Health and Wellbeing Board
Hertfordshire

AGENDA for a meeting of the HEALTH AND WELLBEING BOARD at The Focolare Centre for Unity, 69 Parkway, Welwyn Garden City, AL8 6JG on TUESDAY 15 MARCH 2016 at 10.00 A.M.

MEMBERS OF THE BOARD (15) - QUORUM 8

COUNTY COUNCILLORS (3)

T C Heritage, R M Roberts, C B Wyatt-Lowe (Chairman)

NON COUNTY COUNCILLOR MEMBERS (12)

H Pathmanathan, N Small, B Flowers, N Bell, Clinical Commissioning Groups,
J Coles, Director of Children's Safeguarding and Specialist Services,
I MacBeath, Director of Health and Community Services,
J McManus, Director of Public Health,
M Downing, Healthwatch Hertfordshire,
L Haysey, L Needham, District Council representatives,
N Carver, NHS Provider representatives
D Lloyd, Hertfordshire Police and Crime Commissioner

Meetings of the Board are open to the public (this includes the press) and attendance is welcomed. However, there may be occasions when the public are excluded from the meeting for particular items of business. Any such items are taken at the end of the public part of the meeting and are listed under "Part II ('closed') agenda".

At a meeting of the Board any member of the public who is a Hertfordshire resident or a registered local government elector of Hertfordshire may put a question to the Board about any matter over which the Board has power or which directly affects the health and wellbeing of the population. Written notice, including the text of the proposed question, must be given to the County Council's Chief Legal Officer at least 5 clear days before the meeting.

CHAIRMAN'S ANNOUNCEMENTS

PART I (PUBLIC) AGENDA

1. MINUTES
To confirm the minutes of the last meeting of the Health and Wellbeing Board on 15 December 2015.

2. PUBLIC QUESTIONS
None received at the time of agenda despatch

3. 0-25 INTEGRATION PROGRAMME (attached)

4. HERTFORDSHIRE HEALTH AND WELLBEING STRATEGY 2016-2020
Presentation outlining the draft strategy, public consultation and recommendations for performance measurement process, with a view to launching the final strategy in June/July 2016.

5. 2016/17 BETTER CARE FUND PLAN (attached)

6. HOUSING AND HEALTH IN HERTFORDSHIRE (attached)

7. DOMESTIC ABUSE IMPROVEMENT PROGRAMME & STRATEGY (attached)

8. ANY OTHER URGENT BUSINESS

PART II ('CLOSED') AGENDA
EXCLUSION OF PRESS AND PUBLIC

There are no items of Part II (Confidential) business on this agenda. If items are notified the Chairman will move:

"That under Section 100(A) (4) of the Local Government Act 1972, the public be excluded from the meeting for the following item of business on the grounds that it involves the likely disclosure of exempt information as defined in paragraph … of Part 1 of Schedule 12A to the said Act and the public interest in maintaining the exemption outweighs the public interest in disclosing the information."

If you require further information about this agenda please contact Fiona Corcoran, Democratic Services Officer, Democratic Services, on 01992 555560, or email fiona.corcoran@hertfordshire.gov.uk. Agenda documents are also available on the internet at http://www.hertsdirect.org/hccmeetings.

Minutes

To:	All Members of the Health & Wellbeing Board	From:	Legal, Democratic & Statutory Services
		Ask for:	Michelle Diprose
		Ext:	25566

HEALTH AND WELLBEING BOARD
15 DECEMBER 2015
M I N U T E S

ATTENDANCE

MEMBERS OF THE PANEL

N Bell, B Flowers, N Small, Clinical Commissioning Group Representatives
J Coles, Director of Children's Safeguarding and Specialist Services
J McManus, Director of Public Health
M Downing, Healthwatch Hertfordshire
T Heritage, County Councillor
D Lloyd, Hertfordshire Police and Crime Commissioner
L Haysey, L Needham, District Council Representatives
N Carver, David Law, NHS Provider Representatives
R Roberts, County Councillor
C Wyatt-Lowe, County Councillor (Chairman)

CHAIRMAN'S ANNOUNCEMENTS

The Chairman congratulated Beverley Flowers on her appointment as Chief Executive for East and North Herts Clinical Commissioning Group.

PART I ('OPEN') BUSINESS

ACTION

1. MINUTES

1.1 The minutes of the Health and Wellbeing Board meeting held on 9 October 2015 were confirmed as a correct record of the meeting.

2. PUBLIC QUESTIONS

2.1 There were no public questions.

3. ANNUAL SAFEGUARDING ADULTS REPORT

[Officer Contact: Elizabeth Hanlon]

3.1 The Board received a report in relation to the work of the Hertfordshire Safeguarding Adults Board (HSAB) and Partnership 2014-15

3.2 Members noted that the role of the HSAB was to:

- maintain and develop inter-agency frameworks to safeguard adults in Hertfordshire
- scrutinise the outcomes of Safeguarding Adult Reviews and key performance data to ensure effective delivery of safeguarding practices in Hertfordshire
- challenge current safeguarding practices in Hertfordshire
- seek assurance that the safeguarding practice delivered by all the key organisations was maintained at highest level
- agree and oversee a strategic plan and publish an annual report

3.3 Members were informed of the new structure and new subgroups that sat within the framework of the HSAB. It was noted that the board met every 2 months and work with the subgroups policies were currently being updated. The HSAB policy had been written and would be published in the New Year.

3.4 The Board was pleased to note that the HSAB was working closely with the Hertfordshire Safeguarding Children's Board to ensure links from childhood to adulthood were in place.

3.5 The Board made some suggestions to be included in the Business Plan, these were:

- improvements to survey's
- domestic Homicide review to be linked to HSAB review
- domestic abuse trends over the years to be included pack

The current Business Plan can be found here

Conclusion:

3.6 The Board noted the progress of the Annual Safeguarding Report and made suggestions as listed in 3.5 above, for inclusion in the HSAB Business Plan over the next twelve months.

Elizabeth Hanlon to action

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4. HERTFORDSHIRE PHARMACEUTICAL NEEDS ASSESSMENT

[Officer Contact: Lisa Olins, Pharmacy Consultant, Public Health Team (01438) 843135]

4.1 The Board received a report in relation to the current position of the Pharmaceutical Needs Assessment (PNA). The report described the background and the NHS regulations concerning the PNA.

4.2 Members were informed that the current PNA was produced in April 2015 and there was a legislative basis for the Health and Wellbeing Board to produce a revised publication by 1 April 2018. The document was a framework for commissioning pharmacy services in defined areas. The Board was informed that the PNA was designed to be progressive document.

4.3 Members were informed of the timescales for the tendering process and estimated cost for the production of the PNA

4.4 The Board was pleased to note the development of the Pharmaceutical Needs Assessment. The Board hoped that all statutory partners such as the NHS and the Clinical Commissioning Groups would contribute to the specification of the PNA to ensure that what was included into the assessment, also worked for all partners.

Conclusion:

4.5 The Board noted the content of the report and agreed the process to seek a contractor to undertake this work.

Joel Bonnet / Lisa Olins to action

5. HERTFORDSHIRE COMPACT

[Officer Contact: Ruth Harrington, Head of Community Wellbeing (01438) 845843]

5.1 The Board received a report detailing the work carried out to refresh the Hertfordshire COMPACT which was a voluntary agreement between statutory organisations and the voluntary sector in a geographical location.

5.2 It was noted the COMPACT was last updated in 2005 and work to refresh it in 2015 had been undertaken by a working group which included representatives from Clinical Commissioning Groups; Police & Crime Commissioner and other service areas throughout the County Council. The draft COMPACT for wider consultation was attached as Appendix A to the report. It was proposed that once responses had been received, the final version of the

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COMPACT would be published early 2016.

5.3 The Board acknowledged officers for the good work carried out on the COMPACT and it was hoped it was a piece of work that could be turned into a shared common cycle. Member agreed that they would discuss the COMPACT further at a future development day of the board.

Conclusion:

5.4 The Board noted the work carried out to refresh the Hertfordshire COMPACT, attached as Appendix A to the report, and noted the consultation process for the draft Hertfordshire COMPACT.

Ruth Harrington to note / action

6. BETTER CARE FUND UPDATE

6.1 The Board received a presentation by Jamie Sutterby, Assistant Director, Health Integration, which provided an update on 'Better Care Fund (BCF) in Hertfordshire', along with an update of progress against the national conditions and performance metrics.
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6.2 The presentation gave the board information on:

- key performance indicators
- integrated care services in Hertfordshire
- the national programme for the Better Care Fund
- transformational projects
- monitoring of the BCF performance and performance indicators
- BCF and the comprehensive spending review

6.3 The Board noted that the number of people being admitted to hospital had increased, although this was not always due to emergency admission but to the number of people that were ill and being referred by GP's. Members also noted that in some circumstances ambulances were called as an emergency, where if there had been health intervention available, i.e. to administer antibiotic, the person possibly could of stayed at home, preventing a stay in hospital which added more pressure to the health system.

6.4 It was noted that the Board needed to work with other partners to understand how the BCF could help achieve better processes to manage people through the health care system more efficiently.

Conclusion:

6.5 The Board noted the presentation.

Jamie Sutterby to note / action

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7. STRATEGY REFRESH AND PERFORMANCE INDICATORS UPDATE

7.1 The Board received a presentation in relation to the process for updating the Hertfordshire Health and Wellbeing Board Strategy, which included the consultation and engagement process with stakeholders across the County.

7.2 The presentation gave an update on progress since October 2015 of the six draft priorities', which included:

- The bigger picture (Health Profile Summary 2015)
- Starting well (0-5)
- Developing well (5-25)
- Living well (25-65)
- Ageing well (65yrs plus)
- Communication and wider engagement

7.3 Members thanked officers for the good work that had been carried out to the update of the Health and Wellbeing Board Strategy and noted that a further update would be presented to the next HWB meeting in February 2016

Jackie Bunce to action

Conclusion:

7.4 The Board noted the presentation.

8. CHILD AND ADOLESCENT DRUG AND ALCOHOL SERVICES REVIEW

[Officer Contact: Jim McManus, Director Public Health (01992) 556884]

8.1 The Board received a report and presentation in relation to the Review of Child and Adolescent Drug and Alcohol Services in Hertfordshire. It was noted that the County Council had commissioned 'TONIC' to review existing drug and alcohol services, including that of the role played by specialist and universal services for young people and families.

8.2 'TONIC' engaged with service users; young people; parent's commissioners; providers and partner agencies to find evidence of what worked. 'TONIC' recommended changes to the service model and the commissioning and governance of young person's drug and alcohol services; these were as detailed in the report.

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8.3 Members were informed that the funding for the proposal was from re-focussing the current 'Young Persons Substance Misuse' funding which was funded by Public Health, Children's Services, Youth Justice and the Police and Crime Commissioner.

8.4 The Board heard that the key elements of the proposed model were, Universal Prevention; Building Resilience and Life skills; Nurturing Wellbeing; Empowering Parents; Interventions, Treatment and Targeted Prevention; Enforcement & Availability and Governance.

8.5 The business case for change was about moving from commissioning and re-aligning the budget. This would result in a potential saving of £5.3m.

8.6 The Board acknowledged the work of officers and 'TONIC' into the Child and Adolescent Drug and Alcohol Services Review, and noted the opportunities for the continued work with the CAMHS Transformation Board Plans.

Conclusion:

8.7 The Board:

a. Noted the report and endorsed the direction of travel agreed by the Steering Group.
b. Acknowledged the significant input of stakeholders to the review.

Jim McManus to note /action

9. MONEY ADVICE UNIT'S MENTAL HEALTH PROJECT

[Officer Contact: Gary Vaux, Head of Money Advice Unit (01438) 843456]

9.1 The Board received a report in relation to the Money Advice Unit's (MAU) contribution to the Year of Mental Health and the progress of the Mental Health Project established in May 2014.

9.2 Members heard of a community based team of money advisors, supporting individuals with mental health problems who also experienced debt problems. The team assisted individual in applying for the relevant benefits for increased incomes which improved their mental health and well-being. The key aim was to reduce the demand on NHS costs by reducing demand for clinical; GP and consultant interventions; medication; hospital admissions and specialist staff time.

9.3 Members were informed that although the amount of funding that was transferred from the Department of Work and Pension to

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Hertfordshire County Council was being reduced, it was noted that due to the success achieved by the project, it would be subject to a further three years' service level agreement with Health and Community Services Commissioning to continue its support to the Crisis Intervention Service until March 2019.

9.4 The Board welcomed the project and the work which had been carried out with the mental health intervention project, and agreed that it was a good example of how all partners worked well together. However, the Board highlighted the fact that further planning needed to take place for the continuation of the support to Crisis Mental Health Service post 2019.

9.5 **Conclusion**

The Board noted the Mental Health Project and the contribution it made to mental health well-being.

Gary Vaux to note / action

10. TRANSFORMING CARE FAST TRACK PROGRAMME

[Officer Contact: Katrina Anderson, Assistant Director, East & North Herts Commissioning Care Group]

10.1 The Board received a report outlining the emerging strategic direction of the Learning Disabilities Transforming Care Programme in Hertfordshire and a briefing on the Hertfordshire's position as a Fast Track Pilot site.

10.2 Members heard that the Fast Track Areas brought together organisations across health and social care with a collective access to £10 million transformation fund and technical support to accelerate service re-design and improvement.

10.3 The Board noted that there would be significant re-shaping to services for people with learning difficulties and autism. The service model for Hertfordshire was a multi-agency integrated approach with shared leadership between Hertfordshire County Council, the Clinical Commissioning Groups and Hertfordshire Partnership Foundation Trust.

10.4 Members were informed that a number of agreed crisis intervention/prevention pilots would be commissioned in 2015/16. These were:

- A crash pad pilot – short term accommodation for situations where there had been a placement breakdown or termination of tenancy.

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- A circles project pilot to deliver community support to people with a learning disability who are deemed to be at high risk of sexual offending
- A crisis 'super' team to support and manage people in their own home for an agreed time, rather than admission to hospital
- A creative rehab project

Members noted that additional funding was allocated to support the workforce development and training.

10.5 Officers agreed that they needed to engage further with local authorities and housing associations in order to assist young people being assessed and to be able to obtain housing arrangements quicker. The Board were informed that ultimately the vision was to be a whole age pathway, but it was noted there was work still to do to engage Children's Services and Education.

Conclusion

10.6 The Board discussed the progress that had been made in relation to the Fast Track Pilot site and supported the overall concept underpinning the model ahead of the pilot being initiated.

Katrina Anderson to note / action

11. ANY OTHER URGENT BUSINESS

There was no urgent business.

KATHRYN PETTITT
CHIEF LEGAL OFFICER **CHAIRMAN**_____

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Health and Wellbeing Board
Hertfordshire

Agenda Item No.

3

HERTFORDSHIRE COUNTY COUNCIL

HEALTH AND WELLBEING BOARD
15 MARCH 2016 AT 10.00 AM

0-25 INTEGRATION PROGRAMME

Report of the Director of Children's Services

Author: Danielle Edwards Tel: 01992 588197

1. Purpose of report

1.1. This report sets out the countywide approach to improving support and services for Children, Young People and Young Adults with Special Educational Needs and/or Disabilities (SEND) in Hertfordshire that is being driven forward by the 0-25 Integration Programme Board.

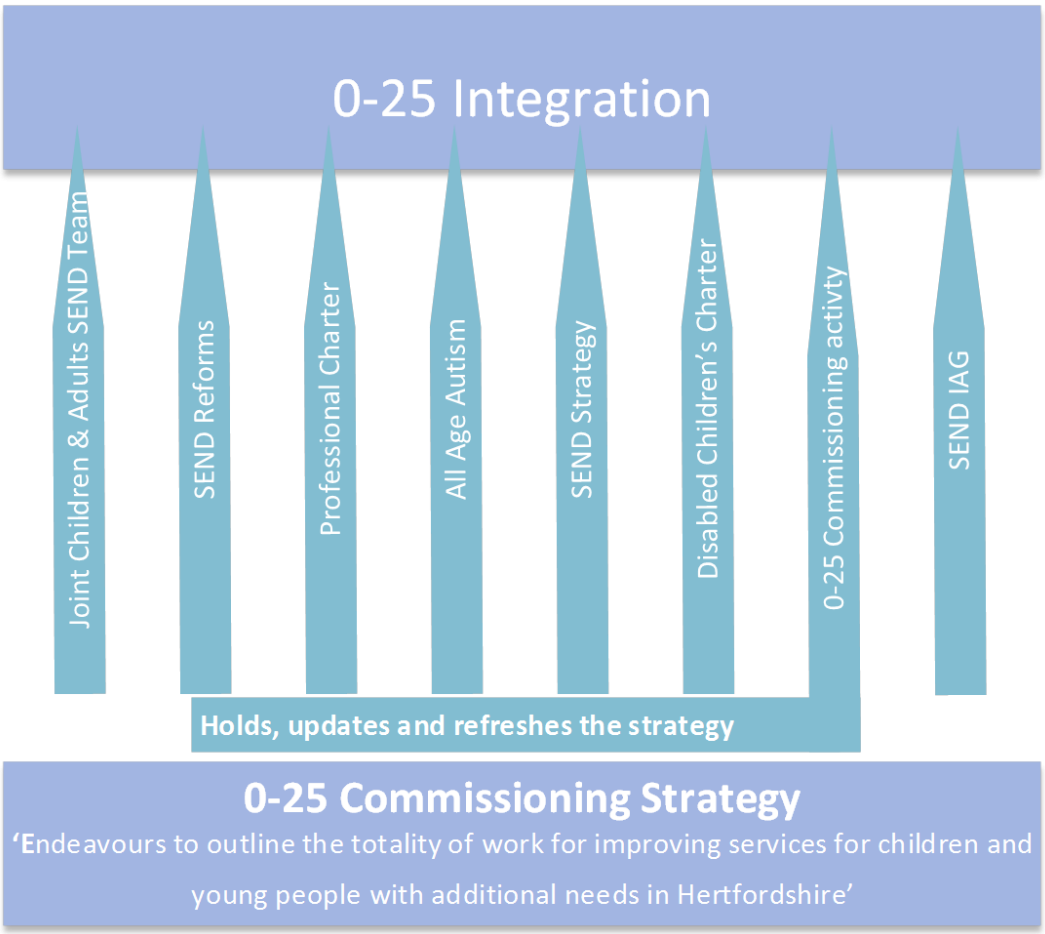
2. Summary

2.1. In Hertfordshire, there are a number of projects and workstreams that aim to improve support and services for Children, Young People and Young Adults with Special Educational Needs and/or Disabilities (SEND) and their families. The 0-25 Integration Programme Board brings together these separate strands of activity to provide oversight, promote alignment and ensure that our countywide ambitions for this cohort are achieved.

2.2. The 0-25 Integration Programme Board membership includes representatives from North and East Herts CCG, Herts Valleys CCG, Children's Services, Health and Community Services, Public Health, Herts Parent Carer Involvement (HPCI), Carers in Herts, as well as representation from Hertfordshire Colleges and Primary, Secondary and Special Schools.

2.3. The Programme board has responsibility and authority for the definition and delivery of the 0-25 Integration Programme. It has ownership of the overall direction and management of the programme, projects and initiatives, and is accountable for delivery.

2.4. The areas of work which feed into the 0-25 board are shown in the image below, with a brief description of each area included in the 'background' section of this report.



3. Recommendation

3.1. The Professional Charter (appendix A) is acknowledged by the Board as a countywide standard for working with Children, Young People and Young Adults with SEND and their families.

3.2. The Board are asked to agree the Disabled Children's Charter evidence file (appendix B) for submission to Every Disabled Child Matters (EDCM).

4. Background

4.1. The 0-25 Integration Programme was set up as part of the wider 'Shaping the Future' programme in Children's Services. It responds to the need for continued development to ensure that the way with we work with Children, Young People and Young Adults with SEND and their families, and the services that we provide for them, are in line with the values that were set out in the 'Support and Aspiration' Green Paper. Consultants from

iMPOWER were contracted in the Summer of 2015 to help us shape our vision for the future.

4.2. Following the review from iMPOWER, work is now underway to develop a joint service between Children's Services and Health and Community Services for disabled children, young people, young adults and their families. A key driver is promoting independence; planning for adulthood from an earlier point and ensuring that we focus on long term outcomes as well as shorter term outcomes. This new service will reduce the number of assessments and plans that service users are subject to, leading to a smoother transition into adulthood and reducing duplication of efforts. The service will combine the current Disabled Children's Service and the Transition Team. As the planning progresses, we will actively seek suggestions and opportunities for how we can further streamline this area by closely aligning with and possibly incorporating other service areas, including Health services. The development of this service is being undertaken with strong involvement from staff, as well as Children, Young People and Young adults with SEND and their families. The new service is due to launch in October 2016.

4.3. The SEND Reforms became law in September 2014 as part of the Children and Families Act. Hertfordshire were a Pathfinder, and latterly a Pathfinder Champion for these reforms. This area of work seeks not only to ensure statutory compliance, but to strive for excellence and to ensure readiness for the new joint CQC and Ofsted SEND Inspection framework which will come into force from May 2016.

4.4. Throughout our time as a Pathfinder authority for the SEND Reforms, and latterly in the development of the 0-25 Integration Programme, parents have highlighted that the systems we put in place will not be successful if we do not ensure that staff are working in the person centred and transparent way that is outlined in the SEND Code of Practice. The Hertfordshire Professional Charter (Appendix A) has been developed to help address this. The Charter was coproduced with Young People, Families and professionals from Education, Health and Care services, and builds upon the professional standards that already exist across the partnership. The Charter was signed off by the 0-25 Integration Programme Board in November 2015, and we are now planning how this is rolled out throughout the workforce.

4.5. The All Age Autism Partnership Board was set up following a review of Autism Services in the County and a review of Autism support in Schools. Although this work goes beyond the scope of the 0-25 Integration Programme, the crossovers are strong and, as such, it is vital that these two work areas are closely aligned.

4.6. The SEND Strategy is specifically focussed on addressing SEND support in Schools and settings. This strategy comprises ten workstreams and will ensure that Children and Young People with SEND have access to high quality local provision that meets their needs. This work area will develop a core quality SEND offer across all schools, settings and local areas, build capacity in local schools, settings and services so that best use is made of resources and facilitate local schools, parents and services to work together in Delivering Special Provision Partnerships to review and improve provision. By the summer term, each of the workstreams are expected to have completed their review and produced options for further developments.

4.7. The Disabled Children's Charter is a national project from Every Disabled Child Matters (EDCM), which asks all Health and Wellbeing Board to agree to a set of pledges which ensure that Children, Young People and Young Adults with Disabilities (including SEN and Health Needs) are well represented in their work. Hertfordshire Health and Wellbeing Board agreed to sign the Charter in March 2015 and, as such, we are due to submit an evidence file which demonstrates how we have been working to meet the pledges. The 0-25 Integration Programme is aligned with the Charter and a multi-agency group have produced this file, which is included for agreement (Appendix B) before it is submitted to EDCM. We still have some way to go before we are fully compliant with the pledges; we have outlined how we will cover the remaining distance within the file and will monitor progress through the 0-25 Integration Programme Board.

4.8. Commissioning has been a major focus of the 0-25 Integration Programme to date, and significant achievements have been made in this area. A new 0-25 SEND Integrated Commissioning Strategy was coproduced with Children, Young People, Families and professionals from across the partnership, and has now been signed off by North and East Herts CCG, Herts Valleys CCG, Children's Services, Health and Community Services and Public Health. This strategy will be driven forward by the new SEND Commissioning Team. Taking a more integrated approach to commissioning in the county will provide opportunities to explore how we can make best use of our resources by pooling, joining and aligning our resources. This area of work is currently governed by the 0-25 Integration Programme Board, but a new governance structure, the SEND Performance and Planning Group, will come into force in the Spring, reporting to the 0-25 board for information only.

4.9. The 0-25 Integration Programme recognises that clear and accurate information must be at the centre of all our work to enable families to support themselves and to ensure that if they do need a service they know

which service would meet their needs and how they can apply for it. The iMPOWER review supported this and went a step further by suggesting that a 'navigation' function be developed for those that need some support but would not meet statutory thresholds. The Information Advice and Guidance (IAG) workstream will review how this function is currently delivered in the county and work with families to ensure that what is provided meets their needs.

Report signed off by	Eg Exec/Board of CCG, Local Authority Board meeting etc
Sponsoring HWB Member/s	Identify Board member(s)
Hertfordshire HWB Strategy priorities supported by this report	Identify which priority/ies: Eg Reducing the harm from tobacco
Needs assessment a Joint Strategic Needs assessment (JSNA) for 0-25 SEND was completed to support this work.	
Consultation/public involvement Public consultation and involvement will be ongoing. Parents are a key strategic partner in this work and their involvement is embedded throughout. Wider involvement with Parent Carers, Children and Young People has been achieved through co-production days and will be further developed through our Young People's Reference Group and Young Commissioners project.	
Equality and diversity implications EQIAs are completed for individual work areas.	
Acronyms or terms used:	
SEND	Special Educational Needs and/or Disabilities
IAG	Information, Advice and Guidance
EDCM	Every Disabled Child Matters
Attachments & appendices:	
Appendix A - 0-25 SEND Integration - Pr	Appendix B - 0-25 SEND Integration - He

Hertfordshire's Professional Charter

We will be honest about what can be achieved

We aim to get it right first time and continue to learn from our experiences to inform changes

We will have the skills to do the job or sign post elsewhere when needed

We will work together in an open and honest way

The views of the child and young person and family will be at the centre of everything we do

We will recognise the strengths and abilities of children and young people and we will build on these

We will communicate clearly and appropriately and in the way that children and young people choose

We will work together towards positive solutions and outcomes

Health and Wellbeing Board Hertfordshire

Hertfordshire's Disabled Children's Charter Portfolio

Hertfordshire Health and Wellbeing Board agreed to sign the Disabled Children's Charter in March 2015. We are committed to working together in partnership with disabled children and young people, and their families to improve universal and specialised services, and ensure they receive the support they need, when they need it.

This evidence portfolio outlines some of the work that has been undertaken in the county to improve the lives of disabled Children, Young People and Young Adults alongside our plans for further developments.

Integrating services for people aged 0-25 that have Special Educational Needs and/or Disabilities (SEND) and for their families is a priority for the Health and Wellbeing Board. The 0-25 Integration Programme is working across all partners to help achieve this.

An update of this portfolio will be developed towards the end of 2016 to review the areas for further improvement that are outlined in this portfolio to ensure that we achieve them.
You can read through the whole file or jump straight to a specific pledge by clicking below. Links to websites and documents are embedded as evidence throughout this document and is also listed in a section called 'evidence' at the end of the document.

1) We have detailed and accurate information on the disabled children, young people and young adults living in our area, and provide public information on how we plan to meet their needs

What we do

Our overall ambition for meeting the needs of Children, Young People and Young Adults with SEND in Hertfordshire is outlined in our 0-25 Commissioning Strategy which is published on our website along with a summary and easy read version. This strategy was developed across the Partnership in Hertfordshire and co-produced with families.

The Local Offer website contains details of all of the services that are available for Children and Young People with SEND and their families; we will continue to improve the Local Offer and develop it as a tool to identify gaps in service provision. The charity Kids are commissioned to administrate the short breaks provision in Hertfordshire; they produce a quarterly report which highlights where they have had requests that we have not been able to fulfil, this data is used to inform our commissioning activity.

We have created a Joint Strategic Needs (JSNA) profile specifically for Children, Young People and Young Adults with SEND aged 0-25. This tool enables professionals to shape services to meet needs locally.

