

Gloucestershire
Domestic Abuse and Sexual Violence
Commissioning Strategy and Outcomes Framework
2014-2018

FINAL DRAFT

Gloucestershire Domestic Abuse and Sexual Violence Commissioning Steering Group

October 2014

1. Where we are now - introduction and context

- 1.1 Through this single commissioning strategy and outcomes framework for Gloucestershire, we aim to ensure a more co-ordinated and integrated response over the next five years to improving outcomes for children and adults affected by domestic abuse and/or sexual violence (DASV). The purpose of the document is to demonstrate what we intend to do collectively, tackling the causes and the effects of DASV.
- 1.2 Commissioning within public services simply means understanding what is needed and deciding on the best ways of meeting those needs, that make a positive difference to people's lives, through the use of all available resources. Consultation and engagement is essential through all stages of commissioning; from the analysis of issues, planning and designing solutions, securing available resources, and evaluating impact and success. An asset based approach, building on the strengths of communities, will guide our activities. Co-production will be central to achieving our outcomes, whereby the development of solutions starts first and foremost with people's energy, skills, interests, knowledge and life experience.
- 1.3 DASV causes harm and long-term problems to children, families and communities, constituting a violation of human rights. It can affect anyone regardless of age, gender, sexual orientation, race, income, class, mental or physical ability or lifestyle. Although it is not gender specific, women and girls experience more repeated, severe abuse and sexual violence, as well as more coercive control, injuries and fear of their partner (Home Office, 2014; NICE 2014a). Risk of victimisation is highest in young adulthood (Department of Health, 2012). The impact on children and young people can affect them throughout their lives (NICE, 2013; CAADA 2014) and they are more likely than the general population to experience poor physical, mental and emotional health and wellbeing as a result.
- 1.4 For the purposes of this strategy references to Sexual Violence covers all instances, i.e. when sexual violence is present as part of a pattern of Domestic Abuse and when the perpetrator is not known to the victim. A separate strategy exists in Gloucestershire for tackling Child Sexual Exploitation (CSE). This also focuses on a multi-agency approach to prevent, identify and support those who are at risk of CSE. Links will be made to this strategy and reflected in the Implementation plan.
- 1.5 The extended cross government definition of domestic violence and abuse (Home Office, 2013) is: '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; and emotional.' The definition includes honour based violence, female genital mutilation and forced marriage.

- 1.6 Repeat domestic abuse rates are amongst the highest in all violent crime, with some victims experiencing abuse more than once and over long time periods. The inter-generational consequences of DASV are significant, with a pattern of repetition of abusive behaviours (Guy et al, 2014). Approximately two thirds of victims have children, most aged under five years, who have been exposed to domestic abuse for most of their lives (CAADA, 2012a). Domestic abuse is also associated with child abuse and neglect.
- 1.7 There are high economic costs imposed on public services and communities for dealing with the symptoms and effects of DASV, with a need to focus more effort and resource on prevention and targeted early help, to reduce the impact of violence on health and wellbeing, crime and disorder. This requires a stronger emphasis on the causes and impact of DASV, to reduce the multiple pressures on public services and wider society. Commissioners have a responsibility to collectively invest public resources where they will have the greatest effect, particularly with action early in life and before problems escalate to cause damaging effects throughout the life course (Chief Medical Officer's Report, 2013). Given the high cost (both human and economic), any intervention that is even marginally effective is likely to also provide value for money (NICE, 2014a).
- 1.8 This strategy has been developed by the DASV Commissioning Steering Group, made up of partner agencies that currently invest in the programme area: Gloucestershire County Council; the Office of the Police and Crime Commissioner; Gloucestershire Constabulary; District Councils; and NHS Gloucestershire Clinical Commissioning Group. The strategy reflects a shared vision, values and ownership of a sustainable outcomes-led commissioning model. The former strategy and action plan: *Reducing the harm caused by domestic abuse and sexual violence in Gloucestershire: a strategy for 2010 – 2013 (revised March 2012)*, has served as the foundation for ongoing work, reflecting the strong partnership approach taken by the multi-agency DASV Board. Implementation of the former action plan has helped to change the lives of many people affected by DASV and to enable families and communities to live safer and more rewarding lives through, for example:

- 1.8.1 the development of educational resources and web-based service information for schools and colleges, to promote healthy relationships;
 - 1.8.2 engagement with victim-survivors of DASV and establishment of a survivors' network;
 - 1.8.3 the piloting and further delivery of group work programmes for children affected by DASV, led by the Gloucestershire Safeguarding Children Board Task and Finish Group;
 - 1.8.4 roll out of the county-wide Sanctuary and home security schemes through a single referral process;
 - 1.8.5 bringing more perpetrators to account through the Criminal Justice System, and providing perpetrator programmes to address and change their abusive behaviours (whether convicted or not):
 - 1.8.6 awareness raising of harmful practices and crimes such as honour based-violence, forced marriage and female genital mutilation,
 - 1.8.7 delivery of training to frontline professionals to help them identify and provide an initial response to those affected by DASV
 - 1.8.8 forging greater links between safeguarding adults and domestic abuse and/or sexual violence by creating resources for the Safeguarding Adults Foundation Training which aimed to raise awareness of these issues for the specific client group .
- 1.9 The DASV Board has supported development of this commissioning strategy and outcomes framework 2014 - 2018 through a Reference Group representing key stakeholders. The findings of an updated local needs assessment inform the commissioning strategy. Reference is also made to the strategic priorities across the life course of the Gloucestershire Health and Wellbeing Strategy – Fit for the Future, and the Gloucestershire Children's Plan. Local strategies and commissioning commitments for reducing the harm caused by substance abuse and by poor mental health are to be viewed in alignment with this DASV commissioning strategy.

