every member is issued with a photo-identity card which includes their Disclosure & Barring Service certificate number and, on the reverse, a statement of their statutory right to be involved in Enter and View visits.

Members are encouraged to claim all out-of-pocket expenses and Lead Members are issued with a mobile phone at Healthwatch Havering's expense for use on Healthwatch business. Oyster cards are available to cover the cost of travel on public transport.

The "Healthwatch" logo and trademark

Havering Healthwatch Limited has a licence agreement with Healthwatch England governing use of the Healthwatch logo and trademark.

The Healthwatch logo is used widely for Healthwatch Havering activity. It is used on:

- The Healthwatch Havering website
- This Annual Report
- Publications such as reports of public consultation events and Enter & View visits
- Reports to official bodies, such as the Health & Wellbeing Board and Overview & Scrutiny Committees
- Official stationery, including letterheads and business cards
- Members' identity cards
- Newspaper advertisements
- Flyers for events

Appendix 5: Summary statement of Income and Expenditure

This Appendix is summarised from the Annual Accounts of Havering Healthwatch Limited. A copy of the full set of Annual Accounts is available from the Company on request, and may be viewed on the Healthwatch Havering website.

	£	£	£	£
INCOME				
Havering LBC: Main grant, 2013/14	**117,359**			
Havering LBC: Supplementary grants, 2013/14	**9,184**			
Havering LBC: Supplementary grant, 2014/15	**12,000**			
Miscellaneous receipts	**376**			**138,919**
EXPENDITURE				
1 COSTS OF MANAGEMENT				
Administration costs				
Office expenses, insurance and fees	9,532			
Office rent (including refundable deposit)	10,340			
Mileage, travel and subsistence	2,118	21,990		
Payroll				
Fees and salaries	74,181			
Employers' NICs and pension contribution	8,629			
Payroll administration	1,829	84,639	106,629	
2 COSTS OF VOLUNTEERING				
Volunteers' out of pocket expenses reimbursed		809		
Publicity		1,476		
Recruitment expenses		1,096		
Equipment and supplies		2,079	5,460	
3 COSTS OF TRAINING AND DEVELOPMENT			1,902	
4 COSTS OF PUBLIC CONSULTATION AND EVENTS			3,624	**117,615**
5 AT BANK				
Carried forward to 2014/15		7,443		
2014/15 supplementary grant (received in 2013/14)		12,000		
2013/14 Corporation Tax provision (due 31 December 2014)		1,861		**21,304**
				138,919

Appendix 6: Directors, Staff and Members

Healthwatch Havering is led by a combination of Directors of the Company, staff and volunteer Lead Members.

Directors and Manager

Executive Chairman and Director: Anne-Marie Dean

Anne-Marie has over thirty years' experience working in the NHS. She has been a Chief Executive and Board Director of an acute hospital and Director of Commissioning of a former PCT. Her career has included eight years' experience as a Director of a private sector organisation working in both health and social care. As well as being Chairman of Healthwatch she is a volunteer for St. John Ambulance at its National HQ, and is also a Non-Executive Director of a mental health and social care trust.

Executive Director and Company Secretary: Ian Buckmaster

Ian is a Chartered Secretary who, until he retired in March 2013, had worked for nearly 40 years in Havering Council's Democratic Services. In his time there, Ian had been clerk to the Social Services Committee, various Health Committees and the Housing Committee, as well as the full Council and Cabinet. He is an expert in governance and is responsible for Healthwatch Havering's legal, business and financial affairs. He is also District President of St John Ambulance for East London.

Non-Executive Director: Hemant Patel

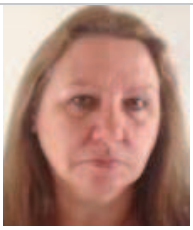
Hemant is a pharmacist, and has for many years been the Secretary of the North East London Pharmaceutical Committee, which represents pharmacists across the region. He has served four terms as President of the Royal Pharmaceutical Society of Great Britain, and is a member of the steering group of the NEL Public Pharmacy Partnership.

Manager: Joan Smith

Joan began her working life as a police officer with the Metropolitan Police, at Stoke Newington. When she left the police, she went to work in the City, in banking, staying there for some 25 years. In 2009, she became Organiser of Havering Local Involvement Network (LINk), and transferred to Healthwatch Havering when it took over from the LINk.

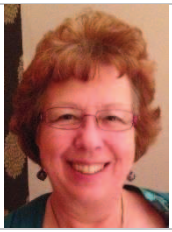
Lead Members

Lead Member, Hospitals: Debbie Baronti



Debbie has over 20 years' experience in NHS management, including 10 years at Assistant Director level with NHS Havering. She is currently employed by a CCG in South London.

Lead Member, Social Care: Christine Ebanks



Christine began her career in the NHS as a cadet nurse in 1970 and then trained as a State Registered Nurse at Harold Wood Hospital. In 1975, she started midwifery training at Barking and Ilford Maternity Hospitals, and then served as a midwife until retirement in March 2013, working initially in hospitals and, from 1989, in as a community midwife in Havering.

Lead Member, Learning Disability: Alan Jones

Alan is a former Detective Inspector, having served with the Metropolitan Police for 30 years. In 2002, when posted to Romford, he became responsible for the Vulnerable Persons Unit, was Chair of the Multi-Agency Public Protection Arrangements and sat on the Elder Abuse Panel. After retiring from the police, Alan worked for the Mayor of London. Previously Chair of Victim Support Havering, he has also worked for Havering Samaritans. Currently, he volunteers with the Citizens' Advice Bureau and is a member of the Independent Monitoring Board at ISIS Prison, Belmarsh.

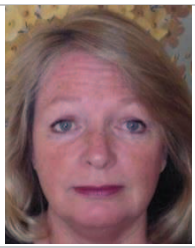
Lead Member, Dementia Services: Cliff Reynolds

Cliff joined Age Concern Havering following early retirement from the Financial Services industry in 2002. At Age Concern, he was as Information, Advice and Advocacy Manager providing support to older people and their carers. In that role, he provided advocacy support for elderly people in care homes. Cliff is Chair of Havering Over 50's Forum, and was Vice Chair of the Havering LINk until it was replaced by Healthwatch in 2013.

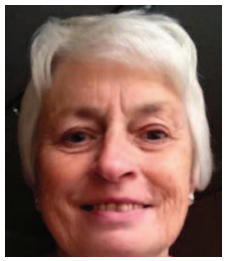
Facilitator, Communication and Design: Irene Buggle

Following a 30-year career holding management positions in an organisation providing market research, marketing and editorial for the pharmaceutical industry, since 2007 Irene has been co-director of a consultancy providing information solutions about that industry to the NHS, media and others, both public and private.

Staff

	
Administrative Assistant: Carole Howard	**Community Support Assistant: Beverley Markham**

Members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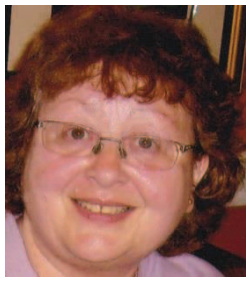
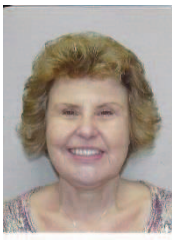
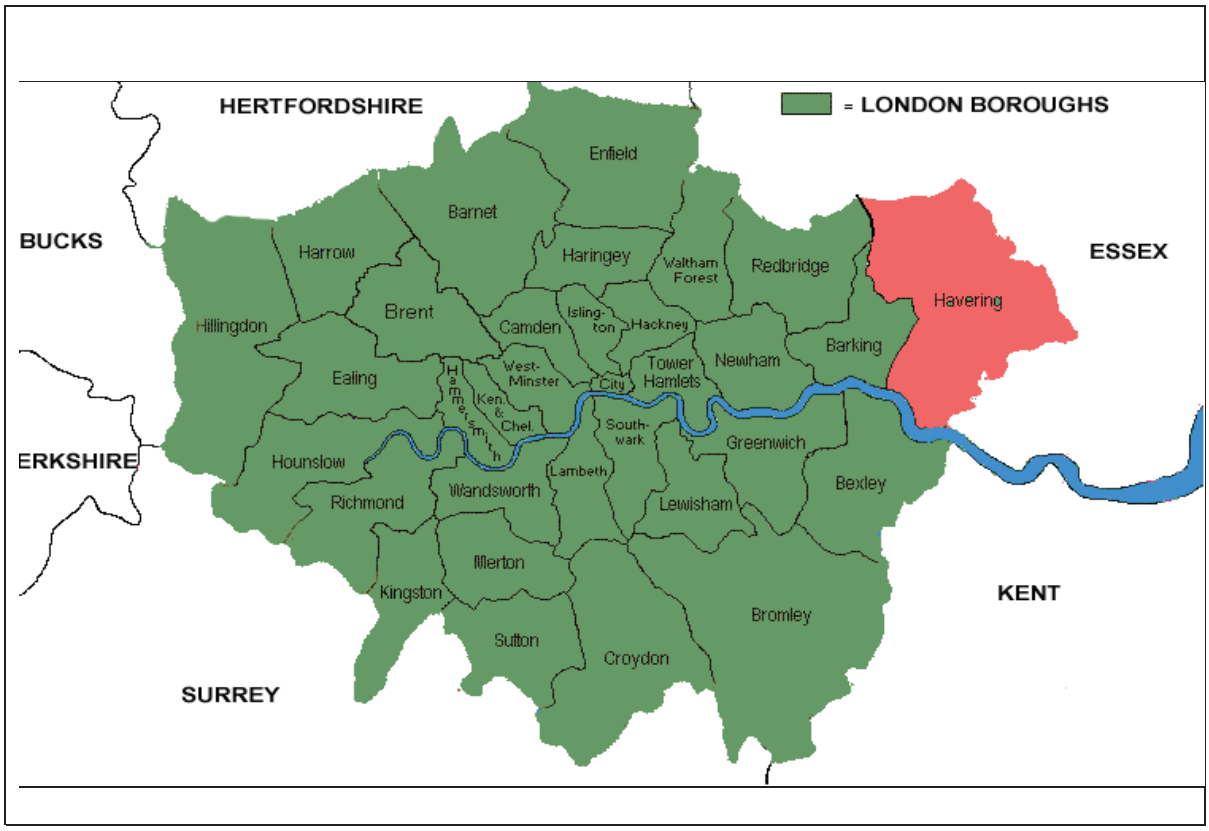
			
Emma Lexton	Terry Matthews	Diane Meid	Dianne Old
			
Lorna Poole	Lucy Sanya	Adrienne Saunderson	John Skillman

Appendix 7: Profile of the London Borough of Havering



The London Borough of Havering was formed in 1965 by the amalgamation of the Borough of Romford and the Urban District of Hornchurch (although the present boundaries differ slightly from the original, as a result of subsequent boundary reviews). It is the third largest of the London Boroughs, and the easternmost, and one of the least built-up, with around 50% of its area designated as green belt, of which a significant part is given over to agriculture or outdoor leisure.

Despite its "leafy borough" appearance, however, the borough has pockets of considerable deprivation: within a couple of miles of each other are wards among the most prosperous in England, and others among the least prosperous.

For many years, the borough has had a disproportionately large, and growing, population of people over 50. This was recognised as a trend likely to affect the provision of health and social care services as long ago as the early 1980s, and has continued without break ever since; the borough has the highest proportion of people aged 85 or over in Greater London and one of the highest such proportions in the whole of England. The proportion of residents from an ethnic minority has also risen markedly since 2000.
Paradoxically, the borough is also experiencing high growth in the proportion of the population aged 18-24; again, that growth (albeit from a much smaller percentage of the population) is among the highest in both Greater London and England.

The following information is extracted from the Havering Joint Strategic Needs Assessment[3]:

It is estimated that 236,100 people currently live in Havering. Greater London Authority population projections estimate that:

- By 2016, Havering's population will have grown by 5.4% (12,699 people), compared to 5.2% in London
- By 2021, Havering's population will have grown by 11.5% (27,095 people), compared to 8.6% in London
- By 2026, Havering's population will have grown by 14.1% (33,314 people), compared to 10.7% in London

243,508 people are registered with a GP in Havering (GP list population). The GP list population is larger than Havering's estimated population, which could be due to factors such as residents from neighbouring Boroughs being registered with Havering GPs, or patients moving away and not informing their GP.

There are 54,018 people aged 0-18 in Havering, 23% of Havering's population; 36% of the population are aged 50+ (85,999 people); and 21% of the population are of retirement age (60+ females, 65+ males; 49,122 people).

Of the 236,100 Havering residents:

- 52% are female
- 48% are male

The greater number of females than males in Havering's population may in part be explained by the longer life expectancy of females: 55% of the 50+ population are female and 45% male; but in the very elderly (aged 75+), 61% are female and 39% male, with 72% of the most elderly (90+) being female.

Among young people and middle aged adults (aged less than 65), there is a fairly even proportion of males and females at most ages. However, for children and young adults (up to age 33), there is often a greater proportion of males than females by up to several percent. Between the ages of 34 to 65, the proportion of females is often greater than the proportion of males by up to several percent.

In terms of deprivation, Havering is ranked 177th out of 326 local authorities for deprivation (1st being most deprived, 326th being least deprived). However, there are pockets of deprivation, with two small areas of Havering falling into the 10% most deprived areas in England and 11 small areas in Havering falling into the 20% most deprived areas in England.

[3] As published on the Council's website **www.haveringdatanet/research/jsna.htm** – permission to reproduce these findings is gratefully acknowledged

Havering's current population is less ethnically diverse than London overall, with the greatest diversity being among young people:

	0-15			16-64M/59F			65M/60+F		
Ethnicity	Havering	London	England	Havering	London	England	Havering	London	England
White	83%	62%	83%	88%	69%	86%	96%	83%	96%
Mixed	4%	8%	4%	1%	3%	2%	0%	1%	0%
Asian or Asian British	6%	14%	8%	5%	14%	7%	2%	8%	2%
Black or Black British	5%	13%	3%	4%	10%	3%	1%	6%	1%
Other	1%	2%	1%	1%	4%	2%	1%	2%	0%

It is estimated that between 2011 and 2016, Black African and Black Caribbean groups will be the fastest growing ethnic groups in Havering, and will increase faster than in London or outer London Boroughs overall:

	% Growth 2016 Havering	% Growth 2016 Outer London	% Growth 2016 Greater London	% Growth 2021 Havering	% Growth 2021 Outer London	% Growth 2021 Greater London
All Ethnicities	5%	4%	5%	12%	7%	9%
White	4%	1%	3%	9%	1%	4%
Black Caribbean	22%	8%	5%	42%	13%	8%
Black African	33%	16%	11%	61%	25%	18%
Black Other	21%	13%	10%	41%	23%	18%
Indian	11%	8%	8%	21%	13%	13%
Pakistani	11%	12%	11%	20%	19%	19%
Bangladeshi	10%	16%	9%	18%	27%	17%
Chinese	14%	12%	13%	27%	19%	21%
Other Asian	17%	11%	11%	33%	19%	18%
Other	21%	19%	17%	39%	31%	29%
Black and Minority Ethnicities	21%	12%	10%	40%	20%	17%

The Borough is served by

- Havering London Borough Council
- Havering Clinical Commissioning Group
- Barking, Havering & Redbridge University Hospitals NHS Trust
- North East London Foundation Health Trust

Participation in Healthwatch Havering

We need local people, who have time to spare, to join us as volunteers. We need both people who work in health or social care services, and those who are simply interested in getting the best possible health and social care services for the people of Havering.

Our aim is to develop wide, comprehensive and inclusive involvement in Healthwatch Havering. To achieve this we have designed 3 levels of participation which should allow every individual and organisation of the Havering Community to have a role and a voice at a level they feel appropriate to their personal circumstances.

We are looking for:

Lead Members

To provide stewardship, leadership, governance and innovation at Board level. A Lead Member will also have a dedicated role, managing a team of members and supporters to support their work.

Active members

This is the key working role. For some, this role will provide an opportunity to help improve an area of health and social care where they, their families or friends have experienced problems or difficulties. Very often a life experience has encouraged people to think about giving something back to the local community or simply personal circumstances now allow individuals to have time to develop themselves. This role will enable people to extend their networks, and can help prepare for college, university or a change in the working life. There is no need for any prior experience in health or social care for this role.

The role provides the face to face contact with the community, listening, helping, signposting, providing advice. It also is part of ensuring the most isolated people within our community have a voice.

Supporters

Participation as a Supporter is open to every citizen and organisation that lives or operates within the London Borough of Havering. Supporters ensure that Healthwatch is rooted in the community and acts with a view to ensure that Healthwatch Havering represents and promotes community involvement in the commissioning, provision and scrutiny of health and social services.

Interested? Want to know more?

Call our Manager, Joan Smith, on **01708 303 300**;
or email **enquiries@healthwatchhavering.co.uk**

Healthwatch Havering is the operating name of
Havering Healthwatch Limited
A company limited by guarantee
Registered in England and Wales
No. 08416383

Registered Office:
Morland House, 12-16 Eastern Road, Romford RM1 3PJ
Telephone: 01708 303300

Email: enquiries@healthwatchhavering.co.uk

Website: www.healthwatchhavering.co.uk

Barking and Dagenham, Havering and Redbridge
Clinical Commissioning Groups

Making intermediate care better

in Barking and Dagenham, Havering and Redbridge

Foreword from the clinical directors

As doctors, we want to help people live as healthily as possible, making sure they get the right care, when they need it. As local GPs, we've always known what our patients need and want. Now we're also in a position to lead changes that we believe will make a real difference to local people.

We've always known that people don't want to go into hospital unless they really have to and that if they do, they want to come home again as soon as they can. We also know that they are likely to recover better outside hospital, in a familiar place, close to their family and friends - as long as they also have the right care and support from nurses, therapists and care workers. That's what we want to make happen.

In the past we haven't done as well as we could to provide care for people at home. We've known for some time that in other areas they do things differently and people generally recover more quickly. We wanted to learn from them and provide a different, better sort of care, but we didn't want to make any permanent changes until we knew that they really were an improvement and until we'd heard what patients thought of them. We have looked at evidence from the UK and overseas which shows better results for patients and want to implement this locally. We're pleased to see that the trials of the new community treatment team and the intensive rehabilitation service have helped more people to get care and treatment outside hospital.

We are also pleased to hear from patients and carers that they've appreciated this support at home. This success means we're now in a position to talk about what we do in the longer term.

This document explains what we want to do. Please do read about our proposals, ask us if anything's not clear and let us know what you think about what we want to do.

It's your NHS and we want you to help shape it locally.

Dr Jagan John, clinical director, integrated care, Barking and Dagenham Clinical Commissioning Group

Dr Gurdev Saini, clinical director, frail elders, Havering Clinical Commissioning Group

Dr Mehul Methukia, clinical director, integrated care, Redbridge Clinical Commissioning Group

"I couldn't have got a better service if I went private."

Introduction

This document talks about intermediate care in Barking and Dagenham, Havering and Redbridge. It explains what we have been doing during the past year to try out new ways of working and what we would like to do in the future to make those services better.

We have set out different options and what we think would be the best option and why. We want to know your views, whether you agree or disagree, and if there is anything else you want us to consider.

We want to establish permanently the new intermediate care services that we have been trialling, which would mean that more people could receive care in their own homes. We also want to merge the three existing community rehabilitation units into one unit, on the King George Hospital site in Goodmayes. We believe this would result in better, more individual care that would help people to recover more quickly.

These services are currently provided by North East London NHS Foundation Trust (NELFT), and we intend for these services to continue to be provided by NELFT.

We would especially like to hear from local residents, people aged 65 years and over (as most of the people who use intermediate care services are in this age group), carers, health professionals and our partners in the community and voluntary sectors about whether they think our proposals would improve intermediate care services for local people.

Intermediate care means services that provide people with specialised care from nurses, therapists and other professionals, without them needing to go to (or stay longer in) hospital. These services can be provided in different places - people's own homes, community rehab units or residential homes, for example.

Our new intermediate care services are the **community treatment team (CTT)** – a team of doctors, nurses, physiotherapists, social workers and others who together care for people at home having a health or social care crisis at home – and the **intensive rehabilitation service (IRS)**, a team of physios, occupational therapists, healthcare assistants and others offering intensive physio and other therapy in a patient's home.

Rehabilitation means helping people to recover after an illness or injury. **Community rehabilitation (or rehab) units** are buildings with beds for people who don't need to be in hospital any more, but can't go home because they need intensive 24 hour support and care.

How to make your views known

There are a number of ways in which you can give your views:

Visit our websites and fill in the online questionnaire

Complete the questionnaire at the end of this document and send it back to us

Write a letter to
FREEPOST I Y 426
ILFORD
IG1 2BR

Email: haveyoursay@onel.nhs.uk

Call: 020 3688 1089

All comments must be received by 5pm, Wednesday 1 October 2014.

Our websites:

www.barkingdagenhamccg.nhs.uk/intermediatecare
www.haveringccg.nhs.uk/intermediatecare
www.redbridgeccg.nhs.uk/intermediatecare

How to find out more

If you want to find out more about our work to improve intermediate care before you comment, you can visit the intermediate care page on our websites. Or call us and we can send information to you.

We will be out and about in Barking and Dagenham, Havering and Redbridge talking to people about our proposals – the dates and times for these events are below, and you can also find the latest information on our websites.

If you would like someone to come and talk to your community group about our proposals, please email **haveyoursay@onel.nhs.uk** or call **020 3688 1089**.

Barking and Dagenham – Thursday **11 September, 4-7pm**
Barking Learning Centre
2 Town Square
Barking IG11 7NB

Havering – Thursday 21 August, 4-7pm
Romford Central Library
St Edwards Way
Romford RM1 3AR

Redbridge – Thursday 31 July, 4-7pm
Redbridge Central Library
(formerly Ilford Central Library), Clements Road
Ilford IG1 1EA

Background to the proposals

Barking and Dagenham, Havering and Redbridge Clinical Commissioning Groups (CCGs) have been working together with the local councils and local health service providers to improve health and social care services for local people. We want to make services more joined up with each other and focused on what individual people need, not on what is convenient for the services.

We need to improve people's experience of care and make sure it's the best quality, so we know we are delivering the right care, in the right place, at the right time.

We need to make sure the health and social care system is 'future proof'. We know the population is growing and getting older. We need a system that will care better for people now and can also care for more people in years to come.

We must ensure that services are efficient and deliver value for money.

As part of this work, we have been focusing on improving local intermediate care services.

"This is an outstanding brilliant service, what you have done in 21 days is unbelievable. My mum was in hospital for 13 weeks and was nowhere near where she is today with her walking. My mum is now able to walk which I never thought would happen."

So what is intermediate care?

Intermediate care helps people get better quicker without needing to go to hospital, and also helps get people out of hospital and back home, sometimes after a stay in a community rehab unit.

These services are most often needed by older people, for example if they have a fall and hurt themselves which makes them less mobile and less able to care for themselves. They can also be needed by younger people, though, if they have an ongoing health problem that sometimes flares up making them unwell and needing help. We do not include specialist care for people who have had a stroke when we talk about intermediate care.

Historically, local people needing this kind of care have generally been cared for in beds at community rehab units when they could have been cared for at home, if the right services were in place to help them. This means that there are more intermediate care beds across our area compared with other areas.

This is an old-fashioned way of providing care and it does not take into account people's individual needs. The results for patients are generally not quite as good as if care was provided in other ways. For example, it often takes longer for people to recover fully. Being in a bed makes patients more likely to get an infection and to lose their independence.

People tell us they want to be cared for and supported in their own homes. We know people locally have been spending longer in community rehab units than people do elsewhere, and this can make it much harder for them to return home and live independently. By providing home-based services, patients recover more quickly and have a good experience of care.

To find out more about the evidence behind this, visit our websites:

www.barkingdagenhamccg.nhs.uk/intermediatecare
www.haveringccg.nhs.uk/intermediatecare
www.redbridgeccg.nhs.uk/intermediatecare

By caring for people at home where possible we would prevent most people from having to go into a community rehab unit.

Of course, there are times when people *do* need to stay in a community rehab unit – for example they're not mobile enough to go home – and we would make sure that they can do this and the care they get there is excellent.

By improving the way we look after people in a community rehab unit and making sure they get personalised, focused care, with access to a range of therapies, patients would need to spend less time there.

To be clear, both the care at home and the care in a bed at a community rehab unit are intermediate care.

What are the new services we have been trialling?

We have been trialling two new services to help people to stay at home.

Community treatment team (CTT)
This is a team of doctors, nurses, physiotherapists, social workers and others who together care for people at home so that they either don't need to go into hospital or return home from hospital sooner.

The CTT started in Barking and Dagenham and Havering in January 2013, where it ran from 8am - 8pm, seven days a week. In November 2013, the service was expanded to include Redbridge, and the hours across the three boroughs were extended for an additional two hours a day, until 10pm.

Intensive rehabilitation service (IRS)
This is a team of physios, occupational therapists, healthcare assistants and others offering intensive physio and other therapy in a patient's own home, with up to four visits a day depending on the patient's needs. The service operates from 8am - 8pm, seven days a week.

What do patients think of these services?
Patient satisfaction rates for both the new services have been consistently high across the three boroughs since the trials began. On a scale of 1-10, with 10 being 'very satisfied' with the service, CTT has averaged 8.7 and IRS 9.0 out of 10. You can see some of the comments patients have made about the services throughout this document.

"The patient is getting about now and is able to go up and down the stairs, can go the length of his footpath and manage a big step with little difficulty, something he could not do previously."

Community rehab units

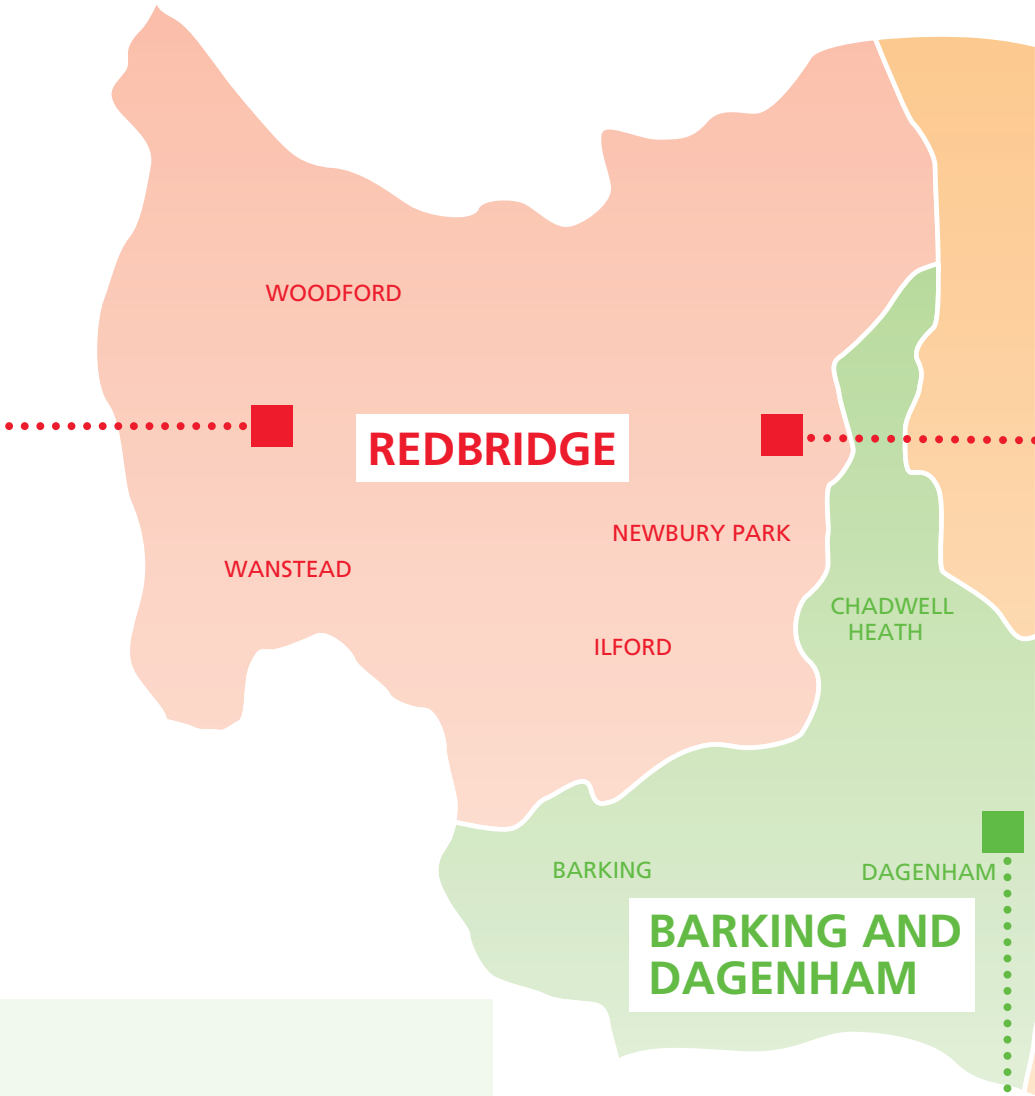
At the moment there are three community rehab units used by people from Barking and Dagenham, Havering and Redbridge.