Additional useful analysis can be found on the JSNA for Sensory and Physical Disabilities and the Child and Adolescent Mental Health (CAMHS) JSNA. We also make use of school census data.

We use a variety of methods to keep detailed and accurate information on the disabled children and young people living in the county via the following databases:

- Disabled Children's Team including Short Break Local Offer
- Learning Disabilities and Difficulties (LDD) Youth Connexions
- Details of Children, Young People and Young Adults with Education, Health and Care Plans (EHCPs) held on our internal database system

In addition to these we also have the Herts Additional Needs Database (HAND) which offers families that register access to information via the monthly newsletter and discounts in certain Hertfordshire retailers and leisure facilities.

Plans for further improvement

A commissioning delivery plan is in development which will specifically outline the work that will take place over the next three years. This includes improving our sources of intelligence to ensure that we have an accurate picture of the sort of services we should be commissioning.

Hertfordshire County Council is working with partners to develop an integrated IT solution that is intended to drive integrated practice between education, health and social care services to support the new birth to 25 assessment and care process for those with SEND and their families.

Delivery is being planned in three phases:

- Streamlined recording and management of the statutory process for Education, Health & Care Plans – including information sharing across partner agencies via the Professional Portal

- The extension of EHCP to include online access by children, young people and their families via the Children's Portal

- Support for Personal Budgets, Personal Health Budgets and the management of High Needs Funding payments to schools & colleges

The new system will reduce duplication and increase robustness by incorporating multiple spreadsheets/manual processes in its design.

We have a nominated person to lead on continuing the development of the JSNA, including broadening the dataset to ensure that it makes use of all the appropriate data held across the Partnership. The JSNA will be updated regularly to ensure that it remains an accurate reflection of needs in the county.

2) We engage directly with disabled children and young people and their participation is embedded in the work of our Health and Wellbeing Board

What we do

In Hertfordshire we work hard to ensure that children and young people are at the heart of the services that we provide for them and were commended for our work in our recent Ofsted Inspection:

Particularly noteworthy is the progress the local authority has made in ensuring planning is better influenced by the views of children, young people and carers – an area for improvement in their last inspection of child protection services. Users' views are now routinely sought to inform individual intervention and planning, and also at an organisational level to inform commissioning and strategic planning.

As part of the 0-25 Integration Programme we have developed a Professional Charter, building on the professional standards already in place in Education, Health and Social Care as well as from Voluntary and Community Sector (VCS) organisations and turning them into one, simple set of behaviours that all people working with Children, Young People and Young Adults with SEND can use. One of these behaviours states:

'The views of the child and young person and family will be at the centre of everything we do'.

We have worked with our partners, including Parent Carers, at every stage of this work and so consider it to be an excellent model of coproduction.

Hertfordshire County Council has staff dedicated to developing the involvement of children and young people through the Participation Team and the Youth Engagement Team.

Healthwatch Hertfordshire has a 'Youth Ambassador' that takes an active role in ensuring the voice of young people is heard through Healthwatch. His work has included involvement in:

- Herts Young Carers
- Hertfordshire Partnership University Foundation Trust's CAMHS Youth Council
- Youth Connexions Herts1125
- UK Youth Parliament
- Youth Connexions' 'Who Not What' group

The County Council and its partners are leading on a Young Commissioners pilot to develop the skills of Young People with SEND so that they can take an active role in the commissioning of services. We

are in the process of developing a quality assurance framework which outlines our expectations from the Young Commissioners project, including what we expect from the young people themselves and which pieces of work they will be informing.

We are currently developing a Young People's Reference Group that will have the ability to input on developments in Education, Health and Social Care. The format of this group is being designed by a group of young people and it will sit closely alongside the Young Commissioners work.

In November 2015 more than fifteen young people, many of whom had SEND, attended the 0-25 Integration Programme Board as part of a 'Takeover Day', the young people had the opportunity to fully participate in the board and the session was valuable to everyone involved.

As well as ensuring young people's voice at a strategic level we have been working to ensure that the voice of Children and Young People is clear in their own provision planning. This is common place in our LDD Youth Connexions Service. Staff have received training on personalisation as part of the SEND reforms and ongoing training is provided for Schools through Herts for Learning. Many Schools and Colleges in the county have developed the way that they work with Children and Young People with SEND to put a stronger focus on involving them in the planning of their support. You can look through the 'Local Offers' of Schools and Settings on our Local Offer page.

What our further plans are

Our Youth Engagement Team are working to ensure that Hertfordshire Youth Parliament is more accessible to Young People with SEND by developing Easy Read versions of their materials which will be embedded every year and throughout the system. The team are planning to more actively engage with Hertfordshire Special Schools in next year's elections; involving them in the Priority vote this year as a stepping stone to making that happen and to enable both students and the schools to experience how it all comes together**.**

We recognise that there is more to do to ensure that the voice of Children as well as Young People with SEND is heard at the strategic level, the need to make improvements in this area will be reflected in our commissioning delivery plan.

3) We engage directly with parent carers of disabled children and young people and their participation is embedded in the work of our Health and Wellbeing Board

What we do

Health and Wellbeing Board Members are committed to ensuring that the voice of parent carers is embedded in our work, Herts Parent Carer Involvement (HPCI) are a key strategic partner in all of our work around SEND, you can find out about them here: http://www.hertsparentcarers.org.uk/about/. HPCI are members of many strategic boards across Education, Health and Social Care.

As part of the 0-25 Integration Programme HPCI members produced a document which was agreed at Programme Board outlining how we as a county work with parents. This document has been included as part of other developments in the partnership. The Professional Charter makes it explicit that we expect our staff to put the views of Children, Young people and Young Adults with SEND and their families at the centre of our work.

Parent Carers are involved at the forefront of commissioning by being members of panels and assisting with specification development; parents were a key partner on the Hertfordshire Short Breaks Local Offer tender.

The Hertfordshire CCGs have parent representatives as well as using the NHS 'Friends and Family Test' and other NHS national benchmarking. In the West of the county the Your Care, Your Future project continues to work with all service users to shape the future of services provided in the area.

Hertfordshire have worked directly with a wider group of Parent Carers during consultation and coproduction events from the beginning of our work as an SEND Pathfinder and continue to do so in the 0-25 Integration Programme and beyond.

What our further plans are

The Hertfordshire Health and Wellbeing Strategy is currently being updated; engagement with parent carers will be embedded in the updated strategy.

We will continue to embed the principles of coproduction across the partnership, championing the benefits for working with parents.

HPCI will continue to ensure that they are representative of Hertfordshire parents.

Hertfordshire County Council will explore the viability of specific easy read questions in tender documentation which can be scored specifically by children and young people and parent carers and explore other ways of their input such as marketplace events.

4) We set clear strategic outcomes for our partners to meet in relation to disabled children, young people and their families, monitor progress towards achieving them and hold each other to account

What we do

The 0-25 Joint Commissioning Strategy outlines our strategic objectives for Children and Young People with SEND. We have published this document along with a summary and easy read version.

We hold each other to account as partners through the Health and Wellbeing Board, which comprises representation from the County Council, District Councils, both CCG's, Healthwatch and the Police and Crime Commissioner. Beneath the Health and Wellbeing Board there are a range of multi-agency groups. Our multi-agency boards and panels are also a forum to facilitate quality assurance and monitoring of outcomes.

The 2014 SEND reforms set out the requirement for an accessible 'Local Offer'. Part of the intention of the Local Offer is to monitor the services that are available in Hertfordshire and to assess quality and gaps in provision; there are further plans to develop the Local Offer. To support this function the public are invited to feedback on the services they have used and where they have not been able to find a service that meets their needs.

All contracted providers are expected to work towards the strategic outcomes which are embedded within their contractual arrangements; this is evidenced through contract monitoring arrangements.

The strategic outcomes of the Health and Wellbeing Board partners are referenced in our commissioning guidance.

What our further plans are

Launch of the 0-25 Planning and Performance Group, which will have representation from across the partnership to monitor progress against the 0-25 Commissioning Strategy.

A dataset for 0-24 Special Educational Needs and/or Disabilities will be put in place across the partnership.

5) We promote early intervention and support for smooth transitions between children and adult services for disabled children and young people

What we do

The 0-25 Joint Commissioning Strategy outlines how we promote early intervention for children and young people with SEND. A specific commissioning strategy around Early Intervention is also in development.

The Hertfordshire SEND Strategy focuses on developing educational provision for Children and Young People with SEND by:

- Developing and evaluating a core quality SEND offer across all schools, settings and local areas
- Building capacity in local schools, settings and services so that best use is made of resources
- Local schools, parents and services working together in Delivering Special Provision Partnerships to review and improve provision

The 2014 SEND reforms set out the requirement for an accessible 'Local Offer' website. A high quality Local Offer site will enable children, young people and their families to access information about all services in Hertfordshire related to SEND, including their access criteria, to support them in identifying the service that they need. In Hertfordshire, like everywhere, we still have work to do to ensure that our Local Offer is as good as it can be and we have set up a Local Offer Stakeholder group to help us do so. In addition to the Local Offer the SEND reforms introduced the requirement for a SEND Information, Advice and Support Service (SENDIASS) to be a first port of call for families that need advice and support.

Hertfordshire offer Short Breaks as both a preventative service and a service for those with substantial and complex needs. Short Breaks are part of the continuum of universal and specialist services which support disabled children and their families. To improve families' access to Short Breaks including community leisure and play activities which serve as a Short Break, Hertfordshire has introduced a Short Break Local Offer.

Between 2013 and 2015 Hertfordshire were the Eastern Region Champion for the SEND reforms, in 2014/2015 we held an additional role alongside this as National Champion for Preparing for Adulthood, in recognition of our work around transition. LDD Youth Connexions work with young people to support transition and to ensure that they remain fully at the centre of the process.

The Hertfordshire All Age Autism Partnership Board (HAAPB) is a multi-agency forum that is developing our Autism provision and support across all ages. This support a smoother transition into adulthood.

What our further plans are

To ensure that transition from children's to adults service is smooth for young people with SEND that have more complex needs we are developing a new 0-25 SEND Service which will combine the current Disabled Children's and Transitions teams. This new service aims to ensure a focus on independence and a smooth transition into adulthood for those with the most complex needs.

The 0-25 integration project highlighted that a major issue faced by families is knowing where to go for advice and information. Although SENDIASS and the Local Offer go a long way to addressing this issue there is still much duplication and confusion throughout the system. A piece of work is currently underway to review the whole Information, Advice and Guidance offer for children and young people with SEND in Hertfordshire so that we can ensure that there is a clear and simple system in place that will support families to get the information they need.

The Hertfordshire Health and Wellbeing Strategy is currently being updated. The Disabled Children's Charter will be included under the 'Starting Well and Developing Well' heading.

6) We work with key partners to strengthen integration between health, social care and education services, and with services provided by wider partners

What we do

The Health & Wellbeing Board brings together the CCGs, Public Health, Health and Community Services, Children's Services, District Councils, the Police and Crime Commissioner and Hertfordshire Healthwatch, to plan how best to meet the needs of Hertfordshire's population and tackle local inequalities. Integrating and aligning services for Children, Young People and Young Adults with SEND is one of the key priorities for the board.

Since September 2014 Hertfordshire have been working on a 0-25 Integration Programme with the aim of improving service provision and the service user experience for Children, Young People and Young Adults who have additional needs and their families. Partners from Hertfordshire County Council, Herts Valleys CCG, North and East Herts CCG, Schools, Colleges, Public Health and VCS organisations, including Herts Parent Carer Involvement (HPCI), have been involved in this work which continues to develop new thinking, embed the SEND reforms and provides a platform to drive change.

The 2014 SEND Reforms introduced an increased duty to work in a more integrated way at both a strategic and individual level. The 0-25 Commissioning Strategy, which has been agreed by all key partners, outlines the areas of priority for joint commissioning in the county; our current commissioning priorities are:

- Therapy Services: We will deliver speech and language therapy, occupational therapy and physiotherapy for CYP by the same provider in Hertfordshire, but will be jointly funded by the Local Authority, designated schools money and NHS Clinical Commissioning Groups. This work will ensure that all partners have agreed shared outcomes for CYP, and there will be a single, agreed service specification for the provider to deliver these outcomes.

- Short Breaks: We will commission a wide variety of short breaks across the partnership to meet the needs of disabled young people and their families, in line with the Short Breaks Local Offer. The level of demand is set to increase.

- We will work with CYP with autism, Parents/Carers and health colleagues to ensure a single diagnostic referral pathway, which is compliant with national best practice.
- Specialist Homecare: We will develop the market to ensure that the right level of homecare support is available to families with disabled children, at the right time.
- Mediation: We will continue to ensure that we meet our statutory obligations to provide mediation support to families who need it through the EHCP process, through a joint mediation service.

Operationally, partners in Hertfordshire have worked to develop increasingly aligned processes for assessments and for EHC Planning for children and young people with SEND. A referral form has been developed so that all of the information that multi-agency partners will need to progress an EHC assessment request can be collected at the same time.

What our further plans are

- Closer financial arrangements between the County Council and the CCGs
- The development of Personal Budgets and Personal Health Budgets
- Launch of the 0-25 Planning and Performance Group, which will have representation from across the partnership to monitor progress against the 0-25 Commissioning Strategy

7) We provide cohesive governance and leadership across the disabled children and young people's agenda by linking effectively with key partners

What we do

In Hertfordshire, our Health and Wellbeing Board has excellent representation from both of the Hertfordshire CCGs, Hertfordshire County Council, VCS organisations and other partners.

Both Hertfordshire CCGs have boards with multi-agency membership which focus on integrated physical and mental health services to expectant parents, young people, children and infants whilst ensuring that safeguarding remains at the forefront of delivery.

The many areas of activity that are currently underway in Hertfordshire to improve services for Children, Young People and Young Adults with SEND are brought together in the 0-25 Integration Programme Board. Areas within this work have their own governance such as The SEND Executive, which oversees the Education specific work of the SEND Strategy and the All Age Autism Board whose reach is far beyond 0-25 years.

The multi-agency Strategic Operation Leadership Group (SOL) oversees the implementation of the SEND reforms and strives to ensure not only full compliance but excellent standards in meeting the requirements of the SEND Code of Practice.

The Children and Young People's Integrated Commissioning Executive (CYPICE) oversees all commissioning for Children and Young People in Hertfordshire in the CCGs and in the Council. As we develop closer financial arrangements there will be updated governance and leadership arrangements.

The Directors of Children Service's and Health and Community Services have worked together in the development of the 0-25 arrangements and agreed the launch of the '0-stability' service, which will combine the current Disabled Children's and Transitions teams.

What our further plans are

- Launch of the 0-25 Planning and Performance Group, which will have representation from across the partnership to monitor progress against the 0-25 Commissioning Strategy
- Development of closer financial arrangements between the County Council and the CCGs

Evidence

Commissioning and Service Development	
0-25 SEND Commissioning Strategy	http://search3.openobjects.com/mediamanager/herts/enterprise/files/herts_0_25_integrated_commissioning_strategy_18.pdf
Easy Read Commissioning Strategy	http://search3.openobjects.com/mediamanager/herts/enterprise/files/easy_read_-_0-25_commissioning_strategy.pdf
Young Commissioners pilot	http://childrensservicesnews.hertscc.gov.uk/november-2015/learning-development/shaping-the-future
Commissioning guidance	*Back to Strategic Outcomes section*
Jointly Commissioned Kids service.	*Back to engaging with Parents section*
Local Offer Feedback page	http://directory.hertsdirect.org/kb5/hertfordshire/directory/service.page?id=I3fM14PumvU&familychannel=4
SEND Strategy	https://search3.openobjects.com/mediamanager/herts/enterprise/files/hertfordshiresendstrategy-sept2015_a_.pdf
CYPICE Terms of Reference	*Back to governance section*
Hertfordshire Local Offer	www.hertsdirect.org/localoffer
School's Local Offers	http://directory.hertsdirect.org/kb5/hertfordshire/directory/family.page?familychannel=4-4-1&sorttype=field&sortfield=title
Herts for Learning Training for SEND	http://www.hertsforlearning.co.uk/content/training-and-support
Data and Information	
SEND 0-25 JSNA profile	http://jsna.hertslis.org/top/lifstaggroup/chilyoungpeop/childsen/
JSNA for Sensory and Physical Disabilities	http://jsna.hertslis.org/top/discondis/senphysdis/
Child and Adolescent Mental Health (CAMHS) JSNA	http://atlas.hertslis.org/IAS/Custom/Resources/ChildMentalHealthDetailedPDF.pdf
Herts Additional Needs Database (HAND)	http://www.hertsdirect.org/services/edlearn/css/hand/
School Census	https://www.gov.uk/government/statistics/schools-pupils-and-their-characteristics-january-2015.
Involvement	
HPCI website	http://www.hertsparentcarers.org.uk/about/
Working with Parent Carers	*Back to engaging with Parents section*
Healthwatch Youth Ambassador work	http://www.healthwatchhertfordshire.co.uk/wp-content/uploads/2015/07/Annual-Report-2015-FINAL.pdf
NHS 'Friends and Family Test'	http://www.nhs.uk/NHSEngland/AboutNHSservices/Pages/nhs-friends-and-family-test.aspx
Hertfordshire Ofsted report	http://reports.ofsted.gov.uk/sites/default/files/documents/lo

(November 2015)	cal_authority_reports/hertfordshire/053_Single%20inspection%20of%20LA%20children%27s%20services%20and%20review%20of%20the%20LSCB%20as%20pdf.pdf
Professional Charter	*Back to engaging with CYP section*
Supporting Early and Transitioning Well	
SENDIASS	http://www.hertsdirect.org/services/healthsoc/childfam/specialneeds/educ/parpart/
Short Break Local Offer	https://search3.openobjects.com/mediamanager/herts/enterprise/files/local_offer_fact_sheet_1_1.pdf
Kids Hubs	http://www.kids.org.uk/hub
Local Offer website	www.hertsdirect.org/localoffer
LDD Youth Connexions	http://www.youthconnexions-hertfordshire.org/advice-and-support/young-people-with-learning-difficulties-andor-disabilities/
Other	
EHC assessment request form	https://search3.openobjects.com/mediamanager/herts/enterprise/files/doc_2_ehc_assesment_request_form_nov15_1.doc
Multi-agency EHC Planning 'at a glance' document	https://search3.openobjects.com/mediamanager/herts/enterprise/files/doc_4_ehc_needs_assessment_at-a-glance_aug15v3_1.doc

Health and Wellbeing Board
Hertfordshire

Agenda Item No.

5

HERTFORDSHIRE COUNTY COUNCIL

HEALTH AND WELLBEING BOARD
TUESDAY 15 MARCH 2016 AT 10.00 a.m.

2016-17 BETTER CARE FUND PLAN

Report of the Director, Health & Community Services

Author: Jamie Sutterby Tel: 01992 588950

1.0 Purpose of report

1.1 To provide an update on the 2016-17 Better Care Fund Plan to be submitted to NHS England in April following sign off by Health and Wellbeing Board.

2.0.1 Summary

2.1 Hertfordshire's 2016-17 BCF Plan guidance from NHS England on content and structure of the Better Care Fund Plan was published on the 23rd February 2016. The guidance has required that the Plan contribute towards the ambition to 'integrate health and social care by 2020,' as outlined in the Spending Review, and work is underway to make sure it aligns closely with CCG operational and transformation plans. Submission timescales are below:

- 2 March (provisional first submission) – headlines only
- 21 March (second submission) – first full submission
- 25 April (final submission) – final submission

2.2 As a number of the priorities in the 2015-16 plan were set over a long-term planning horizon, the 2016-17 plan will have a number of areas where we continue to make progress against county wide priorities. They include:

- Further development of the Hertfordshire health and social care data integration work, building upon the capability of our 'Medeanalytics' system, and further progress against 4 agreed priority areas:
  - Interoperability for direct care
  - Live urgent care dashboards
  - Integrated intelligence and further development of risk stratification
  - Infrastructure and provision
- Implementation of joint strategies in other 'enablers' such as workforce planning and estates management
- Delivery of 7 day services:

    - Achieving the national clinical standards for seven day working e.g. integrated discharge planning and service provision
    - Developing system wide plans for extending core hours of community services, including assessment and case management teams, access arrangements, rapid response services and homecare / care home services
- A system-wide approach to reducing delayed transfers of care, as well as improving acute transfer through innovative homecare scheme, e.g. Home from Hospital
- Roll out of the Specialist Support at Home lead provider model, providing enabling home care to support discharge from hospital and prevent admissions into care homes or acute services
- Ongoing development and roll out of community integrated care models, including rapid response. This will expand CCG area coverage with an aim of effective discharge support, a rapid response service and virtual case management.
- Further development and rollout of an Interface Geriatrician-led frailty service in East & North Herts to support frail and elderly patients in the community.
- Roll out of a responsive frailty vehicle service as an alternative response to emergency calls

2.3 Additionally, the 2016/17 plan will outline progress being made in the following areas:

- East & North Herts CCG and HCC Vanguard Programme – investment into the care home workforce via the Complex Care Premium to help improve care to complex residents and reduce the use of inappropriate or unnecessary and expensive crises services.
- Herts Valleys CCG's 'Your Care Your Future' priorities for joining up care closer to home. This includes integration around local 'hubs', frailty services, diabetes, and community urgent care models.
- Ensuring the involvement of Housing Authorities and District Councils in integration of services, for example, work led by District Councils to explore the possibility of a more collaborative model for use of Disabled Facilities Grant monies, which is a part of the BCF.
- Further development of shared finances and risk sharing between organisations in developing the Hertfordshire wide commissioning integration work supported by the Kings Fund, with a view to developing a roadmap towards full health and social care integration by 2020
- Developing a joint HVCCG and HCC commissioning strategy for improvements in care home services, including short-term rehabilitative services, commissioning of long-stay residential and nursing home beds, and continuing care.

2.4 This year's national BCF totals £3.9bn, which includes the Disabled Facilities Grant, rising from last year's £3.8bn. In line with last year, although required to pool a minimum of £74m, Hertfordshire will pool a much larger budget of in the region of last year's £328m. This will enable the joint commissioning of a wider range of health and social care services.

2.5 The final detail of the finances which will make up the Hertfordshire Better Care Fund are, at the time of writing, being finalised. This information will be

brought to the HWB meeting on the 15th March and presented as an addendum to this report, and consequently made publicly available.

3.0 Finances

3.1 Hertfordshire has agreed in principle to continue its contribution to the pooled better care fund from 15/16 into 16/17, covering broadly the same service areas. The table below provides a summary overview of each organisations' contribution, against the nationally expected minimum contribution. It is important to recognise that the size of the fund matches Hertfordshire's ambition to continue towards health and social care integration, and the national better care fund metrics and conditions.

Table 1: Summary of Contributions to the BCF

	Minimum Contribution	Additional Funding	2016/17 Total	2015/16 Total
East & North Herts CCG	32,954	49,201	**82,155**	67,173
Herts Valleys CCG	34,755	63,268	**98,023**	92,844
Cambridge & Peterborough CCG	1,051		**1,051**	1,000
Hertfordshire County Council		116,895	**116,895**	122,609
Total	**68,760**	**229,364**	**298,124**	**283,626**
DFG Allocation			**5,652**	3,070
Social Care Capital Grant				2,302
Total Fund			**303,776**	**288,998**
Add back Client Income				40,817
Total BCF Pool 2015/16				**329,815**

3.2 It should be noted on the table above that these figures are predicted but subject to change as contributions are finalised. It also should be noted that client income will form a part of the Hertfordshire County Council contribution in 16/17, and the 15/16 figure has been altered to allow a like for like comparison.

3.3 A reduction in the contribution by HCC between 15/16 and 16/17 takes into consideration the impact of the financial settlement on the overall budget position of the council, but does not represent a significant proportional change in contribution.

4.0 Recommendation

4.1 That the Board endorse the above high level content for the 2016-17 Better Care Fund Plan, and delegate sign-off of final submission to the HWB Chair.

5. Background

5.1 The Better Care Fund (BCF) is the pooling of funding between the NHS and social care. It seeks to drive integration of services and provide people with the right care in the right setting, including significant investment into care in the community. The BCF Plan details how HCC and the CCGs will use Hertfordshire's BCF allocation over the coming year.

5.2 The 2016-17 BCF Plan will deliver to the same vision and priorities that were outlined in last year's 2015-16 Plan. These sought to:

- Deliver better care for patients and service users
- Reduce reliance and spend on acute services
- Meet national conditions to deliver against the metrics
- Release efficiencies for Hertfordshire County Council and both CCGs to help deliver against efficiency targets.

5.3 In line with last year, the 2016-17 BCF Plan must evidence how Hertfordshire will meet 6 existing 'national conditions', to include a further two added for 16/17:

- '7 day working' in health and social care
- Plans to be agreed jointly between the NHS and social care
- Better data sharing between NHS and social care
- Joint assessment and 'accountable professionals'
- Protection of social care services (not spending)
- Agreement on the consequential impact of changes in the acute sector
- *New condition for 2016-17* - Agreement to invest in NHS commissioned out-of-hospital services, which may include a wide range of services including social care
- *New condition for 2016-17* - Agreement on local action plan to reduce delayed transfers of care

Whereas last year a proportion of funding was subject to non-elective admissions performance, this year's pay for performance framework will be linked to agreement to invest in NHS commissioned out-of-hospital services.

5.4 In line with last year, the BCF needs to deliver against the following national metrics:

- Delayed transfers of care
- Avoidable emergency admissions
- Effectiveness of re-ablement
- Admissions to residential and nursing care
- Patient and service user experience
- Estimated diagnosis rate for people with dementia (locally agreed metric)

Report signed off by	Colette Wyatt-Lowe, HWB Chair
Sponsoring HWB Member/s	Iain MacBeath, Beverley Flowers, Nicola Bell
Hertfordshire HWB Strategy priorities supported by this report	The Better Care Fund proposals relate to the following Health & Wellbeing priority areas:

	• Living well with dementia • Enhancing quality for life for people with long-term conditions • Supporting carers to care • Integrating services

Needs assessment (activity taken)

The Better Care Fund identifies initial priorities for integration based on our understanding of both need in the area and future demographic challenges, which is why the priorities include:

- Support to frail elderly populations
- Long term conditions
- Dementia
- Stroke Care

Consultation/public involvement (activity taken or planned)

The 2015-16 BCF Plan, which forms the basis of this year's Plan, was created further to extensive consultation activity around the BCF process, with patient groups, statutory bodies, provider organisations and the voluntary and community sector. Further consultation, including with NHS providers, is planned to ensure this year's priorities are relevant and coherent with the overall vision.

Equality and diversity implications

Each project that is delivered as part of the Better Care Fund work will be subject to robust equality impact assessments, to ensure the impact on different groups is understood and where necessary mitigated against.

Acronyms or terms used

Initials	In full
BCF	Better Care Fund
CCG	Clinical Commissioning Group
HCC	Hertfordshire County Council
HWB	Health & Wellbeing Board

Health and Wellbeing Board
Hertfordshire

Agenda Item No.

6

HERTFORDSHIRE COUNTY COUNCIL

HEALTH AND WELLBEING BOARD
15 MARCH 2016 AT 10.00 a.m.

HOUSING AND HEALTH - REPORT OF THE PUBLIC HEALTH BOARD

Report of the Director of Public Health

Author: Bethan Clemence Tel: 01982 555363

1. Purpose of report

1.1 To share with the Health and Wellbeing Board the draft work undertaken to understand the role of housing services across Hertfordshire and their links to health and wellbeing.

1.2 To enable and facilitate discussion about next steps in the context of the report's recommendations.

2. Summary and Background

2.1 The role of housing in determining good health and wellbeing is recognised by both the Public Health Board and Health and Wellbeing Board as a clear priority. In September 2015, the Public Health Board requested that work was undertaken to understand the scope and scale of housing services across the county and how these services link to, and may influence, health and wellbeing. The Director of Health and Community Services also led a piece of work by the Housing Local Improvement Network recently on housing and care.