- 1.10 Continuous stakeholder engagement is core to the success of reducing the harm caused by DASV. Stakeholders include people affected by and survivors of DASV, organisations providing specialist DASV services in the public, voluntary, community and private sectors, and mainstream services that may be accessed by people at risk. Co-production is an assets-based approach which starts first and foremost with people's energy, skills, interests, knowledge and life experience. By doing this co-production connects public services with valuable community-based resources and opens up opportunities for improving outcomes without increasing costs
- 1.11 Accountability arrangements acknowledge the recent changes to the public sector landscape including reforms to policing, Public Health and the NHS, and establishment of the Gloucestershire Health and Wellbeing Board. In April 2014 the Health and Wellbeing Board acknowledged it had a clear role to play in supporting, promoting and monitoring the DASV commissioning strategy and outcomes framework, and that success would depend on all agencies working together to offer early help and support to individuals and families, through mainstream as well as more specialist DASV services. The local Community Safety Partnerships, Children and Adult Safeguarding Boards, Criminal Justice Board and Safer & Stronger Network all maintain a key role in the programme area.
- 1.12 A Concordat will be developed which details Gloucestershire's vision and commitment for supporting victims of domestic abuse and/or sexual violence. This will invite engagement with organisations across all sectors and communities in Gloucestershire – to publically commit to creating supportive communities with a public zero tolerance to DASV

2. What we want to achieve – our joint vision, principles, strategic objectives and outcomes

In acknowledgement that DASV is a complex issue to be addressed by a range of organisations, this commissioning strategy and outcomes framework reflects a collective approach to what we want to achieve, how we will go about this and how we will know that it has made a difference. Nationally defined cross governmental strategies and outcomes relating to DASV have been drawn on from the Ministry of Justice, Home Office, Department for Education, Public Health England and the Department of Health.

- 2.1 **Our local vision** is that individuals, families and communities who are at risk of, or exposed to, domestic abuse and/or sexual violence are able to access information and support to minimise harm, and to maintain healthy relationships. Our commitment is to ensuring a zero-tolerance approach.
- 2.2 **The principles** underpinning our vision are based on those outlined in the National Institute for Health and Care Excellence guidance on domestic abuse (NICE, 2014a) - agencies working together, aligning budgets and resources where relevant, with the commissioning of evidence-based services that address all levels of need.
- 2.3 **Three local strategic objectives** define our collective intentions:
- 2.3.1 Focus on early help programmes (alongside specialist services for victims) for the whole family affected by DASV, taking a risk reduction and recovery led approach to improving health and wellbeing, and reducing crime and disorder.
 - 2.3.2 Ensure health, social care, police and other professionals who are in contact with individuals and families vulnerable to DASV are confident and competent in their response to support them, creating environments for disclosure at all levels of contact
 - 2.3.3 Provide a co-ordinated approach across partner agencies, aligning the commissioning and delivery of DASV services to ensure effective and efficient use of resources.
- 2.4 **Locally defined outcomes** are grouped under the three strategic objectives. Existing local indicators are used to measure progress with the outcomes and any additional indicators will be developed and agreed with partner agencies in support of the strategy (see Appendix A).

<p>Outcomes for strategic objective 1: Focus on early help programmes (alongside specialist services for victims) for individuals and the whole family affected by DASV, taking a risk reduction and recovery led approach to improving health and wellbeing, and reducing crime and disorder.</p>
1.1 Reduced exposure to DASV by children and young people, with rights to safety and family life upheld
1.2 Improved health and wellbeing of families and communities
1.3 Individuals and families achieve economic success
1.4 Individuals, families and communities are safe and feel safe
1.5 Communities are stronger in their awareness of and support for victims of DASV, accepting it is the responsibility of all
1.6 Perpetrators change their behaviour and develop respectful, non-abusive relationships
1.7 Improved attitudes of young people (especially young men) towards healthy relationships
<p>Outcomes for strategic objective 2: Ensure health, social care and other professionals who are in contact with individuals and families vulnerable to DASV are confident and competent in their response to support them, creating environments for disclosure at all levels of contact</p>
2.1 Frontline professionals (eg teachers, doctors, nurses, midwives, police, prosecutors, voluntary sector organisations) are confident and competent in asking about and responding to DASV at an early stage
2.2 Employers recognise and support people who are at risk or victims of DASV

<p>Outcomes for strategic objective 3: Provide a co-ordinated approach across partner agencies, aligning the commissioning and delivery of DASV services to ensure effective and efficient use of resources.</p>
<p>3.1 Partner agencies are able to measure the difference being made through a single multi-agency strategy and performance framework</p>
<p>3.2 Good understanding of the current collective spending patterns enables local partner agencies to resource the strategy</p>
<p>3.3 Commissioning intentions for DASV aligned with those for substance misuse and mental health – the ‘toxic trio’</p>

3. What guides and informs our decision making - policy drivers and national research on what works

3.1 Many policy and legislative drivers for change have influenced development of this commissioning strategy and outcomes framework for 2014 - 2018:

- 3.1.1 The Home Office definition of domestic abuse was extended in 2013 to include 16 and 17 year olds, and coercive behaviour.
- 3.1.2 With the establishment of Health and Wellbeing Boards in 2012 as part of the Health and Social Care Act, and a task force and guidelines developed by the Department of Health to support victims, DASV has moved up the agenda locally and nationally (NHS Confederation, 2014).
- 3.1.3 Directors of Public Health in local authorities now have a statutory responsibility for the public health aspects of the promotion of community safety and violence prevention.
- 3.1.4 NHS England has responsibility to collaborate with police and pool their budgets to jointly commission Sexual Assault Referral Centres (SARCs) on a supra-local basis.
- 3.1.5 Services for victims at risk of serious harm or homicide are implemented through a co-ordinated community response, with Independent Domestic Violence Advisors (IDVAs) and Independent Sexual Violence Advisors

(ISVAs) working with local agencies to keep victims and their children safe. Multi-Agency Risk Assessment Conferences (MARACs) co-ordinate safety planning for the highest risk cases (Home Office, 2014).