Heronwood and Galleon Unit in Wanstead

Capacity and facilities: 48 beds, in two wards. Physiotherapy gym, dining room and day room.

Public transport: Average links. Two bus routes are within five minutes' walk. Nearest underground station is 10-15 minutes' walk.

Parking: Free limited parking on site for staff and visitors. Limited parking in residential streets.



Grays Court in Dagenham

Capacity and facilities: 26 beds, in single rooms, some of which have en-suite facilities but which are too small for equipment like hoists and wheelchairs. Physiotherapy gym, day rooms, dining area, consultation rooms.

Public transport: Poor links. Nearest bus route is 10 minutes' walk away. Nearest underground station is 20 minutes' walk.

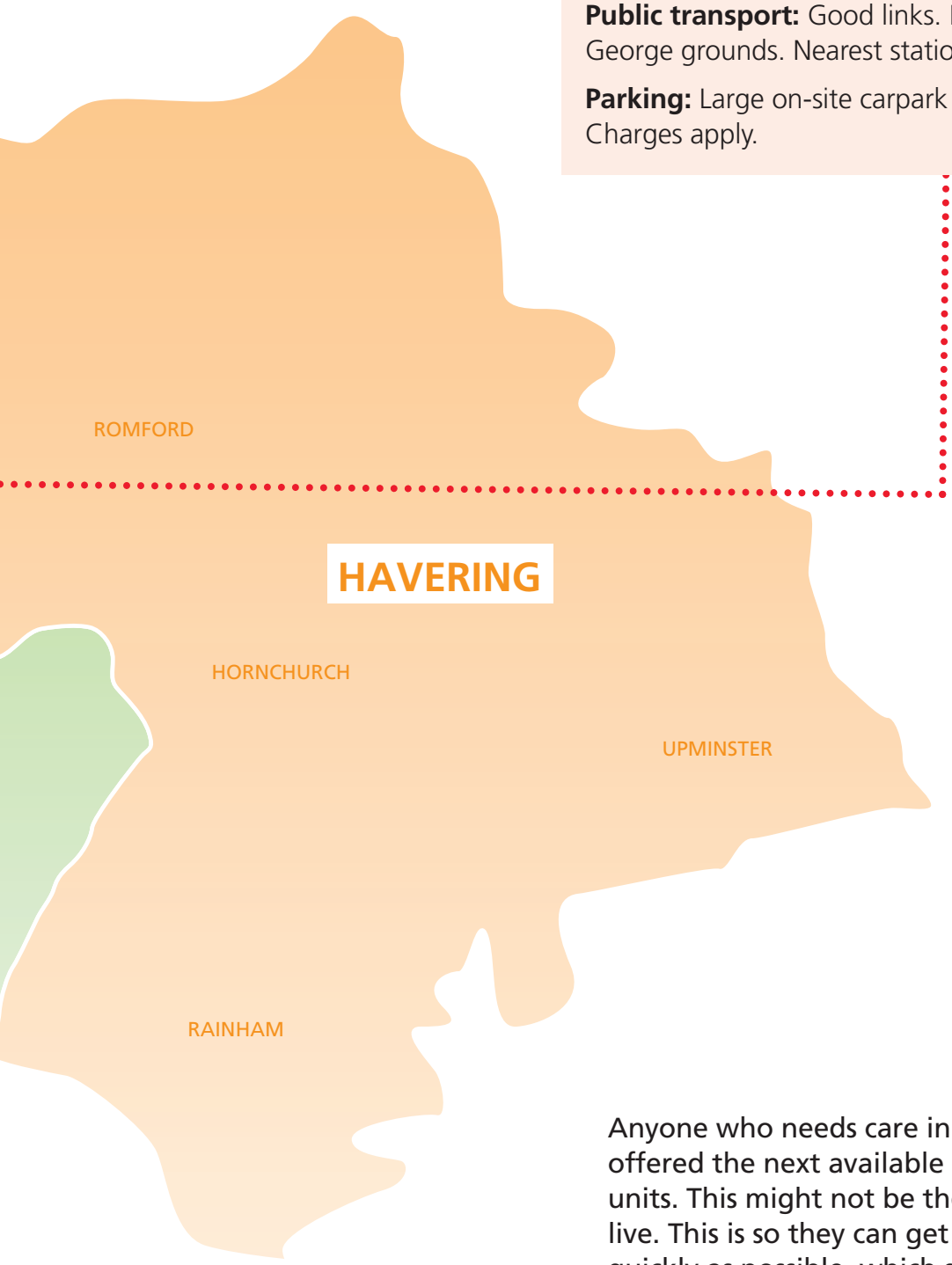
Parking: Free limited parking on site, used by staff and visitors. Limited parking on residential streets.

Foxglove Ward (King George Hospital) in Goodmayes

Capacity and facilities: 30 beds, in one ward (with another ward identified for expansion). Day room, physiotherapy gym on ward and access to a larger hospital gym. Access to other hospital services and facilities.

Public transport: Good links. Four bus routes stop in King George grounds. Nearest station is 15 minutes' walk.

Parking: Large on-site carpark for staff and visitors. Charges apply.



Intermediate care services used to be provided at St George's Hospital in Hornchurch, but this site was closed for health and safety reasons in October 2012 and remains closed.

Anyone who needs care in a community rehab unit is offered the next available bed in any of the three units. This might not be the one closest to where they live. This is so they can get access to rehabilitation as quickly as possible, which should help to speed up their recovery. If they prefer to wait for a bed at another unit, they can do so, but generally people want to start their rehabilitation quickly.

Bed numbers: now and in the future

There is capacity for 104 community rehab beds across these three sites. However at the moment these beds are not all being used as there is no need for them. From looking at how the services have been operating recently and particularly since the trial of new services began, we have worked out that we would only need between 40-61 community rehab beds over a year if the home-based CTT and IRS were both running all the time. This is because most people would receive care in their own home and so would not need a community rehab bed.

When working this out, we have taken into account the fact that more beds are generally needed over the winter months.

This means if we did not reduce the numbers of available beds, at any one time during a year there would be between 43 and 64 unused community rehab beds. It costs hundreds of thousands of pounds to keep these available, whether they are occupied or not, in building upkeep, electricity and so on. We also need to duplicate staffing across the sites.

Case study: Sunita stays in a community rehabilitation unit

Sunita is a 77 year old woman who is unsteady on her feet and is in hospital following a fall. She also has a chest infection. She no longer needs to be in the hospital, but she's not mobile enough to go home, and she is afraid of falling over again. CTT and IRS won't be enough for her – she needs help to move around safely, but she also needs 24 hour care. Sunita is referred to a community rehab unit. A nurse from the unit comes out to visit her, assesses her to make sure that the unit is the right place for her to go. It is and she's offered the next available bed.

While in the unit, Sunita receives 24 hour nursing care, physio and occupational therapy. The team regularly assess her and set her small but achievable goals to build her confidence and make sure she is progressing. After two and a half weeks, Sunita is feeling confident enough to go home, and the unit team supports this. They plan how she will manage after leaving. IRS staff visit her on the ward and once she's back home and develop an intensive rehab plan for her. The district nurses and the social care team also review Sunita's needs and provide the support she needs to stay at home safely, with the support of her family.

Sunita is happy to go home, pleased that she will have the support she needs to continue to recover. She is feeling stronger and more confident.

Why we want to change the way we offer intermediate care

We want people to get better care and to recover more quickly. We want them to be able to stay at home, if at all possible, because that's what patients and their families want. Keeping people at home helps them to stay independent for longer and it reduces the risk of them picking up a new infection and becoming more unwell.

We want to make sure that we are using NHS money in the best possible way. This means spending our budget on services that would help patients the most. It means making sure that we are running services as efficiently as possible, saving money where we can so we can reinvest it in different and better services.

Since introducing CTT and IRS on a trial basis, we have found that a lot of beds in community rehab units are not now being used, because the teams care for people in their own homes (in the first six months of the trial, 29 beds weren't used). During the trial we have found that people are able to access care and support sooner. We know that for the majority of people care at home is the right thing, they do not need to go to hospital or a community rehab unit, and they recover as well, and in some cases better and quicker at home. Patients who have used the new services have told us they have had a very good experience and received high-quality care.

"Everybody wants to go home from hospital – as soon as they are ready and able to."

"I could not have managed without the support from the team."

Case study: Reg is helped at home by the Community Treatment Team

Reg is 55 years old. He lives on his own and he has Chronic Obstructive Pulmonary Disease (COPD) which sometimes makes it hard for him to breathe.

Reg visits his GP a lot about his COPD because he's not confident about managing it and he's ended up in A&E in the past. His GP tells him about the local community treatment team (CTT), who can help him to manage his condition.

Reg has struggled to breathe all day but tries to manage with his existing medication. By 4pm, Reg is finding it harder to breathe and this triggers a panic attack. (Panic attacks can be very frightening and intense, but they are not dangerous and won't cause you any physical harm).

Instead of calling 999, as he would have in the past, he calls the CTT. The administrator asks him some questions and tells him how long it will be before someone calls him back. He's called back within 10 minutes as his case is a priority because it is clear he is having difficulty breathing. (The CTT will contact all patients within two hours). A senior nurse asks him questions about how he's feeling. Because of what he says, she allocates his case to a community nurse who arrives at his house within two hours. Reg is thankful that he can receive help at home as, like lots of people, he finds hospitals stressful, which generally makes him feel worse.

The nurse does various tests and notes his temperature has gone up and his oxygen levels are outside the normal range. They talk through his medical history and what medication he is on. The nurse advises Reg that he should now start taking the medication he has for when he has an attack. They discuss how he can manage his shortness of breath, and she carries out a blood test to rule out any further medical concerns. The CTT continues to monitor Reg's progress over the next two to three days and they keep his GP informed.

The nurse also refers Reg to the specialist respiratory team who will work with him in the longer term to help him manage his condition, looking in detail at the medication he's on and working with a physio and occupational therapist.

Reg feels much more confident about managing his COPD in the future, and knows he can always call the CTT if he needs them.

What are the options for intermediate care?

We looked at the possibilities for improving intermediate care services for local people then drew up a list of five options. We then looked at the advantages and disadvantages of each option.

- What would be best for patients and help them to recover as quickly as possible?
- What would be easiest for patients and carers to help them live their normal lives where possible?
- How well does each option fit in with all the other local health and social care services and any plans there might be to develop those in the future?
- Could we afford to pay for the services in each of the options and are some options more or less expensive than others?

We have to make sure that we spend our limited NHS money in a way that makes sure we get the most we can for local people. We do not have enough money to spend on everything that everyone wants and if we spend more on one service then we have less to spend on another. That's why it's really important that we get the balance right.

As well as thinking about how much it would cost to run the services in the future, we thought about how much it would cost to make any changes. This would include the cost of any changes that we might need to make to modernise buildings, for example.

When we evaluated the options, we took into account both non-financial and financial criteria and we weighted these 60:40, meaning the financial aspects were not as important as things like quality of care and patient experience. Detail of these processes and the evidence behind our thinking, including information on finances and the pre-consultation business case is on our websites:

www.barkingdagenhamccg.nhs.uk/intermediatecare
www.haveringccg.nhs.uk/intermediatecare
www.redbridgeccg.nhs.uk/intermediatecare

"Walks well now, able to walk with a stick."

The five options we considered in detail were:

Option 1: Stay as they are now

CTT and IRS – same number of beds – beds on three sites

This option means things would not change from how they are now. There would be the same number of beds on the same sites and there would be the new CTT and IRS services that we have been trialling.

Under this option, patients would benefit from the popular home-based care services which help patients to recover more quickly. They would also have more choice if they needed care in a community rehab unit as there would be three community rehab units offering care.

Under this option, there would be unused beds in the community rehab units because more people would be cared for in their own homes. This means money would be wasted.

This option would not be affordable because it is the most expensive option. We would not be able to pay for the new home-based services while still running the same number of beds across three community rehab units. We managed to find additional money to pay for the trial but we cannot carry on running both home-based and bed-based services at this level in the long term.

Option 2: Go back to before the trial

No IRS – No CTT in Redbridge and reduce CTT hours in BD and Havering – same number of beds – beds on three sites

This option means we would go back to how things were before we started trialling the new services. That means there would be no IRS in any of the boroughs and no CTT in Redbridge. The CTT in Barking and Dagenham and Havering would reduce their hours again, by two hours a day. There would be the same number of beds on the same sites.

Under this option patients in all areas would get a reduced service, particularly in Redbridge. The reduction in services would be in the home-based services that patients and carers really like and which help people to recover more quickly.

This option is not affordable in the longer term. No IRS (and no CTT in Redbridge) to support other services would mean longer waits for the services that do exist. That would make those services less productive and patients would take longer to leave hospital. That would be more expensive in the long term than what we are proposing.

"We're extremely happy with the service and have recommended to our friends already."

Option 3: New services and three sites

CTT and IRS – fewer beds – beds on three sites

This option means we would have the new home-based services (CTT and IRS) in all boroughs and we would still have three community rehab units. There would be fewer beds overall though because we would take out the ones that aren't needed.

Under this option patients would benefit from the popular and effective home-based services. Those who needed to stay in a community rehab unit would still be able to choose from the three current units (although they might have to wait for a bed if they wanted a specific unit, as they do now).

Having beds on a number of sites has some disadvantages. It is harder to ensure the same consistency and quality of care. If beds are spread over a number of sites, we need more staff than if they are all on one site. The workforce is less flexible if we are running a number of units.

This option is not the most affordable option because we would have to pay all the costs of keeping three community rehab units open, even if we weren't using all the space in each building.

Option 4: New services and two sites

CTT and IRS – fewer beds – beds on two sites

This option means we would have the new home-based services (CTT and IRS) in all boroughs. We would reduce the number of community rehab units to two and we would reduce the overall number of beds.

Under this option patients would benefit from the popular and effective home-based services. Those who needed to stay in a community rehab unit would be able to choose from two units (although they might have to wait for a bed if they wanted a specific unit, as they do now).

Having beds on a number of sites has some disadvantages. It is harder to ensure the same consistency and quality of care. If beds are spread over a number of sites, we need more staff than if they are all on one site. The workforce is less flexible if we are running a number of units.

We considered all combinations of which two sites could stay open, but for the reasons explained above, did not feel this option would provide high quality care. For a detailed description of this process, see the pre-consultation business case on our websites:

www.barkingdagenhamccg.nhs.uk/intermediatecare
www.haveringccg.nhs.uk/intermediatecare
www.redbridgeccg.nhs.uk/intermediatecare

This option is more affordable than options 1-3, but it doesn't offer the best value for money because we would still have to run two separate units on two separate sites.

Option 5: New services and one site

CTT and IRS – fewer beds – beds on one site at King George Hospital

This option means we would have the new home-based services (CTT and IRS) in all boroughs. We would reduce the number of community rehab units to one at King George Hospital and we would reduce the overall number of beds.

Under this option patients would benefit from the popular and effective home-based services. Those who needed to stay in a community rehab unit would be able to.

This option would be the most affordable because we would pay for the new services with the money that we saved by reducing bed numbers and by reducing the number of sites from three to one. It would also be the best value for money as we would reduce duplication (for example paying to run three buildings).

This is also the best option clinically – it would allow us to deliver a better service, with better results for patients. Clinicians tell us the safest way to provide high-quality care is by having a service in one place rather than in a number of smaller units, as this means patients get better more quickly. Running one unit would mean we could use staff much more efficiently and flexibly and patients would have better access to specialist therapy and nursing support.

This option is our preferred option and we explain why in the following section.

Summary of options

Option	Is there a community treatment team?	Is there an intensive rehab service?	How many beds overall?	How many community rehab units?
1	Yes	Yes	104	3
2	Yes, with reduced hours (Barking and Dagenham and Havering) No (Redbridge)	No	104	3
3	Yes	Yes	40-61	3
4	Yes	Yes	40-61	2
5	Yes	Yes	40-61	1

What do we think would be best in the future?

We want to be able to continue the new services that we have been trialling – the community treatment teams in all three boroughs for 14 hours a day, and the new intensive rehabilitation service, because the trial has been very successful. We have had really good feedback from patients and carers about the services – they think they are an improvement.

As much as possible, patients have been helped to stay at home, which has helped them to get better quicker and to stay independent.

We also want to make sure that we have the right number of beds for people who do need to stay in a community rehab unit. We want those beds to have the right supporting services around them.

After thinking about the advantages and disadvantages of all the options, **we think option five is the best option**. This is because we think it would result in the best and safest care.

Option five would mean:

- **We would continue to run the community treatment team and the intensive rehabilitation service that we have been trialling.**

  This means most people would get care at home and would not need to travel or stay in hospital. They would be able to lead as normal a life as possible and stay close to family and friends. We know that helping people to stay out of hospital means they are more able to stay independent for longer. Those people who do need to go into hospital would be helped to return home more quickly than in the past. This is because people who have been helped by these services think they are much better than going into hospital.

- **We would reduce the total number of beds across the three boroughs to between 40 and 61.**

  This means that we would always have 40 beds and we would always be able to increase the number of beds up to a maximum of 61, depending on how many people need a bed at a time. We do not think we would ever need more than 61 beds at any one time. This is because fewer people would need a bed because they are being cared for at home and those who do need a bed for a while would not have to stay in the unit for as long.

We would move all the beds onto one site

Having a service in one place rather than in a number of smaller units, means patients get better more quickly. It is much easier to make sure care is of consistent quality and clinicians say this is the safest way to provide care (rather than on two or three sites).

We could use staff much more efficiently and flexibly and we would cut down on duplication of tasks, which would mean staff would have more time to spend with patients. A single larger rehab unit is much better able to cope with fluctuations in demand. Patients would have better access to specialist therapy and nursing support. The links with CTT and IRS would be better than if they were dealing with a number of units.

We realise that moving from three sites to one would make it harder for some people to visit a relative or friend, but we think the benefits to patients should make it worthwhile. For example, patients will go home sooner than they do now. Some people are already travelling – people in Havering travel to Redbridge to visit Foxglove ward. We think this can be offset by the majority of people being seen in their own home, and not needing to travel.

We would locate the service on the King George Hospital site.

This location is fairly central to the three boroughs, there are good, well-established transport links and car parking is available on the site.

Locating the service on this site means it could link in with other health services where necessary. There is enough room here to be able to have up to the maximum number of beds that we think we might need at any one time. There is not enough room on either of the other two sites for 61 beds.

It would mean that we would no longer need two community rehab units – Heronwood and Galleon unit in Wanstead and Grays Court in Dagenham.

We do not own either of these sites, so we cannot make decisions about what would happen to them, but we would work with the owners and other local stakeholders to help them decide how best to use the sites.

For information on the advantages and disadvantages of the different sites, look at the ‘Community rehab units’ section.

"The service has made a massive difference to my mobility. I would not have been able to recover to the level I have."

Case study: Doreen goes home from hospital with the help of the Intensive Rehabilitation Service

Doreen is an 86 year old widow living by herself. She has high blood pressure, rheumatoid arthritis and walks with a stick but is otherwise in good health.

One day, Doreen falls down her stairs and can't get up, so her neighbour calls 999. An ambulance takes her to Queen's Hospital where an x-ray shows she's broken her leg. She has her leg set under anaesthetic, and spends three weeks recovering on an orthopaedic ward.

While she is in hospital, Doreen has physiotherapy to work on her strength and mobility and an occupational therapist helps her to practise tasks like washing and dressing and moving about safely.

When Doreen no longer needs to be in hospital, instead of going to a community rehab unit, she is referred to the Intensive Rehabilitation Service (IRS). Staff from the service talk to the hospital therapists, nurses and doctors and to Doreen about her situation - how she is recovering, and what kind of care she needs to complete her recovery at home.

Once Doreen is back home, the IRS team visit her and talk to her about her goals. She wants to be able to climb her stairs safely, and walk to her neighbour's house, so between them they work out a plan to help her achieve this.

This involves up to 21 days of intensive rehabilitation at home. She is visited twice a day every day and receives care from a physio, occupational therapist, rehabilitation assistants and a nurse. As Doreen becomes more confident moving around, the team does more with her – helping her to manage the steps in her back garden.

The team reviews Doreen's progress throughout her rehabilitation and looks at what other help she needs. Both they and Doreen think she has recovered well, thanks to the intensive support. They let Doreen's GP know about her progress so she can follow up and refer Doreen to other services such as district nursing. They also talk to the council's social care team to make sure she has someone to help her do her shopping

Doreen feels safe to continue to live in her own home, with the support of NHS and council services.

Questions and answers

How did you decide on the preferred option?

The executive committees of the three CCGs set up a steering group with senior doctors and managers (including the nurse director and finance director) from all three boroughs. This group developed and appraised the options against a set of criteria, coming up with a recommended preferred option. The governing bodies of the three CCGs then considered what they had done, and agreed we should consult the public and other stakeholders on that preferred option.

When would you make these changes?

If agreed, we would need to talk to Barking, Havering and Redbridge University Hospitals NHS Trust, which owns King George Hospital, to agree when we would be able to start to use more space. We'd need to take the time to make any changes properly, at minimum disruption to patients, so any move would probably take place in the 2015/16 financial year.

Have you factored population changes into the planning?

Yes. We always use the most up-to-date population information and projections to make sure that we plan appropriately for current and future needs.

Isn't this just all about saving money?

No. The reason we want to make changes is because we think we can make things better for patients so they recover more quickly and most of the time recover in their own homes. We have also had great feedback on the services – patients like them. This is about spending money where it will have the greatest impact and result in the best care and results for patients.

But anything we do has to be affordable. We have a limited NHS budget and if we spend more on one service then we have to cut what we spend on something else.

What if I want to recover in a bed at a community rehabilitation unit, not at home?

If you wanted to recover in a bed at a community rehab unit, we would talk to you about why you wanted to do this. If we thought you would recover more quickly at home we would explain why. We would discuss any social care needs you might have and we would talk to you about how we could help you remain independent. Of course, anyone who is in clinical need of a bed would get a bed.

Why can't we keep three community rehab units?

Clinicians tell us the safest way to provide high-quality care is by having a service in one place rather than in a number of smaller units, as this means patients get better more quickly. Running one unit would mean we could use staff much more efficiently and flexibly. We would cut down on duplication of tasks, which would mean staff would have more time to spend with patients. A single larger community rehab unit is much better able to cope with fluctuations in demand. Patients would have better access to specialist therapy and nursing support. The links with CTT and IRS would be better than if they were dealing with a number of units.

What would happen to the buildings if the decision is made to centralise services?

We do not own the sites, so we cannot make decisions about what would happen to them. We would work with the owners and other local stakeholders to help them decide how best to use the sites.

Work would also need to be done to the available space at King George Hospital. This would mean looking at the way the space is laid out so government requirements to put men and women in different areas are met. Other work, such as painting and decorating and getting IT systems set up would also be needed.

What about the St George's Hospital site in Hornchurch?

Havering CCG is still working with the site's owners and NHS England to develop a new health centre on the site. That is still in the planning stage and so any new centre would be some way off.

Wasn't it the plan to put the rehabilitation beds that moved off the St George's Hospital site in 2012 back into the new health centre?

The public consultation on the redevelopment of St George's supported the preferred option not to include any beds, but to ensure flexibility the CCG has made sure there is enough space in the plans for some short-term care beds (not intermediate care beds). As this is still at the planning stage, it would be some time before any new centre was up and running and we want to make these improvements more quickly.

What about involving social care and social workers?

The CTT includes social care staff as well as NHS staff, so the team thinks about the patient's needs as a whole, rather than separating them out into health or social care. The IRS also has very good links with social care.

Do local authorities and care providers support these proposals?

These proposals have been agreed by the Integrated Care Coalition (ICC), a group of health and social care partners including local councils and care providers, which was established to review and propose how health and social care services can be made better for local people.

Following an in-depth review of local services, the ICC published a 'case for change' which identified a need to improve and modernise the way intermediate care services are delivered. A strategy was developed which took into account examples of alternative models and approaches here and overseas, and involved extensive local clinical, professional and public engagement.

"I would like to be able to score higher than 10."

We want your views

We want you to tell us what you think of these proposals. Please complete the questionnaire at the end of this booklet and send it back to us, or write to:

FREEPOST I Y 426
ILFORD
IG1 2BR

If you'd prefer to send an email, send it to **haveyoursay@onel.nhs.uk**

You can also call: **020 3688 1089**

All comments must be received by 5pm, Wednesday 1 October 2014.

How your views will be considered

Once the consultation closes, we will review and analyse all the responses we receive.

We will use this information to write a report for each of the three CCGs' governing bodies to consider, alongside any other evidence and/or information available (for instance the equalities impact assessments) and make a decision on the most appropriate way forward. They will also be able to see all the consultation responses in full.

If you are responding on behalf of an organisation or you represent the public (like an MP or a councillor) your response may be made available for the public to look at. If you are responding in a personal capacity, we will not publish your response but we may use unnamed quotes to show particular points of view.

We will put the dates of the governing bodies' decision-making meetings on our website. These are meetings held in public, so you are welcome to attend and all the reports they will look at will be published on our websites.

If you let us know your contact details (by filling this in on the questionnaire), we can keep you up to date with our work.

"Brilliant service, helpful, good treatment, and good communication."

Questionnaire

Please tell us to what extent you agree or disagree with the following statements:

1 The NHS should permanently run the new home-based services that have been trialled (the community treatment teams and the intensive rehabilitation service) because they help people to get better more quickly and to stay independent.

☐ Strongly agree ☐ Strongly disagree ☐ Agree ☐ Don't know ☐ Disagree

Comments

2 The NHS should reduce the numbers of community rehabilitation beds if it can be shown that they are not used and are not needed.

☐ Strongly agree ☐ Strongly disagree ☐ Agree ☐ Don't know ☐ Disagree

Comments

3 The NHS should reduce the number of community rehabilitation units because this is the best way to provide high quality, safe care.

☐ Strongly agree ☐ Strongly disagree ☐ Agree ☐ Don't know ☐ Disagree

Comments

Questionnaire continued

4 We believe that option five – home-based services where possible and one community rehabilitation unit on the King George Hospital site, with 40-61 beds - is the best way to organise intermediate care services in the future.

☐ Strongly agree ☐ Strongly disagree ☐ Agree ☐ Don't know ☐ Disagree

Comments

5 If you disagree with our preferred option (option 5) please tell us what you think we should do instead.

☐ Option 1 ☐ Option 2 ☐ Option 3 ☐ Option 4 ☐ None of them

Comments

Use this space if you want to tell us anything else

Monitoring questions

We would find it useful if you could tell us a bit about yourself so we can see what sorts of people are responding and whether they think differently from other groups. That helps us to understand if what we want to do might have more of an impact on some groups of people than others.

You don't have to give us your name if you don't want to and we will still take your views into account.

Name

Are you providing this response as a representative of a group:

Yes No

If yes, what is the name of the group

Would you like to be kept up to date with information about the NHS (including this consultation)

Yes No

If yes, please give us your email or postal address

Which borough do you live in

Barking and Dagenham
Havering
Redbridge
Other

Are you?

Male Female Prefer not to say

Are you responding as a…

Service user
NHS staff member
Carer
Local resident
Other
Prefer not to say

Are you employed by the NHS?

Yes No Prefer not to say

What is your ethnic background

White

White British
White Irish
Any other white background

Mixed

White and Black African
White and Black Caribbean
White and Asian
Any other Mixed background

Asian

Asian British
Indian
Bangladeshi
Pakistani
Chinese
Any other Asian background

Black

Black British
Black African
Black Caribbean
Any other Black background

Any other ethnic group
Prefer not to say

Which belief or religion, if any, do you most identify with?

Agnosticism
Atheism
Buddhism
Christianity
Hinduism
Islam
Judaism
Sikhism
Other
Prefer not to say

Do you consider you have a disability?

Yes No Prefer not to say

How old are you?

Under 16
16-25
26-40
41-65
Over 65
Prefer not to say

This document is about our plans to improve some of the health services in Barking and Dagenham, Havering and Redbridge. If you cannot read the document and would like to know more, please contact us and tell us what help you need. Let us know if you need this in large print or a different format. If you do not speak English, please tell us what language you speak.