2.2 These initiatives, and the recent King's Fund report on the important role of District Councils in health and wellbeing, underline the need for the Board and partner agencies to have a considered approach to the strategic importance of housing for better health.

2.3 The current draft report represents the outcome of this project and asks a number of fundamental questions in order to identify gaps and priorities moving forward:

- How does housing impact health and wellbeing, and what is the Public Health interest?

- What housing services are delivered across Hertfordshire?
- Are there any gaps in those services, that impact on health and wellbeing?
- What role can partners play, in the provision of housing services, to improve health and wellbeing?

2.4 The scope of the project covers the following areas of investigation:

- **Housing Quality**: the health impact of housing that is in poor condition. These are conditions that represent a threat to the health or safety of the occupant and include issues such as poor energy efficiency, trip hazards, damp and mould, fire risks, etc.

- **Housing Availability**: the health impact of the absence of secure accommodation and homelessness. This covers rough sleeping, but extends to the provision of temporary accommodation and support to access stable housing.

2.5 To avoid duplication with work being undertaken elsewhere, the scope of the report does not cover either **Housing Accessibility** (home adaptions, specialist housing, supported living services) or **Housing Supply** (the planning and supply of new housing). However, stakeholder engagement did cover both of these areas and, in particular, there are clear links that can be made with Health and Community Services and its partners in the provision of housing accessibility services.

2.6 The report has not made concrete recommendations. It is assumed that this is for a discussion between partners since this would involve making assumptions about the priorities and resources available to the various stakeholders involved. A further discussion will be held to identify:

- the priorities going forward;
- who will lead on delivery of certain priorities; and
- what resources can be made available to support this.

2.7 Members of the Health and Wellbeing Board are asked to consider and feed into the Draft Final version of the report. Various stakeholders who engaged with the work have the opportunity to comment over the latter half of February, with a final report submitted to the Public Health Board for consideration on March 11. Views of Members about which forum/fora to take forward this agenda through would be welcomed.

3. Recommendation

3.1 That Board members consider the proposed next steps within the report and how they can be progressed:

- With due consideration to joining up with other, related, strategic priorities, especially linking with work led by the Director of Health and Community Services; and

- In the context of no budget or staff resource currently available amongst partners for delivery.

3.2 That Board members consider how this work might inform the ongoing Strategy refresh.

4.0 Further detail

4.1 Further detail can be found in the attached Draft Final Report.

4.2 There are no financial implications at this stage. However, the report highlights a number of areas where further work could be undertaken to either build on existing areas of good practice, or fill gaps in delivery.

4.3 Any future work will require resource, either through increasing staff capacity at one or more partner organisation, or through direct project funding.

4.4 There is currently no funding identified to support further work.

Report signed off by	Public Health Management Board, Public Health Board
Sponsoring HWB Member/s	Jim McManus
Hertfordshire HWB Strategy priorities supported by this report	The influence of housing upon health and wellbeing is such that it will link to Healthy Living, Promoting Independence and Flourishing Communities.
Needs assessment (activity taken)	
Consultation/public involvement At the point of writing, informal consultation on the draft final report	
Equality and diversity implications An EQIA has been undertaken, monitored and updated throughout the course of this work and available on request. In summary however, any outcomes of this report are anticipated to have positive implications, but monitoring and further evidence will be required.	
Acronyms or terms used. eg:	
Attachments & appendices:	
 Draft final report - Housing and Health ir	

Health and Housing Project

Draft Report to the Public Health Board

Contents

Executive Summary

Introduction

The role of housing in determining good health and wellbeing is recognised by both the Public Health Board and Health and Wellbeing Board as a clear priority. This report asks a number of fundamental questions in order to identify gaps and priorities moving forward:

- How does housing impact health and wellbeing, and what is the Public Health interest?
- What housing services are delivered across Hertfordshire?
- Are there any gaps in those services, that impact on health and wellbeing?
- What role can Public Health and partners play, in the provision of housing services, to improve health and wellbeing?

The scope of the project covers the following areas of investigation:

1. **Housing Quality**: This project has looked into the health impact of housing that is in poor condition. These are conditions that represent a threat to the health or safety of the occupant and include issues such as poor energy efficiency, trip hazards, damp and mould, fire risks etc.
2. **Housing Availability**: This project has looked into the health impact of the absence of secure accommodation and homelessness. This covers rough sleeping, but extends to the provision of temporary accommodation and support to access stable housing.

In order to avoid duplication with work happening elsewhere, the scope of this project does not cover either **Housing Accessibility** (home adaptions, specialist housing, supported living services) or **Housing Supply** (the planning and supply of new housing)

Housing Quality

A review of the literature indicates that there is clear evidence of the health impact of poor quality housing. Much this impact relates to indicators on the Public Health Outcomes Framework, as well as Public Health priorities around health inequality and healthy life expectancy.

There is also evidence that Hertfordshire has a significant number of homes in poor condition, particularly in the private sector. The continued growth in the size of the private rented sector, and in the numbers of older people living in general accommodation, is also cause for concern.

The main providers of home improvement services in Hertfordshire are those offered by District & Borough Environmental Health, Hertfordshire County Council Community Protection, and Herts Healthy Homes:

- **District & Borough Environmental Health**: Challenges remain around the proactive identification of homes in poor condition (particularly housing in the private rented sector), and limited staff and financial resources. Although the use of data varies, some Districts have been successful in developing intelligence on the condition of housing in their area, and this data has the potential to better target housing interventions.
- **Safe and Well Visits**: HCC Community Protection are developing a new 'Safe and Well' visiting service that is likely to include advice, support and referral around home warmth, security and fire prevention to around 8,000 homes per year. It is important that there is sharing of data and intelligence on both vulnerable people and poor housing from housing, health and social care providers to help target these visits effectively.
- **Herts Healthy Homes:** This service offers housing interventions, from advice to home repairs, to help vulnerable people stay independent. Together with the above services, it represents a good range of provision to help tackle poor housing. However, there are challenges around generating referrals, and there is a need to increase the number of referrals from health providers including GPs, in order to make best use of these existing services.

Housing Availability/Homelessness

People who are homeless are much more likely to have health problems, particularly around mental health and substance abuse, and place greater demands on acute health services. At the same time, they are less likely to access community based health services.

In this paper a number of issues with housing availability/homelessness have been identified:

- **Homeless prevention:** Hertfordshire's rate of statutory homeless acceptances is slightly higher than the England average, and there are districts/boroughs where the level is much higher. In addition there are concerns that the expected growth in homelessness is coinciding with increased financial pressure on providers of homeless prevention and support services. There are also gaps in the provision of shelter for rough sleepers in certain Districts. The relationship between homelessness and poor health makes this a health as well as housing concern.
- **Hospital discharge:** Challenges were identified around the co-ordination of hospital discharge for patients who require housing support. This creates the risk that people with housing needs are being discharged from hospital and becoming homeless, or being placed in inappropriate temporary accommodation, both of which may have health consequences, particularly with patients with mental health needs.
- **Adults with complex needs:** Problems also exist in supporting adults with complex needs to access appropriate accommodation. There needs to be

more done to ensure that adults with housing, substance abuse and/or mental health needs receive sustained multi-agency support. For adults who have a combination of acute substance abuse, mental health and housing problems there is no single service that is able to provide them with the support they need to access appropriate accommodation or prevent recurring homelessness. This has an inevitable health impact as well as causing the repeated use of health or housing services.

Next Steps

This report has refrained from making concrete recommendations as doing so would involve making assumptions about the priorities and resources available to the various stakeholders involved. Further discussions are needed to identify: the priorities going forward; who will lead on delivery of certain priorities; and what resources can be made available to support this.

Housing Quality

Theme	Action	Opportunities
JSNA	The JSNA currently has a Housing chapter, but this it is recognised that it can be developed further. The chapter can be updated in light of this report and any work taken forward as a result. However, further exploration of how this might look is required given that the JSNA is currently undergoing review.	
Data and Intelligence	Explore how the evidence and data from this report and the Building Research Establishment's Housing and Health Cost Calculator can: • inform the JSNA • promote the value of the work of housing improvement services to the wider health and social care sector Oversight is needed of the housing intelligence available across the District and Boroughs, with consideration of how: • data can be most effectively shared to support the work of	Evidence of the relationship between health and housing creates incentives for providers of health and housing services to work in partnership. The development of improved housing intelligence makes it possible to both demonstrate the health impact of housing services and identify areas of housing where interventions are likely to have the greatest health impact. The Excess Winter Deaths report (see pp24). recommended improving identification of householders at risk by training and data sharing with health

	existing services across Hertfordshire • how housing intelligence can be developed countywide	services and local authorities
Safe and Well service development	Explore the opportunities to support the sharing of data on vulnerable people between health and social care providers for the purposes of Safe and Well visits	There is currently an opportunity to make appropriate links between Environmental Health Officers and Community Protection in the development of Safe and Well visits to address the full housing situation of the vulnerable people using the service.
Referrals	Consideration is needed into how the number of referrals into home improvement services, particularly from health providers, can be improved, in order to make best use of existing services.	The Excess Winter Deaths report highlighted the importance of improving the number of referrals and awareness of services to address cold homes, including those from health providers such as GPs
Protecting and expanding home improvement services	There is justification for exploring the business case for protecting or expanding home improvement services such as Herts Healthy Homes. This can include the consideration of proposals for housing improvement projects that are targeted at the worst homes and/or most vulnerable people, and therefore have the greatest potential health impact.	The existence of a range services to address poor quality housing, which are having a health impact, means that there is a good foundation of services that can be built upon. The Excess Winter Deaths reported recommended the creation and implementation of strategies to address excess winter deaths and fuel poverty, and to develop an action plan to tackle falls, including potential physical changes to the home.

Housing Availability

Theme	Description	Opportunities
JSNA	As above	
Partnership working	Closer working relationships are needed between partners in the following areas: • Improving the co-ordination between health and housing services around of the hospital discharge of patients needing housing support	Public Health has good links with the NHS, other County council departments and District & Borough councils, which can be used to help link up housing and health providers. There are also forums such as the Health and Wellbeing Board or the Public Health Board that can support partnership working.

	• The exploration of how access to open access emergency night shelter can be improved for adults with substance abuse issues or for residents of Districts/Boroughs lacking adequate provision. • The development of multi-agency services to support adults with complex needs to access and maintain stable and appropriate accommodation.	There is currently a research project underway at Stevenage Haven Hostel (funded by North Herts District Council) aiming to investigate the health benefits of the services offered by the hostel, and the effectiveness of local health services in engaging with homeless people. This scheduled to complete in April 2016.[1] There is a pilot underway in Hertsmere and Three Rivers to offer multi-disciplinary support and access to services to adults with complex needs Watford Borough Council are developing a Single Homeless Pathway that has the potential to provide supported housing to single people with an additional need
Protecting and expanding homeless prevention services	There is justification for exploring the business cases for protecting or expanding homeless prevention activities	Evidence of the relationship between health and housing availability can serve as an incentive for providers of health and housing services to work in partnership.

[1] http://www.stevenagehaven.org.uk/news/28-north-herts-street-homeless-research-project

Table 1: Stakeholder housing roles

The table below gives an overview of what this report was able to identify as the functions of key housing stakeholders. Although this table will inevitably not capture every housing stakeholder or housing service, it demonstrates where there are overlaps between the various stakeholders and services.

	Housing Theme	Stakeholder Function				
		District & Borough Councils	**Housing Associations**	**HCC Health and Community Services (HCS)**	**CCG/other NHS**	**Other**
Housing Quality	**Enforcing minimum legal standards in private rented accommodation**	Private rented accommodation enforcement and regulation of homes of multiple occupation				HCC Community Protection Fire Home Safety Visits
	Improving the condition of social housing stock	Have direct responsibility for council owned housing and work in partnership with housing associations	Responsibility for the condition of their housing stock			HCC Community Protection Fire Home Safety Visits
Vulnerable people	**Providing home improvement services and advice to vulnerable people**	Manage the provision of Disabled Facilities Grants and other home improvement grants and advice	Advise vulnerable residents on home energy	Herts Healthy Homes home visits and grant funded improvement services Herts Equipment Service (funded by HCS and NHS to provide minor home adaptions) Telecare services	Herts Equipment Service Herts Healthy Homes (funding and referrals) Telecare services	Various voluntary sector services, some part funded by public sector organisations HCC Community Protection: Fire Safety Visits, Herts Home Safety Service, new Safe and Well visits
	Other supported living services to help older people and people with physical disabilities remain independent		Offer various low-level informal services e.g. support for older people to get online	Home based independent living services (e.g. domiciliary care) Integration team partnership over home based health services e.g. HomeFirst Community Wellbeing funded services (including home visiting, befriending, meals on wheels , Herts Community Meals and hospital discharge support HertsHelp and Community Navigator funding	Various forms of hospital discharge co-ordination HertsHelp and Community Navigator funding and referral Home based health services e.g. HomeFirst	
	Provision of specialist accommodation for older people and people with physical disabilities	Take an interest in supporting the development of specialist housing for older people and people with physical disabilities Sit on dual district accommodation boards with HCS	Development/improvement of sheltered housing schemes and flexi-care	Integrated Accommodation Commissioning team (main commissioner of specialist accommodation places) Coordinate dual-district accommodation boards		Public Health coordinate JSNA on 'Housing for Adults with Additional Needs'
Homelessness	**Housing for homeless people in priority need groups**	Manage housing register and council owned social housing, support access to private sector accommodation and provide temporary accommodation	Support the provision of social housing and temporary accommodation			
	Housing support for adults with complex needs (housing need combined with mental health or substance abuse related needs)		Some housing associations offer accommodation for single homeless with additional needs	Integrated Accommodation Solutions funds specialist housing for people with complex needs HCS Integrated Care is delivering a pilot complex needs service in Hertsmere and Three Rivers	Hertfordshire Partnership Foundation Trust provide in-patient and floating support services to people with mental health needs	Public Health coordinate JSNA on 'Housing for Adults with Additional Needs' YMCA and other homeless charities provide housing and support for single homeless people with additional support needs Public Health fund supported housing for people recovering from drug and alcohol addiction
	Homeless prevention	Have a broader responsibility around the long term planning of affordable housing Housing options, private sector landlord liaison, tenancy sustainment and rent deposit schemes	Some housing associations provide tenancy sustainment support to vulnerable residents	Hospital discharge coordination, Herts Help and Community Navigators (see above)	Hospital discharge coordination, Herts Help and Community Navigators (see above)	Public Health coordinate JSNA on ''Assessment of Homeless People's Needs' Herts Young Homeless (mediation, crash-pad, advice and education programmes) – funded by HCS, Public Health, Children's Services and some District & Borough Councils Herts Young Homeless Dual-Diagnosis support
	Night Shelter (open access)	District & Borough Councils work in partnership with night shelters				A number of homeless charities provide open access emergency shelter

1. Introduction

1.1 Purpose, Objectives and Scope

1.1.1 The role of housing in determining good health and wellbeing is recognised by both the Public Health Board and Health and Wellbeing Board as a clear priority. Understanding the housing and health agenda across Hertfordshire is an important step towards taking action.

1.1.2 There are already Joint Strategic Needs Assessments (JSNA) on the 'Health needs of homeless people' and 'Accommodation for adults needing support', as well as a HertsLIS profile on housing[2]. These resources give an introduction to some of the themes discussed in this report. However this report wanted to give a more comprehensive overview of the housing agenda in Hertfordshire, and the relationship it has with health and wellbeing.

1.1.3 This report asks a number of fundamental questions in order to identify gaps and priorities moving forward:

- How does housing impact health and wellbeing, and what is the Public Health interest?
- What housing services are delivered across Hertfordshire?
- Are there any gaps in those services, that impact on health and wellbeing?
- What role can Public Health and partners play, in the provision of housing services, to improve health and wellbeing?

1.1.4 'Housing' represents a potentially vast array of services, from town planning to social care. The scope of the project covers the following areas of investigation:

1. **Housing Quality**: This project has looked into the health impact of housing that is in poor condition. These are conditions that represent a threat to the health or safety of the occupant and include issues such as poor energy efficiency, trip hazards, damp and mould, fire risks etc.
2. **Housing Availability**: This project has looked into the health impact of the absence of secure accommodation and homelessness. This covers rough sleeping, but extends to the provision of temporary accommodation and support to access stable housing.

1.1.5 The project also initially explored **Housing Accessibility** - the provision of home adaptions, specialist housing and supported living services. However it has become clear that there are other workstreams exploring the development of these services, and this project does not want to duplicate

[2] http://jsna.hertslis.org/top/healtdemo/accomo/

these efforts. There is an overview of current provision of these services, local context and existing workstreams in Appendix C.

1.1.6 The scope of the project does not include **Housing Supply** i.e. the role of planning and development of new housing and its relationship with health and wellbeing. This is already being addressed, from a Public Health perspective, in the wider work of the Planning and Place Agenda.

1.2 Methodology

1.2.1 The project has employed the following methodology to answer the above questions:

- Meetings with stakeholders both from Hertfordshire County Council (HCC) and other organisations across the County (see Appendix B).
- A literature review into the impact of housing on health and wellbeing, including relevant legislation and policy, and examples of best practice (See Appendix A)
- Desk based research into the operations and strategies of providers of housing services, to gain a greater understanding of their priorities and challenges

1.2.2 It should be noted that, due to the scale of the subject and resource available, not every stakeholder could be engaged with. This includes NHS mental health providers and housing associations. The findings of the project must be seen in light of this limitation.

1.3 Structure of this paper

Chapter 2 of this paper discusses the research into the health and wellbeing impact of the various aspects of housing, and how these link to HCC Public Health's priorities and the Public Health Outcomes Framework.

Chapter 3 looks at the local housing context by discussing what is known about the prevalence of poor housing and the extent of homelessness, and the likely health impact both.

Chapter 4 is an evaluation of the housing services delivered across the County. This will include an analysis of these services to understand if there are any gaps in provision relevant to health and wellbeing.

Chapter 5 will include a summary of the main conclusions of the report, and possible next steps.

2. Housing and health: The Public Health Interest

2.1 The Health and Financial Impact of Poor Housing Quality

2.1.1 There is a growing body of evidence indicating that poor housing quality has both a negative impact on health, and a corresponding financial impact on health providers (see Appendix B for the full review of the research that informs this section).

2.1.2 This report considers housing quality by looking at the impact of certain housing hazards. A housing hazard is a problem in a home that could harm the health or safety of the occupant[3]. Many of these hazards can be related to health indicators on the Public Health Outcomes Framework; a data tool created by Public Health England that sets out the desired outcomes for public health and how they will be measured[4].

2.1.3 A summary of the impact of specific housing hazards can be found in the section below.

Table 1: The Health and Wellbeing Impact of Poor Housing Quality

Housing Hazard	Health and Wellbeing Impact	Public Health Outcome[5]
Excess cold and damp/mould	Circulatory and respiratory illness amongst older people and children Leading contributor of excess winter deaths Correlates with higher levels or hospital admissions, weight gain and poor educational attainment amongst children Correlates with higher levels of mental illness £850m estimated annual cost to NHS of excess cold	1.02 School readiness 1.17 Fuel Poverty 2.06 Excess weight (children) 2.23 Self-reported wellbeing 4.01 Infant mortality 4.04 Under 75 mortality from circulatory illness 4.07 Under 75 mortality from respiratory illness 4.11 Hospital readmissions

[3] http://england.shelter.org.uk/get_advice/repairs_and_bad_conditions/health_and_safety/health_and_safety_assessments_of_rented_homes

[4] https://www.gov.uk/government/publications/healthy-lives-healthy-people-improving-outcomes-and-supporting-transparency

[5] http://www.phoutcomes.info/public-health-outcomes-framework

		4.13 Health related quality of life for older people 4.15 Excess winter deaths
Hazards related to accidents (falls, fire, entrapment etc.)	Increased occurrences of physical injury and death of children under 5 Links with increased falls amongst older people £480m estimated annual cost to NHS of accidents in the home	2.07 Child hospital admissions 2.24 Injuries caused by falls in over 65s 4.03 Preventable mortality 4.11 Hospital re-admission 4.14 Hip fractures in people aged over 65
Hazards related to exposure to toxins (e.g. carbon monoxide, lead pipes, asbestos)	Lead pipes linked to impaired neurological development amongst children Carbon monoxide poisoning can be deadly, also has negative impact on nervous system	1.02 School readiness 4.01 Infant mortality 4.03 Preventable mortality

Excess cold, damp and mould

2.1.4 Excess cold, damp and mould have a particular impact on older people, people with long term illnesses, and children[6]. Their presence is associated with increased respiratory and circulatory illness[7] [8] in these groups and has also been found to correlate with weight gain, higher levels of hospital admissions and poorer educational attainment amongst children[9]. In addition the World Health Organisation (WHO) estimates that damp and mould can be

[6] Marmot Review 'The Health Impact of Cold Homes and Fuel Poverty. Available online at http://www.cieh.org/policy/housing/poor-housing.html

[7] Ormandy D. 'Housing and Child Health' Paediatrics and Child Health Volume 24, Issue 3, March 2014, Pages 115–117 available online at http://www.sciencedirect.com/science/article/pii/S1751722213002072

[8] J. Stewart M. Rhoden, (2006),"Children, housing and health", International Journal of Sociology and Social Policy, Vol. 26 Iss 7/8 pp. 326 – 341 Permanent link to this document: http://dx.doi.org/10.1108/01443330610680416

[9] See reference 4

linked to the deaths of 83 children across Europe each year due to their association with asthma[10].

2.1.5 Excess cold is a major component of excess winter deaths due to its association with circulatory and respiratory illness, which together account for 70% of deaths[11]. Across Europe, indoor temperatures are a much closer determinant of excess winter deaths than outdoor temperatures[12], and research indicates that increasing the temperature in a person's home can lead to a faster recovery from circulatory illness[13] [14].

2.1.6 In addition to impacting on physical health, excess cold is also linked with poor mental health; people living in the coldest quarter of housing are 5 times more likely to develop a mental health problem than the general population[15].

Other housing hazards

2.1.7 Other housing hazards can have a negative impact on health and wellbeing. These include a number of hazards related to accidents (including accidents related to fire), and exposure to toxins.

2.1.8 Housing hazards disproportionally affect vulnerable groups, including older people and children. Children are particularly at risk of sustaining physical injury from hazards in the home[16]. In Europe home accidents are the leading cause of deaths amongst under 5s[17]. Older people tend spend a greater proportion of their time at home which further increases their risk from housing

[10] WHO: Quantifying Health Impact of Housing available online at http://www.euro.who.int/__data/assets/pdf_file/0017/145511/e95004sum.pdf?ua=1

[11] Public Health England 'Making the Case for Cold Weather Planning'. Available online at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/252854/Cold_Weather_Plan_2013_Making_the_Case_final_v2.pdf

[12] Shaw, M. 'Housing and Public Health' Annu. Rev. Public Health 2004. 25:397–418. Available online at http://www.annualreviews.org.ezproxy.herts.ac.uk/doi/pdf/10.1146/annurev.publhealth.25.101802.123036

[13] Curl A, Kearns A 'Can Housing Improvements Cure of Prevent the Onset of Health Conditions Over Time in Deprived Areas'. http://ud7ed2gm9k.search.serialssolutions.com/?ctx_ver=Z39.88-2004&ctx_enc=info%3Aofi%2Fenc%3AUTF-8&rfr_id=info:sid/summon.serialssolutions.com&rft_val_fmt=info:ofi/fmt:kev:mtx:journal&rft.genre=article&rft.atitle=Can+housing+improvements+cure+or+prevent+the+onset+of+health+conditions+over+time+in+deprived+areas%3F&rft.jtitle=BMC+public+health&rft.au=Curl%2C+Angela&rft.au=Kearns%2C+Ade&rft.date=2015&rft.eissn=1471-2458&rft.volume=15&rft.spage=1191&rft_id=info:pmid/26615523&rft.externalDocID=26615523&paramdict=en-UK

[14] Thomson et al 2013, 'Housing Improvements for Health and related socio-economic outcomes' http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD008657.pub2/abstract

[15] See reference 4

[16] See reference 10

[17] See reference 5

hazards[18]. Older people are particularly at risk from hazards related to fire and falls[19].

2.1.9 As well as being at greater risk, vulnerable people are also more likely to live in non-decent accommodation[20]. Socio-economic exclusion can result in people with poor health being more likely to live in poor housing, which then exacerbates existing health problems[21]. Poor housing quality can therefore be seen as both a cause and consequence of health inequality.

Financial Impact

2.1.10 The Building Research Establishment (BRE)[22] has calculated that the cost of housing hazards to the NHS is approximately £2.5 billion, with the greatest cost coming from hazards related to excess cold and falls. Addressing the most serious hazards would be expected to cost £10 billion nationwide, but the resulting savings to the NHS would repay the cost in 7 years. This implies that there is a financial justification for investment in interventions designed to tackle the most serious of housing hazards.

Conclusion

2.1.11 The evidence that poor housing conditions have a negative impact on health, particularly amongst vulnerable groups, as well as placing additional financial burdens on health providers, indicates the potential positive health impact of interventions to improve housing conditions, especially when focused on the worst housing, and/or the most vulnerable people.

2.1.12 Many of the health issues associated with poor housing quality relate to indicators in the Public Health Outcomes Framework. More generally, the health impact of poor housing suggests that these issues are relevant to Public Health priorities including helping our residents to live longer, healthier lives as well as starting and staying healthy. Finally, the conception of poor housing conditions as being a contributory factor in health inequality fits with

[18] Donald I. 2009 'Housing and Health for Older People' http://ageing.oxfordjournals.org.ezproxy.herts.ac.uk/content/38/4/364
[19] See reference 10
[20] See reference 10
[21] Libman et al. 2012, 'Housing and Health: A Social Ecological Perspective' http://ud7ed2gm9k.search.serialssolutions.com/?ctx_ver=Z39.88-2004&ctx_enc=info%3Aofi%2Fenc%3AUTF-8&rfr_id=info:sid/summon.serialssolutions.com&rft_val_fmt=info:ofi/fmt:kev:mtx:journal&rft.genre=article&rft.atitle=Housing+and+health%3A+A+social+ecological+perspective+on+the+us+foreclosure+crisis&rft.jtitle=Housing%2C+Theory+and+Society&rft.au=Libman%2C+Kimberly&rft.au=Fields%2C+Desiree&rft.au=Saegert%2C+Susan&rft.date=2012-03-01&rft.issn=1403-6096&rft.eissn=1651-2278&rft.volume=29&rft.issue=1&rft.spage=1&rft.epage=24&rft_id=info:doi/10.1080%2F14036096.2012.624881&rft.externalDBID=n%2Fa&rft.externalDocID=364479727&paramdict=en-UK
[22] See the Hertfordshire County Council's Public Health Strategy http://www.bre.co.uk/filelibrary/pdf/87741-Cost-of-Poor-Housing-Briefing-Paper-v3.pdf

the Public Health priority of narrowing the gap between the most and least healthy[23].

2.2 Health and availability of housing/homelessness

2.2.1 The Public Health Outcomes Framework has two indicators relevant to homelessness; statutory homeless acceptances, and adults in contact with mental health services living in stable accommodation. However the health impact of the absence of stable accommodation suggests a broader Public Health interest.

2.2.2 The relationship between health and the absence of stable accommodation can be seen in terms of the direct health impact of homelessness, and the indirect health impact arising from the challenges homeless people face in accessing health services.