- 3.1.6 Since 2011, local areas are legally required to consider undertaking a multi-agency Domestic Homicide Review (DHR), following a domestic homicide. This is to establish lessons learned in order to help prevent future violence. The responsibility rests with Community Safety Partnerships. In addition, a stalking offence was introduced in 2012.
- 3.1.7 Clare's Law (the Domestic Violence Disclosure Scheme) has been rolled out in England and Wales since March 2014, allowing police to disclose details of an abusive partner's past. In addition, the Domestic Violence Protection Orders (DVPOs) are now operational, enabling the police and magistrates courts to provide protection to victims in the immediate aftermath of a domestic violence incident.
- 3.1.8 the Victims Right to Review Scheme launched by CPS which makes it easier for victims to seek a review of a CPS decision not to bring charges or terminate all proceedings.
- 3.1.9 Criminalisation of Forced Marriage under the Anti Social Behaviour, Crime and Policing Act 2014
- 3.1.10 Since April 2014 it is mandatory that all NHS acute hospitals provide information on patients who have undergone Female Genital Mutilation (FGM)
- 3.1.11 Recent policy developments and evidence that have put an emphasis on addressing the needs of children include:
 - the change in the definition of domestic abuse to include 16 and 17 year olds;
 - statutory guidance for Local Safeguarding Children Boards, setting out the framework for children's services (HM Government, revised March 2013) and the recent statutory duty to investigate children suffering 'significant harm' through witnessing domestic abuse;
 - HM government action plan on sexual violence against children and vulnerable people (HM Government, 2013);

- the 2010/11 Allen Review of early intervention for children at risk of harm;
- evidence informed practice to improve preventive and early help services, particularly in relation to young children (Research in Practice, 2013; Wave Trust, 2013);
- the 2011 Munro Review of child protection;
- the Chief Medical Officer's Annual Report (Department of Health, 2013) on improving services for children and families;
- evaluation of the national Troubled Families Programme (Casey, 2012);
- the Early Intervention Foundation (2014) review demonstrating the risk of domestic abuse to children's health and wellbeing;

3.1.12 ongoing evaluation of the national Troubled Families Programme, identifying domestic abuse as a discretionary criteria. Specialist Young People's Violence Advocate (YPVA) training is being funded in each local authority area by the Department for Education, with five Regional Young People's Advisors to support the programme. A national young person's dataset will be developed, enabling the measurement of outcomes and design of services for young people experiencing domestic abuse.

3.2 National research and guidance highlighting evidence of what works in reducing the harm caused by DASV has also informed this commissioning strategy and outcomes framework.

3.2.1 Through the annual action plans of the Home Office 'Call to end Violence against Women and Girls' programme, a lot has been achieved to maintain momentum and drive progress towards the elimination of domestic abuse and sexual violence (Home Office, 2014). Campaigns such as 'This is Abuse', evaluation of pilots for Clare's Law and the Domestic Violence Protection Order, progressing legislation to criminalise forced marriage, and development of a programme of work through the National Group on Sexual Violence against children and Vulnerable People constitute examples of this progress.

- 3.2.2 Co-ordinated Action Against Domestic Abuse (CAADA) has produced policy reports on the experience of adult and child victims of domestic abuse (CAADA 2012a, 2012b, 2014). The accompanying Insights Datasets reveal troubling evidence, such as almost 50% of children exposed to domestic abuse being unknown to children's social care. Recommendations include the move from a 'culture of referrals' to one of 'practical joint action based on high- quality, effective services for both adults and children'. Perpetrator interventions and parenting support are also recommended.
- 3.2.3 The Ministry of Justice has reviewed support for victims and developed a commissioning framework for victim's services (Ministry of Justice, 2012 and 2013)
- 3.2.4 The National Institute for Health and Care Excellence (NICE) has recently produced public health guidance on domestic violence and abuse, detailing how health services, social care and the organisations they work with can respond effectively to identify, prevent and reduce harm (NICE, 2014a). It uses the Home Office endorsed co-ordinated community response model for domestic violence and abuse, identifies gaps in service provision and reports on the costs and benefits of interventions that prevent and reduce domestic violence and abuse. Seventeen recommendations for local partnerships to address are put forward, including collective commissioning and planning of services, information sharing, creating environments for disclosure, overcoming barriers to accessing services, specialist services for children and young people, programmes for perpetrators and training for frontline professionals.
- 3.2.5 In their guidance for practitioners and managers regarding **Adult safeguarding and domestic abuse** (April 2013), ADASS and the LGA state that making the links between adult safeguarding and domestic abuse is crucial. They identify that the impact of domestic abuse is often especially acute where the abusive partner is also the carer, who has considerable power and control and the victim relies on them. The guidance recognises the various forms and triggers of domestic abuse in such relationships; from forms of abuse that exploit, or contribute to, the abused person's impairment and those referrals arising as a result of carer stress. Recommendations include an expectation for domestic abuse services to have clear and fully developed disability policies and disability equality training, and make specific attempts to reach, involve and provide for adults with care and

support needs experiencing abuse. Where there are opportunities for joint assessment and joint working across services these should always be considered.

3.2.6 The Early Intervention Foundation has assessed the effectiveness of services aimed at preventing domestic violence and abuse, to enhance understanding of what works in relation to children's health and wellbeing (Guy et al, 2014). Key findings demonstrate the high levels of domestic abuse experienced by children and young people with long term inter-generational impacts and resulting high costs. Recommendations are made for parenting programmes, relationship education in schools, building the confidence of the wider workforce, and increasing perpetrator interventions.