English

This document is about our plans to improve some of the health services in Barking and Dagenham, Havering and Redbridge. If you cannot read the document and would like to know more, please contact us and tell us what help you need. Let us know if you need this in large print or a different format. If you do not speak English, please tell us what language you speak.

Bengali

এই নথিটি বার্কিং ও ড্যাগেনহ্যাম (Barking and Dagenham), হ্যাভারিং (Havering) ও রেডব্রিজ (Redbridge)-এ কিছু স্বাস্থ্য পরিষেবার উন্নয়ন সংক্রান্ত আমাদের পরিকল্পনার বিষয়ে তৈরী করা হয়েছে। আপনি যদি নথিটি পড়তে না পারেন এবং এ বিষয়ে আরো জানতে চান, অনুগ্রহ করে, আমাদের সাথে যোগাযোগ করুন এবং আমাদের বলুন যে, আপনার কি সহায়তা প্রয়োজন। আপনার যদি এটি বড় হরফের মুদ্রন বা অন্য একটি ফরম্যাটে প্রয়োজন হয়, আমাদের তা জানান। আপনি যদি ইংরেজীভাষী না হন, অনুগ্রহ করে, আমাদের জানান যে, আপনি কোন ভাষায় কথা বলেন।

Lithuanian

Šiame dokumente atsispindi mūsų planai patobulinti kai kurias sveikatos priežiūros paslaugas Barkinge ir Dagenheme (Barking and Dagenham), Haveringe (Havering) ir Redbridže (Redbridge). Jei negalite perskaityti šio dokumento ir pageidaujate išsamesnės informacijos, susisiekite su mumis ir pasakykite, kokios pagalbos Jums reikia. Informuokite mus, jei pageidaujate dokumento stambiais rašmenimis ar kitokio formato. Jei nekalbate angliškai, informuokite, kokia kalba kalbate.

Portuguese

Este documento é acerca dos nossos planos para melhorar alguns dos serviços de saúde em Barking e Dagenham, Havering e Redbridge. Se não puder ler o documento e desejar saber mais, contacte-nos e informe-nos que tipo de ajuda necessita. Informe-nos se necessita em tamanho maior ou num formato diferente. Se não fala Inglês, informe-nos qual o seu idioma preferido.

Punjabi

ਇਹ ਦਸਤਾਵੇਜ਼, ਬਾਰਕਿੰਗ ਅਤੇ, ਡਾਗਨਹੈਮ (Barking and Dagenham), ਹੈਵਰਿੰਗ (Havering), ਅਤੇ ਰੈੱਡਬ੍ਰਿਜ਼ (Redbridge) ਵਿਚ ਕੁਝ ਸਿਹਤ ਸੇਵਾਵਾਂ ਵਿਚ ਸੁਧਾਰ ਸਬੰਧੀ ਸਾਡੀਆਂ ਯੋਜਨਾਵਾਂ ਦੇ ਬਾਰੇ ਹੈ। ਜੇ ਤੁਸੀਂ ਦਸਤਾਵੇਜ਼ ਨੂੰ ਪੜ੍ਹ ਨਹੀਂ ਸਕਦੇ ਅਤੇ ਇਸ ਬਾਰੇ ਹੋਰ ਜਾਣਕਾਰੀ ਚਾਹੁੰਦੇ ਹੋ, ਤਾਂ ਕਿਰਪਾ ਕਰਕੇ ਸਾਡੇ ਨਾਲ ਸੰਪਰਕ ਕਰੋ ਅਤੇ ਸਾਨੂੰ ਦੱਸੋ ਤੁਹਾਨੂੰ ਕੀ ਚਾਹੀਦਾ ਹੈ। ਜੇ ਤੁਸੀਂ ਇਸ ਸਫ਼ੇ ਨੂੰ ਮੋਟੀ ਛਪਾਈ ਜਾਂ ਕਿਸੇ ਹੋਰ ਫਾਰਮੈਟ ਵਿਚ ਚਾਹੁੰਦੇ ਹੋ ਤਾਂ ਸਾਨੂੰ ਦੱਸੋ। ਜੇ ਤੁਸੀਂ ਅੰਗਰੇਜ਼ੀ ਭਾਸ਼ਾ ਨਹੀਂ ਬੋਲਦੇ ਤਾਂ ਕਿਰਪਾ ਕਰਕੇ ਸਾਨੂੰ ਦੱਸੋ ਕਿ ਤੁਸੀਂ ਕਿਹੜੀ ਭਾਸ਼ਾ ਬੋਲਦੇ ਹੋ।

Romanian

Acest document este despre planurile noastre de a îmbunătăți o parte din serviciile de sănătate din Barking și Dagenham, Havering și Redbridge. În cazul în care nu puteți citi acest document și ați dori să aflați mai multe, vă rugăm să ne contactați și să ne spuneți de ce ajutor aveți nevoie. Spuneți-ne dacă documentul trebuie să fie într-un format mare sau într-un format diferit. Dacă nu vorbiți limba engleză, vă rugăm să ne informați ce limbă vorbiți.

Tamil

இந்த ஆவணம் பார்க்கிங் அண்டு டாகென்ஹம் (Barking and Dagenham), ஹாவெரிங் (Havering) அண்டு ரெட்ப்ரிட்ஜ் (Redbridge) ஆகியவற்றில் உடல்நல சேவைகள் சிலவற்றை மேம்படுத்துவதற்கான எங்களின் திட்டங்கள் பற்றியது. உங்களால் இந்த ஆவணத்தைப் படிக்க இயலவில்லை என்றால் மற்றும் மேலும் தகவல்களைப் பெற விரும்பினால், எங்களைத் தொடர்புக் கொண்டு, உங்களுக்கு என்ன உதவி வேண்டுமென்று கேளுங்கள். உங்களுக்கு இது பெரிய எழுத்துக்களிலோ அல்லது வேறு வடிவத்திலோ வேண்டுமென்றால் எங்களிடம் தெரிவியுங்கள். உங்களுக்கு ஆங்கிலத்தில் பேச தெரியாது என்றால், நீங்கள் என்ன மொழியில் பேசுவீர்கள் என்று எங்களிடம் கூறுங்கள்.

Urdu

یہ دستاویز بارکنگ اور ڈی جینہم (Barking and Dagenham) ہیورنگ (Havering) اور ریڈ برج (Redbridge) میں صحت کی چند خدمات کو بہتر بنانے سے متعلق ہمارے منصوبوں کے بارے میں ہے۔ اگر آپ یہ دستاویز نہیں پڑھ سکتے اور اس کے بارے میں مزید جاننے کے خواہاں ہیں، تو براہِ کرم ہم سے رابطہ قائم کریں اور ہمیں بتائیں کہ آپ کو کیا مدد درکار ہے۔ اگر آپ کو یہ دستاویز بڑے پرنٹ یا کسی دیگر فارمیٹ میں درکار ہے تو ہمیں بتائیں۔ اگر آپ انگریزی میں گفتگو نہیں کرتے، تو براہِ کرم ہمیں بتائیں کہ آپ کون سی زبان بولتے ہیں۔

This document was developed with the help of patient representatives from across our area.

Havering
LONDON BOROUGH

HEALTH & WELLBEING BOARD

Subject Heading:	Domestic Violence
Board Lead:	***Joy Hollister***
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The subject matter of this report deals with the following priorities of the Health and Wellbeing Strategy

- ☒ Priority 1: Early help for vulnerable people
- ☐ Priority 2: Improved identification and support for people with dementia
- ☐ Priority 3: Earlier detection of cancer
- ☐ Priority 4: Tackling obesity
- ☐ Priority 5: Better integrated care for the 'frail elderly' population
- ☒ Priority 6: Better integrated care for vulnerable children
- ☐ Priority 7: Reducing avoidable hospital admissions
- ☐ Priority 8: Improve the quality of services to ensure that patient experience and long-term health outcomes are the best they can be

SUMMARY

This report provides an overview of Domestic Abuse within Havering and the associated Health and wellbeing implications for victims, their children and the wider community. The report identifies current gaps in knowledge and service provision and asks that the Board consider the recommendations below.

RECOMMENDATIONS

1. That the Board consider refreshing the JSNA for Violence Against Women and Girls (VAWG) given the changing demographics in the Borough
2. That the Board support the HCSP to develop a joint VAWG strategy for Havering

3. That the Board adopt a consistent approach across the Council and CCG to the commissioning of services for victims and their children, and perpetrators, and seek to secure a long-term joined up partnership response to DV/VAWG.

REPORT DETAIL

1. Background

Domestic Violence is defined as

"Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass but is not limited to the following types of abuse:

- psychological
- physical
- sexual
- financial
- emotional

Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim."*

*This definition includes so called 'honour' based violence, female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group.

In 2011/12, 7.3% women (1.2 million) and 5% men (800,000) in the UK reported having experienced domestic abuse (ONS 2013). An analysis of 10 separate domestic violence prevalence studies found consistent findings that 1 in 4 women experience domestic violence over their lifetimes and between 6-10% of women suffer domestic violence in a given year (Council of Europe, 2002). On average, two women a week are killed by a violent partner or ex-partner. This constitutes nearly 40% of all female homicide victims. (Povey, (ed.), 2005; Home Office, 1999; Department of Health, 2005.)

Abused women are more likely to suffer from depression, anxiety, eating problems and sexual dysfunction. Violence may also affect their reproductive health. (WHO 2000). It is estimated that 30% of domestic violence starts in pregnancy and domestic violence has been identified as a prime cause of miscarriage or still-birth and of maternal deaths during childbirth. (Lewis and Drife, 2001) Many women use alcohol or drugs as a response to and a way of dealing with abuse. Women experiencing domestic violence are up to fifteen times more likely to misuse alcohol and nine times more likely to misuse other drugs than women generally.

Children who live with domestic violence are at increased risk of behavioural problems and emotional trauma, and mental health difficulties in adult life. (Hester et al 2007). The term 'toxic trio' is used to describe the comorbidity of domestic abuse, mental ill-health and substance misuse. National level biennial reports reviewing the learning from serious case reviews (SCRs) note the prevalence of domestic violence, misuse of alcohol and/or drugs, and parental mental health problems in the lives of the families at the centre of SCRs. The last biannual report, drawn from 139 overview reports, finds 'evidence that about two-thirds of cases featured domestic violence, and mental ill health of one or both parents was identified in nearly 60% of the families. A wealth of research has been conducted in this field and more background information is available in Appendix 1

2. Domestic Abuse in Havering

Domestic violence (DV) is prevalent in the borough and we know that it has a significant impact on the health and wellbeing of victims and their children.

The current rate of Domestic Violence in Havering (represented as DV Offences and Incidents in below table) stood at 8.6 per 1,000 residents, slightly below the MPS average of 9.2 per 1,000 residents; for the 12-month rolling period to October 2013 with Havering ranked 19th of 32 boroughs, where 32 is best.

In the current financial year Havering has seen one of the highest increases in Domestic Violence. Havering as of June 2014 ranks as 16th highest in London, and has a rate higher than the regional average. This is due to a significant rise in reported incidents. Havering has seen one of the highest increases for both DV crimes and DV incidents this financial year (5th highest increase of 32 boroughs).

The table below shows there have been 985 VAWG offences in Quarter 1 of 2014, a rise of 213 compared to the same period in 2013 (+27.6%).

Official Performance Data Metropolitan Police				
Offence	FYTD June 2014	FYTD June 2013	Change No.	Change %
DV Offences	170	119	+51	+42.9%
DV Offences and Incidents	283	214	+69	+32.2%
Rape	675	544	+131	+24.1%
Other Sexual	27	14	+13	+60.0%
Total Violence against Women & Girls	985	772	+213	+27.6%

Source: MPS Violence Against Women and Girls Report June 2014

Based on MPS raw CRIS data for Havering for the 12-months to June 2014, there were 172 repeat victims who reported three or Domestic Violence events to police (10 fewer than in December 2013). This accounts for 6.8% of total victims reporting to police 19.6% of all DV incidents on record (put simply, less than 1 in 10 victims contributed to almost 1 in 4 records). If we consider those with 2 or more reports to police, then 19.3% of victims contributed to 38.6% of the total number of reports (486 victims).

Last 12 Months Rolling	Domestic Crime				Domestic Crime & Incidents Total			
Number of Calls	No. Victims	% Victims	No. Crimes Reported	% Crimes	No. Victims	% Victims	No. Crimes Reported	% Crimes
4 or more	5	0.7	20	16.0	80	3.2	370	11.2
3 calls	18	2.4	54	43.2	92	3.7	276	8.4
2 calls	51	6.7	102	81.6	314	12.5	628	19.0
1 call	829	108.4	829	663.2	2,028	80.7	2,028	61.4
Total	903	118.0	1,005	804.0	2,514	100.0	3,302	100.0

Source: MPS CRIS/Crime Recording Incident System data for 12-months to June 2014

The table which follows gives a breakdown of sanctioned detections, arrests charges and cautions for Havering compared with the MPS average. In the most recent 12-months there has been a decline in sanctioned detection rates for DV offences and DV Violence with Injury offences. The rates in Havering at June 2014 were below the MPS average. Similarly, there has been a reduction in the charge and caution rate which is also currently below the MPS average.

Sanctioned Detection (SD) Data Metropolitan Police			
Offence	Havering Current 12-months	MPS Current 12-months	Havering Change compared to Previous 12-months
Domestic Violence – Violence with Injury (Sanctioned Detection)	36.3%	50.5%	-14.7
Domestic Violence – Total Offences (Sanctioned Detection)	38.5%	45.2%	-6.4
Domestic Violence – Arrest Rate	71.0%	84.0%	-7.0
Domestic Violence – Charge Rate	20.1%	25.9%	-5.1
Domestic Violence – Cautions	18.4%	19.3%	-1.2

Source: MPS Met Stats data for 12-months to June 2014

In the 12-months to November 2013 Havering had a successful prosecution rate of 69.8% (157 successful prosecutions) for DV cases heard at Magistrates Courts, this was the 5th highest within the MPS and above the London average of 63.4%. The national average was higher at 74.3%. For cases heard at Crown Courts, of which there were 35 in Havering, the successful prosecution rate was 57.1% locally compared to a regional average of 62.4% and national average of 75.7%. Havering ranked 21st within the MPS.

Prosecution Data						
Havering Data	Successful no.	Total no.	Conviction Rate	Regional Rate	National Rate	Rank in London
Crown	20	35	57.1	62.4	75.7	21st
Magistrates	157	225	69.8	63.4	74.3	5th

Referrals to children's social care are made when someone believes that a child may be at risk of significant harm. In 2012/13, 168 referrals were made to Havering's children's social care where domestic violence was recorded as the primary need. Domestic violence is likely to be a factor in many more referrals, but it will not always be recorded as the primary issue.

All instances of a child or young person, who comes to the attention of a police officer, where it is believed there are concerns about the child's well-being or safety, must be recorded onto a MERLIN PAC form. Jan – June 2013 saw an overall 15.5% increase in the number of police Merlin reports where domestic violence was a factor, compared to the same time period in 2012.

3. Why is this an issue for the Health and Well Being Board?

In November 2013 the Mayor of London launched his second strategy on violence against women and girls (VAWG) with one of the key objectives being "addressing health, social and economic consequences of violence." Boroughs are being encouraged to develop a wider response to VAWG which includes domestic violence , rape and other sexual offences, Female genital mutilation, forced marriage , Honour-based violence and trafficking and prostitution (See appendix 2)

Domestic Abuse remains a high priority for the Havering Community Safety Partnership. However limited funding is available through the Mayor's Office for Policing and Crime to develop responses to domestic violence and wider VAWG agenda, with only £76,000 made available in 2014-15.

Commissioning of services for victims of domestic abuse is limited compared to other London Boroughs

- The Council current funds a full time Independent domestic violence advocate based in victim support to support high risk victims of DV, commissioned by Community Safety .
- Domestic violence advocacy services are provided for 8-12 hours per week through Havering Women's Aid (HWA) funded through MOPAC grant funding. The SLA for this service is managed by Community Safety.
- Refuge provision in the Borough is again provided by HWA, commissioned by Homes and Housing, via two refuges within Havering. The three year contract is due to end October 2014 (with an option to extend for one year), and future funding will be reviewed between September and December 2014.
- There are no specific services for children experiencing violence at home and limited funding is available to deliver prevention work with young people and perpetrators. However for 2014-15 the Early Help team has seconded a DV specialist worker to support staff in early help settings to support families with children experiencing DV.

A DV JSNA was completed by Health in 2012 (see appendix 3) which made a number of key recommendations for decision makers and commissioners - many of which have not been taken forward due to the changes in Health care provision locally and nationally.

Referrals to the MASH have seen an increase in families where comorbidity of domestic abuse, mental ill-health and substance misuse is an issue.

The recently published "Domestic homicide review: lessons learned" (Home Office, Nov 2013) found that a number of reports identified the need for improved training and awareness on domestic violence and abuse for GPs and healthcare professionals. There have been cases where victims had made disclosures but they had not been followed up or referred on to the appropriate agencies. In some cases, the review has stated that the healthcare professional had not known what to do when a patient disclosed domestic violence.

Although NELFT have recently developed a domestic abuse and sexual violence strategy and associated policy there is to date no borough wide strategy setting out the responsibilities and agreed actions of all borough including the CCG, Local Authority, Police and Acute Trust. The recently established VAWG group has recognised the need for such a plan and work is now in progress.

The plan will need to address emerging issue identified for partners including the rising trends, effective identification of prevalence within health services; the GP is usually a victim's first route into the statutory sector and maternity services at BHRUT are also often the first to spot signs of abuse and well placed to intervene early. With the removal of the dedicated resource in the Trust we need to ensure that they are meeting their obligations in this area.

In addition the Borough needs to improve identification of repeat victimisation across services (victims report victimisation to multiple different agencies). To do this we need to obtain data from health services for the purpose of crime prevention, gauging prevalence and identifying gaps in service provision, which is currently not easily available.

Once the plan is drafted it will be presented to the Health and Wellbeing Board for comment before being considered by the Crime and Safety Partnership.

4. Recommendations for consideration by commissioners including short and long term priorities

Prevention

- Develop focus on early identification and early intervention (just 29% of GP's in England said they felt comfortable asking appropriate questions of suspected victims of abuse - Royal College of General Practitioners 2012).

- Introduction of the Identification and Referral to Improve Safety system (IRIS). IRIS is a general practice-based domestic violence and abuse (DVA) training support and referral programme that has been evaluated in a randomised controlled trial. Core areas of the programme are training and education, clinical enquiry, care pathways and an enhanced referral pathway to specialist domestic violence services. The target patient population is women who are experiencing DV from a current partner, ex-partner or adult family member. IRIS also provides information and signposting for male victims and for perpetrators.

Provision

- Consider the case for additional Independent Domestic Violence Advocacy Services (IDVAs), support and community resources for victims/survivors

- Enhance alcohol, substance misuse and mental health services for victims/survivors of DV/VAWG

- Enhance services for people from minority groups, children and young people

Protection

- Address high level of repeat cases through the Multi Agency Risk Assessment Conference (MARAC). Havering MARAC is a monthly meeting where information is shared on the high risk domestic violence cases between representatives of local police, probation, health, child protection, housing practitioners, Independent Domestic Violence Advisors (IDVAs) and other specialists from the statutory and voluntary sectors.

- Improve levels of practitioner referrals to MARAC (just 24% of GPs said they were prepared to make appropriate referrals for victims – Royal College of General Practitioners 2012)

IMPLICATIONS AND RISKS

Financial implications and risks:

Failure to identify funding to tackle the issues raised in this report may impact on the Councils and other partner's ability to respond to a trend of rising domestic abuse within Havering.
The services already provided for domestic violence victims are funded from existing resource and, in the case of the Women's Aid advocacy service, via a grant from MOPAC.
Failure to comply with terms and conditions of the grant agreement, which does not allow any flexibility in spend, may result in funding for future years being withdrawn

Legal implications and risks:

The Council and other statutory partners including Health has a responsibility under the Crime and Disorder Act 1998 to address crime and disorder within the borough.
Although the funding available to the HCSP is consistent with previous years , we no longer have the flexibility of how we spend the funds which will impact on the Partnerships ability to respond to emerging crime trends over the coming year.
Failure to comply with terms and conditions of the grant agreement may result in funding for future years being withdrawn.

Human Resources implications and risks:

The Domestic Violence IDVA is employed by Victim Support London on an annual contract and therefore there are no HR implications for the Council if future funding is not secured.

Equalities implications and risks:

Equalities implications run throughout each of the strands of the MOPAC VAWG strategy and analysis of data in relation to the demographics of victims and offenders must be used to develop future services to address violence against women and girls.
Data will continue to be collected and reviewed to ensure services are delivered appropriately and that the needs of the changing communities in Havering are accommodated.

All commissioned services must ensure as part of our contractual arrangements and corporate procurement processes that they are compliant with the Equality Act 2010 and in particular the Public Sector Equality Duty. This will be monitored through the equalities monitoring of those who access the services

BACKGROUND PAPERS

Appendix 1 Women's Aid – Statistics on Domestic Violence
Appendix 2 MOPAC Mayoral Strategy on violence against women and girls 2013-17
Appendix 3 Havering JSNA for Domestic Violence 2012

Statistics about domestic violence

Incidence and prevalence of domestic violence: General

- There are ***no*** **reliable national data** on the general incidence of domestic violence in the UK[1].

- In 2011/12, 7.3% women (1.2 million) and 5% men (800,000) report having experienced domestic abuse[2].

- 31% women and 18% men have experienced domestic abuse since the age of 16 years. This amounts to **5 million women** and 2.9 million men[3].

- Domestic violence has repeatedly been identified as a major factor leading to **death** in or related to **pregnancy and childbirth**: see below.

- In 2011/12, the police reported nearly **800,000 incidents** of domestic violence[4].

- Domestic violence accounts for **10% of emergency calls[5].**

- Domestic violence has consistently accounted for between **16%** and **one quarter** of all recorded violent crime[6].

- There has been a **65% increase** in number of domestic violence **prosecutions** between 2005/6 and 2010/11 and a corresponding 99% increase in number of defendents convicted[7].

- Despite this, domestic violence **conviction rates** in the five years to 2011 stood at just **6.5%** of **incidents reported to police** – though a much higher proportion of around **70% of those charged[8]**.

- **Women** are much more likely than men to be the victim of **multiple incidents of abuse**, of different types of domestic abuse (partner abuse, family abuse, sexual assault and stalking) and in particular of **sexual violence[9]**.

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[1] Hester, 2008.
[2] Office for National Statistics (ONS), 2013.
[3] This is a smaller proportion of the population than identified by Syvia Walby and Jonathan Allen in their analysis of the BCS 2011. (Walby and Allen, 2004) They concluded that 45% women and 26% men had experienced at least one incident of inter-personal violence in their lifetimes, and that women were much more likely than men to be the victim of multiple incidents of abuse. This discrepancy could be due, at least in part, to methodological and definitional differences.
[4] ONS, 2013. The police record domestic abuse incidents in accordance with the National Standard for Incident Recording (NSIR) but they are not accredited national statistics and hence not subject to the same level of quality assurance as in the main recorded crime collection. In the year reported on here, the police did not record incidents of domestic violence where the victim was 16 or 17 years.
[5] From Labour party under Freedom of Information requests February 2013.
[6] Home Office, 2004; Dodd et al., 2004; BCS, 1998; Dobash and Dobash, 1980.
[7] CPS, 2011.
[8] Watson, 2010; CPS, 2011; CPS 2012.
[9] Walby and Allen, 2004.

- On average **2 women a week are killed** by a male partner or former partner: this constitutes around one-third of all female homicide victims[10].

- The prevalence of domestic violence is greater among young women (uinder 24 years), and those who have a long-term illness of disability[11].

Sexual violence

- 1 in 5 women (20%) have been victim of sexual abuse since the age of 16[12].

- There are around **500,000 victims of sexual assault** each year, 85%-90% of whom are women.

- 1 in 20 women report being victim of a serious sexual offence (i.e, rape or assault involving penetration) since the age of 16, and 0.5% in the past year.

- **90%** of the victims of the most serious offences knew their perpetrator, and **56% were partners/ex-partners**[13].

- Only 15% of victims said they had reported offences to the police.

- The police recorded a total of 53,700 sexual offences across England and Wales, 71% of which were rape of serious sexual assault.

- In 2011, 2,873 men were prosecuted for rape and 40% (1153) were convicted[14].

- While the majority of adults questioned did not think victims were ever responsible for someone sexually assaulting them, 1 in 12 thought the victim was "completely" or "mostly" responsible if she was under the influence of drugs, 6% thought this if she was drunk, and 7% if she had been flirting heavily beforehand.

[10] Coleman and Osborne, 2010; Povey, ed. 2004, 2005; Home Office, 1999; Department of Health, 2005.
[11] ONS, 2013.
[12] Figures in this section are taken primarily from Ministry of Justice, Home Office and Office for National Statistics (January 2013) *An overview of sexual offending in England and Wales* (London: MoJ, Home Office and ONS) http://www.justice.gov.uk/downloads/statistics/criminal-justice-stats/sexual-offending/sexual-offending-overview-jan-2013.pdf
[13] See also Walby and Allen (2004) who found that 54% of UK rapes are committed by a woman's current or former partner.
[14] CPS (2012) *Violence against women and girls crime report 2011/12* (London: CPS)

Gender differences

- Research consistently shows that **more women than men** are or have been victims of violence and abuse from an intimate partner/former partner. However, due to different definitions and different methodologies, the degree of difference varies considerably.

- The difference between men's and women's experiences of domestic violence are greater when asked about their **lifetime experiences** than for experiences of violence and abuse during the last year[15].

- Female victims of intimate partner violence experienced **more severe violence** and control, with **more serious psychological consequences**, than did male victims; and women were much more likely to be **fearful** of their partners[16].

- 32% of women who had ever experienced domestic violence did so four or more times, compared with 11% of the (smaller number) of men who had ever experienced domestic violence; and women constituted 89% of all those who had experienced 4 or more incidents of domestic violence[17].

- Men are significantly more likely than women to be **repeat perpetrators** of violence.

- Intensity and severity of violence used by men was more extreme, men being more likely to use physical violence, threats, and harassment[18].

- Men's violence creates a context a **fear and control** – this is not usually so for women's violence.

- It is important to distinguish between the different types of intimate partner violence in order to understand, intervene effectively in individual cases, or make useful policy recommendations: "**intimate terrorism"**, "**violent resistance"**, "**situational couple violence"**, and "**mutual violent control**" have "different causes, different patterns of development, different consequences, and require different forms of intervention"[19].

- Population surveys (e.g. BCS/CSEW) are likely to be dominated by reports of "situational couple violence", and include fewer examples of "intimate terrorism" and/or "coercive control"[20], due to their focus on **incidents** and on "crime".

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[15] Hester, M., 2010.
[16] Ansara, *et al.*, 2010, 2011.
[17] Walby and Allen, 2004; see also Coleman *et al.*, 2007.
[18] Hester, M., 2009. These figures do not include sexual violence, which is also much more likely to be part of male violence to female partners.
[19] Johnson, M.P., 2006.
[20] Stark, 2007.

- With (heterosexual) men, there is evidence that **the distinction between "victim" and "perpetrator" is often blurred**: of 171 men referred to one project for male victims, more than one-third had a history of perpetrating domestic violence[21]. And follow-up interviews with men reporting abuse in the Scottish Crime Survey also indicated that a significant proportion were either primary perpetrators, or engaged in mutual violence with their partners[22].

- A study specifically seeking male victims found that only a minority of men abused within heterosexual relationships were apparently the primary perpetrator (8 out of 22 cases) and none of them had experienced sexual abuse from their partners[23].

- A study based on reports to police, (taking account of context and consequences, and reflecting the view that domestic violence is a pattern of behaviour over time) found that in only **5% of cases** were female perpetrators in heterosexual relationships[24].

Calls to the National Domestic Violence Helpline

- The Freephone 24-Hour National Domestic Violence Helpline (run in partnership between Women's Aid and Refuge) received just over a quarter of million calls during its first 12 months.

- During 2011-12, the National Helpline received an average of 445 calls per day, 78% were answered.

Forced marriage

- Statistics from the Forced Marriage Unit show that between January and December **2011**, the unit dealt with **1,468 cases,** a significant increase since 2007, when 400 cases were undertaken.

- **86 applications under the Forced Marriage Act** were brought nationally during 2009, and this number also seems to be rising[25].

- In one study of south Asian women who had accessed specialist BAMER domestic violence services, **21%** of women had experienced forced marriage – though only one of these had applied for a Forced Marriage Protection Order under the Act[26].

[21] Robinson and Rowlands, 2006.
[22] Gadd, *et al*., 2003; Gadd, *et al*., 2002) See also Carnell, 2008.
[23] Hester, *et al.,* 2012.
[24] Hester, 2009.
[25] Chokowry, et al., 2011.
[26] Thiara and Roy, 2010.