2.2.3 The evidence that homeless people have poor health is stark. A survey by Homeless Link[24] found that 41% of homeless people had a long term health condition (against 28% in general population) and 45% had being diagnosed with a mental health issue (25% in general population). Substance abuse is particularly problematic with 39% of homeless people either taking drugs or recovering from a drug problem. Half of homeless people reported drinking or taking drugs to help cope with mental health issues. Issues around substance abuse are particularly relevant to Public Health as a statutory provider of substance abuse related services.

2.2.4 Whilst the above data doesn't indicate whether homelessness is a causal factor in these health outcomes there is evidence to suggest that poor health and homelessness are co-related; health problems can put people at greater risk of losing secure accommodation, and the absence of secure accommodation can cause or exacerbate poor health.

2.2.5 A number of studies have investigated the ways in which the experience of homelessness can contribute to poor health outcomes:

- Rough sleeping can involve exposure to extreme temperatures or damp conditions. This can cause new health problems or exacerbate existing ones[25].
- Rough sleeping can also can contribute to skin and foot problems[26].

[23] http://www.hertsdirect.org/your-council/hcc/publichealth/
[24] http://www.homeless.org.uk/facts/our-research/homelessness-and-health-research
[25] See reference 10
[26] Cited in Hwang 'Homelessness and Health' Available online at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC80688/?tool=pmcentrez#r23-27

- Poor health outcomes can also arise from living in hostels or other forms of temporary accommodation where there can be problems related to hygiene and safety[27].
- Conditions favouring TB outbreaks in temporary accommodation include crowding, large transient populations and inadequate ventilation[28].
- Homeless people (rough sleepers and those living in hostels) are at increased risk of physical violence; a study in Toronto found that 40% of homeless people had been physically assaulted[29].

2.2.6 Substance abuse can be the cause of a person becoming homeless. A survey of homeless people with substance abuse issues found that in the majority of cases drug abuse was the primary reason behind them being evicted from rented accommodation or being asked to leave a family home[30]. Other research suggests that homelessness can make people more vulnerable to developing substance abuse issues as a way of coping with the stress and hardship of daily life[31]. A survey of homeless people in London found that 80% of homeless people had started using at least 1 new drug since becoming homeless and 72% of those with lifetime addictions to cocaine, started taking the drug after becoming homeless[32].

2.2.7 For mental health, becoming homeless can exacerbate existing conditions, and make that person more vulnerable (e.g. to crime or physical harm)[33]. One study suggests that the stress caused by the threat the breakdown of tenancies and experience of eviction can exacerbate existing mental illnesses[34]. However a survey of homeless people with mental health issues found that the primary cause of their homelessness was barriers accessing housing due to low income or unemployment[35], rather than their mental health issues.

2.2.8 This suggests that structural solutions, such as wider availability of low-cost housing and income support, would reduce the risk of homelessness among persons with mental illness, as among other vulnerable social groups.

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[27] See reference 10
[28] An outbreak of tuberculosis in a shelter for homeless men. A description of its evolution and control. http://www.ncbi.nlm.nih.gov/pubmed/1990937
[29] Cited in Hwang 'Homelessness and Health' Available online at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC80688/?tool=pmcentrez#r23-27
[30] 'Homelessness amongst drug users: a double jeopardy explored' International Journal of Drug Policy 12 (2001) 353–369
[31] As Above
[32] Homelessness and Drug Use: Evidence from a Community Sample http://www.sciencedirect.com.ezproxy.herts.ac.uk/science/article/pii/S0749379707001043
[33] 'Mental Health and Homelessness: The Challenge: http://isp.sagepub.com.ezproxy.herts.ac.uk/content/61/7/621
[34] 'Homelessness and Complex Trauma' http://www.homelesspages.org.uk/node/24195
[35] Perceived reasons for loss of housing and continued homelessness among homeless persons with mental illness'. http://www.ncbi.nlm.nih.gov/pubmed/15703344

However it is important to note that mental health can contribute to poverty and unemployment through discrimination or social exclusion, and therefore cause homelessness indirectly[36].

2.2.9 Homelessness can also have an indirect negative health impact due to the barriers homeless people have in accessing health services. People who live in temporary accommodation or are sleeping rough are much less likely to use GP services despite the potential that community based services have to reduce the need for acute care[37]. A review of the health needs and healthcare costs of rough sleepers in London found that barriers to accessing services include discrimination by health professionals, not being allowed to register with a GP, a lack of knowledge of services, a lack of continuity of care, and cost[38].

2.2.10 The difficulty homeless people face in accessing appropriate health care increases their dependency on acute health services. The A&E attendance rates of homeless people are 4 times higher than the general population[39], with 35% visiting A&E in the last 6 months[40]. Homeless people are more likely to be admitted to hospital and stay for longer, due to their acute health needs[41].

2.2.11 Regardless of the cause and effect relationship between health and housing, there are studies indicating the positive impact that the provision of secure housing can have on health outcomes. Two studies found that the provision of housing was associated with decreased substance abuse and less reliance on health services[4243]. A literature review found that people with mental health issues were less likely to become homeless if they were provided with financial assistance to access housing as well as community based health and social services[44].

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[36] See reference 31

[37] See reference 22

[38] http://www.jsna.info/sites/default/files/Rough%20Sleepers%20Health%20and%20Healthcare%20Summary.pdf.

[39] Public Health England 'Preventing Homelessness to Improve Health and Wellbeing' www.homeless.org.uk/.../Final%20Rapid%20Review%20summary.pdf

[40] See reference 22

[41] St Mungos 'Health and Homelessness: Understanding the Costs' www.mungos.org/documents/4153/4153.pdf

[42] 'To House or Not to House: The Effects of Providing Housing to Homeless Substance Abusers in Treatment' http://ajph.aphapublications.org/doi/abs/10.2105/AJPH.2004.039743

[43] Long-Term Housing and Work Outcomes Among Treated Cocaine-Dependent Homeless Persons http://link.springer.com/article/10.1007%2Fs11414-006-9041-3

[44] 'Effectiveness of interventions to improve the health and housing status of homeless people: a rapid systematic review' http://bmcpublichealth.biomedcentral.com/articles/10.1186/1471-2458-11-638

Conclusion

2.2.12 The lack of availability of secure accommodation has a significant health impact. Whilst the worst health outcomes are associated with rough sleeping, living in various forms of temporary accommodation can also have a negative impact. In addition health problems such as substance abuse, and mental health issues, can make someone more likely to become homeless. This suggests a public health interest in services that either prevent homelessness from occurring, support those who are homeless to find more stable and secure forms of accommodation, or supports homeless people to access health services. It also makes the availability of housing and homeless both a health and housing concern.

3: The Local Context: Housing and Health in Hertfordshire

3.1 Housing Quality

Housing Conditions in Hertfordshire

3.1.1 Gaining an understanding of the quality of housing in Hertfordshire is complicated by the variation in housing data across the County. Whilst some District and Borough Councils have started to develop more sophisticated stock modelling techniques (see below for more information), the primary source of evidence is from District and Borough housing stock condition surveys.

3.1.2 Not every stock condition survey was available during the course of this work, and the significant variation in the date they were produced, and methodology employed makes it difficult to compare housing across the County. It is therefore difficult to give a comprehensive analysis on how Hertfordshire performs compares against other areas, or trends of over time. However, a snapshot of the data gives an indication of the extent of housing in poor condition across Hertfordshire:

Table 2 A Snapshot of District & Borough Stock Condition Surveys

Geographical area	% non-decent homes	% non-decent homes in private sector	% vulnerable people living in non-decent homes	Notes
England	**20**	**22**	**-**	
East Herts	49	53	43	Major factor excess cold
North Herts	20	40	52	-
Welwyn Hatfield	-	23	-	Major factors excess cold and fire hazards
Stevenage	-	13	17	-
Watford	23	-	-	Higher than average numbers of vulnerable people in non-decent housing
Three Rivers	-	10	12	-

3.1.3 The variation in data between District/Boroughs, and the likely variation within the Districts/Boroughs themselves, indicates that more needs to be done to understand exactly where poor housing can be found (see Chapter 4 for more information). Nevertheless the above data indicates that there will be areas in the County with poor housing conditions.

3.1.4 In addition to the direct evidence of poor housing quality, there are a number of factors that provide indirect evidence that there may be problems with housing conditions more generally in Hertfordshire.

3.1.5 Firstly, Hertfordshire has seen a huge growth in the demand for private rented accommodation (PRS). In some parts of the County the size of the private rented sector has doubled to become larger than the social rented sector. This is problematic as conditions in PRS tend to be worse than other forms of housing tenure, as suggested both in academic research, local housing stock condition surveys, and the responses from the District and Borough housing staff. In addition, the high demand for PRS reduces the incentives for landlords to improve the condition of rented accommodation, and creates disincentives for tenants to take action against landlords (due to fears of eviction etc.). Therefore the growth in PRS accommodation raises concerns about the conditions of this form of housing.

3.1.6 Secondly Hertfordshire's population is ageing; there has been a significant increase in the numbers of people aged over 65 with future growth expected between 2015-2035[45]. Older people are more likely to own their home, but also to under occupy it[46]. This is problematic because firstly larger homes are harder to heat, increasing the problems caused by housing with poor energy efficiency, and as people age there are increased challenges around home maintenance[47]. Finally older people are more vulnerable to the impact of poor housing conditions, and are at risk from living in homes that are not accessible to those with mobility issues. Therefore an ageing population, living in owner-occupied accommodation, increases the potential health impact of poor housing conditions.

3.1.7 There is no countywide data available that specifically links particular health outcomes in Hertfordshire with poor housing quality. Finding evidence of a direct causal link between a health outcome and housing is always be problematic as ill health is usually the result of multiple factors that can be difficult to disentangle.

3.1.8 Nevertheless there has been a recent report into potential causes of Excess Winter Deaths (EWD)[48], in Watford, Broxbourne and Hertsmere. This has given some insight into the impact that cold homes have on older people and potential interventions/service improvements that could address it.

[45] See the Hertfordshire JSNA on 'Adults Needing Accommodation and Support' http://jsna.hertslis.org/top/healtdemo/accomo/

[46] http://npi.org.uk/blog/housing-and-homelessness/why-targeting-older-people-under-occupation-half-baked-appro/

[47] http://www.ageuk.org.uk/latest-press/archive/home-maintenance-concerns/

[48] See Appendix D for an executive summary, key findings and recommendations

Box 1: Excess Winter Deaths Report

The project surveyed over 65s over a 12 month period in owner-occupied accommodation in order to collect data about them in areas such as health, knowledge and use of health services, finances, behaviour (e.g. physical activity or social contact), and knowledge of benefits/support services.

Housing: The vast majority of those surveyed were owner-occupiers and 70% lived in a house. The average age the property occupied was between 50 and 80 years. 55% of people lived alone and almost all lived in households where all the occupants were over 65. Whilst most of the homes were considered in good condition there were large variations. For example 21% of homes were affected by damp or mould. Homes with widespread mould were associated with poor health amongst the occupants. There was also variation in respondents' knowledge of what constituted a safe indoor temperature, and 28% didn't fully understand how to use their heating system.

Health: Both poor health and advanced age made people more susceptible to excess winter deaths. Respondents had on average 2 health conditions and 2 out of 3 people had a condition that can be made worse by excess cold. In addition, over 12 months of the study there was a general decline in health, particularly amongst over 75s with the main causes including the development of COPD, falls and pneumonia.

Falls: 37% of responds aged over 75 reported having had a fall in the home and, of the total number of responds who had fallen, 85% said falls had led to restricted mobility.

Finances: Over half of respondents had yearly incomes under £16K. There was also a significant reliance on benefits with 45% of those surveyed receiving benefits and over half relying on winter fuel or cold weather payments to stay warm.

Behaviour: Whilst there was evidence of healthy behaviours, there were also some troubling findings. 42% of 65-74 stayed at home all day, mainly due to mobility issues and 64% said their health limited their physical activity. 16% spent longer in bed when cold and 96% did not drink enough water, indicating that improving awareness of healthy behaviour may be important.

Use and knowledge of services: The vast majority of respondents used GP services, on average of 7 times a year. However 23% had used emergency services in last 12 months. In addition 82% had never heard of Hertshelp, and it the report concludes that more needs to be done to promote services available to people.

In addition to this, Welwyn Hatfield Borough Council have commissioned the BRE to undertake a Health Impact Assessment of private sector housing and prospective housing interventions in the Borough.

Box 2: Welwyn Hatfield Housing Health Impact Assessment

The health impact assessment used information from a stock modelling exercise (see chapter 4 for more information) in order to get a better understanding of the health impact of private sector housing and the potential benefits of interventions.

This required an estimate of extent of hazards in private sector housing, the health impact of these hazards, the cost this health impact had on society and health providers, and the likely cost of interventions in order to form a health cost benefit analysis.

Some of the findings include:

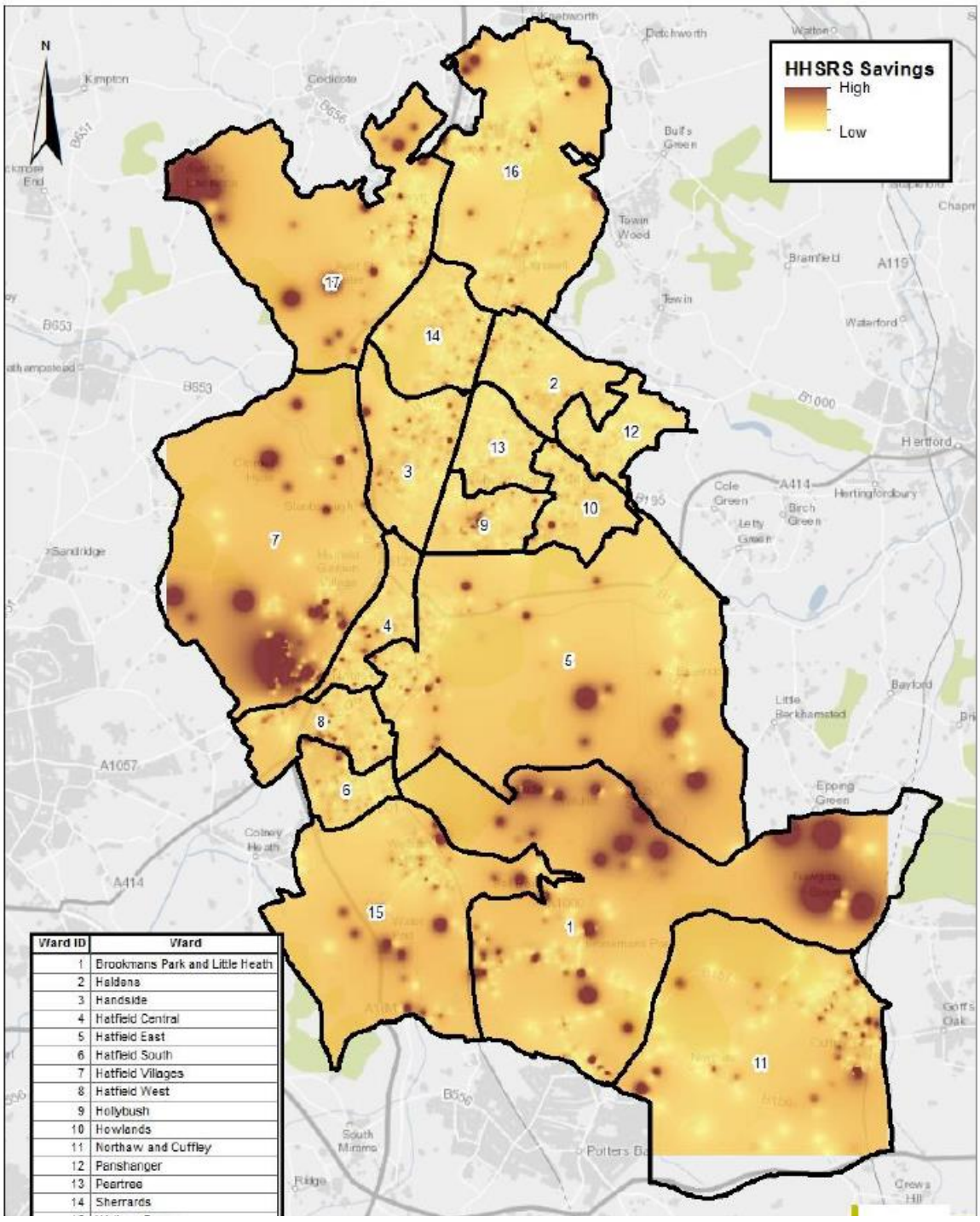
- There are almost 6,000 category 1 hazards in private housing stock in the Borough, with 1,500 in the private rented sector. The cost of mitigating these hazards is £12.7m and £4m respectively
- The estimated cost to the NHS of treating accidents and ill-health caused by these hazards is £1.1 million each year. If the wider costs to society are considered, the total costs are estimated to be £2.6 million.
- If these hazards are mitigated then the total annual savings to society are estimated to be £2.4 million, including £1 million of savings to the NHS.
- Interventions were likely to be more cost effective when focused on people at greater risk from hazards (e.g. older people).
- The greatest savings were likely to come from addressing hazards related to excess cold and falls.

The assessment concluded that the evidence supported an active housing enforcement strategy, interventions to address excess cold and hazards related to falls, particularly when targeted at the most at risk people.

The assessment demonstrates the kinds of data that can be generated to show the local health impact of poor housing and the wider benefits of mitigating it. This kind of data has all kinds of potential uses in helping to target interventions in a way that will have the greatest health impact. More work needs to be done understand what other data is available in other District and Boroughs and the potential uses for this data.

The Savings to Society of addressing Category 1 Hazards in Welwyn Hatfield

The report compared the estimates for particular hazards against estimates for concentrations of over 65s, and high prevalence of COPD and asthma to map the areas where interventions generate the greatest savings (see below).



Ward ID	Ward
1	Brookmans Park and Little Heath
2	Haldens
3	Handside
4	Hatfield Central
5	Hatfield East
6	Hatfield South
7	Hatfield Villages
8	Hatfield West
9	Hollybush
10	Howlands
11	Northaw and Cuffley
12	Panshanger
13	Peartree
14	Sherrards

3.1.9 The evidence cited earlier indicating a causal link between poor housing quality and health, combined with local data indicating that there are many homes in Hertfordshire in poor condition, provides a good rationale for suggesting that poor housing quality is likely to be a driver of certain negative health outcomes in the County.

3.2 Housing Availability and Homelessness

3.2.1 The main source of data available on homelessness is that on statutory homelessness acceptances. Statutory homeless acceptances are the cases of those who register as homeless with their local authority and are in a priority need group. Priority need groups are families with children, care leavers aged 18-21, people made homeless by a disaster (e.g. flooding), or those who are vulnerable (e.g. older people, those with a physical or mental disability, or victims of home violence).

3.2.2 Between 2010/11 and 2014/15 the proportion of statutory homeless acceptances in Hertfordshire (from 1.3 to 2.5 per 1,000) has almost doubled and is now slightly higher than the average for England (2.4 per 1,000). This figure also masks the differences between districts; from 0.8 per 1,000 people in East Herts to 6 per 1,000 people in Watford.

Table Statutory Homelessness Acceptances 2014/15

Geographical Area	Statutory homeless (per 1000 people 2010/11)	Statutory homeless (per 1000 people 2014/15)	Difference 2010/11 to 2014/15
England	2.0	2.4	+0.4
East of England	1.8	2.7	+0.9
Hertfordshire	**1.3**	**2.5**	**+1.2**
Cambridgeshire	2.1	2.3	+0.2
Buckinghamshire	1.2	1.7	+0.5
Essex	1.9	2.5	+0.6
Watford	**4.3**	**6**	**+1.7**
East Herts	**0.7**	**0.8**	**+0.1**

3.2.3 The figures for statutory acceptances only provide a partial picture of homelessness. This is because they capture only those individuals who both present themselves to local authorities, and are in a group of priority need. This usually excludes single people (without vulnerability) or those who are intentionally homeless.

3.2.4 A review of District and Borough strategies on homelessness, and interviews with senior housing officers, suggest that homelessness is a growing problem with every authority reporting increased demand on their services and

increased pressure on their temporary accommodation. In addition the West and Central YMCA report that their hostels regularly operate at full capacity.

3.2.5 District and Borough councils report that homelessness is partly driven by the demand in the housing market that is making it harder for people to access affordable accommodation. The ending of shorthold tenancies is the most common cause of homelessness in Hertfordshire and Districts face challenges in engaging with private sector landlords.

3.2.6 There are concerns from District and Borough housing officers that there will be more people at risk of homelessness as a result of changes to welfare. These include reforms such as the benefit cap, restrictions on access to housing benefit and the removal of the spare room subsidy. There are also concerns about the impact of the future introduction of universal credit. These changes come alongside increased financial pressure on local authorities and registered social landlords which constrains their ability to provide access to affordable accommodation and support for people who are currently homeless or at risk of becoming so. As a result of these factors the stakeholders in District and Borough Councils are predicting that there will be huge challenges around homelessness and access to accommodation.

4 Analysis of housing services in Hertfordshire

*For a summary of housing services and stakeholders see the Executive Summary (p8)

4.1 Services to address poor housing quality

District & Borough Councils

4.1.1 District and Borough councils have broad responsibility for maintaining and improving the condition of housing in their district. Housing teams have influence over the condition of social housing, either through the management of their own stock or by working closely with social landlords. Providers of social housing undertake work to reduce housing hazards and many also offer advice and support to tenants around issues such as energy efficiency. Environmental Health Officers (EHOs) have responsibilities around the enforcement of housing conditions. Although their remit can extend to all forms of housing, they tend to focus on the private sector, and many (but not all) District and Borough councils have an operational distinction between their housing and environmental health teams.

4.1.2 EHOs have legal powers to force landlords to take action to remedy the most serious of housing hazards (known as category 1 hazards[49]). Recent legislation has introduced greater regulations around the provision of smoke and carbon monoxide alarms and from 2018 landlords will no longer be able to rent properties with an EPC (Energy Performance Certificate) rating of F or G.

4.1.3 EHOs are involved in the regulation and licensing of homes of multiple occupation (HMOs). Although landlords renting HMOs require a licence from their local authority, there is no requirement for landlords renting out other forms of accommodation (other than HMOs) in England to be licenced (Scotland has blanket licensing of landlords). Some Districts have voluntary landlord accreditation schemes. However the success of these schemes varies from district to district, with questions over the incentives for landlords to join, given the demand for private rented accomodation.

4.1.4 Despite the absence of blanket licensing, the legislation around the regulation of HMOs, and the establishment of legal minimum standards in private rented

[49] Category 1 Hazards refer to hazards in the home that pose a high risk to the health and safety of the occupant according to the national Home Health and Safety Rating System (HHSRS). These hazards are assessed by considering both the physical defect and the vulnerability of the occupant. Although this means that what constitutes a category 1 hazard can vary, they would usually cover homes that, for example, have excess cold, faulty stairs, or the absence of basic security features such as locks on external doors. For more information visit www.cieh.org/WorkArea/DownloadAsset.aspx?id=57137

accommodation, gives EHOs the legal tools enforce against the worst housing conditions.

4.1.5 Beyond enforcement, EHOs are able to offer advice around housing conditions and District and Borough councils are able provide limited grants for home improvements for vulnerable or low income groups including the Disabled Facility Grants scheme (see Appendix C for more detail).

4.1.6 There is a consensus amongst District & Borough housing officers that social housing is generally of good condition, and that there are adequate services to maintain and improve housing, and to provide advice to residents on issues such as home warmth. This is supported by evidence from stock condition surveys indicating that homes in the social housing sector had a much lower rate of non-decency than the private sector. Discussions with housing and EHOs indicates significant concern over the condition of homes in the private sector, particularly private rented accommodation and HMOs which are much more likely to feature hazardous conditions and there is an increased risk of fire related injury and death.

4.1.7 The key challenge for EHOs is being able to identify housing with poor conditions. The majority of the casework of EHOs is based on complaints from tenants. This is problematic as there may be a lack of awareness amongst tenants of their legal rights or fears that improvement orders may lead to increased rents or even eviction. EHOs feel that there is a lack of awareness about their work amongst the wider public sector, and that they rarely received referrals from other agencies. EHOs were of the consensus that they would like to be able to do more to identify housing in poor condition, or unregulated HMOs, as well as increase referrals.

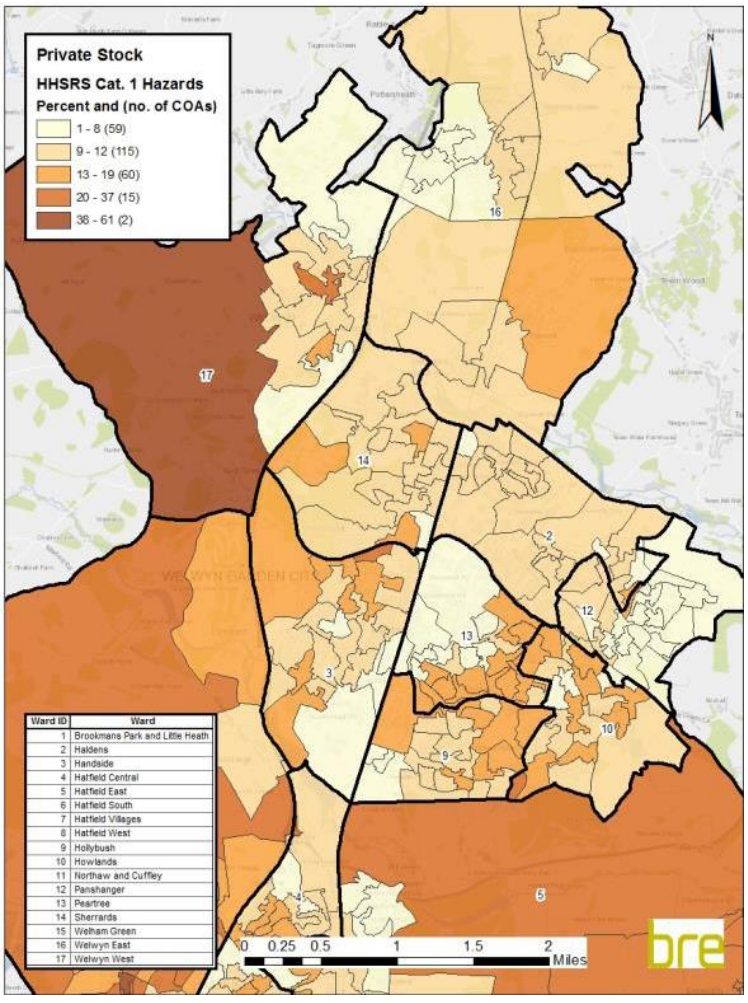
4.1.8 The ability of EHOs to identify housing in poor condition is impacted by limited data, and resources. In most Districts, there is a lack of data on where poor housing conditions are most likely to be concentrated as stock condition surveys only take a sample of homes, and are not able to be used to identify particular streets or neighbourhoods likely to have homes in poor condition. Without knowing which areas are likely to have poor housing conditions or unlicensed HMOs it is difficult to know where resources are best focused. However, as this case study below demonstrates some District and Borough councils are increasing the kind of data available to them.

4.1.9 Nevertheless the type of data being produced is not uniform across the County and it is not clear if this kind of stock modelling is happening in every District/Borough. Stock modelling exercises require funding, and environmental health teams generally have limited resources. In addition there is a consensus amongst EHOs that limited staff and financial resources make difficult to take on additional casework without extra resources being

made available. This implies that whilst improving access to data, and even increasing the number of referrals will have a positive impact, there are limits to how much can be achieved without extra funding.