3.2.7 A report published by the NSPCC 'All babies count' in 2011 highlighted a number of principles that should guide service provision to keep babies safe, nurtured and able to thrive. These include; services need to 'think family', prevention: we must do all we can to stop abuse before it starts and it's never too late: we must stop abuse happening again. Since the initial inspection by HM Inspectorate of Constabulary into the way the Constabulary responds to domestic abuse within the county was released in March 2014, there has been a significant amount of activity to address the thirteen recommendations. Much of the energy has been around a joint sustainable training programme with Gloucestershire University but there have also been significant improvements in the supervision of investigations, safety planning and assessment of risk.

4. Building the local picture – analysing needs and assets

4.1 The story in Gloucestershire is largely in line with the national picture for DASV. While anyone may experience DASV, there is clear evidence of the main characteristics of victims and those at risk of becoming victims (NICE, 2014b).

4.1.1 Women are far more likely to be the victims of DASV, with men as the main perpetrators.

4.1.2 Young women (aged 16 – 24) are at highest risk.

- 4.1.3 While there is no statistically significant difference in terms of ethnicity for those at risk of DASV, female genital mutilation, forced marriage and so called 'honour' based violence are more prevalent in black and minority ethnic communities. Nationally in 41% of incidences of reported forced marriage, the person forced to marry is under 18.
- 4.1.4 In terms of sexual orientation, DASV can occur in heterosexual, lesbian, gay, bisexual relationships. DASV can also affect transgender people.
- 4.1.5 There is a higher prevalence of reported DASV in communities experiencing deprivation and health inequalities.
- 4.2 In some cases (although not automatically assumed) vulnerability to DASV may be increased by the following associated risk factors: previous history of abuse; women separated from their partner, especially at the time of separation; pregnant or recently given birth; alcohol and drug misuse; mental health problems; long term physical or learning disability.
- 4.3 **Needs Assessment**
- 4.3.1 The updated Gloucestershire needs assessments for domestic abuse and sexual violence are attached at appendices B and C, mainly covering the period April 2010 to September 2013. This three and a half year period is in keeping with the previous assessments of prevalence completed in 2010, which covered a similar time span. The two needs assessments can be viewed as stand-alone documents and will be updated on a regular basis, as part of the Gloucestershire Joint Strategic Needs Assessment.
- 4.3.2 As with national findings, the updated Gloucestershire needs assessments do not represent the true nature and scale of the problem, due to significant under-reporting to the police and other services.
- 4.3 **Domestic Abuse**
- Highlights from the updated domestic abuse and violence needs assessment for Gloucestershire:
- 4.3.1 22,817 domestic abuse incidents were recorded on the police database between April 2010 and September 2013.

- 4.3.2 There were 7,140 domestic abuse related crimes recorded on the police database between April 2010 and September 2013, 38% fewer crimes compared to the previous three and a half year period - this is in line with national findings.
- 4.3.3 Three quarters of all victims of recorded domestic abuse related crimes are females.
- 4.3.4 Of the 22,817 domestic abuse incidents recorded, 50% are repeat victims, a higher proportion of the overall total when compared to the previous reporting period.
- 4.3.5 84% of perpetrators of domestic abuse are categorised as either 'partner' or 'ex-partner'.
- 4.3.6 Based on police recorded victim data, victims of domestic abuse are nine times more likely to live in one of the 27 areas of Gloucestershire that are in the most deprived quintile of deprivation in England, compared to those living in one of the least deprived areas.
- 4.3.7 One third of all incidents recorded on the police database had at least one child present witnessing the domestic abuse. Analysis of children and young people at risk following social care initial assessments demonstrates the link between domestic abuse, substance misuse and mental health (the 'toxic trio').
- 4.3.8 An encouraging finding from the Online Pupil Survey 2012 shows the percentage of young people having never seen, heard or been a victim of domestic abuse has increased by 20%, compared to the 2010 data.
- 4.3.9 With regard to ethnicity, the picture remains uncertain due to the large proportion of crime recordings of 'unknown' or 'other ethnicities'.

4.4 Sexual Violence

Highlights from the updated sexual violence needs assessment for Gloucestershire:

- 4.4.1 There were 1,827 sexual offence crimes recorded on the police database between April 2010 and September 2013, representing a 12% decrease compared to the previous reporting period.

4.4.2 86% of victims are female, in line with national findings.

4.4.3 Girls and young women in the 10-19 age range are most likely to be recorded as a victim of a sexual offence crime, with the highest prevalence at age 14 years.

4.4.4 Hotspots showing the highest volume of sexual offences are found in areas of deprivation, as is the case nationally.

4.4.5 Data for adult and child rape show that compared with other police forces in England and Wales, Gloucestershire is overall in line with the average.

4.5 Working in Partnership

4.5.1 Monitoring and evaluation of specialist DASV services for victims, including programmes for perpetrators, are providing valuable information to add to the story in Gloucestershire. A monitoring group has been convened by Gloucestershire County Council, bringing together a range of agencies to pool information and work on joint solutions.

5 What people tell us matters - stakeholder engagement

Engagement with stakeholders has led to a wide range of views being reflected in the development of this commissioning strategy – in acknowledgement that the success of the strategy is reliant on the support and participation of stakeholders and customers saying what they feel can make a difference. Engagement is an ongoing process and will continue for the time span of this commissioning strategy 2014 – 2018. We have drawn on engagement events from the last three years, as part of the ongoing process, and organised specific events between October 2013 to April 2014 to specifically get feedback on where we are now and what is needed for the future. The views expressed are largely in line with national findings and add qualitative information to building the story of DASV in Gloucestershire.

