Outline Business Case Template

Strand title	Domestic Abuse
Sponsor(s)	Bath and North East Somerset Council, PCC, Safeguarding Boards, Police, IVASP, Community Safety Partnership, Public Health, Sirona, Curo Housing Group, Health and Wellbeing Board
Lead	Bath and North East Somerset Council
Project team members	Safeguarding, Mental Health, Strategy and Performance, IVASP Community Safety, Julian House
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1. Aims and objectives

What's the problem we're trying to fix? What will the benefits be for local residents?

We know from victims that that taking the first steps and speaking with someone about their domestic abuse is the hardest and most nerve- wracking thing to do.

Victims have told us that they want to access services in one place – with someone to follow and guide them through the entire journey – to help them take that leap of faith that we are there to support them and help change their lives for the better.

They want to feel that someone is listening and not be made to feel guilty because they need help. They want to move from being passed from pillar to post and having to chase so many different hard to reach services within our current systems and structures. More detail on what we have heard is set out in Appendix One.

Avon and Somerset PCC has also undertaken a Victim Experience Consultation. This and the results from the Avon and Somerset Constabulary's '*Public Voice* 1' found that victims of domestic violence want their crime and criminal justice agencies to:-

- Respond quickly when I first call . . . there aren't enough female officers
- Listen, believe me and don't judge my life choices
- Show you care and give support
- Take domestic violence seriously
- Explain the process and the next steps
- Maintain lines of communication . . . Don't wait for me to chase
- Link me to appropriate support agencies

We are proposing a new model of helping victims of domestic abuse designed around their needs. It will be based on a well evidenced business case that considers the whole system and prioritises prevention and early intervention.

The business case is being developed with the PCC, Probation Service and the Health and Well Being Board to ensure that is aligned with new Police neighbourhood-based operating models, the PCC's Integrated Victims strategy and our developing Multi Agency Safeguarding Hub.

2. Case for change

What's the evidence for change? Why would you do this, what's the rationale? Is it the scale of the issue? Is there a system-wide problem? Why aren't we satisfied with current outcomes? Might include a description of the current arrangements and any relevant evidence around why we need to do things differently.

It is estimated that the total annual economic cost to services of domestic and sexual abuse

experienced by women in B&NES is over £17 million, and the greatest cost is to the health care services, making up 22% of the total cost (£3.7 million). Studies of previous GP led projects to support domestic abuse victims have demonstrated up to £2,450 cost-effectiveness per year of quality adjusted life. The Health Foundation stated in its 2010 report, assessing the IRIS scheme, that NHS services have a notably poor record when it comes to the identification and handling of cases of domestic abuse.

The recent University of Bristol assessment of IRIS found that on average GP practices that adopted the IRIS scheme saved £37 pa in societal costs and, saved £1 per patient pa, which equates to an average of £3000 per general practitioner practice per year.

Through a number of detailed service reviews and assessments including analysis of Serious Case Review we have identified that our current system does have some important strengths. These include:

- A long-standing and effective system of Independent Domestic Violence Advisors linked with Victim Support services
- An effective understanding of local needs through our Domestic Abuse profile
- Community projects and charities located in the heart of our local and rural communities with over 100 volunteers. E.g. The New Way Service works with couples with domestic abuse issues that impact on children, but that are not going through the criminal justice system
- Effective connections to the Community Safety Partnership Responsible Authorities Group, Safeguarding Boards and Curo Affordable Housing Group

In saying that, there are areas where we believe there is a strong case for change. These are:

1) Improve integration with health and use of health data

Victims of domestic abuse and their families are likely to have range of health needs, including mental illness, alcohol and drug use. Women who suffer ill health and disability are almost twice as likely to experience domestic abuse and victims of domestic abuse are three times more likely to experience depression or anxiety disorders. The health care professional that victims are most likely to come into contact with are general practitioners (GP's).However we know that:

- Nationally, only 15% of women suffering domestic abuse had any reference to this fact in their NHS primary care record.
- Using national hospital admission codes, there were fewer than 10 hospital admissions for 2009-2011 in B&NES and no A&E admissions, however there were between 33 -47 and 45 - 43 emergency hospital admissions for abuse per 100,000 age standardised population
- No current data exists to gather domestic abuse information from GPs
- Avon and Wiltshire Mental Health Partnership NHS Trust has stated that it holds no information on domestic abuse

2) A more co-ordinated approach to low and medium risk victims

In 2011, independent research showed that in the year after the MARAC, 45% of victims experienced no further police call outs, 20% of victims had fewer reported incidents and 14% reported an increase.