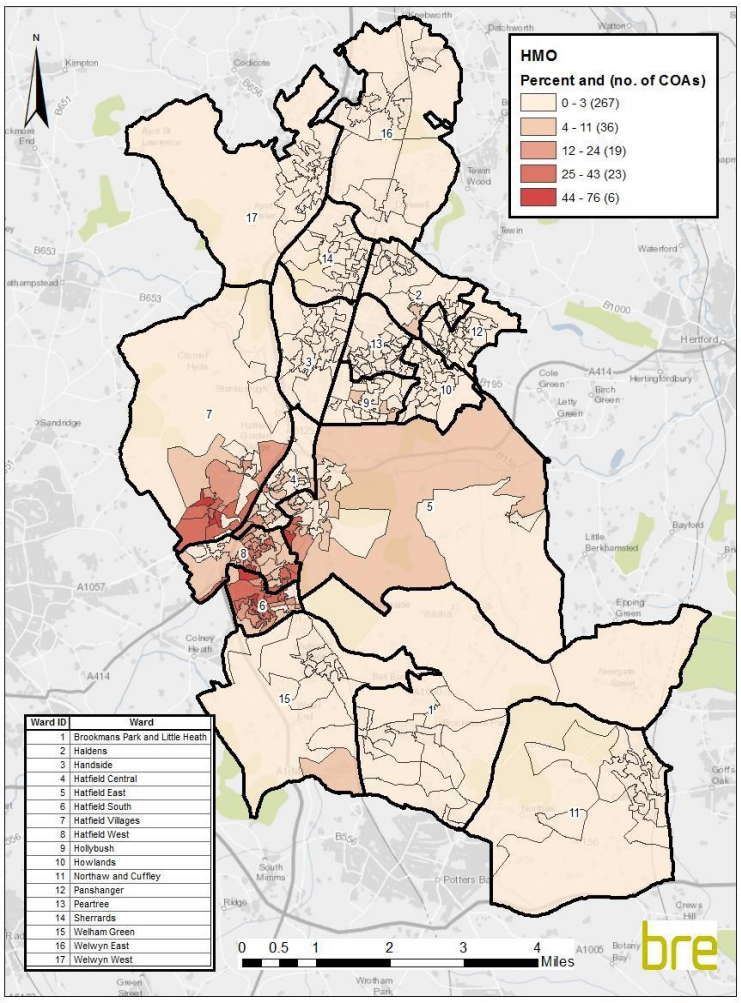
Box 3: District & Borough Stock Modelling Exercises

A number of District and Borough councils are now investing in stock modelling exercises to give them better data on areas of poor housing quality. For example, Welwyn Hatfield Council commissioned a BRE stock modelling exercise using the data such as the English Housing Survey, Energy Performance Certificates and Experian Consumer Dynamics to map which areas (down to the level of Census Output Area of 125 houses) were most likely to have issues such as excess cold or hazards relating to falls. North Herts, Dacorum, and East Herts councils have all invested in similar stock modelling exercises that are helping them to identify hotspots of poor housing.



Map indicating the distribution of housing hazards in Welwyn Garden City (taken from the Welwyn Hatfield Borough Council Stock Modelling Database report)

Welwyn Hatfield Council's housing teams also have been taking a proactive approach in identifying potentially unlicensed HMOs using council tax returns followed by speculative mass mailing to potential properties and targeted visits. The development of more sophisticated data and techniques, to allow for the proactive identification of housing likely to pose a threat to health, means that future interventions can be better targeted



Map indicating the estimated distribution of homes of multiple occupation in Welwyn-Hatfield taken from the Welwyn Hatfield Borough Council Stock Modelling Database report)

Hertfordshire County Council Community Protection

4.1.10 Community Protection has objectives around the prevention of fire and promoting home safety. The services they provide include the Herts Home Safety Service (HHSS) and Home Fire Safety Visits. HHSS is an advice and handyperson service, based mainly on referrals from the police, that supports vulnerable people to remain secure in their home. The home Fire Safety Visits, also based on referrals, provide home fire prevention advice, and free installation of smoke/carbon monoxide alarms to the general population.

4.1.11 Proposals are currently being developed for the expansion of Fire Safety visits into a new 'Safe and Well' visiting service. This service is still in the development stage, with a pilot service scheduled for March 2016, but broadly

aims to go beyond the initial fire safety visits to offer more holistic support to vulnerable people in their homes. As with the original Fire Safety Visits it will be funded primarily by HCC Community Protection, although there are discussions about additional financial support via Herts Healthy Homes.

4.1.12 At present the service is planning to target older people and those with long term conditions, but there is the potential for it to reach a wider group of vulnerable people. The Safe and Well Visits are likely to be based partly on referrals, supported by services such as HertsHelp (see section 4.1.16 for more information). However, it has been highlighted that access to data from health and social care providers on vulnerable individuals would be of significant benefit in order to undertake proactive, targeted visits. Community Protection needs to be supported both to access data from health and social care providers on people who are potentially at greatest risk, and to generate referrals from across the public sector.

4.1.13 Community Protection is working with partners, including Public Health, to explore the kinds of issues that could be addressed through advice, referral or more direct interventions. There are discussions around covering issues such as home safety (i.e. fire, carbon monoxide and crime), and warm homes. The development of the new Safe and Well Visit service has the potential to address some of the housing hazards related to these areas and the associated health benefits with doing so. Currently the Fire Safety Visits access 8,000 people each year; if the new service could cover a similar population could potentially support a significant number of vulnerable people.

4.1.14 However, it is important that the service is supported to ensure that all aspects of a vulnerable person's housing situation are covered. The evidence cited in section 2.1 suggests that focusing action on the homes occupied by vulnerable people is likely to have the greatest health impact. There are challenges in this as the visits are not solely concerned with housing; they include other issues such as dehydration and nutrition. There are therefore limits to expanding the remit of the service further. In addition Fire Officers are neither housing nor health specialists and therefore would not necessarily have the skills to do a full housing and health assessment.

<u>Hertfordshire County Council: Herts Healthy Homes (and Hertshelp)</u>

4.1.15 Herts Healthy Homes is a project funded by the County Council and the two Hertfordshire Clinical Commissioning Groups (CCGs). The aim of the service is to support vulnerable people manage their home in order to promote independence, health and protection from harm.

4.1.16 Herts Healthy Homes works together with Hertshelp, a telephone and email based referral and advice service (funded by the County Council and Hertfordshire CCGs). Referrals are made into HertsHelp, who can offer advice

and referral to services, for people needing support to maintain or improve their homes. Sources of referrals range from health providers, voluntary organisations, or other County Council or District & Borough council departments.

4.1.17 Herts Healthy Homes also commissions voluntary organisations to offer home improvement services and advice to vulnerable people. An example of this is a partnership between East Herts District Council, Herts Healthy Homes and Crossroads to offer practical advice and home improvements for people with dementia.

4.1.18 The programme offers a mixture of advice, referral and direct interventions to help to improve the home conditions of vulnerable people. Together with Herts Help to enable referrals, it represents an example of multi-agency cooperation.

4.1.19 It should be acknowledged that at present the service does not have the resources needed to be able to comprehensively address poor housing conditions; many of its grant funded services cover only part of the county, and are limited to the most vulnerable people. The service relies on the continued investment of funding agencies, which may be affected by the broader financial constraints on public spending.

4.1.20 In addition, the service relies on a good system of referrals, in order to identify and support vulnerable people to improve their homes. Identifying those in need of support should involve referrals from anyone who is in contact with a vulnerable person. Although HertsHelp provides the infrastructure to manage referrals, raising awareness of the service and generating referrals is a constant challenge. Whilst services, such as HertsHelp aim to build good working relationships with health providers, at present there is no systematic process to ensure that health providers refer potentially vulnerable people into the service. The data on from both Herts Healthy Homes and the Community Navigators scheme indicates that referrals from GPs and other health providers only form a small proportion of the total, despite the large number of potentially vulnerable people accessing these health services.

<u>Other services</u>

4.1.21 There are national schemes to support home improvement. Most of these are based around improving home energy efficiency. These include the Energy Company Obligation, the Winter Fuel Payment, Cold Weather Payments, and a number of advice and outreach programmes.

4.1.22 Discontinued schemes include the Warm Front, Green Deal and the Warm Homes Healthy People Fund. The latter scheme distributed £20m in funds to local authorities to prevent cold related excess winter deaths and was

considered to be effective in targeting resources and promoting partnership working. The ending of these schemes represents a reduction in the resources available to tackle excess cold. The government has announced further reduction in funding for national energy efficiency schemes, and there is doubt over whether funding will be sufficient to hit government home energy efficiency targets[50].

4.1.23 The voluntary sector also offers services to help people improve their homes. Examples include the Groundwork Trust's garden clearance, Age UK handyperson services, and the advice provided at Citizen's Advice Bureaus. Some of these services are part funded by Hertfordshire County Council or the various District and Borough Councils. However this project was not able to evaluate the current or future provision of these voluntary sector provided services.

Demand for Services

4.1.24 There is little evidence into what levels of demand there are in Hertfordshire for services to address poor housing conditions. Services range from relatively low cost interventions such as advice or referral, through to more resource intensive solutions such as formal enforcement activities or comprehensive home repairs or adaptions. Understanding what kinds of services are needed is important as improving different services have different cost and design implications.

4.1.25 The review into Excess Winter Deaths (see Box 1) indicated some demand for advice and referral services. However, it is also likely that many people will need more intensive interventions. More work needs to be done with stakeholders to understand demand for various services.

Conclusions

4.1.26 Housing in poor condition has a clear impact on health and therefore a case for Public Health involvement in supporting services that aim to address this issue, particularly interventions that are targeted at vulnerable people and/or the worst housing. The evidence presented in this report, combined with the data collated in the BRE Housing Cost Calculator can be used to demonstrate the wider value of services that tackle poor quality housing.

4.1.27 The data available on concentrations of poor housing conditions in Hertfordshire is improving via stock modelling exercises. This source of intelligence can be used both by District & Borough councils, and potentially by other stakeholders, so that targeted interventions can be informed by housing as well as health data. Even in Districts that haven't developed formal

[50] http://www.businessgreen.com/bg/news/2415010/government-energy-efficiency-plans-off-track-official-review-warns

data sources, the local knowledge of EHOs can be useful. An example of this could be using information about areas of poor housing to help HCC Community Protection prioritize Safe and Well Visits.

4.1.28 The new Safe and Well Visits service presents an opportunity to reach vulnerable people and offer support, some of which is related to housing. The service needs support to help access data on vulnerable people from health and social care providers. In addition it is important that the opportunity presented by this service is taken advantage of by ensuring that the full housing situation of a vulnerable person can be addressed. For example this could potentially involve partnership working between housing professionals and Community Protection to allow for referrals or even dual-visits. However, there is recognition that adding to the casework of housing service providers may require additional resources.

4.1.29 The Safe and Well Visits, together with the housing services offered via Herts Healthy Homes, and District and Borough Councils, offer a good range of services that can help to tackle poor housing. But in order to fully realise the potential it is important to take make full use of these services by improving the numbers of referrals from elsewhere in the public sector. An assessment of a person's housing situation, when presenting to health or social care providers, could help to identify those whose health is being impacted by the home environment. An example of this kind of system is in place in Liverpool, where GPs and other health professionals systematically questioned patients about their housing situation, and if necessary, refer them to a relevant housing service[51].

4.1.30 Although there are already a good range of services, to help improve housing conditions, there is still more that can be done if resources are made available. Existing services either are based on referral or data on individuals already known to care providers, however it is possible that there will be vulnerable people, living in poor quality or unsafe accommodation that remain hidden. This suggests a need for a countywide service that proactively seeks identify poor housing conditions and signpost for support.

[51] http://www.24dash.com/news/housing/2013-01-29-Liverpool-makes-direct-link-between-health-and-housing-with-GP-referral-scheme

Box 4, Case Study: Wirral Healthy Home

Wirral Healthy Homes serves as a case study into a project aiming to improve the housing of vulnerable residents, who were unlikely to report housing defects. Funded jointly by the local council, NHS and police, the project first used a housing stock modelling exercise to identify areas in the district likely to have poor quality housing. This area was then targeted by housing officers who did door to door visits to offer a home safety assessment as well as referring residents to other existing health or housing support services (including health services) where appropriate. As such the project was able to make best use of existing services by using intelligence to identify areas of poor housing, and proactively seeking vulnerable people whose home could be contributing to ill health. A similar project could work in Hertfordshire to take advantage of both improving housing data, as well as existing services to support home improvement.

4.2 Services to address housing availability/homelessness

Homeless Prevention and Access to Accommodation

4.2.1 District & Borough Councils are the main providers of services to prevent homelessness and support people to access accommodation. They have legal responsibilities to offer housing advice and to offer accommodation to people in priority need groups (such as families with children, or older people).

4.2.2 Temporary accommodation and social housing, for priority need groups, are provided either by the Districts themselves or via housing associations. In addition, since the Localism Act (2011), local authorities have been able to support homeless people to move into private rented accommodation.

4.2.3 For children and young people, other services are available to prevent homelessness and house those who have become homeless. HCC Children's Services has a responsibility to find appropriate housing for children under 16. In addition there is a joint protocol between the County council and District & Borough councils to work in partnership to prevent homelessness or resolve existing cases of homelessness, amongst 16/17 year olds, and 18-21 care leavers.

4.2.4 All of the District and Borough councils in Hertfordshire offer housing advice to those at risk of becoming homeless. Most of these services are based on self-referral although some Districts take a more proactive approach to identifying those in need of advice. For example Dacorum Housing Options team proactively target vulnerable people at risk of homelessness by holding surgeries in a range of venues including children's centres.

4.2.5 A number of District and Borough councils, and some housing associations, offer tenancy sustainment support and training to people at risk of becoming homeless, or those who need extra support before they can manage moving into permanent accommodation. Other districts offer prevention services such as home visits to those at risk, or funding for educational programmes in schools. However, beyond basic housing advice, the level and type of homeless prevention activities varies across the County.

4.2.6 Although the degree of pressure on housing services varies across the County, each district reported concerns about the growth in demand for housing advice and options services. Some districts/boroughs have significant pressure on temporary accommodation and in some cases are having to rely on B&B accommodation. There is an expectation that the numbers of people at risk of homeless will rise, putting further pressure on services.

4.2.7 In addition, there are many services offered by both District and Borough councils and Housing Associations, such as tenancy sustainment or other forms of low level community support, which are not part of their statutory responsibility. The broader financial pressure on both local authorities may put these services at risk leading to people being at greater risk of becoming homeless, and the associated health impact this may have. There is therefore a combination of increasing demand for homeless prevention services, and support to access accommodation at a time of reducing budgets.

4.2.8 Evaluating the impact of any particular homeless prevention scheme is considered to be problematic, by District and Borough housing teams, as they are rarely offered in isolation. Nevertheless, despite the variation in the kinds of services offered from district to district, there is a consensus amongst all housing teams that, taken together, the homeless prevention services are effective in helping to prevent people becoming homeless. Given the relationship between of homelessness on poor health, these services will be likely to be having a positive health impact.

4.2.9 A key part of District and Borough level homeless prevention work involves engaging with private sector landlords and helping people to access private rented accommodation. All districts and boroughs have staff involved with private landlord liaison work, and low income residents have access to rent deposit schemes. Engaging with private sector landlords is a priority for housing teams and there is a desire to make the offer attractive to landlords.

4.2.10 Preventing homelessness from the ending of shorthold tenancies in the private sector and assisting people to access stable private rented accommodation are extremely challenging. Many senior housing officers feel that the combination of welfare reforms, and the demand for private rented accommodation make it difficult to engage with private landlords to prevent

eviction, or encourage them to take on social tenants. This is problematic given the existing divide, in every district, between the demand and availability of social housing.

Support for non-priority groups

4.2.11 District & Borough councils only have statutory responsibility towards those in priority need groups. This means that groups such as single people or those intentionally homeless don't necessarily qualify for support, even though many of these people can be vulnerable.

4.2.12 Some District and Borough council support such as housing advice, or access to rent deposit schemes, extend to support non-priority groups. For example, the St Albans rent secure scheme works to assist single people to access private sector accommodation. Watford Borough Council is making a priority of assisting single homeless people and is currently developing a single homeless pathway. Charities such as Herts Young Homeless can offer support to single homeless people under the age of 25.

Box 5: Watford Borough Council Single Homeless Pathway

Watford Borough Council (WBC) has created a proposal for a rehabilitative service to support single homeless people with an additional vulnerability to access stable accommodation. The intention of the service is for WBC to facilitate the provision of accommodation and multi-agency intensive support, with regular assessments, in order to assist that client towards recovery over a 12 month period.

After 12 months it is envisioned that the client will be able to sustain a tenancy without additional support. WBC are proposing that following a successful completion of the scheme, they would be prepared to relax their housing register requirements to give the client the opportunity to access social housing. By supporting the client towards recovery, and secure accommodation, the service has the potential to improve the health outcomes and the reduce the reliance on acute health services associated with homelessness.

WBC are currently exploring the options for the provision of accommodation and multi-agency support, including possible sources of funding.

A process map of the single homeless pathway can be found in Appendix E

4.2.13 There is support available from voluntary sector homeless charities. In Hertfordshire there are a number of emergency open access (i.e. the client does not need to be referred) night shelters available to those without access to other forms of accommodation.

4.2.14 Some parts of the Hertfordshire do not have this provision, and the quality of accommodation, and degree of support available varies. Although areas such

as Watford, Dacorum and St Albans, have shelters for homeless people, who otherwise would be sleeping rough, there is a lack of provision in a number of Districts/Boroughs As mentioned previously, rough sleepers have the worst health outcomes, indicating that this gap in provision is a health as well as housing concern.

Hospital Discharge

4.2.15 Although not exclusively concerned with homelessness, hospital discharge services in Hertfordshire are intended to support people with all aspects of leaving hospital, including consideration of their housing situation. These include hospital-based discharge teams, and voluntary organisation hospital discharge services such as those offered by Age UK or the British Red Cross.

4.2.16 A recurring theme, in discussions with District and Borough councils, are the challenges they face in co-ordinating the hospital discharge of people in need of housing support. Experiences were noted of patients being discharged without advanced notice. This problem was noted as being particularly serious with patients who had mental health needs. As well as putting extra strain on housing teams this often leads to vulnerable people being placed in temporary accommodation, without the support they need, or even being placed in B&B, both of which may pose a risk to their health and safety.

4.2.17 District and Borough housing teams feel that they want to improve the co-ordination between themselves and local hospitals in order to better support those leaving hospital with housing needs.

4.2.18 Improving the co-ordination of hospital discharge is also of importance to hospitals themselves. The absence of appropriate accommodation can delay the discharge of patients, creating extra pressure on hospital capacity. The coordination of housing support, with hospital discharge, is needed to reduce the likelihood of re-admission, particularly amongst older people[52].

Support for Adults with Complex Needs

4.2.19 There are many people in Hertfordshire who have complex needs that can put them at risk of homelessness or make it more challenging for them to access stable accommodation. These needs can be a combination of problems related to housing, substance abuse or mental health that require holistic multi-agency support. The challenges of supporting even a small number of adults with complex needs were noted by stakeholders at the County Council and District/Boroughs.

[52] http://www.kingsfund.org.uk/blog/2015/10/improving-hospital-discharge-and-intermediate-care-older-people

4.2.20 Hertfordshire Partnership Foundation Trust (HPFT) provides health services for those with mental health needs including in-patient accommodation as well as care in the community. There is also access to specialist accommodation places for those with the most acute needs. Public Health's services related to substance abuse include housing support. These are abstinence-based services providing access to floating support, short and medium stay accommodation, and a private rented sector scheme. Public Health also part fund the Herts Young Homeless dual-diagnosis service.

4.2.21 HCC and Herts Valleys CCG fund a Community Navigator service for residents in their locality. This service aims to help people, with intermediate needs, to access services, particularly from the voluntary sector. Part of their role is therefore to help people with multiple needs get coordinated care which includes considerations of housing needs. They can therefore refer people to District and Borough housing services, voluntary homelessness organisations as well as home improvement services such as Herts Healthy Homes. In Watford, the community navigator is hosted by the Watford Housing Trust which helps to connect housing tenants with health services and vice-versa. It should be noted that, at present, the Community Navigator service is not available countywide.

4.2.22 Hertfordshire County Council is involved with a work steam to promote partnership working to support adults with complex needs. There is a currently a pilot underway in Hertsmere and Three Rivers to offer multi-disciplinary support and access to services to adults with complex needs. The expected impacts of the pilot are reduced service use by the participants and improved health outcomes. In Stevenage there is also a complex needs service called 'No More' that aims to assess people with multiple needs around substance abuse, mental health and housing and provide them with multidisciplinary support.

4.2.23 District/Borough councils find it difficult to solve the housing needs of an individual who also has problems related to substance abuse or mental health. There is understandably a reluctance to house such individuals in the general accommodation available to District and Borough Councils, as doing so poses a safety risk both to the person in need and those around them. Some Districts and the YMCA noted the difficulties involved in coordinating with mental health services and the challenges of finding specialist accommodation for adults with complex needs. High eligibility criteria for statutory support mean that many adults with low or intermediate needs are unable to access services to help them sustain stable accommodation.

4.2.24 The YMCA in West and Central Herts is funding a support worker specifically to support adults with complex needs at their hostels in Watford and Welwyn Garden City. Their work will involve offering and helping to co-ordinate multi-

agency support to adults with complex needs to help them sustain stable accommodation. However this service is beyond the core offer of the YMCA, and is therefore always at risk from future financial pressures.

4.2.25 Open access emergency night shelter accommodation tends to be abstinence only and is therefore inaccessible to those with both housing and substance abuse issues. In addition the provision of Public Health substance abuse related housing support is also based on the abstinence model of recovery and therefore excludes those who need housing support but are still drinking or taking drugs. The substance abuse related housing support is unable to support those who have additional mental health needs.

4.2.26 One further area of concern across the District and Borough councils relates to providing support for Syrian refugees. Many of the refugees are expected to have complex needs, and there was a recognition of the need to provide co-ordinated support, both to help protect those in need, and to ensure that such provision did not affect the ability of the general population to access housing services.

Conclusions: Housing Availability/Homelessness

4.2.27 The impact of homelessness on health is clear and services that preventing homelessness will deliver public health outcomes, even if this is difficult to quantify. The expectation that homelessness numbers will rise is therefore a challenge to both housing and health providers.

4.2.28 Although the impact of individual homeless prevention services is hard to measure, and there are limitations on their effectiveness as a result of long term changes to the housing market and welfare system, taken together they are perceived by housing teams to be helping to prevent homelessness from occurring. These services can therefore be seen as services relevant to poor health prevention. There may be need to explore support for the protection or extension of these services, and to be aware of the threats they may be under from the financial pressures facing both local authorities and housing associations.

4.2.29 There are a number of gaps in the provision of homelessness services. Firstly emergency open access night shelter accommodation is lacking in a number of districts. Given that rough sleeping has the most serious health implications, there is a need to help rough sleepers to access some form of shelter, in Districts without night shelter provision. In areas that do have night shelters there are also sometimes issues around the access to this form of accommodation for homeless people with substance abuse issues.

4.2.30 Secondly there needs to be improved co-ordination of the hospital discharge of patients who will require housing support. This is needed to avoid patients

either becoming homeless, or being placed in inappropriate accommodation. More work needs to be done between housing providers, hospitals and existing hospital discharge services to understand how to improve co-ordination of patients at risk. In addition there is particular need for improved co-ordination between mental health services and housing services, in order to ensure individuals with mental health needs are placed in accommodation that is appropriate.

4.2.31 Thirdly there are gaps in the provision of services adults with complex needs, which create obstacles to accessing stable accommodation. There is a need for more co-ordinated support from housing and health providers to ensure adults with complex needs are not excluded from appropriate housing and support.

4.2.32 For substance abuse, the Public Health commissioning team are already aware of the difficulty of providing housing support to those who are still dependent on alcohol or drugs, or also have mental health needs. They are working with stakeholders, including the existing provider, to understand how future service provision can address this gap.

4.2.33 The adults with complex needs pilot study, once completed and evaluated could form the way forward and be made into a permanent countywide model of service delivery.

5. Summary and Next Steps

5.1 Introduction

5.1.1 There is a clear link between housing quality and the ability of many of Hertfordshire's communities to stay healthy and well. Whilst there are a range of services that can help to improve housing conditions they are constrained by the limited resources available to them. There are also challenges relating to referrals into existing housing services and the sharing of information on vulnerable people. However there are potential gains from sharing intelligence on both housing and vulnerable people, partnership working between the various health and housing providers, and from improving the referrals into and awareness of existing services.

5.1.2 There is also a clear link between housing availability and health, and existing homeless prevention services are likely to be having a positive health impact. However there are challenges around issues such as the co-ordination of hospital discharge, services to support adults with complex needs and night shelter provision in some areas. The provision of these services will be even more important given the expectation that the numbers of homeless people are expected to rise.

5.1.13 This report has refrained from making concrete recommendations as doing so would involve making assumptions about the priorities and resources available to the various stakeholders involved. Further discussions are needed to identify: the priorities going forward; who will lead on delivery of certain priorities; and what resources can be made available to support this.

5.2 Key Findings and Next Steps: Housing Quality

5.2.1 The public health interest: Hazards in the home are linked with a number of negative health outcomes, many of which related to specific public health indicators and priorities. Excess cold, hazards relating to home accident, and exposure to toxins relate to circulatory and respiratory disease, increased risk of injury or death, and impaired development. The impact of poor housing conditions is greater amongst vulnerable groups such as older people and young children. In addition there is direct and indirect evidence suggesting that Hertfordshire has significant numbers of homes in poor condition, and that this is likely to be having a negative health impact.

5.2.2 Environmental Health: Poor housing quality is likely to be a greater problem in the private sector, particularly the private rented sector. Environmental

health teams have legal powers to enforce housing conditions in the private rented sector. However limited financial and staff resources make it more challenging to proactively identify illegal housing conditions or take on additional casework, and the grant funding available to owner-occupiers to improve their homes is limited. The majority of casework comes from complaints from tenants, with low levels of referral from other areas of the public sector.

5.2.3 Data: Despite the variation in the availability of data on poor housing, some districts are using stock modelling exercises to pinpoint areas with the poor or illegal housing. This intelligence can help to make sure interventions can be targeted, and there may be benefits in this data being shared more widely.

5.2.4 Safe and Well Visits: Community Protection is working with partners, including Public Health in the development of this new service. Whilst this presents an opportunity to offer greater advice and assistance, related to housing, to vulnerable people, it is important that the service is supported to ensure that all aspects of a vulnerable person's housing situation are covered. In addition there are potential benefits to be gained from the sharing of information from health and social care providers on vulnerable people.

5.2.5 Herts Healthy Homes: By working with partners improve the homes of vulnerable people, and the advice and referral system provided by HertsHelp, this service is likely to be contributing to improved housing conditions and health outcomes. However generating referrals is a constant challenge, and the financial resources allocated to the scheme mean that it cannot represent a comprehensive solution to poor housing conditions.

5.2.6 Referrals: Services to improve housing conditions, such as Herts Healthy Homes, Safe and Well Visits, and the work of Environmental Health, rely heavily on either self-referral, or referrals from elsewhere in the public sector. It is important that best use is made of existing services by improving the number of referrals made into them, particularly from health providers.