5.1 Views from the multi-agency DASV Fora (covering all district council areas and representing the statutory, voluntary and private sectors) demonstrated general support for the approach and model of service provision in Gloucestershire – specialist

DASV services, survivor programmes and perpetrator support are working well. Suggestions for what we can do better over the next few years included:

- 5.1.1 effective education programmes for children and young people on the importance of healthy relationships;
- 5.1.2 training and awareness raising for frontline professionals to identify and respond to people affected by DASV;
- 5.1.3 increased specialist support for children and young people;
- 5.1.4 ensuring sustainable funding for services;
- 5.1.5 greater awareness as part of a community response to improve reporting and access to services;
- 5.1.6 improved communication between specialist and general services to wrap support around the family.

5.2 Views from the DASV Survivor Forum event held in November 2013 built on previously gathered information through ongoing engagement. As well as celebrating and bringing survivors together in unity, the event was used to ascertain views of how services respond to victims.

- 5.2.1 Survivors felt they were not always listened to by the police and that they were often being judged; they wanted the police to give them more information about the process they needed to go through and suggested that the police receive more training in responding sensitively and in completing risk assessments.
- 5.2.2 Survivors felt that children's social care services were good once they were engaged, and that it is important that they 'clicked' with them. They stressed the importance of being given choices rather than pushed into action, and that more training was needed for social workers to respond effectively.
- 5.2.3 Survivors felt that housing services needed to be more focused on domestic abuse and that they would benefit from a specialist domestic abuse trained housing officer in each local authority area.

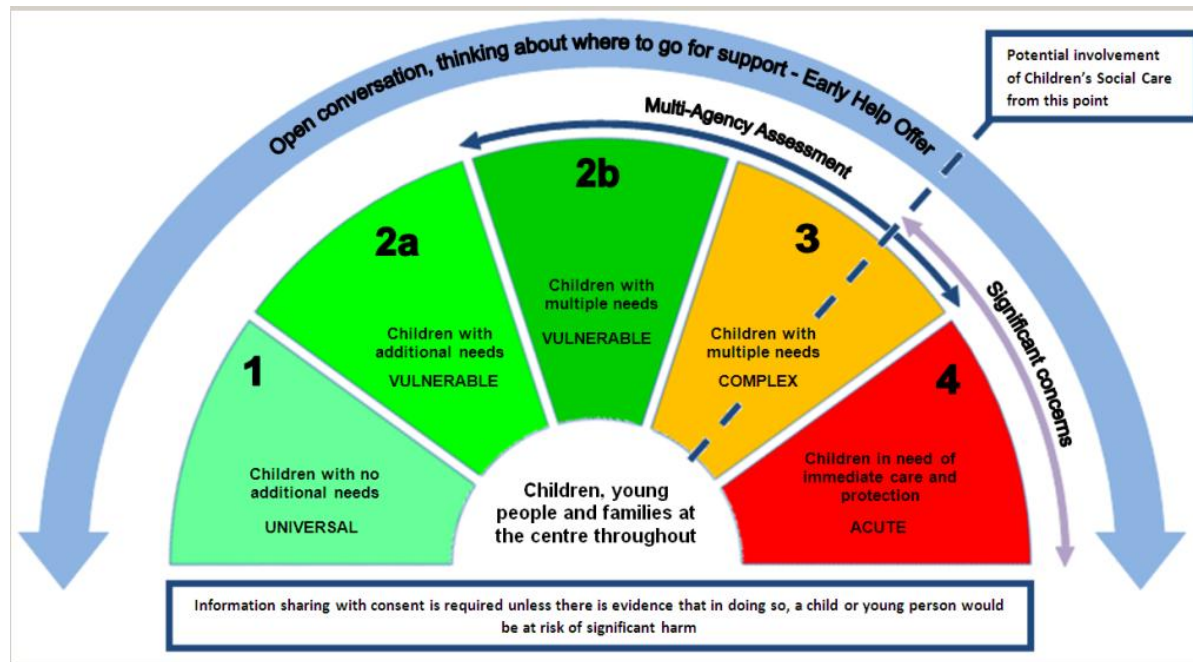
5.3 Views from a small sample of young people aged 16-20 years from local further education colleges were elicited during March 2014, as part of the Association of Chief Police Officers' domestic abuse and violence 'In Focus Week' (52 young women and 20 young men). Key findings included;

- 5.3.1 Most young people understood the definition of DASV to be something that covered a wider range of issues and therefore more than just physical violence
- 5.3.2 most young people would approach their family and friends for information and support, as well as the police; few said they would approach college staff;
- 5.3.3 90% felt that a mobile 'app' would be useful for accessing information and raising awareness; and some would look online.
- 5.3.4 In addition to engagement specifically focusing on DASV we have drawn on the results of other consultations, including the NHS Gloucestershire Clinical Commissioning Group 'Joining Up Your Care' five year communications plan. Themes raised by the public that are consistent with those from our DASV engagement include: information and awareness raising for services; supporting people to help themselves, building on community assets; involvement of people in the planning of services; and care being more joined up and wrapped around the service user.

6 Our local response to individuals, families and communities

- 6.1 Gloucestershire has in place a range of excellent services to protect and safeguard individuals, families and communities from exposure to DASV at the earliest opportunity. Our model includes providing support to achieve and maintain independent living, enabling access to a variety of places of safety, to suit individual needs. The services are delivered by statutory, voluntary and private sectors countywide.
- 6.2 The Gloucestershire Family Information Service (FIS) directory has up-to-date information on a range of services across the county and beyond, including those relevant to DASV, whether specialist or mainstream.

6.3 For children and families, commissioning and delivery of services is aligned to the levels of need and intervention guidance produced by the Gloucestershire Safeguarding Children Board (GSCB, 2014), summarised in the ‘windscreen’ below:



6.3.1 Our aim is to ensure a more integrated approach by partner agencies, with a whole family response across the spectrum of needs by specialist DASV services and mainstream health, social care and voluntary sector services, working to a single set of outcomes.