For lower risk there is less co-ordination of risk assessments, data-sharing, family support and customer feedback. Our local Southside Family Project reduced services for low and medium risk victims, referring victims who have a low MARAC risk assessment score to Victim Support.

IVASP is now looking at how a family focussed approach would strengthen responses for those at low and medium risk, secure improved longer term outcomes and reduce the number of lower risk victims escalating to a more serious level.

3) Addressing repeat victimisation and offending
Between April 2011 and March 2012 out of the 37 women who stayed at Next Link's safe house in Bath, 27% had been to a refuge before. We are also aware prolific offenders with more than one victim of Domestic Abuse.

3. Proposed new delivery models

What are you proposing to do differently? High level description of the new service propositions/delivery models. Include the scope here, e.g. the cohorts you will work with, or the geographical or service scope.

In building a service around the needs of service users we will need to draw on:

1) **The PCC's proposed Integrated Victims Strategy.** The three broad strands of this are:
    a. Integrating victim services within Avon and Somerset Police – transforming their approach to victim care
    b. Developing an integrated victim service across the wider Avon and Somerset Criminal Justice Board – joining up victim care across the criminal justice service, from crime to court
    c. PCC commissioning of services for victims – understanding the needs of victims, ensuring they're referred to the services they need, and improving the practical and emotional support they receive as a consequence
2) **Our "Connecting Families"(troubled families)** initiative
3) **Transforming Rehabilitation**
4) **Integrated Offender Management**
5) **Discussions relating to MASH.** There is currently no consensus about MASH development across B&NES and S.Glos although it was agreed that it would be essential to include domestic abuse within any model as it cuts across both children and adult safe guarding
6) **Our long-term strong relationship with Curo**

The new model is likely to involve:

- A greater focus on perpetrator programmes
- Longer-term integrated commissioning of support services in line with the PCC's Integrated Victims Strategy
- More common risk assessment and information sharing
- Greater linkages with Primary Care

To support this we envisage
More colocation of services. This could mean greater use of "one stop" facilities and/or more local bases and better work with communities. We wish to examine how best to provide services locally. For example, Southside Family Project has established four community hubs at Keynsham, Peasdown, Foxhill and Southdown. These have led to self-managed groups, with the emphasis on providing practical social support and self-development opportunities.
Greater involvement of communities in building resilience. Theough the "hibs" identified above, community group members support each other to improve their parenting skills, deal with domestic and substance abuse, improve their mental and emotional wellbeing, be more assertive, tackle debt etc. In Midsomer Norton, we are working with the Salvation Army to establish a safe place for people to find specialist support from our professionally qualified Independent Domestic Abuse Advisers (IDVAs) to help safeguard families in emotional or physical chaos. We are also looking to train more volunteer IDVAs.

- Better evaluation successful outcomes - *have we made it stop?*
- More influence through the Criminal Justice System and on reducing offending

4. Changes required

What needs to change to make this happen? Include changes at two levels – locally, and asks

of government. Local changes might include things like organisational, financial and cultural changes.

Local changes
Build better links with health, council and community safety services including a better interface between information systems belonging to agencies that deliver domestic abuse services. The aim of the Connecting Data programme is to use local data as a strategic tool to better inform local decision making: realise "Big Data" benefits in a local government setting. This will involve changes to culture and governance to enable information sharing support, new arrangements with Avon and Somerset Constabulary to share risk profiling and opening information flows with IVASP to improve identification of need, referral, early intervention and safeguarding.