Female Genital Mutilation (FGM)

- Estimates from FORWARD show that around 66,000 women resident in England and Wales had been subjected to **female genital mutilation**[27]**.**

Types of violence

- Since the age of 16, partner abuse (non-sexual) was the most commonly experienced type of intimate violence among both men and women. 28% of women and 17% of men reported having experienced such abuse[28].

- In the last 12 months stalking was the most commonly experienced type of intimate violence with 9% of women and 7% of men reported having experienced it in the last year[29].

- Nearly half of women (48%) who had experienced intimate partner violence since the age of 16 had experienced **more than one type of intimate violence**. Men were less likely to have experienced multiple forms of intimate violence (33%)[30].

- Serious sexual assault was most likely to be committed by someone known to the victim (89% of female and 83% of male victims). Just over half (54%) of female victims reported that a partner or ex-partner had been the offender[31].

- Just under a quarter of women (23%) reported having experienced stalking since the age of 16. Obscene or threatening phone calls or letters were the most common types of stalking behaviour experienced[32].

- Around one in ten women (12%) had been victims of non-sexual family abuse[33].

- 16% of women who had been a victim of any type of partner abuse had experienced **sexual assault** and 26% had experienced **stalking** by a partner[34].

- Many victims of partner abuse had experienced more than one type of intimate violence by a partner[35].

- In one study of South Asian women using specialist BAMER domestic violence services, over 40% had been in the violent relationship for 5 years

[27] Foundation for Women's Health, Research and Development - FORWARD.
[28] Coleman, *et* al., 2007.
[29] *Ibid.*
[30] *Ibid.*
[31] *Ibid.*
[32] *Ibid.*
[33] *Ibid.*
[34] *Ibid.*
[35] *Ibid.*

or more, and for most of these, the abuse was a regular and frequent occurrence. The majority had experienced a **wide variety of kinds of abuse**, often from **multiple perpetrators** and various family members[36].

Nature and Impact

- A study of 200 women's experiences of domestic violence commissioned by Women's Aid, found that 60% of the women had left because they feared that they or their children would be killed by the perpetrator[37].

- In the same study, 76% of separated women suffered post-separation violence. Of these women:
  - -76% were subjected to continued verbal and emotional abuse;
  - 41% were subjected to serious threats towards themselves or their children;
  - 23% were subjected to physical violence;
  - 6% were subjected to sexual violence;
  - 36% stated that this violence was ongoing.

  In addition to this, more than half of those with post-separation child contact arrangements with an abusive ex-partner continued to have serious, ongoing problems with this contact[38].

- Women are at greatest risk of homicide at the point of separation or after leaving a violent partner[39].

- 42% of all female homicide victims, compared with 4% of male homicide victims, were killed by current or former partners in England and Wales in the year 2000/01. This equates to 102 women, an average of 2 women each week[40].

- In a study by Shelter, 40% of all homeless women stated that domestic violence was a contributor to their homelessness. Domestic violence was found to be "the single most quoted reason for becoming homeless"[41] .

- **Repeat victimisation** is common. **44%** are victimised more than once, and almost one in five (18%) are victimised three or more times[42]. An earlier British Crime Survey found even higher rates of repeat victimisation: 57%[43].

- Men are less likely to have been repeat victims of domestic assault, less likely to be seriously injured and less likely to report feeling fearful in their own homes[44].

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[36] Thiara and Roy, 2010.
[37] Humphreys & Thiara, 2002.
[38] Humphreys & Thiara, 2002.
[39] Lees, 2000.
[40] Home Office, 2001.
[41] Cramer and Carter, 2002.
[42] Dodd, *et al*., 2004.
[43] Home Office, July 2002.
[44] Scottish Executive Central Research Unit, 2002.

- Nearly 1 in 5 counselling sessions held in Relate Centres in England on 28/9/00 mentioned domestic violence as an issue in the marriage[45].

Health consequences of domestic violence

- Violence against women has serious consequences for their physical and mental health, and women who have experienced abuse from her partner may suffer from or chronic health problems of various kinds[46].

- Abused women are more likely to suffer from depression, anxiety, psychosomatic systems, eating problems and sexual dysfunction. Violence may also affect their reproductive health[47].

- **70%** of incidents of domestic violence result in **injury**, (compared with 50% of incidents of acquaintance violence, 48% of stranger violence and 29% of mugging.) [48]

- **75%** of cases of domestic violence result in physical injury or mental health consequences to women[49].

- The cost of treating **physical health** of victims of domestic violence, (including hospital, GP, ambulance, prescriptions) is £1,220,247,000, i.e. 3% of total NHS budget[50].

- The cost of treating **mental disorder** due to domestic violence is £176,000,000[51].

- Between 50% and 60% of women mental health service users have experienced domestic violence, and up to 20% will be experiencing current abuse[52].

- Domestic violence and other abuse is the most prevalent cause of depression and other mental health difficulties in women[53].

- 70% women psychiatric in-patients and 80% of those in secure settings have histories of physical or sexual abuse[54].

- Domestic violence commonly results in self-harm and attempted suicide: one-third of women attending emergency departments for self-harm were

[45] Stanko, 2000.
[46] Stark and Flitcraft, 1996; Williamson, 2000; British Medical Association, 1998; Crisp and Stanko, 2001.
[47] World Health Organisation, 2000.
[48] Dodd, *et al*., 2004.
[49] Home Office, 2001.
[50] Walby, 2004.
[51] Walby, 2004.
[52] Department of Health, 2003; Bowstead, J., 2000; ReSisters, 2002.
[53] Astbury, 1999; O'Keane, 2000; Humphreys, 2003; Humphreys and Thiara, 2003; Vidgeon, 2003.
[54] Phillips, 2000; Department of Health, 2002.

domestic violence survivors; abused women are five times more likely to attempt suicide; and one third of all female suicide attempts can be attributed to current or past experience of domestic violence[55].

Pregnancy and childbirth

- **30%** of domestic violence **starts** in pregnancy[56].

- Domestic violence has been identified as a **prime cause** of **miscarriage** or **still-birth[57].**

- Domestic violence is also a major factor leading to **death in or related to pregnancy** and childbirth: during the three years 2006-08, 34 of the 261 women who died around the time of giving birth showed signs of domestic abuse (13%) – eleven of these having been murdered by partners or family members[58]- and previous reports indicate an even higher proportion of deaths in childbirth being related to domestic abuse [59].

- Between **4 and 9 women in every 100** are abused during their pregnancies and/or after the birth[60].

- Legally, if a miscarriage is caused by abuse, the assailant can be charged under S.58 of the Offences against the Person Act, "using an instrument with intent to cause a miscarriage[61].

- If a baby is born prematurely as a result of an assault, and then dies, the assailant may be charged with manslaughter[62].

- One study in the USA found a significant relationship between pregnancy, domestic violence, and suicide: pregnant women who attempt suicide are very likely to have been abused[63].

- In one study, 23% of women receiving care on antenatal and postnatal wards had a lifetime experience of domestic violence, and 3% had experienced violence in the current pregnancy[64].

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[55] Stark and Flitcraft, 1996; Mullender, 1996.
[56] Lewis and Drife, 2001, 2005; McWilliams and McKiernan, 1993.
[57] Mezey, 1997.
[58] CMACE, 2011. See also Lewis and Drife, 2001, 2005.
[59] 14% of the women whose deaths were investigated by the 2002-4 Confidential Enquiry were known to have experienced domestic violence – and this was likely to be an under-estimate (CEMACH, 2006). 11 of these were murdered by their partners. And the 2003-2005 Confidential Enquiry into Maternal and Child Health (CEMACH, 2007) reported that 19 pregnant or recently delivered women were murdered by their partners, and 70 out of 295 women who died from all causes (24%) had information consistent with experience of domestic violence documented in their maternity records.
[60] Taft, 2002.
[61] See *Bristol Evening Post* 18th December 2004, report on Nycoma Edwards whose assault on his girlfriend led to miscarrying at 4 and half months.
[62] See report from July 2000 of a Carlyle case where assault resulted in birth of baby (born at 8 and a half months by caesarean section).
[63] Stark and Flitcraft, 1996.

- Routine enquiry about domestic violence in maternity settings is **accepted by women**, provided it is conducted in a safe confidential environment. A pilot project in Leeds found that 92% of women questioned were in favour of routine enquiry. (Price 2004; Leeds Inter-agency Project, 2005).

Impact of Domestic Violence on Children

- At least **750,000 children a year** witness domestic violence[65].

- Children who live with domestic violence are at increased risk of behavioural problems and emotional trauma, and mental health difficulties in adult life[66].

- Nearly three quarters of children on the 'at risk' register live in households where domestic violence occurs and 52% of child protection cases involving domestic violence[67].

- In 75% to 90% of incidents of domestic violence, **children** are in the same or the next room[68].

- The link between child physical abuse and domestic violence is high, with estimates ranging between 30% to 66% depending upon the study[69].

- **70%** of children living in UK refuges have been abused by their father[70].

- A survey of 130 abused parents found that **76%** of the 148 children ordered by the courts to have contact with their estranged parent were said to have been abused during visits: 10% were sexually abused; 15% were physically assaulted; 26% were abducted or involved in an abduction attempt: 36% were neglected during contact, and 62% suffered emotional harm. Most of these children were under the age of 5[71].

- Information received from local Family Court Welfare Services suggests that **domestic violence is present in almost 50% of cases**, where a welfare report is ordered[72].

- 30% of all Children Act cases involve domestic violence and between 50% and 60% of CAFCASS caseload is domestic violence – and these figures increase each year, as domestic violence is better identified[73].

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[64] Bacchus, 2004.
[65] Department of Health, 2002.
[66] Kolbo, *et al*., 1996; Morley and Mullender, 1994; Hester *et al.*, 2000, 2007.
[67] Department of Health, 2002; Farmer and Owen, 1995.
[68] Hughes, 1992; Abrahams, 1994.
[69] Hester et al, 2000,2007; Edleson, 1999; Humphreys & Thiara, 2002.
[70] Bowker et al., 1998.
[71] Radford, Sayer & AMICA, 1999.
[72] Association of Chief Officers of Probation, 1999.
[73] From evidence given to the Home Affairs S.elect Committee, January 2008, as reported in *Family aw* March 2008, Vol. 38, p.270

- In a survey of domestic violence service providers, Women's Aid found that **48%** stated that adequate safety measures are **not** being taken to ensure the safety of the child and the resident parent before, during and after contact[74]. Two years later, **only 3%** said they believed that appropriate measures were now being taken to ensure safety[75].

- Respondents to the same survey (May 2003) reported cases since April 2001 in which a total of **18 children** were ordered to have contact with a parent who had committed offences against children (Schedule 1 offenders); **64** children were ordered to have contact with a parent whose behaviour had previously caused that child to be put on the Child Protection Register; and **21** of these children were ordered to have **unsupervised contact** with the perpetrator[76].

- **46%** of respondents knew of cases where a violent parent had used contact proceedings to track down his partner[77].

- **29 children** in 13 families were **killed** between 1994 and 2004 as a result of contact arrangements in England and Wales, 10 of them since 2002. In five of these families contact was ordered by the court[78].

- In the year 2001, there were 55,743 applications for contact orders under the Children Act 1989. Of those, only 713 (1.3%) were refused. (Lord Chancellor's Department, 2002).

Police

- Every minute in the UK, the police receive a call from the public for assistance for domestic violence. This leads to police receiving an estimated **1,300 calls each day** or over 570,000 each year[79].

- However, only a minority of incidents of domestic violence are reported to the police, varying between 23%[80] and 35%[81].

Attitudes to violence (young people)

- Many young people view violence as a normal aspect of intimate relationships [82].

[74] Saunders, 2001
[75] Saunders with Barron, 2003.
[76] Saunders with Barron, 2003.
[77] Saunders with Barron, 2003.
[78] Saunders, 2004.
[79] Stanko, 2000.
[80] Walby and Allen, 2004.
[81] Home Office, 2002; see also ONS, 2013; British Crime Survey, 1998; Dodd, et al., 2004.
[82] Wood, et al., 2011.

- Nearly a quarter of young people in one study in Wiltshire believed that 'sometimes' abuse or violence was OK, with a small proportion, 1.4%, stating it was 'always' OK[83].

- This is consistent with an earlier study which found that 1 in 5 young men and 1 in 10 young women think that abuse or violence against women is acceptable[84].

Cost of domestic violence

- The cost of **physical healthcare** treatment resulting from domestic violence, (including hospital, GP, ambulance, prescriptions) is £1,220,247,000, i.e. 3% of total NHS budget[85].

- The cost of treating **mental disorder** due to domestic violence is £176,000,000[86].

- The **overall costs** of domestic violence are estimated to be £15,730,000,000.p.a[87].

International statistics

- International comparisons are difficult due to the **lack of internationally agreed statistical standards**, and the use of different approaches, definitions, sample designs, and questions.

- Violence against women has become an issue of international concern and human rights, and domestic violence (or intimate partner violence) is mostly seen within this context[88].

- Domestic violence occurs in all countries, and the "overwhelming burden of partner violence is borne by women at the hands of men." [89]

- Abuse by a partner is much more common than physical or sexual violence from a stranger: in most countries, over 75% of women who had ever experienced physical or sexual abuse (since age 15) reported abuse by a partner[90].

[83] Wiltshire Assembly Community Safety Partnership, 2009.
[84] Burton, S. *et al*., 1998. See also Kinsella, 2006.
[85] Walby, 2004, p.53.
[86] Walby, 2004.
[87] Walby, 2009.
[88] See for example, Amnesty International, 2004.
[89] Krug, et al., (ed.) 2002, p.89; see also Garcia-Moreno, et al., 2005.
[90] Garcia-Moreno, *et al.,* 2005.

- Across Europe, domestic violence is the major cause of death and disability for women aged 16 to 44 and accounts for more death and ill-health than cancer or traffice accidents[91].

- An analysis of 10 separate domestic violence prevalence studies by the Council of Europe showed consistent findings: **1 in 4 women** experience domestic violence over their lifetimes, and between 6-10% of women suffer domestic violence in a given year[92].

- In one study by the World Health Organisation, domestic violence was found to be widespread in all 10 countries studied, though there was considerable variation between countries, and between cities and rural areas[93].

- UN figures also show considerable variation between countries, from 6% of women in China experiencing physical violence from an intimate partner over their lifetimes, to 48% or more of women in Zambia, Ethiopia and Peru[94].

- In almost all countries, younger women (24 years or under) were most likle to experience physical abuse from an intimate partner[95].

- Partner violence accounts for a high proportion of homicides of women internationally: between 40% - 70% of female murder victims (depending on the country) were killed by their partners/former partners, whereas the comparable figure for men is 4% - 8%[96].

- Domestic violence is internationally acknowledged to be one of the health inequalities affecting women particularly, and forms a significant obstacle to their receiving effective health care[97].

- Higher rates of violence against women are found in countries where women's status is lowest[98] - i.e. where there are marked inequalities between men and women, rigid gender roles, cultural norms that support a man's right to sex regardless of a woman's feelings, and weak sanctions against such behaviour; e.g. in Peru, 70% of all crimes reported to the police involve women beaten by their husbands.

- Although violence against women and girls is prevalent everywhere, there is considerable variation between countries, and between cities and rural areas within countries[99]. Higher rates of violence against women are

[91] Parliamentary Assembly of the Council of Europe, 2002.
[92] Council of Europe, 2002.
[93] Garcia-Moreno, C., *et al*., 2005.
[94] United Nations, 2010.
[95] United Nations, 2010.
[96] Krug *et al.* 2002.
[97] World Health Organisation, 1997; United Nations,1993.
[98] Harvey *et al*., 2007; Krug, et al., ed., 2002.
[99] See Garcia-Moreno et al., (2005) *op.cit.*

found in countries where women's status is lowest[100]; e.g. in Peru, 70% of all crimes reported to the police involve women beaten by their husbands.

- Partner violence accounts for a high proportion of homicides of women internationally: between 40% - 70% of female murder victims (depending on the country) were killed by their partners/former partners, whereas the comparable figure for men is 4% - 8%.[101]

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[100] Harvey et al. (2007) *Primary prevention of intimate partner violence and sexual violence: Background paper for WHO expert meeting* (Geneva: World Health Organisatiuon *)*
[101] Krug, et al., *ibid.*

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MAYORAL STRATEGY ON VIOLENCE AGAINST WOMEN AND GIRLS

2013-17

MOPAC | MAYOR OF LONDON
OFFICE FOR POLICING AND CRIME

CONTENTS

FOREWORD

The first duty of the Mayor is to protect Londoners, and I'm determined to do just that. Crime has fallen by 11 per cent since I was elected in 2008, and we are working hard to ensure the capital is one of the safest cities in the world to work and live in. In 2012 I made a commitment to Londoners that we would make London a safer city for women and girls. I believe everyone in London, regardless of age, sex or background, has the right to live free of violence and abuse. In 2010, London became the first major city in the world to launch a comprehensive Violence Against Women and Girls (VAWG) strategy, which has drawn together a coalition of those committed to combatting all forms of violence against women and received positive recognition by the United Nations. **The Way Forward: Taking Action to End Violence against Women** set out a bold and ambitious approach to making London a national and global leader in preventing and eliminating violence against women and girls. And I am proud of our achievements and the progress made in tackling VAWG over the last three years. But there is still much more to do. Female victims in this city are still too common and we need to do more to tackle the scourge of domestic violence, and forms of prostitution and human trafficking. We also need plans both to prevent and prosecute those who commit horrendous crimes like female genital mutilation. The 2013-2017 VAWG Strategy will therefore maintain the commitments I made in **The Way Forward**; and set an ambitious agenda for London over the next three years. It emphasises the importance I place on collaborative work with partners across London to support efforts to tackle VAWG; developing pan-London services in response to specific crimes; and preventative planning. I am confident that this strategy will make a real difference to women and girls living with the fear and reality of violence. My mission is to make London the safest and greatest big city on earth, and we will do this by preventing violence against women and girls. **Boris Johnson** Mayor of London

Tackling violence against women and girls is a key Mayoral priority and the Mayor's Office for Policing And Crime (MOPAC) is dedicated to working with partners across London to address VAWG. This refreshed strategy confirms our commitments to a bold approach to tackling violence against women and girls across London. Cases of abuse, whether physical or sexual, can be some of the worst crimes. Victims, sometimes very young, can often find it hard to talk about their experiences and repeat victimisation is common. Our first ambition is to prevent these crimes happening in the first place. Where violence does occur, we want to ensure that victims have the confidence to report cases. In addition, we want to support victims and their children and relatives to have access to appropriate support, helping them rebuild their lives and protecting them from further harm. Finally, we want to bear down on perpetrators to stop violence, by bringing more of them to justice, more swiftly. MOPAC has consulted widely to refresh this strategy and we have been reassured that the objectives and priorities set in 2010 remain the right ones. In my role as Deputy Mayor and Co-Chair of the London VAWG Panel, I will personally ensure that key partners work together to fulfil the ambitions set out in this strategy. Further work by MOPAC and the VAWG Panel will help to develop a performance framework so we can be confident that we are making progress. **Stephen Greenhalgh** Deputy Mayor for Policing and Crime

THE MAYOR'S MISSION AND PRIORITIES

The first duty of the Mayor is to protect Londoners. As part of his manifesto when he was re-elected in 2012, the Mayor pledged to create a safer London for women by tackling violence against women and girls.

In his Police and Crime plan launched in March 2013, the Mayor set out his mission and priorities for policing and crime reduction in London over the next four years. Tackling violence against women and girls (VAWG) is a key priority within that plan.

INTRODUCTION

In March 2010, the Mayor launched London's first ever strategy to tackle VAWG, **The Way Forward: taking action to end violence against women**. **The Way Forward** strategy outlined a bold and ambitious approach, making London a national and global leader in seeking to end VAWG. The strategy has been hailed by the women's voluntary and community sector as a beacon of excellence for other cities and countries and was highlighted as an example of good practice at the United Nations (UN) Commission on the Status of Women in February 2013.

The Way Forward strategy was a three year strategy which ended in April 2013. The Mayor pledged to publish a refreshed strategy to build on the progress made over the last three years in addressing VAWG in London to respond to key national policy developments, changes in resources allocated at a regional and local level and to respond to the challenge where reporting and prosecutions remain low, even though evidence is clear that this issue affects a large number of women and girls across the capital. The way London identifies and responds to VAWG has improved but many of the systemic problems still need to be tackled.

Through the Police and Crime Plan and delivery of this strategy, the Mayor and Deputy Mayor are committed to reducing the prevalence of VAWG over time and improving confidence of victims by working with partners to:

- Focus on prevention and create a culture based on equal rights and respect.
- Hold perpetrators of VAWG to account.
- Ensure that women and girls have access to protection, justice and support to rebuild their lives.

OBJECTIVES

Stakeholders have confirmed that the vision, approach and five key objectives of **The Way Forward** strategy are still as valid today as they were in 2010 and should therefore remain as the pillars of a refreshed VAWG strategy for London. The five key objectives and overarching commitments are:

1. London taking a global lead to prevent and eliminate VAWG

Work with partners to significantly reduce the prevalence of VAWG over time through the following commitments:

• Political leadership to support boroughs to develop strategic approaches to VAWG which improve the quality and accessibility of specialist services.

• Challenging schools in London to tackle VAWG through a 'whole school approach' focused on prevention, education and safeguarding.

• Co-ordinate an assertive new programme to combat the evils of female genital mutilation (FGM).

• Formulate a preventative plan for so-called 'witchcraft' killings and 'honour' crimes.

• Pave the way for successful prosecutions for FGM by improving the level and quality of cases being referred to the Crown Prosecution Service (CPS).

• Work with the Public Health Minister to ensure cross agency sharing of information/cases in relation to VAWG with a focus on harmful practices.

• Improve the identification and safeguarding of young women and girls at risk of FGM by piloting new ways of identification and engagement in pilot sites across London.

• Encourage proactive identification, risk and needs assessment of gang-associated young women and girls and develop safe exit strategies.

2. Improving access to support

Work with partners to ensure the safety, wellbeing and freedom of women and children through improving access to high quality services through:

• Delivering high quality sexual violence service provision including four Rape Crisis Centres and three Havens (Sexual Assault Referral Centres).

• Use the Ministry of Justice (MoJ) Victims Fund to commission VAWG services in London with a focus on service gaps and innovation.

• Commission and fund pan-London domestic violence provision.

• Maintain the number of Independent Domestic Violence Advocates (IDVAs).

3. Addressing health, social and economic consequences of violence

Work with partners to reduce the long-term consequences of violence and improve the life chances of the women and girls who experience it, and support them to rebuild their lives:

• Address the health impact of VAWG.

• Work with commissioners and providers to build a picture of the future suitability of housing provision in the capital for women and girls experiencing VAWG.

• Develop pan-London provision to address the needs of women involved in trafficking and prostitution and to support them to exit.

• Develop a pan-London protocol in line with the Mayor's objectives which will inform the way all London partners respond to prostitution.

• Improve the identification of and response to victims of trafficking.

• Implement any learning and good practice developed by the Human Trafficking and London 2012 Network.

4. Protecting women and girls at risk

Work with partners to ensure that the whole criminal justice system deters crimes of violence against women and provides full, effective and timely protection and justice for women:

• Work with the Metropolitan Police Service (MPS) to improve the identification of and response to victims of VAWG to improve confidence levels.

• Publish MPS and CPS data on sanction detection rates of VAWG offences as well as court outcomes.

• Improve the way the criminal justice system responds to domestic and sexual violence through specialist courts and special measures for victims.

• Improve young women's access to protection and support.

5. Getting tougher with perpetrators

Work with partners to intervene with perpetrators of violence against women in order to stop the violence, hold them to account, change their behaviour and deter others:

• Challenge criminal justice partners to increase the number of convictions for VAWG offences with appropriate sentencing.

What is VAWG?

The UN defines violence against women as "any act of gender-based violence that is directed at a woman because she is a woman or acts of violence which are suffered disproportionately by women."[1] This includes physical, sexual and psychological/emotional violence, economic abuse and sexual exploitation. VAWG can take place at home, work or in public places such as on the street or public transport.

This strategy covers the following forms of violence against women and girls:

• Domestic violence and abuse • Female Genital Mutilation (FGM) • Forced marriage • 'Honour'-based violence • Prostitution and trafficking • Sexual violence including rape • Sexual exploitation • Sexual harassment • Stalking • Faith-based abuse.

Full definitions can be found in Appendix 1.

This strategy is focused on the needs of women and girls and is a deliberate response to the disproportionate impact of VAWG crimes on women and girls. This does not mean that men are never victims of, for example, rape, forced marriage, or domestic violence, or even that women are not sometimes perpetrators. The Mayor is committed to tackling the needs of men and to addressing all forms of exploitation and abuse across the capital. He wants to drive protection and legal redress for all victims of crime.

Key national developments

Since the publication of **The Way Forward**, the landscape in which VAWG is tackled has changed considerably. Some of the most significant changes are set out in Appendix 2. The refreshed strategy takes into account these changes and also reflects the change in the Mayor's role. The creation of MOPAC has given the Mayor greater responsibility for oversight of the MPS and the wider criminal justice system (CJS) and a duty to bring together partners working in the field of community safety to deliver and commission initiatives to prevent and respond to crime.

The government published its "Call to end violence against women and girls" strategic narrative in November 2010 followed by annual action plans in 2011, 2012 and 2013. This strategy supports the vision and the principles set out by the government.[2]

[1] United Nations, 2006, Secretary General's Report on Violence against women, Para 28 and 104

[2] https://www.gov.uk/government/policies/ending-violence-against-women-and-girls-in-the-uk

PROGRESS IN LONDON OVER THE LAST FOUR YEARS

Both the Greater London Authority (GLA) and the Mayor's Office for Policing and Crime (MOPAC) have worked closely with partners over the last four years to deliver and implement the commitments set out in **The Way Forward** strategy. Key successes include:

• **An improved understanding of the nature and extent of VAWG in London** and of the solutions, policies and services required to address this. The commissioning and publication of independent research into forced marriage, FGM and 'honour'-based violence ("**The Missing Link**" report), domestic violence refuge provision, trafficking and prostitution ("**Capital Exploits**" report) have been of particular importance.

• **A shift towards a more preventative approach** including a sexual violence prevention campaign, work with young people in out-of-school settings such as youth clubs and the funding of a pan-London prevention initiative by London Councils.

• **Improved access to support** by quadrupling Rape Crisis provision, opening three new centres and expanding the only centre in south London. Greater focus on VAWG across London with the development of local VAWG strategies in boroughs[3] and London Councils' development of new pan-London VAWG provision focused on prevention, specialist provision for victims of trafficking and specialist provision to tackle harmful practices (female genital mutilation, forced marriage and 'honour'-based violence).

• **Improvements to the MPS response to VAWG** through the formation of a specialist command to respond to rape and sexual assault which has now merged with the child abuse command to create an integrated "Sexual Offences, Exploitation and Child Abuse Investigation Command" and the formation of a new specialist unit to tackle trafficking and prostitution which has established itself as a centre of excellence renowned for its victim-centred approach.

• **Multi-agency responses to VAWG** including the creation of a multi-agency Human Trafficking and London 2012 Network and delivery of an ambitious action plan including training for all front line police officers and single points of contact for child trafficking in each London borough. The Network was highlighted as a model of good practice by the Institute for Public Policy Research[4] and the Cambridge Centre for Applied Research in Human Trafficking.[5]

• **Scrutiny and support** to all London boroughs through the Domestic and Sexual Violence Board to improve the way the MPS responds to incidents of domestic and sexual violence. A report outlining the pan-London issues identified and subsequent recommendations was published in 2011[6]. The Board was highlighted as a model of good practice by the United Nations Entity for Gender Equality and the Empowerment of Women.[7]

Consultation

This document has been developed further to a two month consultation between June – August 2013 to which approximately eighty organisations and individuals responded.

MOPAC also commissioned Imkaan to consult survivors of VAWG to inform the development of the Mayor's second VAWG strategy for London. The survivor consultation report 'Beyond the Labels' is available online. Both consultations have informed the development of this strategy and will drive delivery of many of the commitments.

Community Impact Assessment

A community impact assessment has been undertaken in conjunction with the development of this strategy which is available on the MOPAC website.