6.3.2 The essence of this commissioning strategy is to monitor and manage current and future demand for services against the identified outcomes framework, with an increased focus on an integrated family response. Models are currently being rolled out that will contribute to the evaluation of what works, such as the Families First programme, PODs project, and Family Drug and Alcohol Court.

6.4 Gaps in service provision have been identified by commissioners and providers, substantiated by the DASV stakeholder engagement and by national research relating to evidence of effectiveness. They include the need for:

6.4.1 more specialist support for vulnerable young children and families;

6.4.2 more specialist support for vulnerable young people, especially care leavers;

6.4.3 frontline professionals in mainstream services offering support through early identification;

6.4.4 more educational programmes in schools, promoting healthy relationships;

6.4.5 improved access to information and advice at the community level;

6.4.6 more interventions for perpetrators.

7 The financial position and what we can do differently - our approach and commissioning priorities

7.1 The effects of DASV are costly to the public sector purse and are creating increasingly substantial demands, particularly on high end services where the bulk of the investment sits. The cost is borne not only by victims and those at risk of DASV, but also by the wider economy and society as a whole.

7.2 The cost of DASV is measured in terms of: spend on commissioned services (specific to DASV and services that include an element of DASV); hidden costs (for example in education); the value of lost economic output; the human and emotional costs (Walby, 2009). Walby's studies are considered to be the best available evidence on the level, trend and allocation of domestic abuse costs nationally and locally. It is acknowledged that very little of the cost is actually

cashable, but that real time monitoring of spend and effectiveness of services is important for commissioning intentions (Early Intervention Foundation, 2014).

- 7.3 It is estimated that the total cost of domestic abuse could be approximately 10% of national income, measured by GDP (Santos, 2013). In England and Wales the overall cost (including all costs to the state, employers and victims) has been estimated to be £15.7 billion per year (Walby, 2009). The cost to services alone (criminal justice, health, social services, housing, civil legal) totals £3.8 billion per year, with high risk domestic abuse making up nearly £2.4 billion of these costs (CAADA, 2010). The human and emotional costs amount to an estimated £10 billion per year, and loss to the economy £1.9 billion per year.
- 7.4 The estimated cost of DASV in Gloucestershire (excluding 'human and emotional' costs) in 2009 was £58.8 million per year (Walby, 2009). The 'human and emotional' costs were estimated to be £101.4 million per year.
- 7.5 Analysing our current collective spending and potential for savings is essential to making the financial case for reform and managing demand. It will help to develop potential budget alignment and joint agreed investment across partner agencies, to promote sustained savings and to manage increasing demand through, for example, earlier interventions.
- 7.6 Our current collective spend in Gloucestershire on directly commissioned DASV services totals an estimated £5.5 million (including County Council, Police, PCC, Health and District Councils). A more detailed financial analysis is being undertaken by the DASV Commissioning Steering Group, with all relevant agencies examining what they spend on DASV (direct and hidden costs), how they spend it and how effective it is in supporting victims, reducing harm and preventing demand from escalating. It is recognised that many other services are separately funded and delivered especially through the voluntary and community sector, adding value to support for those at risk and for victims in Gloucestershire.
- 7.7 Funding has already been identified and targeted as effectively as possible for specialist services in Gloucestershire, with contract periods extending over the next two to four years, in particular for the Gloucestershire Domestic Abuse Support Service (GDASS). Together with additional resources tied up in mainstream services for children and adults, the task is to identify services to retain and grow, to reshape, invest or disinvest in.

- 7.8 The continuing financial challenges for the public sector are prompting the need to re-negotiate our service responses, for both specialist and mainstream services. Together with findings from consultations undertaken by NHS Gloucestershire Clinical Commissioning Group and Gloucestershire County Council, it is essential that we develop alternative community based responses to support families affected by DASV, and in particular to break the inter-generational cycle.
- 7.9 We have identified some priorities and ways of doing things differently over the next five years, in line with the DASV strategic objectives and outcomes framework.

Strategic objective 1 Focus on early help programmes (alongside specialist services for victims) for individuals and the whole family affected by DASV, taking a risk reduction and recovery led approach to improving health and wellbeing, and reducing crime and disorder.

1.1 Review current providers' responses to and impact on families and individuals affected by or at risk of DASV, to ensure a focus on earlier help/intervention:

- commissioners and providers of DASV services will look at what more they can be doing to identify and respond at an earlier stage to families and individuals affected by DASV, as part of the regular contract monitoring process;
- commission and develop integrated care pathways across health and social care for identifying, referring and providing interventions to support adults, children and families exposed to DASV, and to manage perpetrators.

1.2 Focus on hotspots where the prevalence of DASV is highest, to address the causes and impact of DASV across a range of issues:

- re-wire services around people and places where there is high need and high volume, with a common set of outcomes;
- build on the multi-agency social care test PODs project in Gloucester City , taking a 'toxic trio' multi agency and intervention approach to reduce duplication in service provision and breaking down cultural and organisational barriers to allow innovation and to develop new service delivery models;

- develop an early help model for individuals and families affected by DASV, driving down demand for spend in higher end services, taking a community budget approach such as in Essex and Cheshire West.

1.3 Offer more interventions to perpetrators of DASV to prevent the escalation of violent behaviour, building the evidence base of what works locally and nationally:

- build on existing models of good practice nationally and locally, with robust evaluation to inform future commissioning;
- take a whole family approach with the aim of increasing the safety of the perpetrator's partner and children;
- work with young people to prevent escalation of violent behaviour and to reduce harm;
- ensure links are made between perpetrator interventions and specialist DASV services in relation to risk assessments and safety planning.