Next Steps

Table 3: Next Steps: Housing Quality

Theme	Action	Opportunities
JSNA	The JSNA currently has a Housing chapter, but this it is recognised that it can be developed further. The chapter can be updated in light of this report and any work taken forward as a result. However, further exploration of	

	how this might look is required given that the JSNA is currently undergoing review.	
Data and Intelligence	Explore how the evidence and data from this report and the Building Research Establishment's Housing and Health Cost Calculator can: • inform the JSNA • promote the value of the work of housing improvement services to the wider health and social care sector Oversight is needed of the housing intelligence available across the District and Boroughs, with consideration of how: • data can be most effectively shared to support the work of existing services across Hertfordshire • how housing intelligence can be developed countywide	Evidence of the relationship between health and housing creates incentives for providers of health and housing services to work in partnership. The development of improved housing intelligence makes it possible to both demonstrate the health impact of housing services and identify areas of housing where interventions are likely to have the greatest health impact. The Excess Winter Deaths report recommended improving identification of householders at risk by training and data sharing with health services and local authorities
Safe and Well service development	Explore the opportunities to support the sharing of data on vulnerable people between health and social care providers for the purposes of Safe and Well visits	There is currently an opportunity to make appropriate links between Environmental Health Officers and Community Protection in the development of Safe and Well visits to address the full housing situation of the vulnerable people using the service.
Referrals	Consideration is needed into how the number of referrals into home improvement services, particularly from health providers, can be improved, in order to make best use of existing services.	The Excess Winter Deaths report highlighted the importance of improving the number of referrals and awareness of services to address cold homes, including those from health providers such as GPs
Protecting and expanding home improvement services	There is justification for exploring the business case for protecting or expanding home improvement services such as	The existence of a range services to address poor quality housing and homelessness, which are

	Herts Healthy Homes. This can include the consideration of proposals for housing improvement projects that are targeted at the worst homes and/or most vulnerable people, and therefore have the greatest potential health impact.	having a health impact, means that there is a good foundation of services that can be built upon. The Excess Winter Deaths reported recommended the creation and implementation of strategies to address excess winter deaths and fuel poverty, and to develop an action plan to tackle falls, including potential physical changes to the home.

5.3 Key Findings and Next Steps: Housing Availability

Key Findings

5.3.1 The public health interest: The lack of availability of secure accommodation has a significant health impact In addition health issues such as substance abuse, and mental health issues, can make someone more likely to become homeless. Some areas of Hertfordshire have levels of homelessness higher than the national average and the problem is expected to grow in the future. This suggests a public health interest in services that either prevent homelessness from occurring, support those who are homeless to find more stable and secure forms of accommodation, or supports homeless people to access health services. It makes the availability of housing and homeless both a health and housing concern.

5.3.2 Homeless prevention: Whilst there is variation in the kinds of homeless prevention services offered by District/Borough councils, and it is hard to quantify the effectiveness of individual services, it is likely that they are preventing cases of homelessness. Given the health impact of homelessness this is likely to be leading to improved health outcomes for the individuals concerned, and reducing the potential financial burden on providers of health services.

5.3.3 Night Shelter: Emergency open access night shelter accommodation (i.e. shelter for clients to access without referral) is lacking in a number of districts. Given that rough sleeping has the most serious health implications, there is a need to help rough sleepers to access some form of shelter, in Districts without night shelter provision. In areas that do have night shelters there are also issues around the access to this form of accommodation for homeless people with substance abuse issues.

5.3.4 Hospital discharge: There are challenges in the co-ordination of the hospital discharge of patients requiring housing support. This is putting pressure on providers of housing services and leading to people being placed in in appropriate accommodation. It is also likely to be impacting health providers by extending hospital stays, and increasing the chance of hospital readmission.

5.3.5 Adults with complex needs: There are also challenges in providing appropriate housing solutions to adults with a combination of housing and either mental health or substance abuse related issues. There is a need for more co-ordinated support from housing and health providers to ensure adults with complex needs are not excluded from appropriate housing and support.

Next Steps

Table 4: Next Steps: Housing Availability

Theme	Description	Opportunities
JSNA	As above	
Partnership working	Closer working relationships are needed between partners in the following areas: • Improving the co-ordination between health and housing services around of the hospital discharge of patients needing housing support • The exploration of how access to night shelter can be improved for adults with substance abuse issues or for residents of Districts/Boroughs lacking adequate provision. • The development of multi-agency services to support adults with complex needs to access and maintain stable and appropriate accommodation.	Public Health has good links with the NHS, other County council departments and District & Borough councils, which can be used to help link up housing and health providers. There are also forums such as the Health and Wellbeing Board or the Public Health Board that can support partnership working. There is currently a research project underway at Stevenage Haven Hostel (funded by North Herts District Council) aiming to investigate the health benefits of the services offered by the hostel, and the effectiveness of local health services in engaging with homeless people. This scheduled to complete in April 2016.[53] There is a pilot underway in Hertsmere and Three Rivers to offer multi-disciplinary support and access to

[53] http://www.stevenagehaven.org.uk/news/28-north-herts-street-homeless-research-project

		services to adults with complex needs.
Protecting and expanding home improvement services	There is justification for exploring the business cases for protecting or expanding homeless prevention activities	

Appendix A: Literature Review

Introduction

This literature review aims to give an overview of the role of housing in health and wellbeing to inform the final health and housing project report. Within this aim there are three objectives:

1. Outline the relevant legislation and policy covering health and housing
2. Give a review of the academic literature on health and housing
3. Demonstrate examples of effective housing and health interventions

Given its limited purpose, and the broad research area (housing and health), it was not considered appropriate for this review to be a systematic analysis of everything written on the subject. Rather this review will follow a ‘narrative’ literature review

approach in order to give the project the necessary background knowledge on the subject.

The World Health Organization[54] outlines three ways in which housing impacts health. The first is the physical impact of housing hazards or homelessness. The second is the role housing can play in mental health, emotional wellbeing and social status. The third is the wider impact of the built environment on community life, culture and access to services.

This review will not be considering the wider impact of the built environment, as this aspect of housing and health is beyond the scope of the current housing and health project. Rather it will be considering the impact of housing on both the physical and mental health of individuals. This review will firstly look at the physical appropriateness of housing including a consideration of hazards in the home, home adaptions and the provision of specialist accommodation for older and vulnerable people as well as support to help people remain independent in their home. Secondly it will be considering the role of homelessness. In each area it will be considering the relevant legislation and policy landscape, the academic literature and find examples of case studies to inform best practice.

Hazards in the Home

The idea that poor housing conditions have a detrimental effect on a person's health has a long history and seems to be good common sense. Whilst the evidence base is not a substantial as might be supposed[55], there is nevertheless a growing body of evidence showing how specific housing conditions can affect the health and wellbeing of individuals. This review will consider this in light of academic research, national policy trends and case studies of effective local authority interventions.

Excess cold

A review of the literature suggests that cold homes have significant negative consequences for the health and wellbeing of individuals and financial consequences for health providers. The BRE estimates that excess cold is the housing hazard that places the greatest financial burden on the NHS at a cost of £850m per annum.

Cold homes have a particular impact on older people, people with long term illnesses and children[56]. Research by Ormandy[57] and a literature review by Stuart and

[54] WHO: Quantifying Health Impact of Housing available online at http://www.euro.who.int/__data/assets/pdf_file/0017/145511/e95004sum.pdf?ua=1

[55] Shaw, M. 'Housing and Public Health' Annu. Rev. Public Health 2004. 25:397–418. Available online at http://www.annualreviews.org.ezproxy.herts.ac.uk/doi/pdf/10.1146/annurev.publhealth.25.101802.123036

[56] Marmot Review 'The Health Impact of Cold Homes and Fuel Poverty. Available online at http://www.cieh.org/policy/housing/poor-housing.html

Rhoden[58] found that cold homes were associated with increased respiratory illness in children. Cold homes have also been found to negatively affect child weight gain, hospital admissions and educational attainment.[59]

Excess cold is a major component of excess winter deaths due to its association with circulatory and respiratory illness which together account for 70% of deaths[60]. Indoor temperatures are a much closer determinant of excess winter deaths than outdoor temperatures[61]. A survey of beneficiaries of the now closed government 'Warm Front' scheme found that they had higher levels of self-assessed health and wellbeing[62]. A longitudinal study by Curl and Kearns[63] found that reducing cold in a person's home led to faster recovery from circulatory illness. The study found that the greatest impact came from targeting interventions at those who were already vulnerable, indicating that interventions are most effective when targeted at vulnerable people or those with existing conditions. Thomson et al (2013) conducted a literature review of housing interventions and concluded that the most effective interventions were those that addressed excess cold and were targeted at the most vulnerable[64].

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57 Ormandy D. 'Housing and Child Health' Paediatrics and Child Health Volume 24, Issue 3, March 2014, Pages 115–117 available online at http://www.sciencedirect.com/science/article/pii/S1751722213002072

[58] J. Stewart M. Rhoden, (2006),"Children, housing and health", International Journal of Sociology and Social Policy, Vol. 26 Iss 7/8 pp. 326 – 341 Permanent link to this document: http://dx.doi.org/10.1108/01443330610680416

[59] Marmot Review 'The Health Impact of Cold Homes and Fuel Poverty. Available online at http://www.cieh.org/policy/housing/poor-housing.html,

[60] Public Health England 'Making the Case for Cold Weather Planning https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/252854/Cold_Weather_Plan_2013_Making_the_Case_final_v2.pdf

[61] Shaw, M. 'Housing and Public Health' Annu. Rev. Public Health 2004. 25:397–418. Available online at http://www.annualreviews.org.ezproxy.herts.ac.uk/doi/pdf/10.1146/annurev.publhealth.25.101802.123036

[62] Gilbertson et al 2011. Psychosocial routes from housing investment to health: Evidence from England's home energy efficiency scheme http://www.sciencedirect.com/science/article/pii/S0301421512000791

[63] Curl A, Kearns A 'Can Housing Improvements Cure of Prevent the Onset of Health Conditions Over Time in Deprived Areas'. http://ud7ed2gm9k.search.serialssolutions.com/?ctx_ver=Z39.88-2004&ctx_enc=info%3Aofi%2Fenc%3AUTF-8&rfr_id=info:sid/summon.serialssolutions.com&rft_val_fmt=info:ofi/fmt:kev:mtx:journal&rft.genre=article&rft.atitle=Can+housing+improvements+cure+or+prevent+the+onset+of+health+conditions+over+time+in+deprived+areas%3F&rft.jtitle=BMC+public+health&rft.au=Curl%2C+Angela&rft.au=Kearns%2C+Ade&rft.date=2015&rft.eissn=1471-2458&rft.volume=15&rft.spage=1191&rft_id=info:pmid/26615523&rft.externalDocID=26615523&paramdict=en-UK

[64] Thomson et al 2013, 'Housing Improvements for Health and related socio-economic outcomes' http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD008657.pub2/abstract

In addition to impacting on physical health, via circulatory and respiratory illness, the Marmot review cited research that indicated that people living in the coldest quarter of housing were 5 times more likely to develop a mental health problem than the general population[65].

The importance of tackling excess cold, particularly amongst vulnerable groups is widely recognised. The Marmot Review into cold homes suggested that measures to tackle fuel poverty were an effective way of reducing excess winter deaths and the Department of Energy and Climate Change's 'Cutting the cost of keeping warm' fuel poverty strategy prioritizes support to vulnerable and low income households[66]. The Housing and Health Memorandum of Understanding between between government departments, agencies such NHS England, Public Health England and professional and trade bodies recognizes the importance of having a warm home to improved health and wellbeing[67].

The government has established a number of schemes designed to help improve the energy efficiency of housing and therefore reduce the number of cold homes. These include the Energy Company Obligation[68], the Winter Fuel Payment, Cold Weather Payment, and a number of advice and outreach programmes[69]. There are also a number of discontinued schemes such as the Warm Front, Green Deal[70] and the Warm Homes Healthy People Fund. The latter scheme distributed £20m in funds to local authorities to prevent cold related excess winter deaths and was considered to be effective in targeting resources and promoting partnership working[71]. In addition local authorities have their own (albeit limited) discretionary grants to help vulnerable or low income people improve the condition of their home.

The government has introduced a number of pieces of legislation designed to improve the energy efficiency of properties. The Energy Conservation Act included a commitment to reduce fuel poverty by 2016 and in 2014 the government has set a target to make all properties EPC rating of E or above by 2020. The government has also introduced legislation (Energy Act 2011) that will make it illegal to rent domestic properties with an EPC rating of F or G from 2018[72]. Nevertheless the number of fuel poor increased from 1.2m to 4.6m between 2004 and 2010 and is expected to

[65] Marmot Review 'The Health Impact of Cold Homes and Fuel Poverty. Available online at http://www.cieh.org/policy/housing/poor-housing.html,
[66] 'Cutting the cost of keeping warm' Department of Energy and Climate Change https://www.gov.uk/government/publications/cutting-the-cost-of-keeping-warm
[67] 'Housing Memorandum of Understanding' http://www.cieh-housing-and-health-resource.co.uk/phe-housing-and-health-strategy/
[68] https://www.ofgem.gov.uk/environmental-programmes/energy-company-obligation-eco
[69] Healthy Places Toolkit http://www.healthyplaces.org.uk/themes/healthy-housing/fuel-poverty/
[70] https://www.gov.uk/green-deal-energy-saving-measures/overview
[71] PHE Warm Front Scheme evaluation http://webarchive.nationalarchives.gov.uk/20140714084352/http:/www.hpa.org.uk/webc/HPAwebFile/HPAweb_C/1317140133236
[72] http://www.caxtons.com/index.php?option=com_content&view=article&id=147&Itemid=533

rise further due to expected increases to the costs of energy[73]. There is also the concern that the growth in the private rented market will exacerbate the problem as privately rented accommodation tends to have worse energy efficiency performance.[74]These developments must also be considered in the context of financial constraints on both national and local government spending, changes to the welfare system and an ageing population. Older people, as well as being more vulnerable to the consequences of a cold home, are also more likely to live in homes with poor energy efficiency.[75]

To tackle cold homes, the recommendations of the Local Government Association[76] and Public Health England[77] are for local authorities to work to improve energy efficiency. They recommend preventative activities as well as partnership working and effective data sharing in order to ensure that measures are targeted at the most vulnerable.

A good case study is that of the Season Health Interventions Network (SHINE), led by the London Borough of Islington[78]. The service shows the value in partnership working, and ensuring that interventions are targeted. SHINE is a multi-agency programme involving agencies providing health, social care and housing services and aims to reduce excess winter deaths primarily through combatting low indoor temperatures. Frontline staff refer vulnerable people from groups such as over 75s, low income families with young children and people with long term cardiovascular or respiratory illnesses to advisors who then can refer them onto an appropriate service. These services can be housing (such as grants for home improvements), advice (such as information on benefits) or health (such as flu jabs or falls assessments). As a result of the programme it is estimated that SHINE has reached over 5,000 vulnerable people, reduced energy bills by an average of £200 and helped to ease the pressure on local health services[79].

Other housing hazards

Excess cold is the single biggest financial cost to the NHS; however there is evidence that other housing hazards can have a negative impact on health and wellbeing. The Housing Act (2004) brought in the Housing Health and Safety Rating

[73] Marmot Review 'The Health Impact of Cold Homes and Fuel Poverty. Available online at http://www.cieh.org/policy/housing/poor-housing.html,

[74] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/319280/Fuel_Poverty_Report_Final.pdf

[75] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/357409/Review7_Fuel_poverty_health_inequalities.pdf

[76] http://www.local.gov.uk/documents/10180/49936/130729_Fuel+poverty+paper/6886a205-2985-4dea-8fbe-3e45bd456473

[77] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/252854/Cold_Weather_Plan_2013_Making_the_Case_final_v2.pdf

[78] http://nhfshare.heartforum.org.uk/RMAssets/Casestudies/IslingtonSHINE.pdf

[79] http://www.ashden.org/winners/Islington15

System (HHSRS) which provides a system for local authorities to classify hazards in the home and gives them powers to take action if minimum housing standards are not met (otherwise known as category 1 hazards)[80].

The BRE has calculated a number of category hazards, other than excess cold, that have a particularly severe financial impact on the NHS. These include a number of hazards related to falls, fire and carbon monoxide, damp and mould, and entrapment.[81] In addition the physical injury the Department of Health identified good housing as a key component of mental health. Evans et al (2003), found in a literature review that poor housing correlated with poor mental health and suggest this was partly caused by a decline in social status and increased insecurity[82].

As with excess cold, housing hazards disproportionally affect vulnerable groups including older people and children. As well as being at greater risk, vulnerable people are more likely to live in non-decent accommodation[83]. Libmen (2012) argues that socio-economic exclusion can result in people with poor health being forced to live in poor housing, which then exacerbates the problems[84]. Poor housing can therefore be seen as both a cause and effect of health inequality. A number of studies have found that health positively correlates with household wealth[85] or tenure[86]

Ormandy (2014) and Shaw (2004) found that children are particularly at risk of sustaining physical injury from hazards in the home and that in Europe home injury is the leading cause of deaths amongst under 5s [87] [88]. The WHO estimates that damp and mould can be linked to the deaths of 83 children across Europe each year due

[80] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/7853/safetyratingsystem.pdf

[81] http://www.bre.co.uk/filelibrary/pdf/87741-Cost-of-Poor-Housing-Briefing-Paper-v3.pdf

[82] Cited in Barratt et al 'Beyond Safety to Wellbeing' http://repository.essex.ac.uk/8584/1/0d6067ac-5c2a-4941-9edc-0e5c7bb56fcb.pdf

[83] Donald I. 2009 'Housing and Health for Older People' http://ageing.oxfordjournals.org.ezproxy.herts.ac.uk/content/38/4/364

[84] Libman et al. 2012, 'Housing and Health: A Social Ecological Perspective' http://ud7ed2gm9k.search.serialssolutions.com/?ctx_ver=Z39.88-2004&ctx_enc=info%3Aofi%2Fenc%3AUTF-8&rfr_id=info:sid/summon.serialssolutions.com&rft_val_fmt=info:ofi/fmt:kev:mtx:journal&rft.genre=article&rft.atitle=Housing+and+health%3A+A+social+ecological+perspective+on+the+us+foreclosure+crisis&rft.jtitle=Housing%2C+Theory+and+Society&rft.au=Libman%2C+Kimberly&rft.au=Fields%2C+Desiree&rft.au=Saegert%2C+Susan&rft.date=2012-03-01&rft.issn=1403-6096&rft.eissn=1651-2278&rft.volume=29&rft.issue=1&rft.spage=1&rft.epage=24&rft_id=info:doi/10.1080%2F14036096.2012.624881&rft.externalDBID=n%2Fa&rft.externalDocID=364479727&paramdict=en-UK

[85] Shaw, M. 'Housing and Public Health' Annu. Rev. Public Health 2004. 25:397–418. Available online at http://www.annualreviews.org.ezproxy.herts.ac.uk/doi/pdf/10.1146/annurev.publhealth.25.101802.123036

[86] McCann et al 2012 'Why is Why is housing tenure associated with a lower risk of admission to a nursing or residential home? http://jech.bmj.com.ezproxy.herts.ac.uk/content/66/2/166

[87] Ormandy D. 'Housing and Child Health' Paediatrics and Child Health Volume 24, Issue 3, March 2014, Pages 115–117 available online at http://www.sciencedirect.com/science/article/pii/S1751722213002072

[88] Shaw, M. 'Housing and Public Health' Annu. Rev. Public Health 2004. 25:397–418. Available online at http://www.annualreviews.org.ezproxy.herts.ac.uk/doi/pdf/10.1146/annurev.publhealth.25.101802.123036

to their association with asthma[89]. For older people hazards caused by fire and by falls are particularly problematic[90]. Older people spend a greater proportion of their time at home; those over 80 spend on average 90% of their time in the house[91] which increases the risk from housing hazards. As mentioned above, damp and mould are linked with respiratory illnesses which are a leading cause of ill health amongst older people. Although the evidence of the effectiveness of interventions to tackle problems with damp and mould in reducing respiratory illness is not as clear as interventions to reduce excess cold[92].

Private rented accommodation is seen huge growth with estimates suggesting the market is 30% larger than in 2005[93]. The continuing growth in house prices coupled with changes to government welfare and social housing policies mean that this sector is likely to growth further (for more detail see 'Homelessness' section). As mentioned above, private rented accommodation is generally of a much worse standard than social housing or privately owned property. One particular change in the housing benefit rules for single people under 35 means that there will be an increased demand for Homes of Multiple Occupation (HMOs) which have the highest levels of non-decency and risk of death and injury[94].

Addressing the health impact of these wider housing hazards has not generated the same level of focus as excess cold. Nevertheless it is worthwhile to outline the legislative and policy landscape and policy trends.

As mentioned above the Housing Act (2004) introduced the HHSRS rating system and established minimum standards of housing. In addition the Act legislated for the licencing of HMOs by local authorities. Other relevant legislation includes the Deregulation Act (2015), which prevents tenants from being evicted within 6 months of an improvement order being made to a landlord[95], and new regulations for landlords on smoke and carbon monoxide detectors. This is in addition to the Energy Act (2011) which as mentioned above, will restrict the renting of homes with poor energy efficiency.

The above legislative framework places a burden on private and social landlords and gives local authorities tools to conduct enforcement and give advice. However key

[89] WHO: Quantifying Health Impact of Housing available online at http://www.euro.who.int/__data/assets/pdf_file/0017/145511/e95004sum.pdf?ua=1
[90] Shaw, M. 'Housing and Public Health' Annu. Rev. Public Health 2004. 25:397–418. Available online at http://www.annualreviews.org.ezproxy.herts.ac.uk/doi/pdf/10.1146/annurev.publhealth.25.101802.123036
[91] Donald I. 2009 'Housing and Health for Older People' http://ageing.oxfordjournals.org.ezproxy.herts.ac.uk/content/38/4/364
[92] Web et al 2012 'Housing and Respiratory Health at Older Ages' http://jech.bmj.com.ezproxy.herts.ac.uk/content/67/3/280
[93] Barratt et al 'Beyond Safety to Wellbeing' http://repository.essex.ac.uk/8584/1/0d6067ac-5c2a-4941-9edc-0e5c7bb56fcb.pdf
[94] Barratt et al 'Beyond Safety to Wellbeing' http://repository.essex.ac.uk/8584/1/0d6067ac-5c2a-4941-9edc-0e5c7bb56fcb.pdf
[95] http://www.legislation.gov.uk/ukpga/2015/20/contents/enacted

challenges remain in identifying and tackling housing hazards. Local authorities rely predominantly on referrals meaning many cases of hazardous housing are missed[96]. This is especially problematic in the private rented sector due to fears amongst tenants that complaints about the quality of their housing may lead to eviction[97]. Research by Crew (2007) indicates that enforcement activity in HMOs increases the likelihood of eviction or increased rental costs[98]. More generally local authorities struggle with a lack of resources and burdensome legal processes which force them to rely on informal methods of enforcement[99].

This review found that policy trends suggest that a more proactive approach to improve the condition of housing is necessary that includes multi-agency partnerships. The MOU on Housing notes the importance of housing and health providers working in partnership to improve the condition of housing through forums such as Health and Wellbeing Boards. In addition The Care Act (2014) makes explicit that housing must be considered by both health and housing providers to be a component of a person's health and wellbeing[100]. The Chartered Institute of Environmental Health (CIEH) also recommends a multi-agency approach and notes the importance of local authority environmental health officers in providing a robust evidence base of the health impact of their work[101]. However a survey by the Housing LIN suggests that there is an uneven picture of cooperation between housing and health providers across the country despite the evidence suggesting the close relationship between housing and health. There are particular challenges around effective communication and data sharing[102].

The CIEH has published a number of case studies of initiatives to improve housing conditions. Common features include a proactive approach to identifying and

[96] Housing Learning and Improvement Network, 'Housing and Health: Under One Roof. Available online at www.housinglin.org.uk/_library/Resources/Housing/Support_materials/Viewpoints/HLIN_Viewpoint55_PublicHealth.pdf

[97] CIEH: Effective Strategies and Interventions http://www.cieh.org/policy/Effective_Strategies_and_Interventions_Environmental_health_and_the_private_housing_sector.html

[98] Crew 2007 cited in Barratt et al http://repository.essex.ac.uk/8584/1/0d6067ac-5c2a-4941-9edc-0e5c7bb56fcb.pdf

[99] Stewart & Bourn. 2013 'The Environmental Health Practitioner' http://rsh.sagepub.com/content/early/2013/08/29/1757913913491366

[100] http://www.housinglin.org.uk/Topics/type/resource/?cid=9366

[101] CIEH: Effective Strategies and Interventions http://www.cieh.org/policy/Effective_Strategies_and_Interventions_Environmental_health_and_the_private_housing_sector.html

[102] http://www.housinglin.org.uk/_library/Resources/Housing/Support_materials/Viewpoints/HLIN_Viewpoint55_PublicHealth.pdf

address instances of poor housing, improved sharing of data and communication channels, and the pooling of resources between different agencies[103].

A good example of partnership working is the Wirral Healthy Homes Project; a project between the local authority environmental health officers and the NHS[104]. Environmental Health officers used housing data and data on vulnerable people (provided by the NHS) to identify areas that were likely to have poor housing and vulnerable people. The NHS provider then funded Environmental Health officers to do proactive visits to residents in these areas to offer a housing and health assessment. If necessary this was followed by advice or referrals to various housing or health service providers. As a result of this targeted approach almost 1,000 vulnerable people have received support with energy efficiency, fire safety, and health. The project has also helped to strengthen partnerships between housing and health frontline staff and there are future shared project planned as a result.

Housing for vulnerable or older people

As mentioned above, vulnerable groups such as older people or those with long term conditions are particularly affected by poor housing. The HHSRS requires local authorities to consider the vulnerability of the occupants of a home when assessing hazard. Many hazards that may only have a limited effect on non-vulnerable groups may constitute a category 1 hazard if the occupant is vulnerable[105].

With regard to older people, the number of over 65s has grown by 47% since 1974 to equal 18% of the population with further growth predicted[106]. In addition 79% of over 65s are owner occupiers[107] and so are living in private accommodation. Despite this, only 1 in 20 homes are fully accessible to people with disabilities[108]. As noted above older people spend more of their time at home and are particular vulnerable to the effects of housing hazards. The upshot of this is that there is a growing problem around the provision of housing that is safe for vulnerable and older people.

This section of the review will look at what provisions are being made to address these issues. This will include a consideration of home improvements and adaption

[103] CIEH: Effective Strategies and Interventions http://www.cieh.org/policy/Effective_Strategies_and_Interventions_Environmental_health_and_the_private_housing_sector.html
[104] CIEH: Effective Strategies and Interventions http://www.cieh.org/policy/Effective_Strategies_and_Interventions_Environmental_health_and_the_private_housing_sector.html
[105] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/7853/safetyratingsystem.pdf
[106] Parliamentary Briefing Paper 'Housing an Ageing Population'. http://researchbriefings.parliament.uk/ResearchBriefing/Summary/CBP-7423
[107] Parliamentary Briefing Paper 'Housing an Ageing Population'. http://researchbriefings.parliament.uk/ResearchBriefing/Summary/CBP-7423
[108] Parliamentary Briefing Paper 'Housing an Ageing Population'. http://researchbriefings.parliament.uk/ResearchBriefing/Summary/CBP-7423

schemes, the provision of specialist accommodation, and finally the support available to help people remain independent in their home.

Home adaptions and improvements

As noted above, much of the UK housing stock is not appropriate for the needs of people with disabilities. Some of these problems can constitute category 1 hazards that have a financial impact on the NHS and society in general. Whilst new housing today is becoming increasingly accessible it only represents a small proportion of the total housing stock[109]. In addition only 5% of older people live in specialist accommodation[110]. This suggests the importance of improving the accessibility of existing housing stock for vulnerable people. Solutions range from minor improvements such as garden clearance, to telecare systems and other forms of specialist equipment and adaptions.