[3] MOPAC survey into local VAWG responses (17 April- 3 May 2013)

[4] The UK's response to human trafficking: Fit for purpose? IPPR (July 2012)

[5] Human Trafficking, Sporting Mega-Events, and the London Olympics of 2012, Cambridge Centre for Applied Research in Human Trafficking (September 2012)

[6] http://policeauthority.org/metropolitan/dsvb/index.html

[7] http://www.endvawnow.org/en/articles/1104-oversight-by-independent-bodies.html

[8] http://www.homeoffice.gov.uk/rds/pdfs08/hosb0308.pdf

[9] NSPCC (2009) Partner Exploitation & Violence in teenage intimate relationships

[10] Statistical Bulletin Focus on: Violent Crime and Sexual Offences, 2011/12 Office for National Statistics (Feb 2013)

VAWG IN LONDON

Domestic violence

• In 2012/13 there were 48,873 domestic violence crimes reported to the Metropolitan Police Service (MPS) in London.

• In London, 33 per cent of violence with injury occurs within the home.

• Nationally the police remain unaware of 81 per cent of domestic abuse victims.[8]

• 25 per cent of girls experienced some form of physical abuse at least once in their lifetime.[9]

Rape & other sexual offences

• In 2012/13, there were 3,043 rape offences, 7,982 serious sexual assaults and 1,780 other sexual offences reported to the MPS in London.

• In the 2011/12 Crime Survey for England & Wales, 13 per cent of victims of serious sexual assault reported the incident to the police.[10]

• 31 per cent of girls reported experiencing some form of sexual violence at least once in their lifetime.[11]

Female Genital Mutilation (FGM), Forced Marriage & 'Honour'-based violence

• The MPS investigated 46 allegations of FGM in 2008/09 and 58 in 2009/10.[12] However, no prosecutions have been brought under the legislation prohibiting FGM which has been in place since 1985.

• A report published by FORWARD in 2007 estimated that in 2001, 4.5 per cent of maternities in Greater London were to women who were born in FGM practising countries and had some form of FGM.[13]

• The Forced Marriage Unit recorded 1,485 cases of forced marriage across the UK in 2012. Of these cases, 21 per cent were identified in London.[14]

• In 2012/13 there were 50 forced marriage offences and 180 'honour'-based violence offences reported to the MPS.

Trafficking and prostitution

• There were 447 trafficking for sexual exploitation offences reported to the MPS in 2012/13, a significant increase from 32 offences five years ago (2007-08).

• In 2012, 1,186 potential victims of trafficking were referred to the National Referral Mechanism of whom 786 were female. London remains the single largest region for referrals with 315 referrals in 2012 and 258 referrals in 2011.[15]

• Project Acumen identified 2,600 female victims of trafficking for sexual exploitation in England and Wales and 9,600 who are considered to be vulnerable.[16]

• Women in street prostitution are 12 times more likely to be murdered than the rate for all women in same age group in the UK.[17]

• More than half of women in prostitution have been raped and at least 75 per cent have been physically assaulted at the hands of the pimps and punters.[18]

[11] NSPCC (2009) Partner Exploitation & Violence in teenage intimate relationships

[12] Metropolitan Police Service (2010) Female Genital Mutilation Report: 8. 4 November 2010. Project Azure

[13] Efua Dorkenoo, Linda Morrison and Alison Macfarlane (2007) A Statistical Study to Estimate the Prevalence of Female Genital Mutilation in England and Wales, London: FORWARD with The London School of Hygiene and Tropical Medicine and City University

[14] Forced Marriage Unit, Statistics January-December 2012, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/141823/Stats_2012.pdf

[15] HM Government (October 2013) Second report of the Inter-Departmental Ministerial Group on Human Trafficking.

[16] http://www.acpo.police.uk/documents/crime/2010/201008CRITMW01.pdf

[17] Home Office (October 2011) A review of effective practice in responding to prostitution

[18] Home Office (2004) Solutions and Strategies: Drug Problems and Street Sex Markets: London: UK Government

OBJECTIVE ONE: LONDON TAKING A GLOBAL LEAD TO ELIMINATE AND PREVENT VAWG

Work with partners to significantly reduce the prevalence of violence against women and girls over time. London will be a leader in developing and implementing a range of measures to achieve this.

OBJECTIVE ONE: PRIORITIES

As a global city, London faces the full spectrum of violence against women and girls (VAWG). The Mayor believes that VAWG is neither natural nor inevitable. VAWG can and should be prevented and our long-term vision is of a society free of such violence.

The Mayor is committed to ensuring that London takes a global lead to eliminate and prevent VAWG.

1. Promote an integrated approach to VAWG across London

VAWG is a multi-faceted issue that links to, and impacts on, a range of other social issues including poverty, unemployment, youth crime, homelessness, child abuse, health, and problematic substance use. A multi-agency, integrated approach to tackling these issues is therefore required.

Building on the first strategy this means:

- Recognising the links and similarities between the different forms of violence e.g. victims of domestic violence often experience sexual violence. A significant proportion of women involved in prostitution have experienced childhood sexual abuse and domestic violence.
- Tackling all forms of VAWG in a joined up way, linking different forms of violence and addressing their underlying causes.
- Acknowledging the links between VAWG and other issues, and mainstreaming VAWG into other policies and strategies.
- A multi-agency approach that makes the best use of resources.
- Targeting perpetrators and holding them to account.
- Creating a culture in which VAWG is neither tolerated nor condoned and women are encouraged to report it and seek support.

Whilst the Mayor has many levers at his disposal to provide strategic and political leadership across London, tackling VAWG is not something the Mayor can achieve alone. For example, local authorities have a significant role to play in developing, delivering and commissioning services and initiatives to address the needs of their local communities. They also have a leadership role in the areas they serve, including within local Community Safety Partnerships, local Safeguarding Children Boards and Health and Wellbeing Boards.

Through the VAWG Panel, MOPAC will:

- Work with local authorities and partners to ensure that every London borough has local plans in place to address VAWG in an integrated way.
- Develop VAWG commissioning guidance to drive quality and consistency of service provision across London focused on the needs of women, girls and children.[19]

2. Addressing harmful attitudes and behaviour at an early age to prevent VAWG

VAWG is preventable if the root causes including the attitudes and beliefs that condone or tolerate it are tackled. Myths that normalise VAWG, make excuses for perpetrators, and blame victims are too common and should be challenged.

To ensure that harmful behaviour and attitudes are addressed at an early age, it is critical that there is a significant improvement in the consistency and quality of education related to VAWG within schools across the capital. The End Violence Against Women (EVAW) Coalition and Against Violence & Abuse (AVA) have called for a 'whole-school approach to VAWG'.[20] The Mayor wants London to show leadership in tackling these issues through schools.

Research indicates that the sexualisation and sexist stereotyping of women and girls has become prevalent across all forms of media from films, TV programmes, music videos, young women's magazines, 'lads' mags' and advertising and an increase in sexualised products being targeted at children and young people.[21]

[19] This will be informed by the minimum standards and accreditation framework that is being developed by the new VAWG working group consisting of Caada, Imkaan, Rape Crisis, Respect, and Women's Aid.

[20] A 'whole school approach' addresses the needs of pupils, staff and the wider community within a school. It aims to develop an ethos and environment in a school that supports learning and promotes the health, well-being and safety of all. Dimensions include: staff leadership, school policies, good behaviour, child protection, anti-bullying and social inclusion; working directly with students through input to the curriculum, peer-led advocacy and mentoring; researching and consulting with young people, staff and parents to gather data and achieve universal 'buy in'; staff training. (Womankind Worldwide, Freedom to achieve. Preventing violence, promoting equality: A whole-school approach(2010). Taken from EVAW Coalition(2011) A Different World is Possible: A call for long-term and targeted action to prevent VAWG.)

[21] Object (2009) Joining up the dots: why urgent action is needed to tackle the sexualisation of women and girls in the media and popular culture.

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Pornography is also more readily available on the internet. An investigation by the London School of Economics found that 90 per cent of youngsters between eight and 16 have accessed porn online, many without meaning to find it and most while doing their homework.[22] The nature of pornography has changed and it has become increasingly dominated by themes of aggression, power and control, blurring the lines between consent, pleasure and violence.[23] Schools have a fundamental role to play in helping children and young people understand the dangers of pornography as well as empowering them to question and challenge the sexualised nature of media and popular culture.

An NSPCC study[24] highlighted the emergence of 'sexting' as another area of concern for young people, linking technology, social media and abuse.[25] They found that between 15 per cent and 40 per cent of young people were involved in sexting, and many were coerced into doing so.

A recent report by Ofsted reviewing PSHE in 50 schools found that sessions did not adequately focus on the influence of pornography on students' understanding of healthy relationships and that sex education required improvement in over a third of schools. The report also stated that a lack of high-quality, age-appropriate sex and relationships education was of concern due to the risk that it may leave children and young people vulnerable to inappropriate sexual behaviours and sexual exploitation.[26]

Schools not only play a critical role in supporting prevention of VAWG in London but also, through their statutory duty of care, offer a key opportunity for the identification and support of victims of sexual violence at school. A YouGov poll commissioned by the EVAW Coalition highlighted that close to one in three 16-18 year old girls had experienced unwanted sexual touching at school and 71 per cent had heard sexual name-calling towards girls at school daily or a few times per week.[27a]

VAWG can place the educational attainment of girls at serious risk and can lead to behavioural problems, absenteeism and school drop-out. In order to meet their obligations under the Equality Act and child protection laws, schools and other educational institutions need to ensure that the school environment is a safe and supportive space for both boys and girls.

This is a significant challenge for London, requiring schools and partners to drive forward a different approach.

Through the VAWG Panel, MOPAC will:

- Work with schools in London to develop and implement a "whole school" approach to VAWG and promote and disseminate learning.
- Work with OFSTED to integrate VAWG into their assessment framework to understand how schools are responding to and preventing VAWG.
- Bring the MPS and the London Safeguarding Children Board together to explore the changing landscape of social media to improve our understanding of the links between technology, social media and VAWG.
- Work with the London Safeguarding Children Board to identify points of early intervention and improve referral pathways for those at risk of sexual exploitation, teenage relationship abuse, sexual violence and harmful practices and for those who display harmful attitudes or behaviours.
- Increase awareness of VAWG by using days such as the International Day for the Elimination of VAWG (25 November) and the sixteen days of action as a platform for publicly communicating on VAWG issues.

[22] Lizi Patch (31 March 2013) The day my 11-year-old son found violent porn on the web. The Independent (Last accessed on 1 May 2013)

[23] Papadopoulus, L. (2010) Sexualisation of Young People Review.

[24] A Qualitative Study of Children, Young People, and 'Sexting' NSPCC, 2012

[25] Sexting has been defined in the report as the 'exchange of sexual messages or images' and 'creating, sharing and forwarding sexually suggestive nude or nearly nude images'.

[26] Ofsted (May 2013) Not yet good enough: personal, social, health and economic education in schools.

[27a] EVAW (October 2010) Sexual harassment in schools, http://www.endviolenceagainstwomen.org.uk/2010-poll-on-sexual-harassment-in-schools

OBJECTIVE ONE: PRIORITIES

3. Tackle harmful practices

The Mayor has established a Harmful Practices (HP) Taskforce to confront female genital mutilation (FGM) and other harmful practices including forced marriages, so-called witchcraft killings and 'honour' crimes.

In 2011, Imkaan were commissioned to undertake a study examining harmful practices in London to improve knowledge on the needs of black and minority ethnic (BME) women experiencing HP. The **Missing Link** report highlighted a number of issues with current policy and practice around HP in London. The research has helped shape the work of the HP Taskforce.

Key issues include:

- High levels of under-reporting and few cases coming to the attention of the police or other statutory agencies due to multiple barriers that BME women and girls experience.
- No FGM prosecutions in the UK even though there has been specific legislation since 1985.
- A lack of understanding and awareness of harmful practices and a reluctance to intervene due to cultural sensitivity and concerns about being seen as racist. Professionals are missing opportunities to identify girls at risk and prevent harmful practices.
- FGM and other harmful practices are not systematically integrated within local authority and local NHS policies, strategic plans and child protection policies leading to inconsistent approaches and responses across London.
- Safeguarding procedures and frameworks are not consistently being used to protect girls at risk.
- Training of staff in education, health, safeguarding, criminal justice agencies, housing and voluntary sector is inadequate in relation to harmful practices.
- Hospitals that come into contact with women/girls who have undergone FGM (through for instance maternity services) do not routinely record this information or share it with agencies such as the police or social services.
- Currently very few specialist services are available to prevent or respond to harmful practices in London and those that do exist are under pressure.

Through the VAWG Panel, MOPAC will:

- Work with the Public Health Minister to overcome barriers to information sharing by health services and to promote solutions for an effective inter-agency response to end violence and abuse against women and girls. This will include a focus on FGM and other harmful practices. It will support future safeguarding of children or siblings and investigation and prosecution of these crimes in the future.

In addition, MOPAC will work with partners on the HP Taskforce to develop and implement a pilot initiative focusing on four key strands:

Early identification and prevention

- Integrating education on harmful practices into schools and youth-based settings.
- Developing and delivering quality training of professionals across sectors likely to come into contact with those at risk (health, education, police, social services, voluntary sector).
- Developing clear processes and mechanisms to enable practitioners (particularly health and education professionals) to assess and flag risk and to facilitate information-sharing and referrals.

Safeguarding and access to support

- Embedding harmful practices into safeguarding policies and interventions including the Common Assessment Framework (CAF) and Multi-agency safeguarding hubs (MASH).
- Improving access to specialist support services for victims and those at risk of FGM/harmful practices.

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Enforcement and prosecutions

- Securing prosecutions around FGM and forced marriage to hold perpetrators to account and deter them from perpetrating these crimes.
- Monitoring the effectiveness of CJS responses to forced marriage and female genital mutilation (FGM)

Community engagement

- Working with specialist VAWG voluntary and community sector organisations on these issues to develop effective outreach work and awareness raising activities with affected communities to ensure that the voices of women and girls are heard; to work with men and boys to challenge the acceptability of harmful practices within affected communities.

4. Tackling issues associated with girls and gangs

As in all global cities, a proportion of crimes committed in our capital are gang-related. Eliminating gangs and serious youth violence has been a key Mayoral priority since 2008. Key activities include the **Time for Action** programme; the launch of the first pan-London Partnership Anti Gangs strategy and providing over £3 million of London Crime Prevention Funding to gang programmes in London boroughs.

The Way Forward strategy highlighted the key challenges and impact of gang violence on young women and girls including:

- Young women and girls occupying roles within gangs.
- Young women and girls directly involved in offending (often under coercion) including hiding weapons and drugs for partners, brothers or associates fraud, "honey traps", set ups, violence, robbery, shoplifting etc.
- Young women involved in or associated with gangs experiencing domestic and sexual violence from gang members.
- Sexual violence being used as a weapon between rival gangs.

The Race on the Agenda (ROTA) Female Voice in Violence Programme and the Office of the Children's Commissioner's (OCC) Inquiry into Child Sexual Exploitation in Gangs and Groups (CSEGG), have led to a much greater focus on the experiences and needs of gang-associated women and girls.[27] Examples include the cross-government action plan to tackle VAWG, the Ending Gang and Youth Violence strategy and the Tackling Child Sexual Exploitation Action Plan.

[27] Female Voice in Violence: A study into the impact of serious youth and gang violence on women and girls Race on the Agenda, 2010

The Way Forward strategy made a commitment to improve the response to young women and girls affected by gang violence. Over the last few years London has seen a rise in specialist service provision for young women and girls affected by gangs including Young People's Advocates funded by the Home Office. Although provision is still patchy across London, there are new initiatives that have emerged focused on prevention and diversion. However, provision for young women and girls who want to exit gangs remains a significant gap.

Young men and boys who commit VAWG offences will come into contact with dozens of professionals whose role it is to help them change their behaviour. However, the Female Voice in Violence report raised concerns about practitioners working to address gang-related issues without materials which address the needs of young women and girls and which were suitable for safely challenging male attitudes and behaviour towards women and girls. A joint inspection by the probation, police, prison, education, health, care and social services inspectorates recently highlighted that the early indicators of sexually abusive behaviour by young men and boys often against their peers or younger children, are too often disbelieved, denied or minimised and treated as a 'one off' by both professionals and families.[28] Professionals should identify and address these problems at an early stage to avoid more serious, longer-term implications for both offenders and victims.

Through the VAWG Panel, MOPAC will:

- Publish a strategic framework to support London boroughs in devising their strategic and operational responses to young women and girls involved in or associated to criminal gangs.
- Work with the MPS, London boroughs and the "MsUnderstood Partnership"[29] to encourage the proactive identification, risk and needs assessment of gang-associated young women and girls.
- Work with commissioners across London to ensure that interventions for gang associated men and boys address VAWG developing standards that promote positive role models, and respect for women and girls.
- Work in partnership with the London Safeguarding Children Board to address the findings and recommendations of the OCC Inquiry into child sexual exploitation in gangs and groups.
- Review lessons from the MsUnderstood Partnership case review and use these to inform gang exit strategies for young women and girls
- Work with the Youth Justice Board to develop a resettlement model for London promoting London as a leader in the resettlement of young offenders ensuring there is a focus on the needs of young women offenders.

[28] Criminal Justice Joint Inspection (February 2013) Examining Multi-Agency Responses to Children and Young People who Sexually Offend. A joint inspection of the effectiveness of multi-agency work with children and young people in England and Wales who have committed sexual offences and were supervised in the community

[29] The MsUnderstood Partnership has been founded by Carlene Firmin, the author of the Female Voice in Violence reports. It brings together the University of Bedfordshire, Imkaan, and the Girls Against Gangs Project to address young people's experiences of gender inequality by influences the development of policy, practice and research. Building on analysis of MPS and CPS case files, and the broader research into VAWG, gang-associated and serious youth violence, and child sexual exploitation, the partnership will improve local and national responses to peer-on-peer abuse through free strategic and operational support to three local areas for three years to improve the prevention, identification and handling of peer-on-peer abuse cases and a national assessment of provision for boys and young men

OBJECTIVE TWO: IMPROVING ACCESS TO SUPPORT

Work with partners to ensure the safety, wellbeing and freedom of women and children by improving access to, and take-up of, high quality services that meet the needs of London's diverse communities.

OBJECTIVE TWO: PRIORITIES

Women and girls need access to high quality services to enable them to escape violence and to support them to deal with the impact. Independent, specialist women-only VAWG services play an important role in improving the outcomes for women and children affected by violence and abuse. These services empower women by enabling them to talk about and make sense of the violence, find safety, seek justice, rebuild their lives and recover from the long-term consequences of violence.

Over the next three years, MOPAC will work with London boroughs and other agencies to ensure that women and girls have access to appropriate support.

1. Address domestic violence and abuse through the development of pan-London provision

Domestic violence remains the highest volume component of VAWG offences. In addition, domestic homicide is increasing, with 22 homicides in London since April this year, the same number as the whole of 2012/13 already. A third of violence with injury offences (a key MOPAC priority crime type) are also domestic violence cases. However, as with all forms of VAWG, domestic violence is under-reported. A renewed focus on tackling domestic violence is therefore critically needed. Supporting women to have the confidence to report and to access appropriate support is critical.

Since the first strategy was launched, there have been a number of welcome developments to address domestic violence. Most significantly, the government has amended the domestic violence and abuse definition to include those aged 16-17 years, in recognition that young people experience relationship abuse to the same extent as adults. The new definition also includes "coercive control" which recognises patterns of acts or behaviours, assaults, threats, humiliation and intimidation or other abuse that is used to harm, punish or frighten a victim.[30]

Levels of domestic violence service provision for women are patchy and inconsistent across London. The Mayor wants to ensure that wherever they live, victims of domestic violence have access to a high quality, professional and specialist support service. In his manifesto, he pledged to work with partners to commission and fund a pan-London domestic violence service, and to maintain the number of Independent Domestic Violence Advocates (IDVAs).

He has committed to bring together key partners and funders to develop a more coordinated and consistent pan-London approach to delivery to end the postcode lottery for access to high quality VAWG provision.

Consultation for this strategy with stakeholders and victim-survivors has provided insights into current arrangements and highlighted gaps in service provision. These will be taken into account when developing plans for pan-London domestic violence provision.

As of 1 October 2014, funding for victims' services transfers to Police and Crime Commissioners from the Ministry of Justice. The current government proposal is disappointing with regards to the funding allocation that MOPAC will receive for London. However, as part of a victims' review being led by Baroness Newlove, MOPAC will consider how this funding can be utilised to support improvements and changes to VAWG services through co-commissioning and shared funding arrangements with partners across London.

MOPAC will:

- Work with partners to commission and fund domestic violence provision across London informed by consultation for this strategy refresh, existing good practice across London and the findings of the Victims Review.
- Maintain the number of Independent Domestic Violence Advocates (IDVAs).

In developing an approach for commissioning pan-London domestic violence provision MOPAC will ensure that:

- Good practice is identified and applied to a wider London model.
- Gaps are addressed and existing forms of provision are not duplicated.
- The commissioning framework at a pan-London level does not impact negatively on smaller or specialist VAWG and BME organisations which are valued.
- Consideration is given to the development of a commissioning alliance for London where specialist providers, commissioners and practitioners are engaged in the development of a pan-London model.

[30] Home Office (March 2013) Information for local areas on the change to the definition of domestic violence and abuse.

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2. Deliver high quality, specialist sexual violence service provision

As set out in the Mayor's Police and Crime Plan, the Mayor has committed to funding four London Rape Crisis Centres throughout the duration of his Mayoral term. The demand for services at all four centres continues to increase and 91 per cent of women and girls surveyed through MOPAC's survivor consultation spoke about the value and benefit of being directly supported by a specialist women-only service.

The Mayor has allocated a total of £2.48 million (over four years 2012-2016) towards Rape Crisis provision, an increase from £1.4 million during his first Mayoral term. MOPAC has joined forces with the Ministry of Justice to jointly commission rape support provision in London in 2014/15 and 2015/16. The Police and Crime plan sets out a commitment to establishing a sustainable funding model for the Rape Crisis Centres in London beyond 2016.

The Mayor recognises that Sexual Assault Referral Centres (The Havens) provide crucial medical care and support to victims of rape and serious sexual assault and that these services are complementary to those of the Rape Crisis Centres. The London Havens offer high-quality victim care and clinical services such as forensic examinations in the immediate aftermath of rape and serious sexual assault. The Mayor contributes £2.165m towards the cost of the Havens with an equal amount funded by NHS England (London).

Although women and girls are disproportionately affected by sexual violence, the Mayor also recognises that men and boys may also be victims of sexual violence and should be offered appropriate support. The London Havens offer a service to all victims of rape and serious sexual assault including men and boys.

Further plans for supporting male victims of sexual violence in London will be developed over the next year following the completion of the review into victims' services currently being led by Baroness Newlove.

Alongside this, MOPAC has also commenced mapping work to better understand the commissioning and funding landscape of sexual violence provision in London. The longer-term ambition is to move to a model whereby the Ministry of Justice (MoJ), MOPAC, MPS, NHS England (London) and boroughs work together to co-commission all sexual violence service provision.

MOPAC will:

- Work with the MoJ and London boroughs to commission four Rape Support services in London offering support to women and girls who have experienced sexual violence in London.
- Ensure continued MPS funding for London's three Havens (Sexual Assault Referral Centres) in partnership with NHS England (London).
- Ensure that the needs of sexual violence victims are fed into MOPAC's victims review and use the findings to inform the future commissioning of services for both male and female victims.
- Work with NHS England (London), the MPS and boroughs to develop a collaborative, outcome based commissioning approach for sexual violence service provision across the capital.

OBJECTIVE TWO: PRIORITIES

3. Continuing to innovate and invest in specialist support services

The Mayor is committed to driving new and innovative services that tackle VAWG in an integrated manner at the local level.

Through the London Crime Prevention Fund (LCPF)[1] over £3.5 million per year has been allocated to 37 VAWG initiatives over a four year period. This represents an increase in funding for VAWG projects from the previous Community Safety Funding arrangements.

Through the VAWG Panel, MOPAC will:

- Monitor and review the outcomes being delivered through these projects and share learning across London.

VAWG commissioning: an example of promising practice

The London boroughs of Hammersmith & Fulham, Kensington & Chelsea and Westminster have pooled their resources together with funding from the LCPF to deliver a Tri-borough Domestic Abuse and Sexual Violence Service. This new service will build upon their existing successful Independent Domestic Violence Advocacy (IDVA) service, which was commissioned across two of the boroughs and provides additional frontline capacity so that more women can access support.

The first stage of the Tri-borough service is a domestic abuse and sexual violence needs assessment. This will be followed by the commissioning of a new, improved service, which aims to provide robust, consistent, targeted services across the three boroughs and easier access and appropriate referral of domestic abuse and sexual violence victims/ survivors at the earliest possible opportunity through introducing a single point of contact.

It is anticipated that the new and enhanced service for victims/survivors and their families will be delivered through a mix of providers, but with consistency across boroughs and through a single, more flexible service framework, which will deliver better value for money. This ultimately benefits victims/survivors, as it will enable more frontline specialist support staff to increase safety of women and girls and reduce repeat victimisation.

[1] MOPAC worked with London Councils to develop London's new commissioning arrangements for community safety and crime reduction funding. The London Crime Prevention fund replaces previous funding streams from the Home Office.

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4. Raise awareness of VAWG amongst friends and family members and the general public to improve access to support and encourage reporting

Domestic violence homicide reviews have highlighted that in many cases, victims were not known to any support services or statutory agencies such as the police. They have highlighted the issue of child to parent violence and the fact that neighbours often know about domestic violence but do not report it.

Evidence indicates that young women and girls often face additional barriers in seeking support and reporting VAWG. Research by Race on the Agenda highlighted that fear amongst young people that professionals cannot keep them safe frequently prevented them from reporting or seeking support.[31] This is an issue that was also stressed in MOPAC's survivor consultation. Barriers to reporting VAWG included not feeling confident about whom to disclose to, a lack of information about support options and fear that their experiences would not be taken seriously or lead to the successful prosecution of the perpetrator.[32]

This highlights the crucial role that friends and family members can play in preventing and responding to VAWG. MOPAC has published a series of Friends and Family publications (developed in collaboration with Against Violence and Abuse – AVA). These provide guidance and help for friends and family members of victims of VAWG to enable them to provide a supportive response to friends or family members experiencing violence and abuse. The existing series comprises a leaflet for friends and family of victims of VAWG; for parents of an adolescent who has experienced VAWG; for young people on how to help their friends and for non-abusive partners of previous victims of VAWG.[33] These have been well received by partners across London.

New ways of encouraging reporting VAWG need to be explored. Through the London Crime Prevention Fund, MOPAC has funded an innovative pilot in Southwark and Enfield to enhance women's access to support and to encourage reporting of VAWG through the use of technology and social media. A women's safety app will assist women to identify the early signs of an abusive relationship to facilitate earlier take-up of support services.

Through the VAWG Panel, MOPAC will:

- Develop and distribute literature e.g. friends and family leaflets to raise awareness of VAWG and the protection and support available in London.
- Work with partners to develop a pan-London directory of VAWG service provision for victims and professionals.
- Work with the MPS and partners to explore the use of new technology to report crime and access support.
- Work with the London Safeguarding Children Board to explore innovative options to encourage young people to report domestic violence and seek support and to create appropriate referral pathways as a result.

[31] Female Voice in Violence. Final report on the impact of serious youth violence and criminal gangs on women and girls across the country. (Race on the Agenda). London

[32] Imkaan (2013) Beyond the Labels: Women and girls views on the 2013 Mayoral strategy on VAWG

[33] These leaflets were developed in collaboration with AVA and are available on the MOPAC website. http://www.london.gov.uk/priorities/policing-crime/mission-priorities/violence-against-women-girls/know-where-to-go/about-the-directory

OBJECTIVE THREE: ADDRESSING HEALTH, SOCIAL AND ECONOMIC CONSEQUENCES OF VIOLENCE

Work with partners to reduce the long-term consequences of violence, improving the life chances of the women and girls who experience it, supporting them to rebuild their lives.

OBJECTIVE THREE: PRIORITIES

VAWG can have serious long-term health, social and economic consequences. These include mental health problems such as depression, anxiety, post-traumatic stress disorder (PTSD); attempted and successful suicide; low self-esteem, isolation and social exclusion; alcohol and drug misuse; disability; unwanted pregnancy and sexually transmitted diseases; negative impacts on attainment in education and employment.[34]

To support women and girls to rebuild their lives and improve the life chances, the long-term consequences of VAWG need to be addressed.

1. Address the health impact of VAWG

The health impact of VAWG is varied. The impact of abuse on mental health and wellbeing for example, is well-documented. Between 50 and 60 per cent of women mental health service users have experienced domestic violence.[35] 76 per cent of rape victims experienced post-traumatic stress disorder symptoms in the year following the assault.[36]

Research has also demonstrated the links between child sexual abuse and teenage pregnancy.[37] In one study, over a third of pregnant teenagers had been sexually abused or exploited, and girls from minority ethnic communities were more likely to experience a pregnancy in adolescence.[38] Health services are often the first point of contact for victims of VAWG. Women and girls present with different issues that stem from VAWG. For instance, victims may present in Accident and Emergency with injuries following assault, maternity services following FGM complications, GPs or mental health services with on-going depression.