1.4 Safeguard and aid the recovery of children and families affected by DASV through community based responses and resilience (social capital):

- promote a zero-tolerance approach to help change social norms around DASV, through information and awareness campaigns;
- build on the educational programmes offered in schools and colleges to promote healthy relationships;
- maximise the use of existing resources to reach children and families wherever they are, taking a systems leadership approach at the community level and build on the ABCD model of co-production;
- build on stakeholder/survivor commitment and willingness to participate more in both the planning and delivery of services;
- develop volunteering and mentoring programmes to complement commissioned services, linking to the Asset

Based Community Development model.
Strategic objective 2 Ensure health, social care, police and other professionals who are in contact with families vulnerable to DASV are confident and competent in their response to support them, creating environments for disclosure
<p>2.1 Build the capacity and competence of frontline professionals to respond to families and individuals affected by or at risk of DASV:</p> <ul style="list-style-type: none"> - frontline staff in all services to be trained to recognise the indicators of DASV and to help people disclose their experiences. This can be undertaken as part of their induction as well as ongoing professional development; - ensure frontline professionals have access to information about specialist DASV services, policies and procedures for people who are exposed to the issue or who are perpetrators.
Strategic objective 3 Provide a co-ordinated approach across partner agencies, aligning the commissioning and delivery of DASV services to ensure effective and efficient use of resources
<p>3.1 Reshape our response to DASV victims, and potential victims, through identifying additional sources of investment e.g. Social Impact Bonds (SIBs):</p> <ul style="list-style-type: none"> - explore the potential for improving social outcomes related to DASV, through collaboration by government, providers and social investors, with the possibility of driving innovation and acting as a catalyst for reform; - take the opportunity through SIBs to save money in the medium/long term and provide VFM, through up-front funding for preventive action; this enables socially minded investors to fund the provision of a service on the basis that they will receive return on investment from government if outcomes/results are achieved.

8 The way forward – implementation plan

A high level implementation plan will be developed to support the DASV commissioning strategy and outcomes framework 2014 - 2018.

The implementation plan will be broken down by financial year, with a year on year review and update. Monitoring and evaluation of the implementation plan will be undertaken against the strategic objectives and outcomes, as detailed in this strategy.

In all implementation activities we will have due regard to the need to:

- Eliminate discrimination, harassment and victimisation and other conduct prohibited by the Equality Act 2010;
- Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it; and
- Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

Proposed implementation activities	Timescale
8.1 Develop a communication plan for the DASV strategy and outcomes framework 2014-2018	2014/15
8.2 Review DASV governance arrangements	2014/15
8.3 Develop a Concordat - detailing Gloucestershire's vision and commitment for supporting victims of domestic abuse and/or sexual violence. Engage with organisations across all sectors and communities in Gloucestershire – to commit to creating supportive communities with a public zero tolerance to DASV.	2014/15

8.4 Agree monitoring and evaluation processes for the strategic objectives and outcomes, to include a single performance framework	2014/15
8.5 Agree timescales and action plans for each priority listed in section 7 of the DASV strategy and outcomes framework	2014/15
8.6 Complete the financial and cost-benefit/value for money analysis, with invest-to-save options	2014/15
8.7 Ensure robust arrangements are in place for Domestic Homicide Reviews, with links to Safeguarding Boards	2014/15
8.8 Develop proposals and recommendations to improve both specialist DASV and mainstream services	2015/16
8.9 Develop integrated pathways for supporting victims and for managing perpetrators	2015/16
8.10 Adapt existing or develop new protocols for information sharing across partner organisations	2015/16
8.11 Monitor implementation of the strategy and outcomes framework, maintaining continuous stakeholder engagement	Annually

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APPENDIX A Gloucestershire Domestic Abuse and Sexual Violence Outcomes Framework 2014 - 2018

<p>Strategic objective 1: Focus on early help programmes (alongside specialist services for victims) for individuals and the whole family affected by DASV, taking a risk reduction and recovery led approach to improving health and wellbeing, and reducing crime and disorder.</p>	
Outcome	Indicators
<p>1.1 Reduced exposure to DASV by children and young people, with rights to safety and family life upheld</p>	<p>Process indicators: Improved parenting support services</p> <p>Access to regular schooling and improved attendance by children</p> <p>Improved educational activities around healthy relationships, including sexual relationships</p> <p>DASV policies and strategies adhered to in schools, further education and early years settings</p> <p>Reduction in the number of re-referrals of children subject to a Child Protection Plan, with DASV as an issue</p> <p>Impact indicators: Children and young people feel safe, are safer and remain safe</p> <p>Children and young people are aware of and understand issues around power and control in relationships and society</p> <p>Fewer children experience being taken into care as a result of exposure to</p>

	DASV
1.2 Improved health and wellbeing of individuals, families and communities	<p>Process indicators: Services wrapped around the family to support stability</p> <p>Improved access to and uptake of health and social care services</p> <p>Improved access to stable accommodation</p> <p>Impact indicators: Children and adults experience improved physical, mental and emotional health and wellbeing</p> <p>Improved sexual and reproductive health and wellbeing</p> <p>Increased resilience of survivors to prevent further experiences of DASV</p>
1.3 Individuals and families achieve economic success	<p>Increased financial stability and independence</p> <p>Access to appropriate benefits</p> <p>Reduced debt</p> <p>Access to training and employment for people affected by DASV</p>
1.4 Individuals, families and communities are safe and feel safe	<p>Process indicators: Improved access to specialist services for victims of crime</p> <p>Re-integration of victims into the community</p> <p>Compliance with statutory orders</p> <p>Increased conviction rate for DASV crimes</p>