There is evidence of the preventative role that housing adaptions can have. A study of 11 local authorities found that 40% of people with adapted homes had had falls prior to the adaption[111]. A literature review by Heywood and Turner (2007) found that home adaptions can save health and social care providers money by reducing the need for more intensive home or residential care and reducing the likelihood of falls[112].

Since the 1990 NHS and Community Care Act[113] local authorities have had statutory duty to provide home adaptions and practical support to people with disabilities. The Care Act (2014) outlined the role that housing adaptions can play in improving health and wellbeing[114]. The government's 'Housing for Vulnerable People' strategy[115] includes a commitment to fund the work of home improvement agencies (funded via the Supporting People Grant[116]) and maintain grants for home adaptions.

The largest pool of funding for home adaptions is the Disabled Facilities Grant. Since 2010/11 the grant was no longer ring fenced and from April 2015 is allocated to

[109] Housing LIN 'A Progressive Approach to Accessible Housing' http://www.housinglin.org.uk/_library/Resources/Housing/Support_materials/Viewpoints/Viewpoint_22_Accessible_Housing.pdf

[110] Parliamentary Briefing Paper 'Housing an Ageing Population'. http://researchbriefings.parliament.uk/ResearchBriefing/Summary/CBP-7423

[111] Cited in Housing LIN 'From Home Adaptions to Accessible Homes' http://www.housinglin.org.uk/_library/Resources/Housing/Practice_examples/Housing_LIN_case_studies/HLIN_CaseStudy_62_Adaptations.pdf

[112] Heywood & Turner 2007. 'Better Outcomes, Lower Costs' http://www.wohnenimalter.ch/img/pdf/better_outcomes_report.pdf

[113] http://www.legislation.gov.uk/ukpga/1990/19/contents/enacted

[114] http://careandrepair-england.org.uk/wp-content/uploads/2014/12/Care-Act-Integration-Briefing-2-final.pdf

[115] https://www.gov.uk/government/publications/2010-to-2015-government-policy-housing-for-older-and-vulnerable-people/2010-to-2015-government-policy-housing-for-older-and-vulnerable-people

[116] http://researchbriefings.files.parliament.uk/documents/SN03011/SN03011.pdf

higher tier authorities as part of the Better Care Fund[117]. This means that higher and lower tier authorities will need to work together in administering the grant[118], causing some concern amongst lower tier authorities over the loss of direct control[119].

Despite the ongoing commitment from government to fund Disabled Facilities Grants there is evidence that demand for home adaptions outstrips supply with cases of people waiting years for adaptions[120]. This impacts the ability of home adaptions to fulfil their function in helping people to remain independent and prevent the need for more acute services[121].

The challenge for local authorities is how to meet the demand for home adaptions in times of budgetary constraint. The Chartered Institute of Housing recommends[122] the more strategic use of existing stock through closer working the Occupational Therapist and the matching of adapted social housing with tenants most in need. An example was given of a scheme in Salford where there is a separate housing register for people in need of adapted housing. The CIH also notes the value in encouraging people to either downsize or move into specialist accommodation, and thus avoiding the need for a home adaption[123].

Bristol City Council has been successful at creating a more cost effective and person centred home adaptions service that could serve as a model of best practice[124]. Originally the work was split between different directorates that made a slow and unresponsive service for customers. The council decided to create an integrated team with one manager responsible for the entire service. A caseworker was given the role of referring applications to the most appropriate channel so that cases are dealt with more efficiently. In addition they have increased the housing advice available to applicants to support them to explore alternative housing options. The result is a faster system with waiting times being reduced form an average of 71 weeks to an average of 40 weeks and net revenue savings of over £600k.

<u>Specialist Accommodation</u>

[117] http://www.housinglin.org.uk/_library/Resources/Housing/OtherOrganisation/HABINTEG_DFG_Briefing_Single_Page.pdf
[118] http://careandrepair-england.org.uk/wp-content/uploads/2015/04/Integration-Briefing-1-DFG-BCF-Final-April-15.pdf
[119] The DFG Good Practice Guide www.cieh.org/**Work**Area/DownloadAsset.aspx?id=49154
[120] http://www.housinglin.org.uk/_library/Resources/Housing/OtherOrganisation/No_Place_Like_Home_dec_14.PDF
[121] http://www.housinglin.org.uk/Topics/browse/Design_building/AccessibleDesign/accessibility-adaptability/?parent=9082&child=9734
[122] http://www.housinglin.org.uk/_library/Resources/Housing/Support_materials/Other_reports_and_guidance/How_to_make_effective_use_of_adapted_properties.pdf
[123] http://www.housinglin.org.uk/_library/Resources/Housing/Support_materials/Other_reports_and_guidance/How_to_make_effective_use_of_adapted_properties.pdf
[124] http://www.housinglin.org.uk/_library/Resources/Housing/Practice_examples/Housing_LIN_case_studies/HLIN_CaseStudy_62_Adaptations.pdf

This review will look at three forms of specialist accommodation; residential care, extra care housing and sheltered/retirement accommodation.

Residential care represents the more acute end of the housing spectrum and is more expensive than sheltered/retirement accommodation or extra care housing[125]. Nevertheless effective residential care provision is essential to reducing the need for hospitalization amongst older, vulnerable people[126]. The NHS has recognised that improving the quality of care provided to people in residential care is crucial to reduce pressure on hospitals and improving health[127]. This has led to the piloting of various 'vanguard' schemes across the country aimed at both training care home staff and increased provision of NHS health services in the care home setting[128].

There are concerns about the future financial viability of residential care nationally. A report by Respublica indicated that the impact of austerity and an ageing population were likely to lead to a £1 billion funding gap by 2020 that would impose a £3 billion cost to the NHS in additional demand for beds and acute services[129]. Addressing this gap will require extra investment in primary, secondary and tertiary prevention.

Research has indicated the existing and potential role of housing options that lie in between general accommodation and residential care. This includes sheltered accommodation (socially rented)/ retirement homes (private sector), and extra care schemes that will be considered in turn.

Sheltered accommodation refers to social housing where residents live in self-contained properties that have been adapted to be accessible for older people. There is also usually a warden living on site and communal facilities[130]. Retirement homes/villages serve a similar function in the private sector. By providing older people with more appropriate accommodation and support sheltered accommodation can delay or prevent the need for residential care[131]. Research has indicated the potential for sheltered housing to be more closely linked to health providers and improve the health knowledge of sheltered housing officers by building on the

[125] http://www.housinglin.org.uk/_library/Resources/Housing/Support_materials/ASSET_summary_findings.pdf

[126] http://www.housinglin.org.uk/_library/Resources/Housing/OtherOrganisation/ResPublica-The-Care-Collapse.pdf

[127] NHS 5 Year Forward View https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

[128] Overview of NHS Vanguards programme https://www.england.nhs.uk/wp-content/uploads/2015/11/new_care_models.pdf

[129] Respublica 'The Care Collapse' http://www.housinglin.org.uk/_library/Resources/Housing/OtherOrganisation/ResPublica-The-Care-Collapse.pdf

[130] http://www.housingcare.org/jargon-sheltered-housing.aspx

[131] Housing LIN 'Making Use of our Sheltered Housing Asset http://www.housinglin.org.uk/_library/Resources/Housing/SHOP/HLIN_SHOPBriefing3_SHA_v3.pdf

recognition and trust they have built amongst residents[132]. Sheltered housing can also be used as a stage in the process of moving someone from a hospital bed, back into general accommodation[133].

A good example of this potential can be found in a case study of North Tyneside Homes who worked in partnership with their local CCG on a project to improve the health of tenants in their sheltered housing scheme[134]. Sheltered Housing officers received health training in order to offer a Health Needs Assessment of tenants as well as basic advice around falls prevention. There was also work done to improve the referrals of tenants by housing officers into NHS falls prevention and minor injuries services. The partnership meant that health services were more closely matched with the tenants needs and improved their cost effectiveness.

Extra care housing provides a level of support which is higher than that in sheltered accommodation but falls short of residential care. In extra care housing, as in sheltered accommodation, people have residency rights and retain their own 'front door'. However there is access to a range of 24/7 health and community services on site[135]. In doing so, it provides residents with medium-level needs the support they need to delay or prevent the need for institutional care[136]. There is evidence that Extra care housing can reduce the chance of falls, the number of hospital admissions and length of hospital stays and can save the NHS £75,000 per year per person[137]. Extra care is also more cost effective than residential care which has a financial implication for local authorities.[138] Feedback from residents of Extra care schemes is positive and suggests that people appreciate having support whilst retaining independence (compared with being in residential care)[139]. According to the Housing LIN, Extra care is now widely accepted as being a key part of health and social care commissioning[140].

The value of extending and improving the provision of various levels of specialist accommodation is widely recognised[141]. The government's most recent 'Housing

[132] http://www.housinglin.org.uk/_library/Resources/Housing/Housing_advice/EROSHhealth_leaflet2007newlogo.pdf
[133] http://www.housinglin.org.uk/_library/Resources/Housing/SHOP/HLIN_SHOPBriefing3_SHA_v3.pdf
[134] http://www.housinglin.org.uk/Topics/browse/Housing/HousingforOlderPeople/ShelteredHousing/?parent=8956&child=9412
[135] Housing LIN 'Extra Care Housing' http://www.housinglin.org.uk/_library/Resources/Housing/Housing_advice/Extra_Care_Housing_-_What_is_it_2015.pdf
[136] http://www.housinglin.org.uk/_library/Resources/Housing/OtherOrganisation/Older-Owners.pdf
[137] Housing LIN 'Extra Care Housing' http://www.housinglin.org.uk/_library/Resources/Housing/Housing_advice/Extra_Care_Housing_-_What_is_it_2015.pdf
[138] http://www.housinglin.org.uk/_library/Resources/Housing/Research_evaluation/PSSRUsummary.pdf
[139] http://www.housinglin.org.uk/_library/Resources/Housing/Research_evaluation/PSSRUsummary.pdf
[140] http://www.housinglin.org.uk/Topics/browse/HousingExtraCare/
[141] Age UK 'Housing in Later Life' http://www.housinglin.org.uk/Topics/browse/Housing/HousingforOlderPeople/?parent=8955&child=9340

Strategy for England' aims to encourage local authorities to deliver more specialist accommodation include Extra care schemes[142] and there is government recognition of the value of using sheltered accommodation to provide direct health services to residents[143]. The All Parliamentary Group on inquiry on housing and care for older people concluded that the provision of specialist housing ought to be extended due to its potential to prevent the need for more acute care[144].

Nevertheless, key challenges remain around funding and costs. Extra care schemes in particular require a certain scale to be effective and government austerity means that availability of capital funding remains limited[145].The complexity of services provided by extra care (housing, health and social care services), the different needs and means of residents and the drive towards the personalisation of care makes funding equally complex[146]. The risk of a loss of local government funding (now that the Supporting People grant is no longer ring fenced), coupled with the decline in block contracts (as a result of personalisation), makes Extra care developments risky for housing providers[147]. For sheltered accommodation, challenges remain around the quality of housing and its attractiveness to older people[148]. Many homes are bedsits or are placed in locations away from key services and amenities. This means that much of sheltered accommodation needs to be rebuilt, refurbished or remodelled, each of which has a cost implication for the local authority or registered provider[149].

Support to remain independent in the home

In addition to the provision of home adaptions or specialist accommodation, there are also services available that allow an older or vulnerable person to remain in general accommodation. These services can help a person to remain independent, as well as acting to prevent the need for more acute (and expensive) housing

[142] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/7532/2033676.pdf
[143] http://www.housinglin.org.uk/_library/Resources/Housing/Housing_advice/EROSHhealth_leaflet2007newlogo.pdf
[144] http://www.housinglin.org.uk/Topics/browse/Design_building/HAPPI/?parent=8649&child=8650
[145] Housing LIN 'Funding Extra Care Housing' http://www.housinglin.org.uk/_library/Resources/Housing/Support_materials/Technical_briefs/Part1BackgroundPreliminaryTopics.pdf
[146] Housing LIN 'Funding Extra Care Housing' http://www.housinglin.org.uk/_library/Resources/Housing/Support_materials/Technical_briefs/Part1BackgroundPreliminaryTopics.pdf
[147] http://www.housinglin.org.uk/_library/Resources/Housing/Housing_advice/Extra_Care_Housing_-_What_is_it_2015.pdf
[148] http://www.housinglin.org.uk/_library/Resources/Housing/SHOP/HLIN_SHOPBriefing3_SHA_v3.pdf
[149] http://www.housinglin.org.uk/_library/Resources/Housing/SHOP/HLIN_SHOPBriefing3_SHA_v3.pdf

solutions[150]. For older people, difficulties in accessing basic housing support are a key driver to seeking specialist accommodation solutions[151].

This report will consider the provision of adult domiciliary care and the development of home-based services delivered by the NHS.

Adult domiciliary care is funded by local authorities and is designed to provide the resident with the personal support to help them remain independent in their home. It includes help with things like personal hygiene, preparing meals or home maintenance[152]. The Care Act (2014) helped to formalise the statutory responsibility of local authorities to provide means-tested home care, and for each person receiving care to have a personal budget[153].

Nevertheless the ability of local authorities to meet people's needs is being constrained by financial pressures and demographic changes. Real spending on adult social care has declined by £1.2 billion between 2010/11 and 2013/14 whilst the number of over 65s has increased by over a fifth in the last 10 years[154]. It is estimated that there is a £700m gap in spending on adult social care[155]. These financial and demographic pressures are leading to a tightening of the eligibility criteria for people to receive support leaving many people with less support or having support withdrawn entirely[156]. In a survey of older people it was found that 12% of people that had 3 or more permanent barriers to living independently were not receiving any care services whatsoever[157].

The close relationship between adult social care and the NHS is well documented[158]. Research by the Kings Fund found that 9/10 NHS Trust Finance Directors believed

[150] http://www.housinglin.org.uk/Topics/browse/CareAndSupportatHome/InnovativeServiceProvision/?parent=9756&child=9645

[151] Age UK 'Housing in Later Life' http://www.housinglin.org.uk/Topics/browse/Housing/HousingforOlderPeople/?parent=8955&child=9340

[152] http://www.carechoices.co.uk/care-types/domiciliary/

[153] https://www.nao.org.uk/wp-content/uploads/2015/03/Adult-social-care-in-England-overview-summary.pdf

[154] Age UK 'The Health and Care of Older People in England 2015' http://www.housinglin.org.uk/_library/Resources/Housing/OtherOrganisation/Briefing-The_Health_and_Care_of_Older_People_in_England-2015.pdf

[155] Parliamentary Briefing http://researchbriefings.files.parliament.uk/documents/LLN-2015-0047/LLN-2015-0047.pdf

[156] Age UK 'The Health and Care of Older People in England 2015' http://www.housinglin.org.uk/_library/Resources/Housing/OtherOrganisation/Briefing-The_Health_and_Care_of_Older_People_in_England-2015.pdf

[157] http://www.housinglin.org.uk/_library/Resources/Housing/OtherOrganisation/Open-Plan-Building-a-strategic-policy-toward-older-owners.pdf

[158] Parliamentary Briefing http://researchbriefings.files.parliament.uk/documents/LLN-2015-0047/LLN-2015-0047.pdf

that the financial pressures on adult social care was having a negative impact on health services[159]. A Kings Fund report argues that the integration of health and social care services are fundamental to the financial viability of both[160]. To this end, the government has introduced the Better Care Fund which pooled money for the NHS and local government to spend on better aligning health and social care services including the provision of services to help people remain independent in the community[161]. Nevertheless the Better Care Fund only represents 5% of the NHS and adult social care budget

The relationship between health and the absence of stable accommodation can be seen in terms of the direct health impact of homelessness, and the indirect health impact arising from the challenges homeless people face in accessing health services.

The evidence that homeless people have poor health is stark. A survey by Homeless Link[162] found that 41% of homeless people had a long term health condition (against 28% in general population) and 45% had being diagnosed with a mental health issue (25% in general population). Substance abuse is particularly problematic with 39% of homeless people either taking drugs or recovering from a drug problem. Half of homeless people reported drinking or taking drugs to help cope with mental health issues. Issues around substance abuse are particularly relevant to Public Health as a statutory provider of substance abuse related services.

Whilst the above data doesn't indicate whether homelessness is a causal factor in these health outcomes there is evidence to suggest that poor health and homelessness are co-related; health problems can put people at greater risk of becoming losing secure accommodation, and the absence of secure accommodation can cause or exacerbate poor health.

A number of studies have investigated the ways in which the experience of homelessness can contribute to poor health outcomes:

- Rough sleeping can involve exposure to extreme temperatures or damp conditions. This can cause new health problems or exacerbate existing ones[163].
- Rough sleeping can also can contribute to skin and foot problems[164].

[159] https://www.alzheimers.org.uk/site/scripts/news_article.php?newsID=2486
[160] http://www.housinglin.org.uk/_library/Resources/Housing/OtherOrganisation/Options-integrated-commissioning-Kings-Fund-June-2015_0.pdf
[161] http://www.local.gov.uk/health-wellbeing-and-adult-social-care/-/journal_content/56/10180/4096799/ARTICLE
[162] http://www.homeless.org.uk/facts/our-research/homelessness-and-health-research
[163] See reference 10
[164] Cited in Hwang 'Homelessness and Health' Available online at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC80688/?tool=pmcentrez#r23-27

- Poor health outcomes can also arise from living in hostels or other forms of temporary accommodation where there can be problems related to hygiene and safety[165].
- Conditions favouring TB outbreaks in temporary accommodation include crowding, large transient populations and inadequate ventilation[166].
- Homeless people (rough sleepers and those living in hostels) are at increased risk of physical violence; a study in Toronto found that 40% of homeless people had been physically assaulted[167].

Substance abuse can be the cause of a person becoming homeless. A survey of homeless people with substance abuse issues found that in the majority of cases drug abuse was the primary reason behind them being evicted from rented accommodation or being asked to leave a family home[168]. Other research suggests that homelessness can make people more vulnerable to developing substance abuse issues as a way of coping with the stress and hardship of daily life[169]. A survey of homeless people in London found that 80% of homeless people had started using at least 1 new drug since becoming homeless and 72% of those with lifetime addictions to cocaine started after becoming homeless[170].

For mental health, becoming homeless can exacerbate existing conditions, and make that person more vulnerable (e.g. to crime or physical harm)[171]. One study suggests that the stress caused by the threat the breakdown of tenancies and experience of eviction can exacerbate existing mental illnesses[172]. However a survey of homeless people with mental health issues found that the primary cause of their homelessness was barriers accessing housing due to low income or unemployment[173], rather than their mental health issues.

This suggests that structural solutions, such as wider availability of low-cost housing and income support, would reduce the risk of homelessness among persons with mental illness, as among other vulnerable social groups. However it is important to

[165] See reference 10
[166] An outbreak of tuberculosis in a shelter for homeless men. A description of its evolution and control. http://www.ncbi.nlm.nih.gov/pubmed/1990937
[167] Cited in Hwang 'Homelessness and Health' Available online at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC80688/?tool=pmcentrez#r23-27
[168] 'Homelessness amongst drug users: a double jeopardy explored' International Journal of Drug Policy 12 (2001) 353–369
[169] As Above
[170] Homelessness and Drug Use: Evidence from a Community Sample http://www.sciencedirect.com.ezproxy.herts.ac.uk/science/article/pii/S0749379707001043
[171] 'Mental Health and Homelessness: The Challenge: http://isp.sagepub.com.ezproxy.herts.ac.uk/content/61/7/621
[172] 'Homelessness and Complex Trauma' http://www.homelesspages.org.uk/node/24195
[173] Perceived reasons for loss of housing and continued homelessness among homeless persons with mental illness'. http://www.ncbi.nlm.nih.gov/pubmed/15703344

note that mental health can contribute to poverty and unemployment through discrimination or social exclusion, and therefore cause homelessness indirectly[174].

Homelessness can also have an indirect negative health impact due to the barriers homeless people have in accessing health services. People who live in temporary accommodation or are sleeping rough are much less likely to use GP services despite the potential community based services have to reduce the need for acute care[175]. A review of the health needs and healthcare costs of rough sleepers in London found that barriers to accessing services include discrimination by health professionals, not being allowed to register with a GP, a lack of knowledge of services, a lack of continuity of care, and cost[176].

The difficulty homeless people face in accessing appropriate health care increases their dependency on acute health services. The A&E attendance rates of homeless people are 4 times higher than the general population[177], with 35% visiting A&E in the last 6 months[178]. Homeless people are more likely to be admitted to hospital and stay for longer, due to their acute health needs[179].

Regardless of the cause and effect relationship between health and housing, there are studies indicating the positive impact the provision of secure housing can have on health outcomes. Two studies found that the provision of housing was associated with decreased substance abuse and less reliance on health services[180][181]. A literature review found that people with mental health issues were less likely to become homeless if they were provided with financial assistance to access housing as well as community based health and social services[182].

Appendix B: Stakeholder Meetings

[174] See reference 31
[175] See reference 22
[176] http://www.jsna.info/sites/default/files/Rough%20Sleepers%20Health%20and%20Healthcare%20Summary.pdf.
[177] Public Health England 'Preventing Homelessness to Improve Health and Wellbeing' www.homeless.org.uk/.../Final%20Rapid%20Review%20summary.pdf

[178] See reference 22
[179] St Mungos 'Health and Homelessness: Understanding the Costs' www.mungos.org/documents/4153/4153.pdf
[180] 'To House or Not to House: The Effects of Providing Housing to Homeless Substance Abusers in Treatment' http://ajph.aphapublications.org/doi/abs/10.2105/AJPH.2004.039743

[181] Long-Term Housing and Work Outcomes Among Treated Cocaine-Dependent Homeless Persons http://link.springer.com/article/10.1007%2Fs11414-006-9041-3

[182] 'Effectiveness of interventions to improve the health and housing status of homeless people: a rapid systematic review' http://bmcpublichealth.biomedcentral.com/articles/10.1186/1471-2458-11-638

The following list represents the meetings held with key stakeholders for the project

Name	Organization	Position
Claire Bennett	East Herts District Council	Manager, Housing Services
Sheila Winterburn	East Herts District Council	Manager, Environmental Health (Residential)
Martin Lawrence	North Herts District Council	Strategic Housing Manager
Stephen Tingley	Broxbourne Borough Council	Head of Housing and Benefits
Peter Nourse	Stevenage Borough Council	Assistant Director of Housing
Perry Singh	Watford Borough Council	Interim Housing Section Head Community & Customer Services
Kimberley Grout	Three Rivers District Council	Housing Manager
Sian Chambers	Welwyn Hatfield Borough Council	Head of Housing and Community
David Reavill	St Albans City & District Council	Strategic Housing Manager
Natasha Brathwaite	Dacorum Borough Council	Group Manager, Strategic Housing
Kim Harwood	Hertsmere Borough Council	Housing Services Manager
Iain MacBeath	HCC Health and Community Services	Director, Health & Community Services
Kristy Thakur	HCC Community Wellbeing	Deputy Head of Commissioning
Susan Carter	HCC Community Wellbeing	Commissioning Manager Strategic Development
Belinda Yeldon	HCC Community Protection	Project Lead: Safe and Well Visits
Steve Borrell	HCC Community Protection	Community Risk Reduction & Youth Engagement Team Manager
Kristian Tizzard	HCC Integrated Accommodation Commissioning	Deputy Head of Service
Paul O'Hare	Herts Valleys CCG	Community Navigator Manager
Catherine Hook	YMCA West and Central Hertfordshire	Hostel Manager: Watford and Welwyn Garden City

Contributions were also made by:

1. Herts Beds Housing Group (Senior environmental health officers)
2. Herts Heads of Housing Group (Senior housing officers)
3. Hertfordshire Public Health Board
4. Brian Gale, HCC Public Health, Senior Commissioning Manager
5. Natasha Welsh, HCC Public Health, Commissioning Manager
6. David Conrad, HCC Public Health, Consultant (Evidence & Intelligence)
7. Charlotte Holt, HCC Integrated Care Programme Team, Project Manager (DFG Project)
8. Tiranan Staughan, North Herts District Council, Housing Policy Officer
9. Husnara Malik, HCC Integrated Accommodation Commissioning, Commissioning Manager
10. Tracey Webber, HCC Community Wellbeing, Commissioning and Monitoring Officer
11. Joella Scott, HCC Children's Services, Strategy Manager; Parenting and Early Help Commissioning
12. Andy Luck, Welwyn Hatfield Borough Council, Private Sector Housing Manager
13. Alan Gough and Neil Walker: Watford Borough Council

Appendix C: Review of Home Adaptions, Specialist Accommodation, and Supported Living Services

Health and Wellbeing Impact

Many adults in the UK require services to help them remain in general accommodation such as home adaptions or supported living services, or some form of specialist accommodation. Although Public Health does not have a statutory responsibility to provide support of this kind, the health benefits of these services indicate a potential Public Health interest.

Much of the UK housing stock is not appropriate for the needs of people with disabilities. Whilst new housing today is becoming increasingly accessible, it only represents a small proportion of the total housing stock. This suggests the importance of improving the accessibility of existing housing stock for vulnerable people. Solutions range from minor improvements such as garden clearance, to telecare systems and other forms of specialist equipment and adaptions. There is evidence of the preventative role of housing adaptions; studies have found that home adaptions can reduce the need for more intensive care services and the likelihood of falls.

Despite being the most expensive form of support accommodation, effective residential care provision is essential to reducing the need for hospitalization amongst older, vulnerable people. Nevertheless there are various forms of supported housing that lie in between general accommodation and institutional care.

Sheltered accommodation refers to social housing where residents live in self-contained properties that have been adapted to be accessible for older people. Retirement homes/villages serve a similar function in the private sector. By providing older people with more appropriate accommodation and support sheltered accommodation can delay or prevent the need for residential care. Research has indicated the potential for sheltered housing to be more closely linked to health providers and the benefits of improving the health knowledge of sheltered housing officers.

Extra care housing provides a level of support which is higher than that in sheltered accommodation but falls short of residential care. In extra care housing, as in sheltered accommodation, people have residency rights and retain their own ‘front door’. However there is access to a range of 24/7 health and community services on site. In doing so, it provides residents with medium-level needs the support they need to delay or prevent the need for institutional care. There is evidence that Extra care housing can reduce the chance of falls, the number of hospital admissions and length of hospital stays and can save the NHS £75,000 per year per person.

In addition to the provision of home adaptions or specialist accommodation, there are also services available that allow an older or vulnerable person to remain in general accommodation. These services can help a person to remain independent, as well as acting to prevent the need for more acute (and expensive) housing solutions. For older people, difficulties in accessing basic housing support are a key driver to seeking specialist accommodation solutions.

The above discussion indicates that the provision of these kinds of housing support can help to prevent the health of adults with additional needs from deteriorating, and the associated need for more acute levels of care. This suggests that these services are relevant to Public Health outcomes such as healthy life expectancy, injuries caused by falls amongst older people, and hospital re-admissions and the Public Health priority around helping residents to lead longer, healthier lives.

Local Context

As elsewhere in the country, demand for housing services for older people is being driven by changing demographics. There is an expected increase of 31% between 2013-2020 of people aged over 85. The numbers of people with learning disabilities or mental health needs are both expected to increase by around 5% by 2020, and there are concerns around the additional housing needs of these people as they age. These changes are likely to lead to increased demand on specialist accommodation and other forms of housing support.

Given the evidence cited earlier about the health value of home adaptions, specialist housing and supported living services, these demographic changes, and the resulting growth in demand in Hertfordshire for support, is of interest to Public Health. If the demand for support outstrips supply it is likely to result in a negative impact on the health of vulnerable people and greater demand for more acute care. This implies the preventative value of services, such as home adaptions, intermediate housing or supported living services.