We need to make the case to GPs/Health Practitioners for increased reporting, identify other services used by victims and support for pathway redesign and explore local implementation of IRIS as well as examine ideas such as IDVAs in maternity units.

5. Financial case

What is the size and scale of the potential financial benefit? Give a headline, an indication of current spend across partners, where savings are likely to accrue and what level of savings could be anticipated.

It is estimated that the total annual economic cost to services of domestic and sexual abuse experienced by women in B&NES is over £17 million, and the greatest cost is to the health care services, making up 22% of the total cost (£3.7 million).

The potential impacts are on demand-led services such as health and policing. Analysis of domestic violence and welfare reform strands shows that resources are skewed towards high risk cases. However, more work is required to test assumptions about this and to ensure any cost savings are real and robust and to understand the estimated costs and benefits of new service models.

6. Implementation plan

What are we agreeing to progress? What are the next steps? Include a high level plan with key steps and dates, including accompanying risks. e.g. Step – Date – Risks

December 2013

- IVASP met officers from Cheshire West in B&NES, to discuss their experiences and learning

January 2014

- MASH workshop
- Report to Health and Wellbeing Board

February

- Work to understand costs and benefits of different approaches
- Development of joint funding proposal to PCC and CCC for implementation of IRIS
- 24th February: Discussions with PCC's office re linkage to Integrated Victims Strategy
- 26th February: Discussion of optins for model with Chair of IVASP and Police District Commander
- 18th March- Workshop to develop Business Case and new model
- 8th April- Community Safety Partnership receives update report/Business Case

APPENDIX ONE - Victims' voices

In November and December 2013, as part of a '*Victim Experience Consultation',* we held local focus groups and met with over 100 victims – ranging from victims of domestic and sexual abuse, hate crime anti-social behaviour, students, hate crime and older vulnerable groups. Here's what they told us:

- Worried and lack of confidence when reporting domestic abuse to police as they will be punished by the offenders – who seem to know they were the ones who reported the incidents
- When they call the police and the offender is taken away, they are released on bail after a few hours – releasing the offender back to the victim, placing them and their children/family at a higher risk, which only worsens the situation. The offender gets more angry and aggressive. Victims said this is the reason why they did not report further domestic abuse to the police.
- Police don't take it seriously or even respond quickly when the offender constantly breaches their court order and/or injunctions
- Victims received different responses from council staff and police officers – and it depends on who you speak with
- Many would not walk into a police station to report an incident - glass front is a cold reception and intimidating – scared they will be seen by others
- Victim Support lacks understanding of the urgency – many victims felt strongly that they would not want to use this service again as it currently is
- For initial contact – victims preferred one to one face to face contacts to establish trust and confidence and then tele or email/text – just to have someone to call if they needed a brief chat (many said, they didn't want a full scale conversation, just to have someone at the end of the phone who you knew and trusted would be great) – five minute is all they would need - like IDVAs
- With serious cases, many felt our systems (non-service specific) were very clumsy and lengthy to get any response. It made them feel very lonely being passed from pillar to post –constantly chasing up Officer's to call them back - , and often they don't
- Lack of understanding with two different ASB teams working in the Police and Curo
- One DV victim (Southside) attended the family courts and the offender (husband) was defending himself. He cross examined her and this system allowed him to be in control and played on her fear
- Not one victim knew of the Witness Support Service – although, many who used IDVA's did and, received excellent support
- Those who had called 101 for help, felt it wasn't practical for a victim support service – the Control Centre staff sometimes asked *is it a crime or ASB that your reporting?*
- PCSOs were better to approach as they know them by first names – their people skills being excellent and friendly
- Services within the Council are hard to reach such as Social and Health Services, Safeguarding and Mental Health – staff talk down to them
- Lack of communication where victims have to chase up Council officers for a response to find out what is happening with their case – especially when it involves children
- Wouldn't know who to contact in the Council for help – especially out of hours
- No confidence to talk to the school about their situation and the risks to their children – for fear they will be judged, not taken serious or, children taken away from them
- The massive impact this has on their wider families, destroying their health and lifestyle, many needing medication from their doctors for depression and stress
- DV victims highly praised Southside IDVAs and said they would not be alive today without them – local access being paramount

We know from the evidence that victims do not report to the police and when asked who they would trust, a very high proportion - 85% - said their doctor. If the doctor just asked, *is there anything else,* this would be that opening, that invitation to help them reach out for help*.* The victim's do not expect the doctor to take on their case, but refer them to someone who would. A poster in the surgery would be a sign that the doctors cared and, that it's alright to speak out.