	<p>Impact indicators: Increased confidence of victims to access the criminal justice system</p> <p>Survivors experience strong and resilient support networks</p> <p>Survivors have hope and goals for the future</p>
1.5 Communities are stronger in their awareness of and support for victims of DASV, accepting it is the responsibility of all	<p>Impact indicators: Changes in cultural attitudes and societal norms, with more people believing abuse and violence to be unacceptable</p> <p>Developed and/or maintained relationships with neighbours</p>
1.6 Perpetrators change their behaviour and develop respectful, non-abusive relationships	<p>Process indicators: Support programmes delivered and evaluated for perpetrators to address their anti-social behaviour</p> <p>Attendance at perpetrator programmes and increased success rate</p> <p>Increased rate of rehabilitation among offenders</p> <p>Impact indicators: Partner and family relationships are non-abusive and respectful</p> <p>Fewer children and adults experience domestic abuse</p>
1.7 Improved attitudes of young people (especially young men) towards healthy relationships	<p>Impact indicators: Reduced abuse and violence by young people towards partners and family members</p>

Strategic objective 2:

Ensure health, social care, police and other frontline professionals who are in contact with families vulnerable to DASV are confident and competent in their response to support them, creating environments for disclosure at all levels of contact.

Outcome	Indicators
2.1 Frontline professionals (eg teachers, doctors, nurses, midwives, police, prosecutors, voluntary sector organisations) are confident and competent in asking about and responding to DASV at an early stage	<p>Process indicators: Improved awareness and response by cross sector frontline professionals</p> <p>More environments for disclosure available</p> <p>Improved and comprehensive referral pathways</p> <p>Increased referrals to MARAC by agencies other than police</p> <p>Impact indicators: People who find it difficult to access information, advice and advocacy services experience improved access</p> <p>People affected by DASV feel informed and supported</p>
2.2 Employers recognise and support people who are at risk or victims of DASV	<p>Process indicators: Improved policies and strategies for DASV</p> <p>Employers identify and respond to emerging needs</p> <p>Impact indicators: People at risk or victims of DASV experienced improved support by their employers</p>

<p>Strategic objective 3: Provide a co-ordinated approach across partner agencies, aligning the commissioning and delivery of DASV services to ensure effective and efficient use of resources.</p>	
Outcome	Indicators
<p>3.1 Partner agencies are able to measure the difference being made through a single multi-agency strategy and performance framework</p>	<p>Process indicators: Budgets and resources aligned where possible</p> <p>Reduction in repeat victimisation</p> <p>Provision of high quality services based on locally defined needs and assets</p> <p>Improved and integrated pathways developed</p> <p>Agreed approach and methodology in addressing DASV, shared across all partner agencies</p> <p>Protocols developed for information sharing across partner agencies</p> <p>Improved monitoring of outcomes for children and families exposed to DASV</p> <p>Impact indicators: Improved outcomes for health, wellbeing, crime and disorder</p> <p>Reduced prevalence and incidence of DASV across all ages</p>
<p>3.2 Good understanding of the current collective spending patterns enables local partner agencies to resource the DASV strategy</p>	<p>Process indicators: Efficiencies achieved collectively across partner agencies</p> <p>Potential savings identified collectively across partner agencies in the short,</p>

	<p>medium and long term</p> <p>Reduced cost pressures and diverted demand for high cost specialist services</p> <p>Impact indicators: Value for money for public sector purse</p>
<p>3.3 Commissioning intentions for DASV aligned with those for substance misuse and mental health – the ‘toxic trio’</p>	<p>Process indicators: Services wrapped around individuals, families and communities in a coherent way across a range of programme areas</p> <p>Performance management framework includes measures relating to substance misuse and mental health</p> <p>Monitoring of impact of services includes all measures</p> <p>Impact indicators: People experiencing the ‘toxic trio’ get their needs met in one place</p>

Gloucestershire Domestic Abuse and Sexual Violence Commissioning Strategy and Outcomes Framework 2014-2018 – easy read version

Vision

Individuals, families and communities who are at risk of or exposed to domestic abuse and/or sexual violence are able to access information and support to minimise harm, and to maintain healthy relationships. Our commitment is to ensuring a zero-tolerance approach.

Strategic Objective 1

Focus on early help programmes (alongside specialist services for victims) for individuals and the whole family affected by DASV, taking a risk reduction and recovery led approach to improving health and wellbeing, and reducing crime and disorder.

Outcomes

- 1.1 Reduced exposure to DASV by children and young people, with rights to safety and family life upheld
- 1.2 Improved health and wellbeing of families and communities
- 1.3 Individuals and families achieve economic success
- 1.4 Individuals, families and communities are safe and feel safe
- 1.5 Communities are stronger in their awareness of and support for victims of DASV, accepting it is the responsibility of all
- 1.6 Perpetrators change their behaviour and develop respectful, non-abusive relationships
- 1.7 Improved attitudes of young people (especially young men) towards healthy relationships

Strategic Objective 2

Ensure health, social care and other professionals who are in contact with families vulnerable to DASV are confident and competent in their response to support them, creating environments for disclosure at all levels of contact.

Outcomes

- 2.1 Frontline professionals (eg teachers, doctors, nurses, midwives, police, prosecutors, voluntary sector organisations) are confident and competent in asking about and responding to DASV at an early stage
- 2.2 Employers recognise and support people who are at risk or victims of DASV

Strategic Objective 3

Provide a co-ordinated approach across partner agencies, aligning the commissioning and delivery of DASV services to ensure effective and efficient use of resources.

Outcomes

- 3.1 Partner agencies are able to measure the difference being made through a single multi-agency strategy and performance framework
- 3.2 Good understanding of the current collective spending patterns enables local partner agencies to resource the DASV strategy
- 3.3 Commissioning intentions for DASV aligned with those for substance misuse and mental health – the 'toxic trio'