The use of 'routine enquiry' in maternity settings has been found to increase the identification of domestic violence.[39] Enquiry in other health settings such as GP practices through the IRIS model has demonstrated improved identification and referral of victims to specialist services.[40] Similar routine enquiry practices would help the health service identify and address harmful practices and indeed other forms of VAWG.

In addition, the inquiry into gang and group-associated child sexual exploitation conducted by the Office of the Children's Commissioner recommended in its interim report[41] that all health agencies receive guidance to ensure effective information sharing on the issue of child sexual exploitation.

MOPAC is currently working with NHS England (London region) to develop a strategy focused on health in the justice system. This will set out key priorities and intentions to co-commission health provision across the justice system in support of Police and Crime Plan objectives.

Through the VAWG Panel MOPAC will:

- Work with partners including NHS England (London), Clinical Commissioning Groups and the London Health Board[42] to ensure that the needs of victims of VAWG and women offenders are built into the commissioning of health provision.
- Integrate VAWG into the emerging strategy focused on health in the justice system
- Work with partners to enable health professionals to receive training and guidance on VAWG.

2. Safe and secure housing options for those fleeing abuse

Many women who experience VAWG want to remain in their own homes safely. The development of local Sanctuary schemes, injunctions and interventions with perpetrators has enabled more women to achieve better security so that they do not have to flee violence. However, for many women leaving their home or even their local area to make a new start is the only option.

[34] See The Way Forward strategy (2010) Mayor of London, p.45

[35] Department of Health, 2003, cited in Statistics: health and domestic violence , Women's Aid, 2008

[36] Resnick et al, 1987, cited in A prospective examination of post-traumatic stress disorder in rape victims Journal of Traumatic Stress July 1992, Volume 5, Issue 3, pp 455-475

[37] Childhood Sexual Abuse and Adolescent Pregnancy: A Meta-analytic Update, Oxford Journal of Pediatric Psychology, Volume 34, Issue 4, Pp 366 – 378. First published online: September 2008.

[38] Ethnic differences in childhood and adolescent sexual abuse and teenage pregnancy, Journal of Adolescent Health, Volume 21, Issue 1, July 1997, Pages 3–10

[39] Does routine antenatal enquiry lead to an increased rate of disclosure of domestic abuse? Findings from the Bristol Pregnancy and Domestic Violence Programme. Price S, Baird K, Salmon D. (2007) Evidence Based Midwifery 5(3): 100-6

[40] Identification and Referral to Improve Safety (IRIS) of women experiencing domestic violence with a primary care training and support programme: a cluster randomised controlled trial, The Lancet Volume 378, 19 November 2011

[41] The Office of the Children's Commissioner's Inquiry into Child Sexual Exploitation In Gangs and Groups, Interim report (November 2012)

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Research has highlighted that VAWG is a significant cause of homelessness, and fear of losing their home can often trap women in violent situations. Around 40 per cent of young homeless women have left home because of sexual abuse.[43] 14 per cent of homeless women left their last settled home as a result of abuse from a partner.[44] 60 per cent of all homeless women surveyed by Crisis had experienced domestic violence at some point, and 49 per cent other abuse.[45] Insecure housing or homelessness can be both a route into prostitution and a barrier to exit. In one study, 77 per cent of women identified housing as a barrier to exit.[46]

Some women fleeing violence and abuse will go into refuge accommodation which is generally funded by local authorities and London Councils. However, this is not suitable for all women and there is a significant gap in terms of provision for young women and girls fleeing violence and abuse. As highlighted in the accelerated report of the Office of the Children's Commissioner's (OCC) Inquiry into Child Sexual Exploitation in Gangs & Groups, identifying appropriate housing for children at risk of sexual exploitation remains a challenge. New models of housing support are required for young women and girls fleeing violence and abuse.

Through the VAWG Panel MOPAC will:

- Work with partners to develop a more joined up and needs-led approach for future refuge commissioning.
- Work with local authorities and housing providers to encourage training and guidance on all forms of VAWG to be delivered to frontline housing staff.
- Work with local authorities, London Councils and the VAWG sector to explore new housing and financial solutions for women fleeing VAWG in London.
- Work with the London Safeguarding Children Board and boroughs to explore new housing support models and referral pathways for 16 and 17 year olds fleeing violence and abuse.

3. Transforming our approach to women offenders

Baroness Corston's 2007 review identified the complex needs and histories of victimisation of women offenders. The Corston review called for "a radical new approach…..a woman-centred approach", based around the development of specialist community-based centres for women as an alternative to prison. Despite some progress since the review was published, recent reports by Women in Prison and the Prison Reform Trust demonstrate that a lot more needs to be achieved.

Offenders and those at risk of offending experience significant health inequalities compared to the general population. Around 46 per cent of women who were assessed by Together's women-specific Court Liaison & Diversion Services in 2012-13 had some form of mental health diagnosis at the time of assessment and around 60 per cent identified with some level of mental health/wellbeing need which is often due to domestic violence, sexual exploitation, trafficking or other forms of VAWG.[47]

Of young women offenders in custody, 40 per cent have suffered violence at home and 30 per cent have experienced sexual abuse at home.[48] The All-Party Parliamentary Group on Women in the Penal System's Inquiry on girls found that young women and girls are being criminalised in courts when they could be diverted to other services. The Inquiry also found that, once sentenced the needs of girls are overlooked because of the small number of girls in the penal system.[49]

[42] The London Health Board, chaired by the Mayor, provides leadership on health issues of pan-London significance.

[43] Hendessi, 1992, 4 in 10, CHAR cited in The Way Forward Strategy (2010) Taking Action to end violence against women and girls

[44] Reeve, K, Casey, R, Goudie, R, CRESR, (2006), Homeless Women: Still being failed yet struggling to survive

[45] Reeve, K, Casey, R, Goudie, R, CRESR, (2006), Homeless Women: Still being failed yet struggling to survive

[46] London Southbank University & Eaves (2012) Breaking down the barriers. A study of how women exit prostitution

[47] Data from Together's women-specific Court Liaison & Diversion Services delivered in three London Magistrates Courts, in partnership with local NHS Trusts and St Mungo's (July 2012 to July 2013)

[48] Old Enough to Know Better? A briefing on young adults in the criminal justice system in England & Wales. January 2012.

[49] All-Party Parliamentary Group on Women in the Penal System (2012) Inquiry on girls: from court to custody

[50] The Bradley Report: Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system. (April 2009)

OBJECTIVE THREE: PRIORITIES

The need for early identification and diversion of offenders into healthcare and social care services is well documented in the Bradley Report.[50] However, there are currently only three women specific Liaison and Diversion schemes in London.

In relation to sentencing, the Prison Reform Trust's analysis of data for London shows an increase in the use of custodial sentences for women offenders. Between 2009 and 2011 there was an 11 per cent increase in custodial sentences given to women in the Metropolitan Police force area, despite a fall in the number of custodial sentences given to women nationally over the same period.[51] Of these prison sentences, 88 per cent were for non-violent offences, with theft and handling alone accounting for more than four in ten.[52]

In response to this, the Mayor wants London to demonstrate leadership in reforming the way the criminal justice system responds to female offenders, particularly in recognition of the fact that a disproportionate number of women in the criminal justice system have been victims of VAWG. There is an opportunity to explore alternatives to custody.

As part of Integrated Offender Management (IOM) work across London, MOPAC will work with partners to ensure that the needs of women and girls are appropriately addressed. Through the London Crime Prevention Fund, MOPAC has funded the London Borough of Lambeth to deliver an innovative new community-based project working with women offenders.

Through the VAWG Panel, MOPAC will:

- Work with the Youth Justice Board to undertake a strategic needs assessment of young female offenders across London to inform future policy, practice and commissioning.
- Monitor and review the outcomes of Lambeth's new community-based initiative working with women offenders (see box, right) and explore new and innovative alternatives to custody and to divert women away from the criminal justice system.
- Include a work stream for women in MOPAC's work on Integrated Offender Management (IOM) to address the specific needs of women in the criminal justice system to reduce the likelihood of reoffending.
- Work with partners to ensure the needs of women are reflected and prioritised as part of the work of both the National Probation Service and Community Rehabilitation Company under the Transforming Rehabilitation (TR) reforms.

Beth Centre: a service for women offenders

LB Lambeth has commissioned Women in Prison and Eaves to deliver a brand new service for women at risk of and/or involved in the CJS. The service builds on the Corston recommendations (into female offending), the women's centre model and the Gaia Centre (Lambeth's integrated VAWG service).

This is an innovative service that combines the work of Probation, YOS, prison in-reach and IOM and will deliver one referral pathway and one service from point of contact with the CJS until the end of contact. The service will start on 1 January 2014. It aims to reduce reoffending amongst women; to divert women from the criminal justice system and from custody; to prevent family breakdowns through custody or offending and; to offer holistic support which addresses the needs that often drive offending including domestic and sexual violence/ VAWG.

The service will include a women-only space to foster safety and a sense of community; pro-active case management including psycho-social interventions to increase empowerment and self-esteem and promote problem solving/motivation; prison in-reach and through the gate service; peer mentoring and full service user involvement in service development; childcare and crèche arrangements to promote engagement; links to specialist treatment services to develop women only provision; effective links to courts to improve diversion; and prostitution outreach.

[51] Prison Reform Trust consultation response to MOPAC VAWG consultation – August 2013

[52] Prison Reform Trust consultation response to MOPAC VAWG consultation – August 2013

[53] Only 19 per cent of women working in prostitution in flats, parlours and saunas in London are originally from the UK. The Poppy Project (2004) Sex in the City: Mapping Commercial Sex Across London. Around 6,000 of the estimated 8,000 women involved in off-street prostitution in London's brothels, saunas and massage parlours are

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4. Develop a more holistic response to trafficking and prostitution to support women to exit

In **The Way Forward** strategy, the Mayor adopted a bold new approach to tackle prostitution in the capital. This recognised that women involved in prostitution are some of the most vulnerable in our communities and that most women and girls enter prostitution through a lack of choice.

The VAWG consultation has highlighted widespread support for the Mayor's approach to prostitution as set out in **The Way Forward** strategy. This focused on:

- The provision of holistic support to address the physical, sexual, substance use, mental health and housing needs of women to support women to exit prostitution.
- Addressing the demand side of trafficking and prostitution.
- Focusing enforcement on those that pay for sex e.g. kerb-crawlers and not women involved in prostitution.
- Facilitating the reporting of sexual offences and other crimes against women involved in prostitution through third party reporting schemes.
- Clamping down on those who control women in prostitution e.g. pimps and traffickers.

In January 2012, MOPAC commissioned a study into prostitution to improve understanding of the changing nature of the sex industry in London, routes into prostitution and women's needs, indicators of trafficking and exploitation and examples of good practice in responding to prostitution.

The **Capital Exploits** report highlighted evidence of an active sex industry (both on and off street i.e. in brothels and other indoor locations such as private flats and "massage parlours") in the majority of London boroughs. Previous research suggested that the majority of women involved in street-based prostitution were British and women involved in off street prostitution are foreign national women, a significant number of whom are believed to have been trafficked.[53]

However, the **Capital Exploits** study identified an increase in the number of non-British women selling sex on-street, many of whom are understood to be from Romania. There is also evidence to suggest that women are now being exploited and controlled in on-street prostitution as well as off-street and that girls and young women under the age of 18 are being trafficked internally for sexual exploitation.[54]

The **Capital Exploits** study also highlighted the emergence of a transient group of women – those operating both on and off-street in London. Whether this group of women should be categorised as being 'on' or 'off-street' is unclear as they appear to be shifting between the two.[55]

Women involved in prostitution have a range of complex needs. The widely held assumption that women who operate off-street are safer and have fewer health problems and substance misuse issues has, in recent years, been challenged. The **Breaking Down the Barriers** research found that women involved in on-street and off-street prostitution often share similar life histories, routes into prostitution and, despite assumptions to the contrary, similar needs and experiences.[56]

foreign nationals. House of Commons, Home Affairs Committee (May 2009) The Trade in Human Beings: Human Trafficking in the UK. Sixth Report of Session 2008-09

[54] Capital Exploits: A Study of Prostitution and Trafficking in London.(2013) Forthcoming study by Julie Bindel, Ruth Breslin and Laura Brown (Eaves for Women)

[55] London Southbank University & Eaves (2012) Breaking down the barriers. A study of how women exit prostitution

[56] London Southbank University & Eaves (2012) Breaking down the barriers. A study of how women exit prostitution

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Studies show that between 32 per cent [57] and 75 per cent [58] of women involved in prostitution entered before the age of 18 and that 70 per cent of women involved in prostitution have spent time in care.[59] Up to 72 per cent of women involved in prostitution in the UK have experienced some form of childhood violence including emotional, physical, sexual and verbal.[60] 79 per cent suffer from physical or mental health problems [61] and 68 per cent meet the criteria for Post-Traumatic Stress Disorder.[62] 83 per cent have current or former problematic drug or alcohol use.[63]

In trying to respond to this, it is clear that across London approaches to prostitution and to the provision of specialist services are inconsistent. Many boroughs do not have any specialist services and where provision does exist it tends to be focused on harm-minimisation.[64]

Research suggests that 9 out of 10 women involved in prostitution wish to exit [65] but there are a number of barriers that need to be addressed. It is recognised that exit does not occur overnight but is a long-term process that can take many years. Services and support delivered through the pan-London exit service (see below) will not be dependent on a woman's willingness to exit. Recent research has stressed the need for all services working with women involved in prostitution to proactively talk to them about their desire to exit rather than waiting for women to request this.[66] There was widespread support for this approach through the VAWG consultation.

More work is required to join up the approaches of London boroughs, the MPS and the criminal justice system in support of the Mayor's objectives around prostitution.

Through the VAWG Panel, MOPAC will:

- Develop a pan-London protocol in line with the Mayor's objectives which will inform the way all London partners respond to prostitution, setting out the policing and criminal justice approach and the roles of health, local authorities and the voluntary sector. This will focus on women's safety, diverting women away from the CJS;
- Develop a pan-London exit model providing holistic support to address the physical, sexual, substance use, mental health, housing and employment needs of women involved in prostitution who wish to exit;
- Develop good practice guidance for professionals across relevant sectors including health, drug and alcohol agencies, housing and criminal justice agencies on working with victims of trafficking and those involved in prostitution who are at risk of harm.

5. Improving the identification of and response to victims of human trafficking

The hidden nature of trafficking makes it difficult to gain an accurate picture of its true scale and nature. The UK Human Trafficking Centre (UKHTC) Strategic Assessment for 2012 estimated that there are up to 2,255 possible victims of human trafficking in the UK. Sexual exploitation was the most common form of exploitation recorded in the UK, particularly affecting women and children.[67] A study by the Association of Chief Police Officers (ACPO), Project Acumen, estimated that there are at least 2,600 female adult victims of trafficking for sexual exploitation in England and Wales. In London this equates to estimates of 766 trafficked women and a further 2,860 vulnerable women respectively. [68]

However, research shows that a large proportion of cases are never recognised or reported and do not appear in any statistics.[69] The **Capital Exploits** study highlighted a lack of awareness and an understanding of what constitutes trafficking amongst professionals

[57] London Southbank University & Eaves (2012) Breaking down the barriers. A study of how women exit prostitution

[58] Benson, C. and Matthews, R. (1995), Street prostitution: Ten facts in search of a policy in International Journal of Sociology of the Law, Vol. 23, pp395-415

[59] Home Office (2004), Paying the price

[60] London Southbank University & Eaves (2012) Breaking down the barriers. A study of how women exit prostitution

[61] London Southbank University & Eaves (2012) Breaking down the barriers. A study of how women exit prostitution

[62] Farley, M. (ed) (2003). Prostitution, Trafficking and Traumatic Stress. New York: Howarth Press

[63] London Southbank University & Eaves (2012) Breaking down the barriers. A study of how women exit prostitution

[64] Capital Exploits: A Study of Prostitution and Trafficking in London.(2013) Forthcoming study by Julie Bindel, Ruth Breslin and Laura Brown (Eaves for Women)

[65] Farley, M (2003) Prostitution and Trafficking in Nine countries: An update on Violence and Post Traumatic Stress Disorder. Journal of Trauma Practice, Vol.2, No.3/4, 2003

[66] London Southbank University & Eaves (2012) Breaking down the barriers. A study of how women exit prostitution

[67] HM Government (October 2013) Second report of the Inter-Departmental Ministerial Group on Human Trafficking

[68] http://www.acpo.police.uk/documents/crime/2010/201008CRITMW01.pdf

in both the statutory and voluntary sector in London. In particular, there was little recognition that trafficking does not only occur across international borders but also takes places internally within the UK amongst British nationals.

To tackle this, frontline professionals across agencies need to be equipped with the training, skills and knowledge to identify victims of trafficking and to ensure that they are protected and supported appropriately.

Through the VAWG panel, MOPAC will:

- Work with the MPS, NHS England (London) and local authorities to develop plans to ensure that frontline agencies receive training on human trafficking so that staff have the knowledge and skills to identify victims, provide an appropriate response and refer on to specialist support.
- Implement any learning and good practice developed by the Human Trafficking and London 2012 Network.
- Support the European Communities against Trafficking (ECAT) Project (see box, right) and monitor and review the outcomes of this project, pulling together learning and good practice and sharing across London to drive improvements.
- Work with the Home Office to ensure the provisions of the new Modern Slavery Bill are implemented and monitor MPS enforcement of associated offences and the learning that arises from intelligence on individual cases.
- Support campaigns that raise awareness of trafficking and modern day slavery among third parties like taxi companies and the wider services sector in London.

European Communities Against Trafficking Project

The European Communities Against Trafficking (ECAT) Project's mission is to establish a multi-agency, best practice approach to whole community engagement in the prevention of human trafficking alongside victim-centred intervention and aftercare, which can be replicated transnationally.

The ECAT project is funded by the European Commission and is delivered in partnership by the Metropolitan Police Anti-Trafficking Unit, Rahab, STOP THE TRAFFIK, Borgorete, Caritas Lithuania and is supported by the Royal Borough of Kensington and Chelsea, City of Westminster, the Mayor's Office for Policing and Crime and the Institution of the Ombudsperson for Children in Lithuania.

A multi-agency police and NGO team will establish a model of victim identification, rescue, support and reintegration in London alongside enforcement activities including dismantling criminal networks and prosecuting traffickers. Each European Union UK-based Embassy will be supported to develop effective victim support responses. The programme of work is founded upon collaboration, learning, sharing best practice and creating a range of tools, products and systems that will extend the impact of the project far beyond its 24 month period.

For further information please visit the following link:

http://www.rbkc.gov.uk/communityandlocallife/againsthumantrafficking.aspx

[69] Centre for Social Justice (March 2013) It Happens Here: Equipping the UK to fight modern slavery

OBJECTIVE FOUR: PROTECTING WOMEN AND GIRLS AT RISK OF VIOLENCE

Work with partners to ensure that the whole criminal justice system deters crimes of violence against women and provides full, effective and timely protection and justice for women.

OBJECTIVE FOUR: PRIORITIES

It is well documented that many women and girls do not report VAWG crimes to the police[70] and, that a significant proportion of those who do withdraw their complaints.[71] To increase reporting across all forms of VAWG and as a result, increase women and girls' access to safety, support and justice and reduce the risk of re-victimisation, there needs to be greater confidence in the criminal justice system (CJS).

A number of studies have shown that in the policing context perceptions of fairness and decent treatment were at times more important than effectiveness and outcomes in determining satisfaction and confidence. Victims want to be treated with respect and dignity. Research also highlights that the outcomes and sentence are highly influential on victims' views of the CJS.[72]

Steps have been taken to improve the CJS responses to VAWG crimes over recent years with the introduction of specialist teams at the MPS, special measures for victims in court and sexual assault referral centres have all attempted to improve the victims' experience as well as support investigations and prosecutions.

Specialist Domestic Violence Courts (SDVC) aim to fast track domestic violence cases where appropriate, provide prosecutors with a domestic violence specialism for cases and ensure that victims are supported with an Independent Domestic Violence Advocate at court. An evaluation of the West London SDVC between 2002 and 2011 found an increase in the proportion of defendants entering an early guilty plea and decreases in the average numbers of hearings per case and days between arrival and completion at the court, indicating improved efficiency. Whilst some SDVCs continue to ensure that victims have significantly enhanced support whilst going through the court process, others have ceased operating in London, due to closure of the court itself or lack of a coordinator to keep partner agencies in touch and engaged. There is an opportunity to revitalise the London Mainstream Model[73] brought in to provide minimum standards and ensure this good practice is happening consistently across London.

Recent research[74] into domestic violence victims' experience of the criminal justice system highlighted that around three-quarters found the police and the CPS either very helpful or fairly helpful.

The same proportion were either very satisfied or fairly satisfied with the outcome they got from going to the police. While these findings are promising, there is more to be done to improve reporting and to provide effective and timely protection and justice to women.

1. Improving confidence in reporting VAWG crimes

In order to instil confidence in the criminal justice process, the initial response to victims must be consistent, and a professional initial response is more likely to lead to a better investigation and continued victim engagement with the process.[75]

The MPS has established specialist commands to tackle VAWG crimes such as trafficking and sexual offences, exploitation and child abuse. However, in most cases the specialist teams and officers are not the first point of contact for victims. It is therefore crucial that all frontline officers are trained on VAWG issues so they can better identify victims and provide an appropriate and sensitive response, referring on to the relevant specialist team.

In order to ensure that there is a high quality victim response at the core of service provision, MOPAC will work with the MPS to:

- Outline plans to ensure that every frontline police officer including first responders are trained on how to identify and respond to reports of VAWG including trafficking and prostitution.
- Develop clear plans outlining how the MPS intends to improve the support they give victims. This will include targeted programmes aimed at reducing victimisation in key areas such as VAWG.
- Monitor the levels of repeat victimisation, the frequency of victimisation and provide assurance that the MPS is offering effective, targeted support to repeat victims. This will be particularly pertinent to domestic violence cases which have a high proportion of repeat victimisation.
- Work with partners to develop new and innovative ways to report VAWG.
- Prepare a yearly problem profile that sets out key VAWG issues in London, whether the victim and offender profiles have changed over time and how the MPS will respond.

[70] Statistical bulletin: Crime in England and Wales, Year Ending December 2012, Office for National Statistics

[71] CEDAW Thematic Shadow Report on Violence Against Women in the UK, Sen and Kelly (2007)

[72] Victims' views of court and sentencing (October 2011). Commissioner for Victims and Witnesses in England and Wales

[73] The London Mainstream Model is aligned with the national specialist domestic violence court model and is a set of operating standards for domestic violence cases based on identified current best practice.

[74] Homicides, Firearm Offences and Intimate Violence 2010/11: Supplementary Volume 2 to Crime in England and Wales 2010/11 Home Office Statistical Bulletin (January 2012)

FOR THE NEXT THREE YEARS

MOPAC will:

- Launch a new, confidential online survey which all victims of domestic and sexual violence that report to the MPS will be invited to complete to provide feedback on their experience of reporting to the police and the treatment by the police and other services such as health and support services.

2. Improve the way the Criminal Justice System (CJS) responds to domestic and sexual violence

The recent sexual violence bulletin[76] showed that whilst the criminal justice system response has improved, much more is yet to be done to ensure that those who have experienced sexual violence and other forms of VAWG are supported to seek justice.

The average length from report to completion of case for all sexual offence cases was 496 days (for rape cases this increases to 675 days). The lengthiest time periods were 295 days between report and date of summons to court, and 181 days between first listing in magistrates court and completion of case (sentence or acquittal). For all criminal cases overall, the average time to complete a case is 154 days.[77]

In order to drive confidence and to improve the swifter and surer justice objectives set out in the Police and Crime Plan, MOPAC is determined to find innovative solutions to reducing court delays and improving the way the CJS responds to sexual violence.

The MoJ is currently piloting approaches to providing evidence in cases of sexual exploitation and abuse in order to address inappropriate levels of cross examination.There are examples from other countries that are promising. In South Africa for example, specialist sexual violence courts have increased conviction rates and reduced delays.

Through the VAWG Panel, MOPAC will:

- Work with the CPS and partners to reduce court delays for cases associated with VAWG.
- Work with the CPS and partners to explore the feasibility of developing a pilot specialist sexual violence court in London.
- Review the availability of Specialist Domestic Violence Courts in London and the implementation of the London mainstream model to ensure minimum standards and consistent good practice across London
- Work with partners to help 'de-mystify' the criminal justice process through information on what to expect and case studies, made available online.
- Encourage the MPS and CPS to utilise methods of capturing evidence that do not rely on the victim, for instance, the use of body worn cameras to capture strong evidence in domestic violence cases so that the onus is not always on victims to support prosecutions.
- Ensure the MPS fully implements the recommendations from the Independent Police Complaints Commission as a result of historic failures to record crimes reported to the MPS, with a particular focus on the recommendations of the 2013 Sapphire report.
- Review the findings of the MoJ pilot exploring different approaches to evidence in child sexual exploitation cases and ensure good practice and lessons learned are applied across London.

3. Improve young women's access to appropriate protection and support

As of April 2013, the Government and ACPO definition of domestic violence changed to include 16-17 year olds. This now places a duty on statutory agencies to recognise the risk posed towards young people and address teenage relationship abuse. Research conducted by the NSPCC [78] found that 25 per cent of girls reported physical violence from their partners, 75 per cent of girls reported some form of emotional abuse and 33 per cent of girls reported sexual violence. Coordinated Action Against Domestic Abuse (CAADA) reviewed cases which went through the multi-agency risk assessment conference process and found that 67 per cent of teenage victims are classified as high risk, 70 per cent had reported to police (on average twice), 42 per cent had visited their GP and 27 per cent had attended A&E as a result of the abuse.[79]

[75] Policing Domestic Violence, Richards, Letchford and Stratton, Blackstone's Practical Policing, Oxford University Press (2008)
[76] An Overview of Sexual Offending in England & Wales: Statistics Bulletin Ministry of Justice, Home Office & the Office for National Statistics (January 2013)
[77] An Overview of Sexual Offending in England & Wales: Statistics Bulletin Ministry of Justice, Home Office & the Office for National Statistics (January 2013)
[78] Partner exploitation and violence in teenage intimate relationships, NSPCC/ University of Bristol (September 2009)
[79] CAADA Insights Factsheet: Teenage victims of Domestic Abuse CAADA (2012)

OBJECTIVE FOUR: PRIORITIES

The London Rape Crisis Centres have also found that a notable proportion (just over a quarter) of their referrals are younger women under 25 years of age. The North London Rape Crisis Centre received referrals for thirteen young women under the age of sixteen in the year 2011/12. The West London Rape Crisis Centre found that a very high proportion (72 per cent) of young women under the age of 25 used their advocacy service.[80]

To ensure that London agencies are implementing the new definition of domestic violence and abuse and to improve young women's access to appropriate protection and support, MOPAC will:

- Work with the London Safeguarding Children Board to ensure that VAWG is mainstreamed into the London Child Protection Procedures and to develop supplementary practice guidance covering all forms of VAWG.
- Work with the London Safeguarding Children Board and local authorities to ensure that VAWG is firmly embedded within local safeguarding policy and practice and to map how boroughs are responding to young women and girls affected by VAWG including specialist services that are available to under-18 year olds.
- Work with Rape Crisis England & Wales and the four London Rape Crisis Centres to develop guidance on working with young victims of sexual violence to inform the future work of London's Rape Crisis Centres.

The London MASH (Multi-agency Safeguarding Hubs) Project

The London MASH Project is a pan-London programme to improve the way that local safeguarding partnerships deal with child protection referrals, bringing a range of partners together into a single multi-agency safeguarding hub to share information quickly and efficiently. Steered by a high level strategic partnership of local government, health, police, probation and the GLA, the ambition is for every borough in London to implement MASH in their own area by the end of the 2013/14 financial year.

Through the VAWG Panel, MOPAC will:

- Work with the London Safeguarding Children Board to explore opportunities to enhance the awareness of MASH practitioners around VAWG crimes experienced by young women and girls particularly child sexual abuse and exploitation, teenage relationship abuse, harmful practices such as FGM, forced marriage and 'honour'-based violence.
- Ensure that the findings and knowledge base on local challenges and solutions developed by the MsUnderstood Partnership are utilised more widely to support London boroughs in responding to violence against young women and girls.