Victim's voice- Shirley (not real name)
Shirley is a victim of domestic violence and abuse, who suffered for four years before taking that leap of faith and talk to someone about her ordeal. This first step happened outside the school, when picking up her two young children. She was approached by another mother, who herself had been a victim of domestic violence and, recognised the symptoms. The mother invited Shirley for a coffee and a chat at her home. Shirley had a degree and gave up her professional career, a choice made by her husband's soon after they were married. Shirley said, she had lost all her confidence and would not have made the first move without the support and guidance from the mother who she met at the school. Shirley believed – mentally brainwashed by her husband - that she was to blame for his behaviour; it was her fault that he got angry. He threatened to take the children away from her because she was not fit to be a mother or wife. She believed she was stupid and clumsy, ugly and fat. Her self-esteem and confidence were rock bottom, her health deteriorating and her hair was falling out. She dressed the way she was made to feel - dull and lifeless.

The mother was able to gain Shirley's trust and took her along to the local Southside project – a local support service and a safe place for victims of domestic violence and abuse to access. The mother soon became Shirley's buddy and stood by her throughout her ordeal. Shirley was able to gain intensive support from Southside IDVA's and was able to build her life back - building a safer and better home for her two children.

Her ordeal was a big learning curve for us, and Shirley helped us understand how our services and systems are clunky, by sharing her experiences with us. We heard how she was made to feel and that she nearly gave up on many occasions – the mother, police and Southside being her rock throughout. What we were able to do was avoid another serious case review or a domestic homicide. We were able to gain her secure accommodation with Curo, and walk her through her next steps to a normal healthy life and career. Above all, we knew we had to change.

APPENDIX TWO- Our Domestic Abuse profile

In November 2012, Bath and North East Somerset (B&NES) Community Safety Partnership commission a review of the Domestic Abuse profile to provide a more up to date and comprehensive evidence based picture of the extent and nature of the issue of domestic abuse in our areas. Its aim is:

- To bring together data in one single document from Council services and other organisations, charities and agencies that are involved with addressing the issue of domestic abuse, and/or who work with victims or perpetrators of domestic abuse
- Through clear analysis of data from the various agencies involved, to provide a broad, holistic picture of the nature and extent of the domestic abuse issue that is accessible to all
- To highlight the wide range of agencies and organisations that have a role in addressing the causes and effects of domestic abuse
- To identify gaps or weaknesses in information being recorded, as well as particular demographics or needs that may not be being adequately addressed
- To outline a number of recommendations in terms of improving the monitoring of domestic abuse and abuse and in the nature and relationship of the available services.

Some key facts from the Profile

- An estimated 5,936 women aged between16-59 in B&NES have been a victim of domestic abuse in the past year.
- Approximately 40% of women and 20% of men in the UK have been victims of domestic abuse since the age of 16
- 78% of Adult Safeguarding referrals, 97% of Southside's Independent Domestic Abuse Advice Service, 92% of MARAC cases and 77% of recorded crimes involved women as victims of domestic abuse
- 79% of domestic abuse offenders recorded by the police were male, whilst 17% were female and this has not changed over time
- Although white victims represent a lower than expected proportion of police recorded crimes, the ethnicity for a substantial proportion of cases had not been recorded
- Between the 2nd quarter in 2009-10 and the 1st quarter in 2012-13, Southside received 1,118 domestic abuse referrals to their Independent Domestic Abuse Advice Service, and there were 1,758 children affected by the domestic abuse experienced by these referrals
- There were 907 children affected by MARAC cases in B&NES between 2009- 12