4. Ensure learning from domestic violence homicide reviews and domestic violence protection orders drives service improvements

In April 2011, the government enacted section 9 of the Domestic Violence, Crime and Victims Act (2004). This requires local authorities to undertake a multi-agency Domestic Homicide Review (DHR) following a domestic violence homicide.

To ensure that London learns from past homicides and to support agencies to improve services accordingly, MOPAC will:

- Publish an overview of the findings, outcomes and lessons learnt from DV homicide reviews in London and use this to encourage partners to put in place measures to improve agency responses to prevent future DV homicides.
- Undertake a review of homicides related to other forms of VAWG, in particular 'honour'-based violence and trafficking and prostitution to inform future practice.

Changes in civil protections have also taken place. Domestic violence protection notices and orders (DVPO) allows a period of time for the victim to decide what steps to take following a violent incident, by stopping the perpetrator from contacting the victim or returning home for up to 28 days. An evaluation of the government pilot of DVPOs is due by the end of 2013.

[80] Forthcoming evaluation of the London Rape Crisis Centres by Women's Resource Centre.

FOR THE NEXT THREE YEARS

Through the VAWG Panel, MOPAC will:

- Review the DVPO evaluation to consider and inform a possible rollout of DVPOs across London.

5. Improve women's safety on public transport

While travelling in London at night is safe for most people, there are serious concerns about the dangers of unbooked minicabs picked up off the street. Unbooked minicabs have been linked to serious crimes in London, including rape and sexual assault.

In May 2012, the EVAW Coalition commissioned a YouGov opinion poll asking women in London about their experience of sexual harassment on the transport system and in other public places such as the street/ parks/shops. The survey found that 43 per cent of young women in London (aged 18-34) experienced sexual harassment in public spaces over the last year and 41 per cent of women aged 18-34 have experienced unwanted sexual attention.[81] 28 per cent of women (almost double the number of men) say they do not feel safe using London public transport at all times of day and night.

Transport for London's (TfL's) commissioned research found that 15 per cent or women had experienced some form of unwelcome sexual behaviour on public transport, and that 90 per cent of respondents had not reported the incident to the police or any other authority.

Partners are working together to tackle all forms of unwanted sexual behaviour on the transport system. The Mayor through TfL has increased the number of dedicated officers policing the transport system and to enforce laws around cabs to help improve women's safety when travelling home at night. A dedicated Cab Enforcement Unit in the Metropolitan Police Service (MPS) and in City of London Police (CoLP) means that there are 68 officers working full-time to keep women safe when they use cabs.

One of the Mayor's key initiatives to improve women's safety is the Safer Travel at Night (STAN) initiative. STAN is a partnership between the Mayor, TfL, the MPS and CoLP which aims to improve the safety of women travelling at night by focusing primarily on cab safety. This remains a priority. STAN includes industry regulation and licensing, enforcement and education. Considerable progress has been made in reducing the number of cab-related sexual offences since 2002. In 2012/13, official crime figures from the MPS showed that cab-related sexual offences were over 30 per cent lower than they were in 2002/3 (55 fewer offences). The number of rape offences almost halved over the same period. Year to date figures for 2013/14 are showing further reductions.

To continue this success, TfL and MOPAC will work together to:

- Continue to run the STAN campaign to raise awareness of the dangers of using unbooked minicabs, and provide information on safer travel alternatives. The STAN campaign will be supported by targeted police action and problem-solving activities to reduce cab-related sexual offences and improve women's safety when travelling at night.

- Work with TfL, the MPS and British Transport Police (BTP) and CoLP on Project Guardian, a partnership initiative to tackle sexual offences on the transport network and create an environment which is free from harassment and accessible to everyone. Project Guardian reinforces acceptable standards of behaviour, supported by clear rules and robust enforcement action. Project Guardian aims to increase the confidence and willingness of people to come forward and report sexual offences. TfL, with its police partners, will provide avenues for reporting, training for staff and commit to provide the best care and support. The Everyday Sexism Project, End Violence against Women Coalition and Hollaback London have been key advisers to the project.

[81] YouGov opinion poll on sexual harassment (May 2012) EVAW Coalition. http://www.endviolenceagainstwomen.org.uk/sexual-harassment

OBJECTIVE FIVE: GETTING TOUGHER WITH PERPETRATORS

Work with partners to intervene with perpetrators of violence against women in order to stop the violence, hold them to account, change their behaviour and deter others.

OBJECTIVE FIVE: PRIORITIES

The overwhelming majority of perpetrators of VAWG are men and boys. As most cases of VAWG never come to the attention of the criminal justice system, there are few sanctions for their behaviour. In 2011-12, some 91,466 defendants were prosecuted for VAWG offences in England and Wale and the proportion of successful prosecutions rose to 73 per cent, delivering the lowest recorded attrition[82] rates ever. However, in London, a total of 13,405 VAWG cases were prosecuted; a reduction of almost 12 per cent. Attrition for rape cases in London was 45 per cent, whilst for domestic violence it was 38.3 per cent of cases.

The Mayor is committed to ensuring that the criminal justice system improves its service to Londoners ensuring a renewed focus on prosecuting and convicting perpetrators driving victim and wider public confidence.

1. Challenge the MPS and partners to improve the criminal justice response to enforcement and prosecutions of VAWG

Over the last five years, the number of rape cases referred to the CPS for a pre-charge decision has decreased nationally. In London, despite a 15.7 per cent increase in the number of reported rapes over the last 12 months[83], the number of cases referred to the CPS has decreased from a peak of 1,481 in 2010/11 to 844 in 2012/13.[84]

Despite attempts to improve the CJS response to VAWG crimes, nationally the attrition rate in rape cases has worsened over the past ten years.[85] This is due to a range of issues that need to be understood in a London context and tackled accordingly.

MOPAC will:

- Ask the MPS to report to the London VAWG Panel on the cause of the decrease in rape referrals to the CPS and work with the London VAWG Panel to identify solutions.
- Work with criminal justice partners to better understand attrition across VAWG crimes and to identify solutions to address this.

In London, the Mayor is committed to ensuring that sentences are not only proportionate and justified, but act as a deterrent and demonstrate that violence against women and girls is unacceptable.

To achieve this, MOPAC will:

- Establish a sentencing unit to monitor sentencing across a range of offence types, including VAWG cases, and (where appropriate) appeal.
- Work with criminal justice partners to improve the enforcement of community orders.

2. Gearing interventions and funding to 'what works' with perpetrators of VAWG

The majority of perpetrators of VAWG never come to the attention of the CJS; but when they do, it is crucial that the right interventions are put in place to stop their offending, reduce repeat victimisation and increase confidence in the CJS. Given that the overwhelming majority of perpetrators remain outside of the CJS, we also need to ensure that there are appropriate and adequate perpetrator interventions outside of the CJS which do not rely upon a conviction.

Research has shown that most men who take part in well established domestic violence perpetrator programmes that meet national service standards, stop using violence.[86] Perpetrator programmes

[82] Attrition is the process by which complaints of rape, domestic violence or other crimes fail to successfully progress through the criminal justice system.

[83] MPS crime figures http://www.met.police.uk/crimefigures/index.php (Accessed on 06/11/2013)

[84] http://www.publications.parliament.uk/pa/cm201314/cmhansrd/cm131022/text/131022w0003.htm#13102291002097 (Accessed on 6/11/13)

[85] Forthcoming paper by Hohl, K. & Stanko, E.A. (2013) The attrition of rape allegations in England and Wales.

[86] Gondolf (2002), Dobash et al (2000) & Rajagopalan, V., Price, P and Donaghy, P. (2008) Cited in Respect briefing paper: evidence of effects of domestic violence perpetrator programmes on women's safety. 2010

[87] Dobash et al (2000) & Rajagopalan, V., Price, P and Donaghy, P. (2008) Cited in Respect briefing paper: evidence of effects of domestic violence perpetrator programmes on women's safety. 2010

have also demonstrated success in providing support to victims (partners or ex-partners) who may not otherwise have been in contact or received support from any other organisation.[87] Furthermore, women whose partners and ex-partners take part in programmes have reported feeling much safer.[88] Respect, the national Umbrella organisation for perpetrator programmes has commissioned a multi-site research programme on the outcomes of men's participation in UK community based domestic violence intervention programmes. Preliminary findings suggest that 'success' means far more than just 'ending the violence', as it would be possible for physical violence to stop but for women and children to continue living in a threatening and unhealthy atmosphere.[89]

Through the London Crime Prevention Fund, the Mayor is funding a number of projects in London boroughs to address the behaviour of domestic violence perpetrators, and these will be subject to monitoring and review processes. MOPAC will continue to ensure that any interventions developed, funded or commissioned by MOPAC are based on 'what works', and use existing service standards and accreditation frameworks (e.g. Respect service standards for domestic violence perpetrator programmes). The development of the response to perpetrators both within and outside of the criminal justice system has been overwhelmingly directed towards perpetrators of domestic violence (DV). There are a number of good reasons for this. However, this now needs to be widened.

There are some examples of perpetrator interventions across other VAWG crime types: "The Change Course", for example, which targets kerb crawlers, or those who pay for sex with exploited individuals. In other areas, community sector organisations such as the Lucy Faithfull Foundation are at the forefront of working with offenders to address their sexually abusive behaviour towards children.

The change in definition of domestic violence to include 16-18 year olds will not just have an impact on younger victims of Domestic Violence but also on those using violence and abuse in relationships with under 18's. The Youth Justice Board has developed a list of tools and resources for working with young people who use abuse in relationships.[90] The Home Office in partnership with AVA has developed guidance for local areas to support implementation of the new definition.[91]

Whilst this work is promising, more work is needed to ascertain what approaches work best with young offenders.

Through the VAWG Panel, MOPAC will:

- Review 'what works' to address VAWG offending behaviour including domestic violence and abuse perpetrated by young men and boys to inform future commissioning.

3. Clamp down on traffickers, pimps and those who sexually exploit women and girls

The Police and Crime Plan 2013-16 outlines the Mayor's commitment to target the demand side of trafficking and prostitution. The Capital Exploits study found that local residents across London are increasingly calling on police and local authorities to switch tactics and to target pimps, traffickers and those who sexually exploit women and girls instead of targeting and criminalising the women being exploited. However, in the majority of boroughs examined, women selling sex remained the main target of enforcement.[92]

MPS data shows that prostitution-related offences relating to exploitation (such as paying for sex with a child, controlling a prostitute for gain, keeping a brothel or arranging or facilitating child prostitution) have decreased significantly. However, this is still an issue across London and partners are committed to targeting perpetrators and further reducing prostitution related offences.

MOPAC will:

- Ask the MPS to work with local authorities and other agencies to proactively target and develop strategies to tackle perpetrators of child sexual exploitation and those who sexually exploit women involved in prostitution and victims of trafficking.

[88] Gondolf (2002), Dobash et al (2000) & Rajagopalan, V., Price, P and Donaghy, P. (2008) Cited in Respect briefing paper: evidence of effects of domestic violence perpetrator programmes on women's safety. 2010

[89] Domestic Violence Perpetrator Programmes. What counts as success? (August 2010)

[90] www.justice.gov.uk/youth-justice/reducing-re-offending/domestic-abuse

[91] Home Office (March 2013) Information for local areas on the change to the definition of domestic violence and abuse. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/142701/guide-on-definition-of-dv.pdf

[92] Capital Exploits: A Study of Prostitution and Trafficking in London.(2013) Forthcoming study by Julie Bindel, Ruth Breslin and Laura Brown (Eaves for Women)

4. Understand the impact of stalking and harassment

Since **The Way Forward** was first published, the approach to tackling perpetrators of VAWG has developed considerably. At the national level, the government introduced legislation which addresses specific areas of VAWG. New stalking legislation came into effect last year. The new amendments to the Protection from Harassment Act 1997 create two new offences of 'stalking' and 'stalking that causes serious distress or fear of violence'.

In relation to harassment, there were 44,000 offences in London in the last year alone. Successful criminal justice outcomes for these offences have fallen in the last six years, from 2007-08 when 45.5 per cent of cases had a criminal justice outcome, to last year when only 24.8 per cent of cases resulted in a sanction detection.

Policy and practice to address stalking and harassment should take into account the specific issues and experiences of London's diverse communities. BME women and girls at risk of forced marriage or 'honour'-based violence may face ongoing stalking and harassment from multiple perpetrators and it is crucial that specific risks and vulnerabilities are identified. Lesbian, bisexual and transgender (LBT) women often face threats of rape/sexual assault with a view to 'punishing' or 'curing'. The nature of harassment experienced by Londoners needs to be further understood.

MOPAC will:

- Ask the MPS to undertake a review and analysis of harassment and stalking cases to strengthen understanding of the nature of these crimes with a particular focus on the specific risks and vulnerabilities of BME and LBT women and girls.

PERFORMANCE AND ACCOUNTABILITY: MAKING THE STRATEGY WORK

The London VAWG Panel

Established in January 2010, the London VAWG Panel brings together a range of agencies from across the statutory and voluntary sectors and oversees delivery of the current VAWG strategy. The London VAWG Panel is co-chaired by Stephen Greenhalgh (the DMPC) and Joan Smith (journalist, author and women's rights campaigner). Membership consists of representatives from a range of organisations including:

- Metropolitan Police Service
- Crown Prosecution Service
- London Councils
- NHS England (London)
- London Safeguarding Children Board
- Transport for London
- Representatives from the specialist VAWG voluntary and community sector

The London VAWG Panel will oversee delivery of the refreshed strategy. In order to measure success, the Panel will develop a performance dashboard for VAWG. This will enable a comprehensive assessment of the progress that all partners are making against key commitments. The Panel will also use the dashboard to identify and resolve key issues and barriers to delivery should they arise.

The VAWG Panel will report progress to the London Crime Reduction Board which is chaired by the Mayor.

VAWG Reference Group

The DMPC has established a VAWG Reference Group to provide him with independent advice on tackling VAWG in London. The purpose of the VAWG Reference group is to enable the DMPC to stay in regular contact with experts from the specialist VAWG sector to understand emerging issues and concerns on women's safety and VAWG in London. It also seeks perspectives on activity being led by the London VAWG Panel, MOPAC and other London partners to tackle VAWG.

Subgroups and networks

There are also a number of other groups, networks and time-limited working groups in existence that will take forward specific projects and commitments outlined in the refreshed strategy. These include:

- Harmful Practices Taskforce
- The Rape and Criminal Justice System group
- London VAWG Co-ordinators Network

APPENDIX ONE: FORMS AND DEFINITIONS OF VIOLENCE AGAINST WOMEN

Domestic violence and abuse – a pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass, but is not limited to, psychological, physical, sexual, financial and emotional abuse. In extreme cases this includes murder. Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour. Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.

Female genital mutilation (FGM) – involves the complete or partial removal or alteration of external genitalia for non-medical reasons. It is mostly carried out on young girls at some time between infancy and the age of 15. Unlike male circumcision, which is legal in many countries, it is now illegal across much of the globe, and its extensive harmful health consequences are widely recognised.

Forced marriage – a marriage conducted without valid consent of one or both parties, where duress is a factor.

'Honour'-based violence – violence committed to protect or defend the 'honour' of a family and/or community. Women, especially young women, are the most common targets, often where they have acted outside community boundaries of perceived acceptable feminine/sexual behaviour. In extreme cases, the woman may be killed.

Prostitution and trafficking – women and girls are forced, coerced or deceived to enter into prostitution and/or to keep them there. Trafficking involves the recruitment, transportation and exploitation of women and children for the purposes of prostitution and domestic servitude across international borders and within countries ('internal trafficking').

Sexual violence including rape – sexual contact without the consent of the woman/girl. Perpetrators range from total strangers to relatives and intimate partners, but most are known in some way. It can happen anywhere – in the family/household, workplace, public spaces, social settings, during war/conflict situations.

Sexual exploitation – involves exploitative situations, contexts and relationships where someone receives 'something' (e.g. food, drugs, alcohol, cigarettes, affection, protection money) as a result of them performing, and/or another or others performing on them, sexual activities. Violence, coercion and intimidation are common, involvement in exploitative relationships being characterised in the main by the person's limited availability of choice resulting from their social/economic and/or emotional vulnerability. Girls involved in or connected to gangs are at risk of sexual exploitation by gang members.

Sexual harassment – unwanted verbal or physical conduct of a sexual nature. It can take place anywhere, including the workplace, schools, streets, public transport and social situations. It includes flashing, obscene and threatening calls, and online harassment.

Stalking – repeated (i.e. on at least two occasions) harassment causing fear, alarm or distress. It can include threatening phone calls, texts or letters; damaging property; spying on and following the victim.

Faith-based abuse – child abuse linked to faith or belief. This includes a belief in concepts of witchcraft and spirit possession, demons or the devil acting through children or leading them astray (traditionally seen in some Christian beliefs), the evil eye or djinns (traditionally known in some Islamic faith contexts) and dakini (in the Hindu context); ritual or muti murders where the killing of children is believed to bring supernatural benefits or the use of their body parts is believed to produce potent magical remedies; and use of belief in magic or witchcraft to create fear in children to make them more compliant when they are being trafficked for domestic slavery or sexual exploitation. This is not an exhaustive list.

APPENDIX TWO: KEY NATIONAL DEVELOPMENTS

2013

July

The United Nations Convention on the Elimination of all forms of Discrimination Against Women (CEDAW) Committee examined the UK government's progress in implementing the Convention and the recommendations that were made by the Committee in 2008.

The CEDAW Committee made a number of recommendations to the UK Government around VAWG including a recommendation to increase efforts to protect women, including black and minority women, against all forms of VAWG; to continue public awareness-raising campaigns on all forms of VAWG; to intensify efforts to train police officers to eliminate prejudices concerning the credibility of victims of domestic violence; the full implementation of its legislation on FGM; to adopt a comprehensive national framework to combat trafficking in women and girls.

To view the full report and recommendations please visit: https://www.gov.uk/government/news/the-cedaw-committees-observations-and-recommendations-published

April

New arrangements in the devolved health and care system, including Health and Wellbeing Boards, introduced.

March

An extension of the definition of domestic violence to include those aged 16-17 and coercive control.

Launch of the government's revised VAWG action plan.

The United Nations fifty-seventh session of the Commission on the Status of Women, focused on the elimination and prevention of all forms of VAWG, took place.

The agreed conclusions include commitment and actions under the following key areas:

A. Strengthening implementation of legal and policy frameworks and accountability

B. Addressing structural and underlying causes and risk factors so as to prevent VAWG

C. Strengthening multi-sectoral services, programmes and responses to VAWG

D. Improving the evidence-base

To view the agreed conclusions please visit:

http://www.un.org/womenwatch/daw/csw/csw57/CSW57_Agreed_Conclusions_(CSW_report_excerpt).pdf

2012

November

Publication of the Office of the Children Commissioner's interim report of the Child Sexual Exploitation in Groups and Gangs Inquiry.

A new 'Declaration against FGM' was signed by Ministers and a new CPS action plan on FGM launched to address the barriers to investigating and strengthening prosecutions.

The Protection from Harassment Act 1997 was updated by provisions made in the Protection of Freedoms Act 2012, creating two new offences of stalking.

June

The government announced its intention to introduce a new criminal offence of forced marriage.

The government signed up to the Istanbul Convention, the Council of Europe's convention on preventing and combating violence against women and domestic violence.

March

Launch of two national Home Office campaigns – Teenage Rape Prevention Campaign and the Teenage Relationship Abuse Campaign – to change and challenge attitudes, and prevent teenagers from becoming victims and perpetrators of sexual and relationship violence and abuse.

January

The introduction of Police and Crime Commissioners and the creation of the Mayor's Office for Policing and Crime accountable to local communities to cut crime with other changes to the way crime prevention and victims' services are commissioned.

Pilots of Domestic Violence Protection Orders and a Domestic Violence Disclosure Scheme run throughout the year.

2011

October

Publication of Home Office review into effective practice in responding to prostitution.

The government signed up to the EU Anti-Trafficking Directive and published a trafficking strategy.

June

The Bailey Review on the Commercialisation and Sexualisation of Childhood launched, following on from the Inquiry into the sexualisation of young people review by Linda Papadopoulous.

April

Publication of multi-agency practice guidelines on female genital mutilation.

The implementation of section 9 of the Domestic Violence, Crime and Victims Act making domestic homicide reviews a statutory responsibility for local authorities.

2010

November

Launch of the government's national strategy to tackle VAWG.

March

Baroness Stern reported on her review of the handling of rape and sexual violence complaints by public authorities.

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Chinese
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Hindi
यदि आप इस दस्तावेज की प्रति अपनी
भाषा में चाहते हैं, तो कृपया निम्नलिखित
नंबर पर फोन करें अथवा नीचे दिये गये
पते पर संपर्क करें

Vietnamese
Nếu bạn muốn có văn bản tài liệu
này bằng ngôn ngữ của mình, hãy
liên hệ theo số điện thoại hoặc địa
chỉ dưới đây.

Bengali
আপনি যদি আপনার ভাষায় এই দলিলের প্রতিলিপি
(কপি) চান, তা হলে নীচের ফোন নম্বরে
বা ঠিকানায় অনুগ্রহ করে যোগাযোগ করুন।

Greek
Αν θέλετε να αποκτήσετε αντίγραφο του παρόντος
εγγράφου στη δική σας γλώσσα, παρακαλείστε να
επικοινωνήσετε τηλεφωνικά στον αριθμό αυτό ή ταχυ-
δρομικά στην παρακάτω διεύθυνση.

Urdu
اگر آپ اِس دستاویز کی نقل اپنی زبان میں
چاہتے ہیں، تو براہ کرم نیچے دئے گئے نمبر
پر فون کریں یا دیئے گئے پتے پر رابطہ کریں

Turkish
Bu belgenin kendi dilinizde
hazırlanmış bir nüshasını
edinmek için, lütfen aşağıdaki
telefon numarasını arayınız
veya adrese başvurunuz.

Arabic
إذا أردت نسخة من هذه الوثيقة بلغتك، يرجى
الاتصال برقم الهاتف أو مراسلة العنوان
أدناه

Punjabi
ਜੇ ਤੁਹਾਨੂੰ ਇਸ ਦਸਤਾਵੇਜ਼ ਦੀ ਕਾਪੀ ਤੁਹਾਡੀ ਆਪਣੀ ਭਾਸ਼ਾ
ਵਿਚ ਚਾਹੀਦੀ ਹੈ, ਤਾਂ ਹੇਠ ਲਿਖੇ ਨੰਬਰ 'ਤੇ ਫ਼ੋਨ ਕਰੋ ਜਾਂ ਹੇਠ
ਲਿਖੇ ਪਤੇ 'ਤੇ ਰਾਬਤਾ ਕਰੋ

Gujarati
જો તમને આ દસ્તાવેજની નકલ તમારી ભાષામાં
જોઈતી હોય તો, કૃપા કરી આપેલ નંબર ઉપર
ફોન કરો અથવા નીચેના સરનામે સંપર્ક સાધો.

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Domestic Violence

SUMMARY

3.1 What Is The Level of Need in Havering?

- Around 5,460 women and girls in Havering are estimated to experience domestic violence (DV) every year. Actual figures may be higher than this as these estimates do not include men experiencing DV
- 4,880 women and girls annually are also estimated to experience sexual assault, and 9,670 to experience stalking in Havering
- It is estimated that the cost of responding to DV in Havering is £23.3million annually (not including the human and emotional costs)
- Over 1000 cases of DV were supported by Havering DV services in 2010/11
- Havering has the 8th lowest rate of DV offences and incidents (per 1000 population) out of the 32 London Boroughs
- Over a third of DV in Havering takes place at the weekend, and 1 in 10 cases occurs between midnight and 1am

3.2 Current Service Provision in Havering

Services for those experiencing DV in Havering are delivered by a range of organisations such as Women's Aid and include:

- Refuge accommodation for 23 families, floating support for women and men in the community, children's refuge and community services, a drop in service, support groups, a counselling service, a helpline (including an on call 24 hour service for emergencies), skills and training support, an Independent DV Advocate (who supports risk of harm cases) and the East London rape crisis centre (not Havering specific)
- In 2010/11, Havering's Women's Aid supported 1192 women, 539 children and 20 men
- A MARAC (multi agency risk assessment conference) also operates locally. (where partners co-ordinate services for the highest risk DV cases to prevent repeat cases of DV) and supported 112 people experiencing DV in 2010/11. These high risk MARAC cases involved 112 children

3.3 Gaps in Knowledge and Service Provision in Havering

- Referrals from health services including GPs to DV services are extremely low and currently regular information from DV services on health referrals is not captured
- Little feedback has been collated from local service users on their views on how services are supporting them and what improvements are required
- Intelligence on the incidence and nature of issues such as prostitution, sexual violence, trafficking, forced marriage, honour based violence and female genital mutilation in Havering is currently lacking
- An outcome monitoring framework needs to be agreed and implemented by all DV services in Havering
- Data systems used by Children's Social care do not record domestic violence as a reason for referral or a background factor. Due to this gap in data little information is currently shared about children in contact with social care who are experiencing DV

3.4. Domestic Violence (DV): for decision makers and commissioners to consider:

- Update and publish a DV and violence against women and girls strategy for Havering
- Engage GPs in the coordinated response to DV, to improve practice and generate referrals. Consider commissioning a pilot of Project IRIS with GPs, to improve primary care response to patients who are experiencing DV
- Ensure appropriate agencies and representatives attend the MARAC. Continue to improve the collation and analysis of MARAC data to understand the needs of those experiencing DV and to align services accordingly
- Work with health and social care to improve the availability of local DV data. Currently most local data on DV is provided by the police and including information from other partners would improve local intelligence on the prevalence of DV. There is also a need for local partners to begin to record information about areas such as forced marriage, honour based violence and female genital mutilation.
- Develop further joint commissioning for DV/violence against women and investigate the need for specialist services e.g. care for those girls and women affected by female genital mutilation or sexual violence
- DV Forum and Violent Crime Action Group to consider a DV awareness campaign to increase reporting of DV and increase confidence of victims to access help earlier
- Introduce DV performance indicators into the contracts of health service providers
- Consider commissioning specialist support services for families where DV has been identified e.g. a family DV support worker
- Consider how the East London rape crisis centre will be commissioned in the future and what resources will be available to support this commissioning (in 2013/14) when funding from the Mayor of London ceases)
- Develop a process with DV services for recording referrals received from health services to better understand health involvement in responding to DV
- Domestic Violence Forum to work with Havering Magistrate's Court to improve management of domestic violence cases, including information sharing, tracking of results and listing of cases to help support services attend court and support victims
- Partners to explore the use of the Barnardos Risk Assessment Matrix in conjunction with the MARAC risk assessment tool

1. WHAT DO WE KNOW ABOUT DOMESTIC VIOLENCE IN HAVERING?

a) Introduction

Domestic violence (DV) is prevalent in the Borough. We know that it has a significant impact on the health and wellbeing of victims and their children.

DV is defined by the government as:
"Any incident of threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional) between adults who are or have been intimate partners or family members, regardless of gender or sexuality. This includes issues of concern to black and minority ethnic (BME) communities such as so called 'honour based violence', female genital mutilation (FGM) and forced marriage." (1)

DV has a financial impact on agencies and services and we know that it has a significant impact on the health and wellbeing of victims and their children. It is a major public health concern and is a priority safeguarding issues for children and adults.

The significance of domestic violence and its connection to child abuse is now well documented in research. In a recent study on Serious Case Reviews nationally, Marion Brandon noted that "the mention of DV permeated all types of reviews concerning babies, children and adolescents" (2). DV has been a feature of some Serious Case Reviews conducted in Havering since 2007. There were a number of relevant key learning points that affected the outcomes of some of these cases including: the failure to maintain focus on the child and failure to understand domestic violence.

DV is the leading cause of ill health for women aged 19 – 44, greater than cancer, war and motor vehicle accidents (3).

30% of DV starts or gets worse during pregnancy (4, 5).

Between 50% and 60% of women mental health service users have experienced DV, and up to 20% will be experiencing current abuse (6, 7).

The estimated costs of DV (not including the human and emotional costs) pro rated by population to Havering (8) is **£23.3 million**. The hidden costs to NHS in Havering in responding to DV (its immediate and the long term impact) is estimated to be **£7.1 million** a year). This figure includes the costs of visits to GPs and A&E, treatment for injuries, use of ambulances, prescriptions, referral to services for treatment, mental health and rehabilitation.

b) Prevalence of DV

Home Office estimates based on the British Crime Survey (9) makes the following estimates of the level of need for local services for DV, sexual violence and stalking in their area. These estimates can be used to help inform commissioning of services to meet unmet and previously un-recognised need.

Figure 8: Estimated level of need for local DV services. Home Office, 2009.

Borough	Female population	Estimate for area
Havering	116,291	DV 5,466 Sexual Assault 4,884 Stalking 9,673
Redbridge	122,786	DV 5,771 Sexual Assault 5157 Stalking 10,213
Waltham Forest	112,093	DV 5,268 Sexual Assault 4,708 Stalking 9,324
Barking and Dagenham	858,76	DV 4,036 Sexual Assault 3,607 Stalking 7,143

Population data taken from 2001 Census (is total female population and not broken down to 16 – 59 age group). Figures are an estimate of number of women and girls who have been a victim in the past year.

c) DV Offences in Havering

Number of Incidents and Offences
Table 1 shows the number of incidents and offences in Havering for two financial years and the percentage change.

A domestic offence is where an incident occurs and the investigation reveals an offence against a statute of law (ie an assault). If the incident is not against a Statute of Law, e.g. a row between partners) it is defined as an incident. The police record both to ensure a full record of any potential DV is recorded.

Figure 1: DV offences and incidents in Havering in 2009-2011. Police Performance Information Bureau, 2011 (10).

	DV Offences	DV Incidents
2009/10	1,093	2,821
2010/11	1,200	2,817
Change	9.8%	-0.1%

Between 2009/10 and 2010/11, the number of DV offences in Havering have increased by 9.8%. In the same time period, the number of DV incidents has stayed approximately the same.

Some evidence suggests that on average, a women may be assaulted as many as 35 times before her first call to the police, which could suggest that more DV is taking place than is reflected in police figures, however it should be reflected that this figure is taken from 1982 and may not reflect changes in policing practices since then (27).

Havering's Performance

- Figure 2 shows how Havering 'sits' within the 32 other London Boroughs. It shows Havering's position in pure volume of reports and as a per thousand population. (A low number is good; high is bad.)

Figure 2: DV offences and incidents in Havering compared to all London Boroughs. Police Crime Reporting Information System, 2011 (11).

	DV Offences	DV Incidents
Population	8th	8th
Volume	9th	8th

Havering has the 8th lowest rate of DV offences and incidents (per 1000 population) out of the 32 London Boroughs. When only the volume of DV is considered (and size of the population is not taken into account), Havering has the 9th lowest volume of DV offences (out of the 32 London Boroughs) and the 8th lowest volume of DV incidents.

Arrest Rate

The arrest rate is the percentage of those committing DV who are subsequently arrested.

- In 2010/11, Havering had an arrest target of 77% and an actual arrest rate of 84%. In Havering, the sanctioned detection rate target was 47% and a 49% rate was achieved. This means that in almost eight out of ten cases where a DV allegation was made the perpetrator was arrested; of these arrests almost half (49%) result in a caution / charge. Havering is ranked 16th out of the 32 London Boroughs for DV sanctioned detection rate (where a ranking of 1st = best performing Borough) (12).

Victims and Accused

- Figures 3 and 4 show the breakdown of victims and accused respectively.

Figure 3: Table Showing the Proportion of DV Victims In Havering, by age and gender, 2010/11. Police Crime Reporting Information System, 2011 (13).

Age Groups	Female	Male	Total
<10	0%	0.1%	0.0%
10 – 17	1%	1%	1%
18 – 25	28%	24%	26%
26 – 35	30%	30%	30%
36 – 45	24%	25%	24%
46 – 55	11%	12%	12%
56 – 65	4%	5%	4%
66 – 75	2%	2%	2%
76 – 85	0.4%	1%	1%
86+	0.3%	0.4%	0.4%
Total	2329	1585	3914

Figure 4: Table 3: Table Showing the Proportion of those Committing DV in Havering, by age and gender, 2010/11. Police Crime Reporting Information System, 2011 (14).

Age Group	Female	Male	Total
10 – 17	0%	0.2%	0.2%
18 – 25	25%	30%	29%
26 – 35	32%	30%	31%
36 - 45	35%	27%	28%
46 - 55	5%	9%	8%
56 - 65	2%	2%	2%
66 - 75	2%	1%	1%

Total	57	482	539

The table shows the percentage that the gender of a particular age group represents.

So the accused table shows that 35% of all female victims are aged 36 - 45 and 27% of all male victims are aged between that age. A large proportion (80%) of those experiencing DV are aged between 18 and 45.

Time when DV Occurs (15)
Figure 5 shows DV offences by hour of the day separated into Havering (excluding Romford town centre) and Romford town centre only.

Figure 5: Time of day when domestic violence occurs in Havering. Police Crime Reporting Information System, 2010/11 (15).

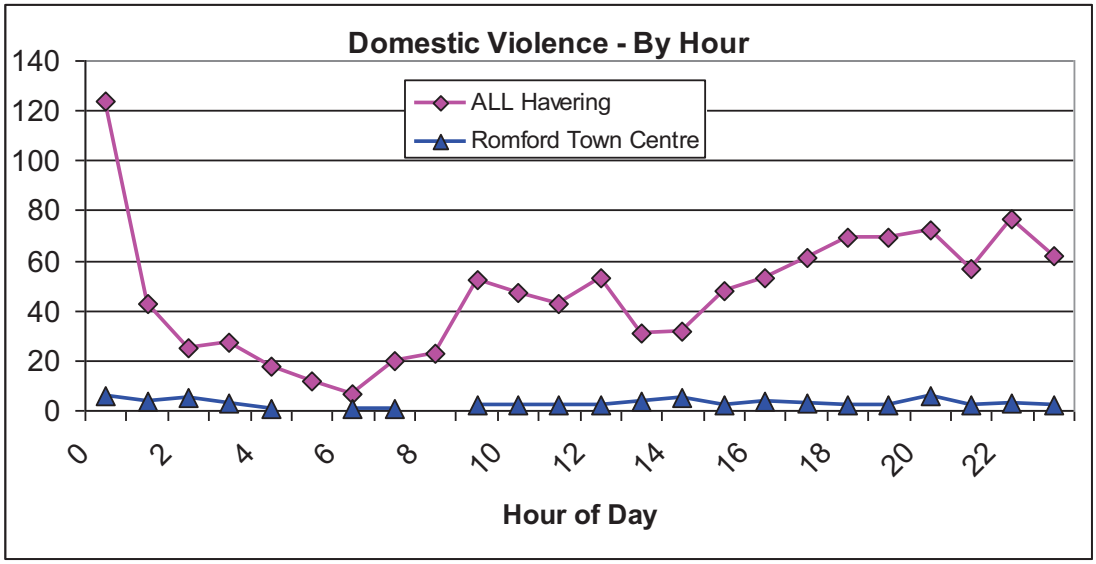
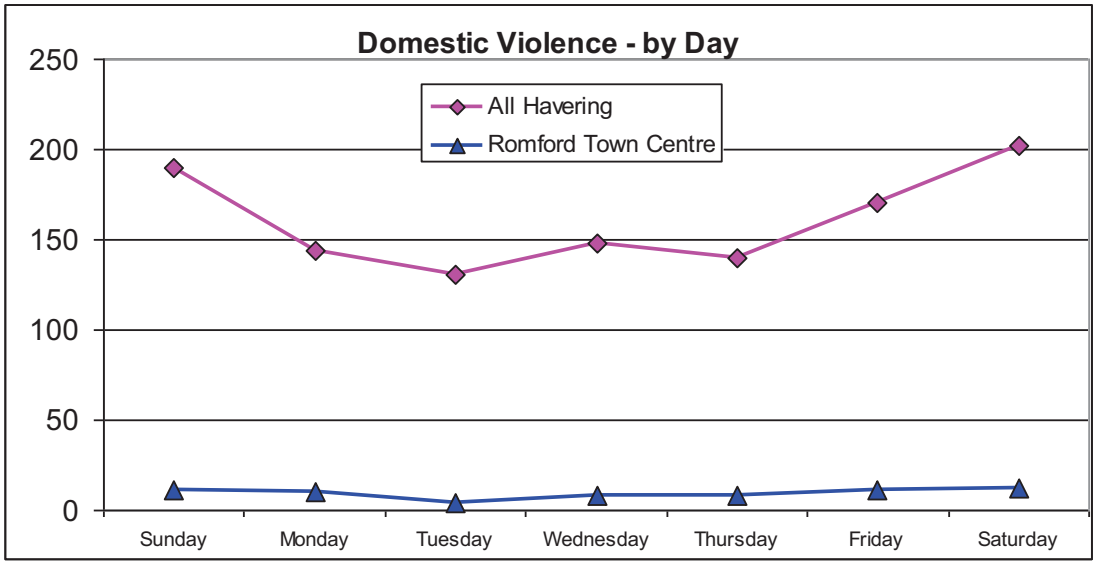


Figure 6 shows the same data but by day of the week.

Figure 6: Days of the week when domestic violence occurs in Havering. Police Crime Reporting Information System, 2010/11(15).



The premise being raised was whether alcohol can be linked to the offence of DV. Romford town centre, where there are a concentration of premises licensed to sell alcohol, does not show any significant increase in DV during licensing hours. Havering as a whole does show an increase in DV from 4.00pm to 1.00am. This may be due to partners being at home (or out) together. This is further supported by the lower number of reports during the 'normal' working day. This does not follow for the other raised reporting times, between 10.00am and 1.00pm. However, a further look at the data shows that these reports are mainly on a Saturday and Sunday which tends to support the argument that alcohol need not be a factor.

Saturday and Sunday account for 28% of the week but 35% of reports are made on these days. When the hours of the day for Saturday and Sunday are examined the fewest reports are made in the 8th hour (17%) (I.e. between 8.00am and 8.59am but this rises to 74% for the 3rd hour (3.00 to 3.59am). This could suggest that alcohol is involved, but further evidence is needed to investigate whether this is the case.

Over one in ten DV offences occur between midnight and 1.00am (11.04%).

Figure 7: Result of DV Cases Where Defendant Pleaded Not Guilty At First Hearing in Havering, September 2010 to August 2011. Havering Magistrates Court, 2011 (16).

				Outcomes		
Month	No of Trials	Victims Attended	Adjourned	Guilty	Not Guilty	Withdrawn
Sep-10	7	6	0	<5	<5	<5
Oct-10	6	<5	<5	-	<5	<5
Nov-10	13	8	<5	<5	<5	6
Dec-10	6	<5	<5	-	<5	<5
Jan-11	8	6	<5	<5	<5	<5
Feb-11	10	7	<5	<5	<5	<5
Mar-11	5	<5	<5	<5	<5	<5
Apr-11	8	8	<5	<5	<5	<5
May-11	10	7	<5	<5	<5	<5
Jun-11	9	7	<5	7	<5	<5
Jul-11	10	7	<5	<5	<5	<5
Aug-11	7	<5	<5	<5	<5	<5
Total	99	70	18	34	16	31
Percentage of Trials			18%	34%	16%	31%

Figure 7 (data provided by Havering Magistrates Court) (16) shows the result for DV cases were the defendant pleaded not guilty on the first hearing. It does not include those who during the remand for a trial changed their plea to guilty.

d) Prevalence of Harmful practices in Havering

Data on the prevalence of harmful practices within the borough is limited. The police data shows that from April 2011 to date there have been five cases of forced marriage and no allegations of female genital mutilation reported (17). In Havering, between 2001 and 2004, it is estimated that there were 47 maternities in Havering where women had female genital mutilation (18). This could present child protection concerns if these mothers the delivered a daughter. Data on the prevalence of FGM locally and reflects the national difficulties in collecting accurate data on the prevalence of FGM ain certain communities.

e) Total Cost of DV (19)

However as mentioned above, the MARAC is estimated to address only around 10% of all DV. Therefore the total cost of dealing with DV is even higher. It is estimated that based on Havering's population size, DV (not including the human and emotional costs) costs **£23.3**

million per year. The hidden costs to NHS in Havering in responding to DV (its immediate and the long term impact) is estimated to be **£7.1 million** a year). This figure includes the costs of visits to GPs and A&E, treatment for injuries, use of ambulances, prescriptions, referral to services for treatment, mental health and rehabilitation.

In comparison to other Boroughs across outer north east London, the costs are:

- Redbridge cost of DV is **£29.9 million**, the hidden costs to NHS are **£9 million per year**
- Barking and Dagenham cost of DV is **£19.1 million**, the hidden costs to NHS are **£5.7 million per year**
- Waltham Forest cost of DV is **£26 million** and the hidden costs to the NHS are **£7.8 million per year**

f) Safeguarding children and domestic violence

DV has been a feature of some Serious Case Reviews conducted in Havering since 2007. There were a number of relevant key learning points that affected the outcomes of some of these cases including: the failure to maintain focus on the child and failure to understand domestic violence.

Although children's social care is currently unable (for systems reasons, which are being addressed) to robustly quantify the actual prevalence of domestic violence as an issue in referrals or in child protection plans, it is acknowledged as a significant concern. The concern relates not only to the volume but to the severity of the violence, and the consequences for the safety and wellbeing of children in the household.

There is limited information about the prevalence of DV against children, however local information suggests that for those 6,150 families referred to Children's Centres over the past two years (2010 and 2011), domestic violence is recorded in 5% of cases. This is not a full indication of the prevalence, as Children's Centres tend to provide support in cases which do not meet child protection thresholds.

Data from the MARAC shows that in 2011/12 112 children were involved in the high risk cases discussed.

Children who experience domestic violence at home are at risk of a number of poor outcomes, for example the extra stress they experience may result in emotional distress, difficulties concentrating at school, behavioural problems, depression and increased risk of criminal behaviour or substance misuse (Unicef, 2006) (26).

2. WHAT CURRENT SERVICES ARE THERE FOR DOMESTIC VIOLENCE (DV) IN HAVERING?

a) Havering Women's Aid

Havering Women's Aid are commissioned by the local authority to provide refuge accommodation and a floating support service for women experiencing DV in Havering?. This is a three year contact from October 2011. Havering Women's Aid have 23 flats and are commissioned to provide 230 hours per week for the Refuge and Floating Support Service. They also provide a drop in and support group for women experiencing DV (commissioned until 2012).

Havering Women's Aid also provide the DV Support Group. , which holds 40 support group sessions annually (funded by Havering police and Havering Council)

2010/2011 Havering Women's Aid supported 1192 women, 539 children and 20 men. Referral to the service is via helpline and Havering Women's Aid provides a wide range of services such as:

- Refuge accommodation for twenty three families
- A Floating support service to women and men in the Community
- Children's services for the refuge
- Children's services for the community
- Drop In service
- Support Groups
- Counselling Service
- Helpline
- 24 hour on call for emergencies.

b) Independent DV advocate

An independent DV Advocate (IDVA) is provided by Victim Support to support high risk of harm cases discussed at the Borough's MARAC. This role is currently funded by the London Borough of Havering and the Home Office until March 2012.

In 2010/11 the IDVA supported 177 high risk victims of DV (169 female, 8 male) (20)

Figure 9: Individuals supported by the independent domestic violence advocate in Havering. Havering Independent Domestic Violence Advocate, 2011.

Age	
16 - 18	<5
18 - 35	93
35 - 50	55
Over 50	8
Unknown	18

Ethnic Origin	
White/Other	137
Black/Carribean	<5
Asian/Other	<5
Black/British	
White/European	<5
Black/African	<5
European	<5
Sri Lanka	<5
Unknown	<5

Over half of the referrals came from the police (90) and 32 from MARAC. The rest of the referrals came from a wide range of services and agencies in the Borough, however only one health referral was noted.

In addition to the 177 high risk of harm cases, the IDVA received a further 708 referrals from the police. These cases are contacted and a risk assessment is completed. Usually this contact is limited to one phone call due to capacity of the IDVA.

c) MARAC

The Multi-Agency Risk Assessment Conference (MARAC) aims to review and co-ordinate service provision in high-risk of harm DV cases. The focus is to reduce repeat victimisation and prevent DV homicides. MARAC has a priority focus on victim safety with links to child protection and multi agency protection arrangements for violent and dangerous offenders. MARAC will facilitate, monitor and evaluate effective information sharing to enable appropriate actions to be taken to increase public safety.

Each individual high risk case of DV discussed at the MARAC costs £20K (21). It is estimated that MARACs deal with around 10% of the total of all DV reported incidents. These are the most serious and high risk cases and should be seen as the "tip of the iceberg".

In the period between April 2010 and October 2011, 204 cases have been discussed at the MARAC, 31 were repeat cases. The MARAC has a repeat victimisation rate of 15.2%, which is lower than for cases not discussed at the MARAC (22). More information about the definition of DV repeat victimisation rates can be found on the Audit Commission website here:

www.audit-commission.gov.uk/localgov/audit/nis/Pages/NI032repeatincidentsofdomesticviolencecasesreviewedatmarac.aspx

This means that the 109 high risk cases of DV discussed at the MARAC in the Borough for 2010/11 cost partners in the Borough (e.g. the police, community safety, housing etc) **£2.18 million** and health services **£545,000** (this includes visits to GP, A&E, prescriptions and other health services such as sexual and mental health).

In comparison to high risk cases discussed at MARAC across outer north east London, the costs are:

- Waltham Forest **£4 million** and health services **£1 million**
- Redbridge: **£3.4 million** and health services **£850 000**
- Barking and Dagenham: **£5.3 million** and health services **£1.3 million**

Using an independently verified analysis (23), MARACs save at least £6,100 of these costs per victim. The net return on investment for the health service is 533%.

d) Family MOSAIC Project

Family Mosaic Project received 12 referrals in 2010/11 for their rent deposit scheme for victims of domestic violence. In the same year they received 7 referrals from Victim Support and from health services for support for victims of domestic violence.

e) Relate North East London

Relate North East London have 18 counsellors working in Havering who have all had training for Domestic Violence. They do not receive any funding to offer our services in Havering. The majority of the adult clients using the service are self referred or recommended by other agencies e.g. GP, Citizens Advice Bureau. These self referrals are usually all self funded, with exception of a few clients who are funded by Social Services.

In 2010/11 Relate saw 1083 adult clients and 341 children from Havering. 43 cases were due to family conflict, constituting approximately 12% of their caseload. Of the 341 children, 225 were referred to the service by education. The remaining 116 have either been referred by their GP, school, children's social care or other health professionals.

f) Women's Trust East London
Woman's Trust East London Counselling and Support Services provide free confidential one to one counselling to women affected by domestic violence. In 2010/12 they received 10 referrals for women living in Havering and in the year 2011/12 to date 8 referrals. No referrals have been from health services. Woman's Trust are funded by the Big Lottery Fund. This is a 5 year grant (April 2010 to March 2015). Woman's Trust work across 8 east London boroughs: Barking & Dagenham, Greenwich, Hackney, Havering, Newham, Redbridge, Tower Hamlets and Waltham Forest. 2 staff members work specifically for the East London Counselling and Support Services: a Senior Counselling Coordinator (28 hours per week), and an Office Administrator (25 hours a week).

g) Rape Crisis Centre
The East London Rape Crisis Centre started to take referrals in March 2011 and has received less than 5 referrals from Havering to date for its counselling service. Initial low take up of the service is expected as it's a new service and the sensitive and complex nature of disclosure and help seeking in cases of rape and sexual assault. An engagement and publicity campaign is underway to raise awareness locally of the service. The Mayor of London has funded the East London Rape Crisis Centre to March 2012. Consideration needs to be given to future commissioning of this essential service if this funding ceases. This is expected to be approximately £30 000 per year from each Borough.

h) Top 100 Families Project
The Top 100 Families project will identify current high contact, high need families across by all public sector partners within Havering. Once these families are identified all agencies will collectively review the intervention and support these vulnerable families receive.

The 'new' targeted approach with these families will be designed using best practice, listening to family feedback and experiences, consulting with frontline practitioners, improving cross sector communication, jointly funding work, sharing roles and responsibilities, improving performance management, eradicating duplication and achieving efficiencies and value for money.

The success factor will be the improved outcomes for families with multiple complex needs, with the majority of families needs being meet by the prevention and early intervention services, and a reduction in demand for specialist, high level targeted services and ultimately reduction to the amount of families at threat of loosing their children (into care), their liberty (offenders) or their home.

Following the piloting of this joined up approach, the changes to service planning and delivery will be imbedded into the day to day ways of working in all public sector agencies over time, to achieve systemic change.

All partners, including Police, Local Authority, Probation and Health Agencies have contributed to the identification of our high contact/high need families. Part of this process has been the identification of which 'complex needs' are experienced within family units, given that currently different agencies identify and assist families with multiple needs. Domestic abuse has been an identified issue in 38% of families identified. Families identified with domestic violence had a higher number of other complex issues in the household, for example, mental health, offending behaviour, debt issues and child protection plans.

The Top 100 Families approach will enable better sharing of intelligence, information and joined up working to both identify and work with families experiencing domestic abuse.

i) Policy framework
National

Call to end violence against women and girls HM Government 2011

www.homeoffice.gov.uk/publications/crime/call-end-violence-women-girls

Call to end violence against women and girls: Action Plan March 2011 HM Government
www.homeoffice.gov.uk/publications/crime/call-end-violence-women-girls/vawg-action-plan

Responding to violence against women and children the role of the NHS – the report of the taskforce on the health aspects of violence against women and children Dept of Health March 2010 – followed by interim government response to the report of the taskforce on the health aspects of violence against women and children Dept of Health March 2010
www.dh.gov.uk/en/Publichealth/ViolenceagainstWomenandChildren/index.htm

Regional
The Way Forward. Taking action to end violence against women and girls – final strategy and action plan 2010 – 2013, March 2010 Mayor of London
www.london.gov.uk/priorities/crime-community-safety/tackling-priority-crimes/violence-against-women/way-forward

Local
Locally, DV is included in the Havering Community Safety Plan. Work to address DV in the Borough is included in theme one of the CSP plan – Serious Violence. This work programme has been developed to address Violence will seek to meet the Local Government PSA 23: Priority Action 1 – *'Reduce the most serious violence, including tackling serious sexual offences and DV'*.

Achievements noted in the CSP plan for 2009 – 2010
- Provision of DV drop in children centres
- Provision of services for people who suffer DV

NHS Barking and Dagenham DV and violence against women and children strategy and action plan 2010 – 2013 (this is now helping to inform NHS Outer North East London's and then Clinical Commissioning Groups response to DV and violence against women and girls)

3. WHAT GAPS ARE THERE IN SERVICES OR KNOWLEDGE IN THIS AREA?

- monitoring framework to be agreed and implemented by all DV services commissioned in the Borough
- Details from children's social care on the number of cases of DV they deal with (where is the primary reason for referral or a background factor)
- Referrals from health services including GPs to DV services are extremely low. We need to obtain regular information from DV services on health referrals, and work to capture information from victims of DV on their use of health services to evidence local need
- Feedback and perspectives of local service users on how our services are supporting victims and improvements they think are needed
- Data sets across services on incidents and concerns regarding DV, forced marriage, honour based violence and female genital mutilation
- Intelligence on the incidence and nature of prostitution, sexual violence and trafficking in the Borough.

4. WHAT DO LOCAL PEOPLE THINK?

No comprehensive recent consultation with women affected by DV in Havering been carried out. However, women survivors of DV who had received support from Refuge were consulted as part of the development of NHS Barking & Dagenham's DV and violence against women and children strategy, and the findings from this may also be relevant in Havering. Although this was not conducted with local women in the Borough it provides relevant feedback on survivors views of how health services can help victims of DV.

The women felt that health services can and must play an important role in responding to DV– both for women and their children.

The women recommended that the health agency response to DV should include prevention and early intervention. They also recommended that training on DV is vital so that women experiencing DV can be confident that they will receive a consistent and professional response if they choose to disclose what is happening to them.

Above all, the health service response should be collaborative in approach and recognise that health services need to work with partner agencies to ensure that all the needs of DV victims are addressed. It is vital that partners from across the community work together in order to properly support women who experience violence.

The Community safety Partnership has agreed that a new DV strategy is needed for the Borough. Feedback from local DV services and their clients will be gathered to help inform and support the development of the new strategy.

5. EVIDENCE OF WHAT WORKS

a) NICE Guidance and national guidance

- Institute of Clinical Excellence (NICE) guidance on preventing and reducing DV between intimate partners is currently being developed and is expected in 2014

- Call to end violence against women and girls (2011). HM Government
www.homeoffice.gov.uk/publications/crime/call-end-violence-women-girls

- Responding to Domestic Abuse: A Handbook for Health Professionals (2005). Department of Health: London.
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4126161

- Domestic Violence, Sexual Assault and Stalking: Findings from the British Crime Survey (2004). Walby, Sylvia and Johnathan Allen. Home Office Research Study 276. Home Office: London.
http://www.ccrm.org.uk/index.php?option=com_content&view=article&id=289&Itemid=354

- The Provision of Accommodation and Support for Households Experiencing Domestic Violence in England (2002). Office of the Deputy Prime Minister: London.
http://www.communities.gov.uk/archived/publications/housing/provisionaccommodation

- Department of Health, Home Office and the Association of Chief Police Officers (2009) A Resource for Developing Sexual Assault Referral Centres (SARCs).
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_107570

b) Project iris

Project IRIS is an intervention to improve the health care response to DV and abuse. GP practices receive training, an audit and ongoing support, a prompt in the medical system, a named advocate based in a DV specialist facility to which GPs can refer, and materials to display in surgeries. The cost of setting up and implementing project IRIS in a local area is approximately £50,000.

The pilot study for Project IRIS found it to be cost effective, with a cost effectiveness ratio of approximately £2,450 per quality of life year (QALY). Operating over 25 GP practices, Project IRIS generated a cost saving of £80 000 against a £50 000 investment (24).

Further information about Project IRIS can be found here:
http://www.health.org.uk/publications/identification-and-referral-to-improve-safety/

c) Independent DV advocates
We know that DV advocates benefit victims of DV. For women and families living with severe DV, MARACs and Independent DV Advisors (IDVAs) offer a real solution. Almost two thirds of women living with high risk abuse report that it stops following intensive, multi-agency support coordinated by an IDVA (25).

6. ACTIONS AND RECOMMENDATIONS

- Develop and publish an updated Borough DV and violence against women and girls strategy
- Engage GPs in the coordinated response to DV, to improve practice and generate referrals. NHS ONEL and Clinical Commission Groups to consider commissioning a pilot of Project IRIS with GPs, to improve primary care response to patients who are experiencing DV.
- Ensure appropriate agencies and representatives attend the MARAC. Continue to improve the collation and analysis of MARAC data to understand the needs of those experiencing DV and to align services accordingly
- Work with health and social care to improve the recording and availability of local DV data. Currently most local data on DV is provided by the police and including information from other partners would improve local intelligence on the prevalence of DV. There is also a need for local partners to begin to record information about areas such as forced marriage, honour based violence and female genital mutilation. Children's Social Care to implement a domestic violence monitoring flag on their records so that data on number of children know to Children's Social Care due to domestic violence can be easily collected to support analysis of needs and trends. Children's Social Care to introduce a flag for all forms of VAWG concerns, particularly for FGM and forced marriage to improve recording and data collection.
- Develop further joint commissioning (particularly between the local authority and NHS ONEL and then Clinical Commissioning Groups) and also cross borough commissioning opportunities for DV/Violence Against Women, particularly in areas where high levels of expertise/specialism is required such as care for those girls and women affected by female genital mutilation, sexual violence
- A cross Borough, multi agency DV publicity campaign to be developed and implemented to raise the public's and practitioners awareness of DV and services available locally. This should include a series of high profile local community engagement events such as white ribbon day. Costed at £5000
- Introduce a series of DV key performance indicators into the contracts of health service providers to help support the mainstreaming of the response to DV within health
- Consider commissioning specialist support services for families where DV has been identified. This could be in the form of commissioning a specialist children and young people/family DV support worker to be located within one of the existing DV commissioned services at a cost of £50K to provide support and early intervention to families where DV has been identified
- Consider how the East London rape crisis centre will be commissioned in the future and what resources will be available to support this commissioning (in 2013/14) when funding from the Mayor of London ceases)
- Develop a process with DV services whereby they systematically record referrals received from health services and use of health services by victims as part of their case

intake system to help develop a better understanding of health activity on responding to DV

- Health service commissioners (NHS ONEL and then Clinical Commissioning Groups) and health service providers to recognise the cost of responding to DV locally and the important role they hold in the coordinated community response to DV
- Domestic Violence Forum to work with Havering Magistrates Court to improve the way in which domestic violence cases are managed, this includes information sharing/tracking of results and listing of cases to help support services attend court and support victims
- Domestic Violence Forum, MARAC and LSCB to explore together the use of the Barnardos Risk Assessment Matix locally in conjunction the MARAC risk assessment tool – DASH

7. FURTHER INFORMATION AND REFERENCES

a) Further Information

- For more information on MARACs visit www.caada.org.uk).
- For information on Project IRIS go to: http://www.health.org.uk/publications/identification-and-referral-to-improve-safety/

b) References

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