Service provision in Hertfordshire

Home adaptions

Disabled Facilities Grants provide the main source funding to help meet the cost of home adaptions for people with disabilities. Responsibility for administering grants sits with District and Borough councils who previously received the grant from central government. Recent changes mean that funding is now provided via the Better Care Fund and thus pooled at HCC, but with responsibility for provision remaining with the Districts. There is now an ongoing project between HCC and the Districts to decide the delivery model and approach of the service going forward.

Other forms of home adaptions include the Hertfordshire Equipment Service, which provides adaptions such as grab rails, alarms, shower chairs and home nursing

equipment. HCC also provides a county wide service offering telecare equipment to help people remain independent in their home.

Specialist Accommodation

Hertfordshire County Council has a statutory responsibility to provide accommodation for adults with additional needs. Accommodation options range from sheltered housing, to flexicare, to residential care and other forms of institutional care.

In Hertfordshire around 5% of people aged over 75 live in a care home. For care homes there are differences across the County in terms of the number of places available, with some areas having a shortage of nursing home places. Around 40% of places are funded by HCC and there have been increased numbers of self-funders who subsequently require financial support, at additional cost to the council. There are also variations in funding for flexicare and sheltered accommodation.

The provision of support for people with learning disabilities and those with mental health needs is mainly focused on supported living services, rather than specialist housing places. The extent and type of provision varies between districts, particularly for mental health accommodation places which are significantly higher in St Albans and Watford, than in the rest of the County.

Hertfordshire County Council works with partners such as District and Borough councils and housing associations in the planning and provision of specialist accommodation. At present the main forum for partnership is via the dual-district Accommodation Boards. HCC Integrated Accommodation Commissioning team are currently working on a strategy for the future provision of specialist accommodation that will include a consideration of the role that preventative services can play in reducing the demand for high level care.

Finally East and North Herts CCG and HCC have been jointly working on a care homes vanguard project. The aim of the project is to improve the provision of health care services to care home residents. This involves improving the skills, knowledge and confidence of care home staff to help support residents with complex needs and providing a support network of health providers. It also involves a ‘rapid response’ team of healthcare professionals that can visit care homes residents in an emergency and possibly prevent the need for hospital admission.

Supported Living Services

As well as providing various forms of specialist accommodation, there are also services provided to assist people to remain independent in general accommodation. Some of these services, such as those offered to adults with complex needs and community mental health nursing have already been discussed.

Hertfordshire County Council funds personal budgets for eligible adults that can be used to fund services such as domiciliary care or floating support to help people to remain independent. There is also a range of voluntary sector services offering visiting schemes, support for people living with long term conditions, befriending, day care, support groups etc. Many of these services receive funding from HCC Community Wellbeing and the District and Borough Councils.

The NHS provides a number of services to provide help people either avoid hospital admissions or to recover more quickly in their own home. Home First is a service available in parts of Hertfordshire and brings together health and social care professional to provide rapid response care to people in their homes. Other services include GP home visiting, falls prevention, stroke and respiratory illness recovery support.

Evaluation of provision

District and Borough councils all have statutory responsibilities around the provision of DFGs. However there is some variation in the budget allocated for DFGs across the county. Currently the provision of DFGs is fairly fragmented with each District have its own approach for delivery. In the structured interviews a number of Districts reported increased demand, which was putting pressure on their DFG budget, but this situation was not uniform across every District. Generally, however there was an awareness of the value of home adaptions in promoting independence and health, and the likely impact of demographic changes on demand for them.

Demographic changes also inform the JSNA for adults requiring accommodation with care and support. The predicted growth of older people, and people with disabilities, is expected to put extra pressure on residential care. Hertfordshire has surprisingly low levels of nursing care and there are variations in the number of places across the County. There is a desire therefore to expand the provision of other forms of accommodation such as flexicare schemes and sheltered housing, as part of the HCC Integrated Accommodation Commissioning's future strategy.

Although Hertfordshire has not been able to develop the targeted number of extra (flexi) care housing places, it still ranks 6th out of 27 counties for provision. It also has high levels of sheltered housing. Improving the provision and attractiveness of housing for older people, in particular sheltered housing schemes are strategic priorities in District and Borough housing strategies. Senior housing officers all noted the importance of partnership working with HCS Integrated Accommodation Commissioning, in order to make possible the improvement of the provision of these forms of housing.

Appendix D: Excess Winter Deaths: A Hertfordshire Keep Warm Stay Well project

Executive summary, key findings and recommendations

The purpose of this project was to identify the trends and triggers for Excess Winter Deaths (EWD), following a high trend in Watford. The project focussed on those over the age of 65, to identify if there are any opportunities to improve how EWD and cold related illnesses are tackled in Hertfordshire. Further, the purpose was to identify if there are any different ways to target interventions and improve accessibility to Herts Help.

The project was undertaken by two in-home interviews, 12 months apart, where 60 participants were asked about their behaviours, circumstances and perceptions. These participants came from Hertsmere, Watford and Broxbourne. 'Data loggers' and 'energy loggers' were installed into a proportion of properties to provide accurate data on energy consumption, comfort levels and humidity.

These were analysed and a number of patterns and trends were identified. Although many of the findings were specific to Watford and/or Hertsmere, the general principals within the findings are likely to be replicated across Hertfordshire.

Key Report Findings:

* Of the 60 interviewees over the last 12 months there were 843 single health interventions (excluding flu jabs). The largest proportion were revisits to GPs which accounted for 399 of the interventions (47.3%). There were also 65 emergency visits to hospital (7.7%)

* Over 12 months, the health of those aged over 75 decreased significantly in comparison to those in the younger group

* Age was not the sole trigger identified as a cause of EWD; general health and well-being, along with housing conditions, are also significant

* Hertsmere had a more active older population, with more employment

* The participants in Watford suffered a higher level of heart conditions, strokes, lung conditions and mobility issues but despite more health conditions, 60% of those in Watford self-reported their health as 'good' or 'very good'1

* 65-74 year olds suffered with more health conditions than those aged 75 or over, but those aged 75 or older were more likely to suffer with mobility issues, heart conditions and strokes

* Watford has a higher rate of hip fractures than the average for England, suggesting a higher rate of falls - on average 1 in 3 people had had a fall, but those aged 75 or over were 15% more likely to fall than those aged 65-74

[1] The number of health conditions people suffered with affected how they rated their health, as follows "Very Good" 1.1 conditions, "Good" 1.6 conditions, "Fair" 2.4 conditions, "Bad" 2.8 conditions, "Very Bad" 4.5 conditions

* There was clear evidence of a link between limited activities and falls, with 85% of those who had fallen undertaking limited activities. Further, 18 out of 20 people who fell had mobility issues

* 1 in 2 people who fell had no visits from friends or family and 1 in 3 people aged 75 or over deliberately limited their activities due to fear of falling

* 96% of those questioned did not drink the recommended daily amount of water. The worst performing group were those aged 75 or over, with only 22% knowing what the recommended amount of water was

* There was a trend that everyone that had fallen, had not drunk the recommended amount of water

* Every person had at least 1 health intervention over the previous 12 months, but those in Watford had more interventions on average at 15.3 than Hertsmere at

10.8, suggesting that those in Watford had more severe health conditions or more regular need to see a GP. (Age did not impact on the number of interventions and type of intervention)

* 78% of those aged 75 or over lived alone, which was considerably more than the 55% of those aged 65-74

* 65-74 year olds had less visits from family and friends than those aged 75 or over. 65-74 year olds stayed at home most often with 41.7% staying at home, unlike those aged 75 or over, who went out more

* The most vulnerable people, with an average of 2.5 health conditions, had no visits. The healthier a person was, the more likely they had regular visits

* 30% of people did not know at what temperature health risks increased

* When it was cold outside 16% of people deliberately stayed in bed longer

* 11% of people were paying more for their fuel by not using Direct Debit

* 50% of people rely solely on winter fuel payments and cold weather payments to pay for winter bills.

* 13% of older people do not understand their heating controls, with a further 15% not fully understanding how to control their heating

* Awareness of Herts Help was poor, with 81.6% initially not knowing about this service.

* Older people prefer receiving advice via the telephone, with face-to-face their second preferred option. Older people would seek advice from friends and family before approaching the Council (which rated fourth)

Key Report Recommendations

1 Develop/modify/implement strategy for EWD in the light of these findings incorporating the recommendations of the NICE guidance (NG6) “Excess Winter Deaths and Morbidity and the Health Risks Associated with Cold Homes”. This work should be tied in with any Fuel Poverty Strategy and be tailored for each LA area to reflect it’s characteristics.

2 Develop/modify/implement a Fuel Poverty Strategy including adopting the objectives of the Government’s publication ‘Cutting the Cost of Keeping Warm: A New Fuel Poverty Strategy for England”

This could include providing support/funding for measures not covered by Energy Company Obligation (ECO) or equivalent schemes; examples could include:

- Improved/simplified heating controls, using wireless thermostats and thermostatic radiator valves (TRV’s).
- Ventilation solutions to minimise heat loss, but reduce indoor moisture

3 Develop an action plan to prevent falls, such as improved engagement with physical activities and overcoming cultural perceptions. This should also include investigating options for support/funding for direct help such as:

- Fitting handrails and/or grab rails
- Re-fixing loose carpets, etc.
- Investigating the use of ‘Lifeline’ type emergency call systems

4 Improve referral systems to ‘Keep Warm Stay Well’ (KWSW) to include more referrals from health services (especially due to the opportunities from health interventions) and ensure the Herts Help service is offered during flu jabs, GP appointments and hospital discharge. KWSW could include new/additional measures taking account of these findings, these could include:

- Outdoor protective clothing – hat, gloves, scarf, etc.
- Hand warmers

5 Improve awareness of Herts Help generally, amongst all those aged 65 or older, but especially focus those aged 75 or older that live alone

6 Promote key messages around health such as improved water consumption, the risks associated with cold homes, the importance of activities and flu jabs

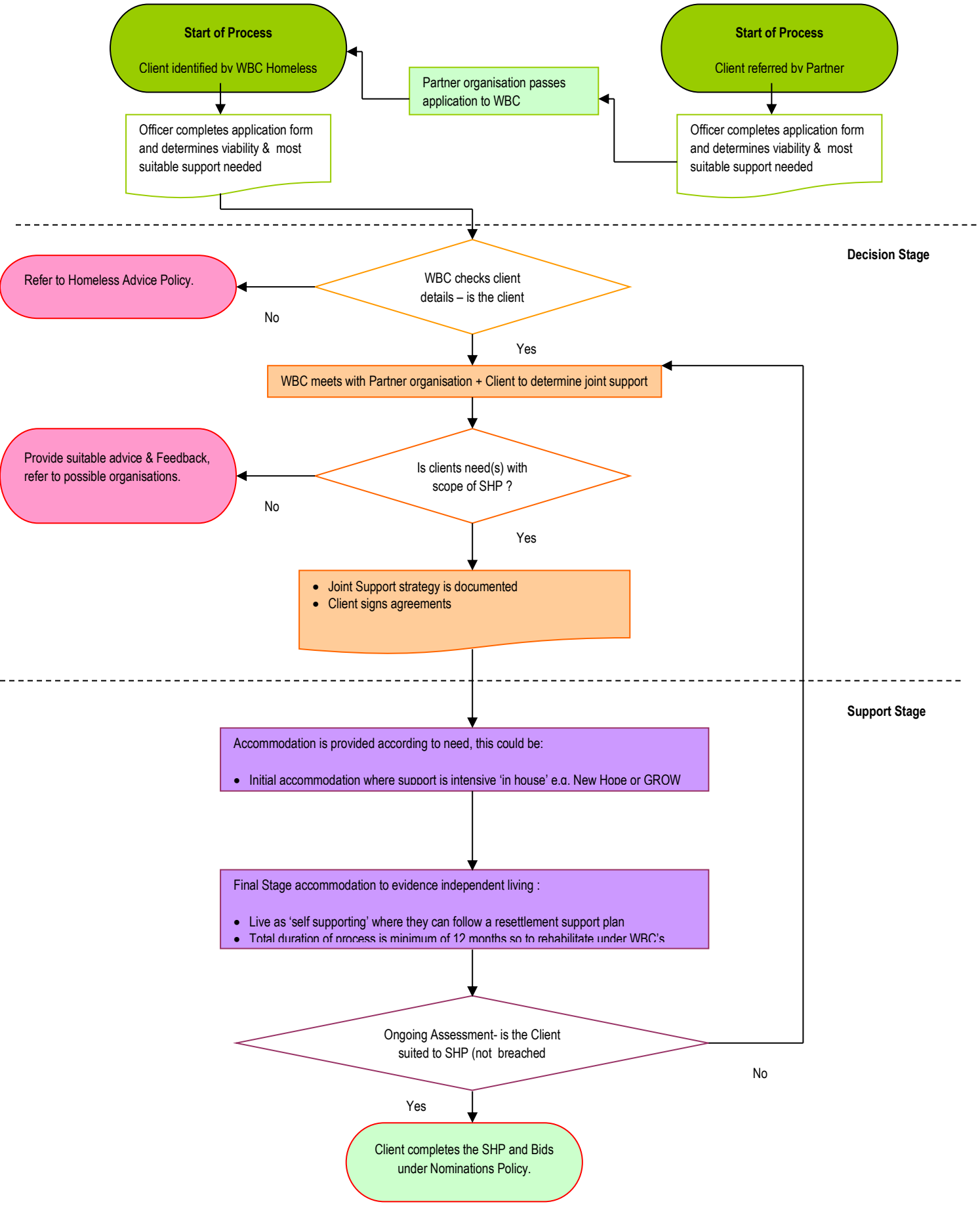
7 Improve identification of householders at risk by training and data sharing with health services and local authorities

8 Those involved with direct delivery of health services to householders, such as GPs and support workers, should identify householders with cold related illnesses that live in cold homes and assess heating needs of householders at each intervention with their service

9 Develop/implement an action plan to combat loneliness

10 Expand the existing stakeholder network

Appendix E: Watford Borough Council Single Homeless Pathway: Draft Process Map



Health and Wellbeing Board
Hertfordshire

Agenda Item No.

7

HERTFORDSHIRE COUNTY COUNCIL

HEALTH AND WELLBEING BOARD
15 MARCH 2016 AT 10.00 a.m.

DOMESTIC ABUSE IMPROVEMENT PROGRAMME UPDATE & DRAFT STRATEGY

Report of Director of Childrens Services, and Chair of the Domestic Abuse Executive Board, Hertfordshire County Council

Author: Julie Chaudary Tel: 01992 507510
HCC Assistant Director (Community Protection)

1.0 Purpose of report

1.1 To provide an update on the Domestic Abuse Improvement Programme, including progress made against SafeLives (previously Co-ordinated Action Against Domestic Abuse, CAADA) main recommendations, and the new draft Domestic Abuse Strategy.

2.0 Summary

2.1 In March 2015, the Board were informed of the main findings and recommendations arising from the SafeLives (previously CAADA) review of domestic abuse. The review was funded by the Police and Crime Commissioner and published in January 2015.

2.2 A significant amount of progress has been made since the review as part of a partnership wide Domestic Abuse Improvement Programme, including the publication of a new draft Domestic Abuse strategy and a Joint Strategic Needs Assessment (Domestic Abuse). This report provides an update on activity to date and a copy of the new strategy for discussion by the Board during the consultation period.

3.0 Recommendation

3.1 The Board receives an update on the Domestic Abuse Improvement Programme.

3.2 The Board provides comments on the draft Domestic Abuse strategy.

4.0 Background

4.1 The SafeLives review into domestic abuse services in Hertfordshire found that focussed improvements were needed in:

- the governance and leadership arrangements for domestic abuse;
- the consistency through which victims are referred to services; and
- the provision of services and support for victims and perpetrators.

4.2 SafeLives' overall recommendation was that Hertfordshire should create an effective care pathway for domestic abuse from initial identification to step-down and recovery, so that families living with domestic abuse can be made as safe as possible.

Improvement programme update

4.3 Following the review, a Domestic Abuse (Improvement) Programme was put into place in order to deliver a series of multi-agency improvements based around the reviews recommendations and findings. The programme is led by an Assistant Director in the HCC Community Protection Directorate, with specialist consultancy support provided by SafeLives. The programme has been successful in bringing about significant change in the way that partners work together to tackle domestic abuse, and discussions are now taking place ahead of formal programme closure, in order to ensure that improvements are sustained and the benefits fully realised.

4.4 The Domestic Abuse Programme is being delivered in tandem with three other multi-agency projects, all of which are contributing to making improvements for women, men and children experiencing or using domestic abuse. These are:

- Family Safeguarding Teams;
- Multi-Agency Safeguarding Hub (MASH); and
- Adults with complex needs pilot.

4.5 The Domestic Abuse improvement programme is structured around eleven work packages, five of which are cross cutting in their nature:

Priority project areas	Cross-cutting
Multi Agency Risk Assessment Conferences (MARACs)	Governance & Leadership
Commissioning	Communications
Domestic Homicide Reviews	Equalities
Perpetrator / Specialist Domestic Violence Courts - effective practice	Performance
Honour Based Abuse	Learning & Development
Children and Young People	

4.6 A new governance structure is in place (Appendix 1). The new Domestic Abuse Executive Board was established in June 2015, chaired by Jenny Coles, and brings together senior leads across statutory agencies with representatives from the Voluntary & Community Sector, and Housing. The previous DA Strategic Programme Board (chaired by Herts Constabulary) has been re-shaped into a Partnership (Operational Board), in order to focus on programme priorities. Five sub-groups, some of which are task/finish, have been established and have clear action plans in place.

4.7 A new draft Hertfordshire Domestic Abuse Strategy *'Breaking the cycle'* 2016/19 has been published for consultation until 21 March 2016 and is included at Appendix 2, together with a summary of commitments. Detailed work on developing a strategic action plan is underway.

4.8 Discussions regarding funding for Domestic Abuse services have been complex across the partnership, and there is still some way to go towards identifying funding for all areas contained in the commissioning timetable. Domestic abuse is no single agency's responsibility, and there is a lack of consistency nationally in funding arrangements. The Executive Board agreed a phased approach to funding discussions and prioritised the Independent Domestic Violence Advisor (IDVA) service and services for perpetrators as a first step.

4.9 An improvement programme risk register is in place and monitored by the Executive Board. The key risks for the programme are around funding, partnership working and communications.

SafeLives recommendations - progress update

4.10 The table below outlines progress against the main SafeLives recommendations.

No.	SafeLives main recommendation	Summary of main activities to date
1	Bring in joint commissioning of all domestic abuse services countywide, based on an agreed understanding and thresholds of need and risk.	i. Senior Domestic Abuse Commissioning Manager in post from 27/07/2015 (HCC Health and Community Services). ii. Commissioning timetable developed and agreed by the Executive Board (Appendix 3). Pre-market engagement workshops held. iii. Formal notice given to existing Independent Domestic Violence Advisor (IDVA) service provider (Victim Support) – with new contracts expected to come into place from Autumn 2016. Funding for the expansion of the high risk IDVA service has been underwritten by the Executive Board, with funding being sought from HCC, the Police and Crime Commissioner and Clinical Commissioning Groups. iv. Work on developing clear pathways and referral routes for victims and professionals is underway with a stakeholder workshop delivered on 1 February 2016.

No.	SafeLives main recommendation	Summary of main activities to date
		v. Accommodation - Work with Refuge providers is currently taking place in order to redesign future accommodation models for high risk victims within the existing HCC budget (c..£800k). A stakeholder workshop to include wider housing providers is planned for 10 March 2016. vi. A Domestic Abuse Joint Strategic Needs Assessment has been developed and used to inform the draft Hertfordshire Domestic Abuse Strategy. It is published on Hertsdirect alongside the new draft Domestic Abuse Strategy. http://www.hertsdirect.org/docs/pdf/d/domabjsnastrategyassess.pdf vii. The "Herts change" perpetrator pilot has been expanded via the existing service provider (Relate).
2	Set up a champion's network, where workers in all agencies are trained in domestic abuse awareness and how to refer victims.	There is general support across the partnership for a Champion's Network that builds on existing infrastructures – e.g. the Domestic Abuse forums, the Domestic Abuse Action Group (chaired by HCC) and existing services such as the Sunflower website and drop in service. A workshop to develop a model for Hertfordshire was held on the 2 February as part of the regular Domestic Abuse Action Group meetings, with proposals to be taken to the DA Executive Board in June 2016. A small working group is in the process of being established.
3	Build on the Targeted Advice Service (TAS) approach for addressing risk to children, by including related issues such as parental substance misuse and/or mental health problems and by reviewing risk to both the victim and the child in the round with the aim of providing linked support.	The Hertfordshire Children's Multi-Agency Safeguarding Hub (MASH) went live in July 2015. Contacts that appear to indicate high risk to children require a response to information requests within 4 hours, medium risk within 24 hours and low risk contacts are passed to the Early Help desk within 72 hours.

No.	SafeLives main recommendation	Summary of main activities to date
4	For victims and families at all levels of risk, make sure that universal services provide information and signposting.	The identification of clear referral routes and pathways for victims and professionals is a critical piece of work currently being taken forward by the DA Senior Commissioning Manager in consultation with service providers. An initial mapping exercise is complete and a stakeholder workshop was held on 1 February. There are recognised gaps in services and these now form part of the commissioning timetable and strategy. The new governance structure provides a forum for developing a Hertfordshire wide approach to signposting. The establishment of a Champion's network will support this by the provision of consistent DA awareness training to frontline workers with lead 'champions' identified in agencies. This will be supported by further development of the Sunflower website, and the delivery of a county wide communication strategy to ensure that messages are consistent and the successful branding of 'Sunflower' services used as widely as possible.
5	For victims and families at medium and high-risk, make sure there are enough IDVAs and specialist caseworkers helping victims and families to be safe. There also needs to be support to recover once the abuse has stopped, with linked support for children.	Since the review, a number of additional IDVA's were put in place (funded by the Police and Crime Commissioner) to support high risk victims. The DA Commissioning Manager has also worked closely with the existing service provider to improve contract monitoring arrangements and to stabilise the service, at the same time as improvements being made to the Multi Agency Risk Assessment Conferences' (MARAC) referral process. The IDVA service for high risk victims is in the process of re-tender with new contracts coming into place in Autumn 2016. The expansion to include a medium/ standard risk victim service is planned for April 2017. Work is now required to reconcile the SafeLives recommended IDVA level with improvements made across the programme, such as the impact of other specialist caseworkers and better use of the DASH (Domestic Abuse Stalking & Harassment) risk assessment tool. The Family Safeguarding project introduced 22 specialist domestic abuse workers to work with families with children on child protection plans, and the Herts constabulary Safeguarding restructure has increased capacity to respond more effectively to the issue overall.

No.	SafeLives main recommendation	Summary of main activities to date
6	For victims and families at high-risk, ensure that Multi Agency Risk Assessment Conferences (MARAC) are appropriately resourced so it can make high- quality action plans to stop high-risk abuse.	An additional two co-ordinator posts have been filled since the review increasing capacity for the administration of the five MARACs. The Chair of the MARAC steering (or sub) group was elevated to a more senior position and moved to Herts constabulary in recognition of their lead role and to reflect national models. The membership of the group has been reviewed and is now operating more effectively. MARAC objectives have been agreed, and a clear action plan is in place including the expansion of software to further automate the referral process amongst agencies. MARAC development days have been held for core members, with more to be planned, and arrangements for single point quality assured referrals are progressing well. Strategic leads have also been identified in the main agencies. The MARAC information sharing protocol and operating procedures are under review and expected to be refreshed shortly.
7	Make sure that there are enough specialist community and residential domestic abuse services.	The provision of community services is included in the commissioning activity timeline with funding sources to be agreed. Work on designing the new accommodation model, including Refuge, is underway.
8	The Hertfordshire Partnership should pilot proactive management of serial and repeat perpetrators.	A new perpetrator sub-group has been established and is developing an evidence led, multi-agency approach for domestic abuse perpetrators including prevention, provision of services, management and assessment. The existing perpetrator pilot (Stevenage) has been expanded and extended into 2016/17 until the work of the perpetrator sub-group is complete, with funding provided by the HCC Community Protection Directorate. The Family Safeguarding Project is receiving referrals for perpetrator group work with programmes up and running across the County.
9	Build capacity for innovation, learning and development, so that Hertfordshire knows	The establishment of champion's network/alliance will assist in identifying notable practice and provide a forum to help cascade a Herts wide domestic abuse learning and development programme, alongside development of

No.	SafeLives main recommendation	Summary of main activities to date
	what works to stop domestic abuse, and can roll it out.	the 'professional' area of the Sunflower website. Learning and development activity is being taken forward in conjunction with the Safeguarding Learning & Development sub-groups including identification of front line worker training via a multi-agency audit.
10.	Improve governance and leadership for Domestic Abuse across the partnership.	A new governance structure is now in place (Appendix 1). A new draft Hertfordshire Domestic Abuse Strategy *'Breaking the cycle'* 2016/19 is currently out to public consultation (Appendix 2).

Domestic Abuse Strategy 2016/19 – Breaking the cycle

4.11 The SafeLives review found that previous domestic abuse strategies were not necessarily owned or resourced at the right level and did not comprehensively set out an approach to the commissioning of Domestic Abuse services.

4.12 A new draft Domestic Abuse (partnership) Strategy 2016/19 'Breaking the Cycle' was approved by the Domestic Abuse Executive Board in December 2015 and published for consultation on the 22 January 2016. The strategy has been developed in consultation with a wide range of stakeholders and includes a new strategic framework (page 11 of this report) which will help to achieve a common and collective response to the issue.

4.13 A new vision has been included "Women, men and children in Hertfordshire are kept safe from domestic abuse and have opportunities leading to healthy and happy lives", and this is supported by three aims, four objectives and ten outcomes. One of the intended outcomes is that "victims report improved health, wellbeing and resilience" and this directly supports the work of the Health and Wellbeing Board.

4.14 The majority of planned activities have been sourced from the improvement plan, detailed sub-group plans and discussions with various stakeholders including the six Domestic Abuse Forum chairs.

5. Next steps

5.1 The next key milestones for the programme are:

- To publish a final Domestic Abuse (partnership) strategy in May 2016;
- To re-tender the Independent Domestic Violence Advisor service;
- To re-model the provision of accommodation for domestic abuse victims and perpetrators, and develop a clear action plan for housing providers;
- To fully identify clear referral routes and pathways for service users; and

- To determine how various elements of the improvement programme should be mainstreamed into existing services and structures such as Safeguarding.

6. Conclusion

6.1 Agencies across the partnerships and districts have given their commitment to support the improvements necessary. The Health and Wellbeing Board has an important role in leading on commissioning arrangements in Hertfordshire to help drive the improvement plan forward. The Board are asked to acknowledge the update on the SafeLives recommendations, and provide comments on the new draft Domestic Abuse strategy.

Report signed off by	Chair of Domestic Abuse Executive Board
Sponsoring HWB Member/s	Jenny Coles
Hertfordshire HWB Strategy priorities supported by this report	Helping all families to thrive

Needs assessment

Joint Strategic Needs Assessment (Domestic Abuse) published on 22 January 2016

Consultation/public involvement

Draft Domestic Abuse Strategy published for public consultation - closes on 21 March 2016.

www.hertsdirect.org/dastrategy

Equality and diversity implications

The Joint Strategic Needs Analysis (Domestic Abuse) brings together a range of data from partner agencies in respect of the profile of victims, perpetrators and service users. Detailed Equality Impact Assessments (EqIAs) have been drafted via each of the sub-groups and these are in the process of being combined to create a single over-arching EqIA. Major commissioning projects have their own EqIAs.

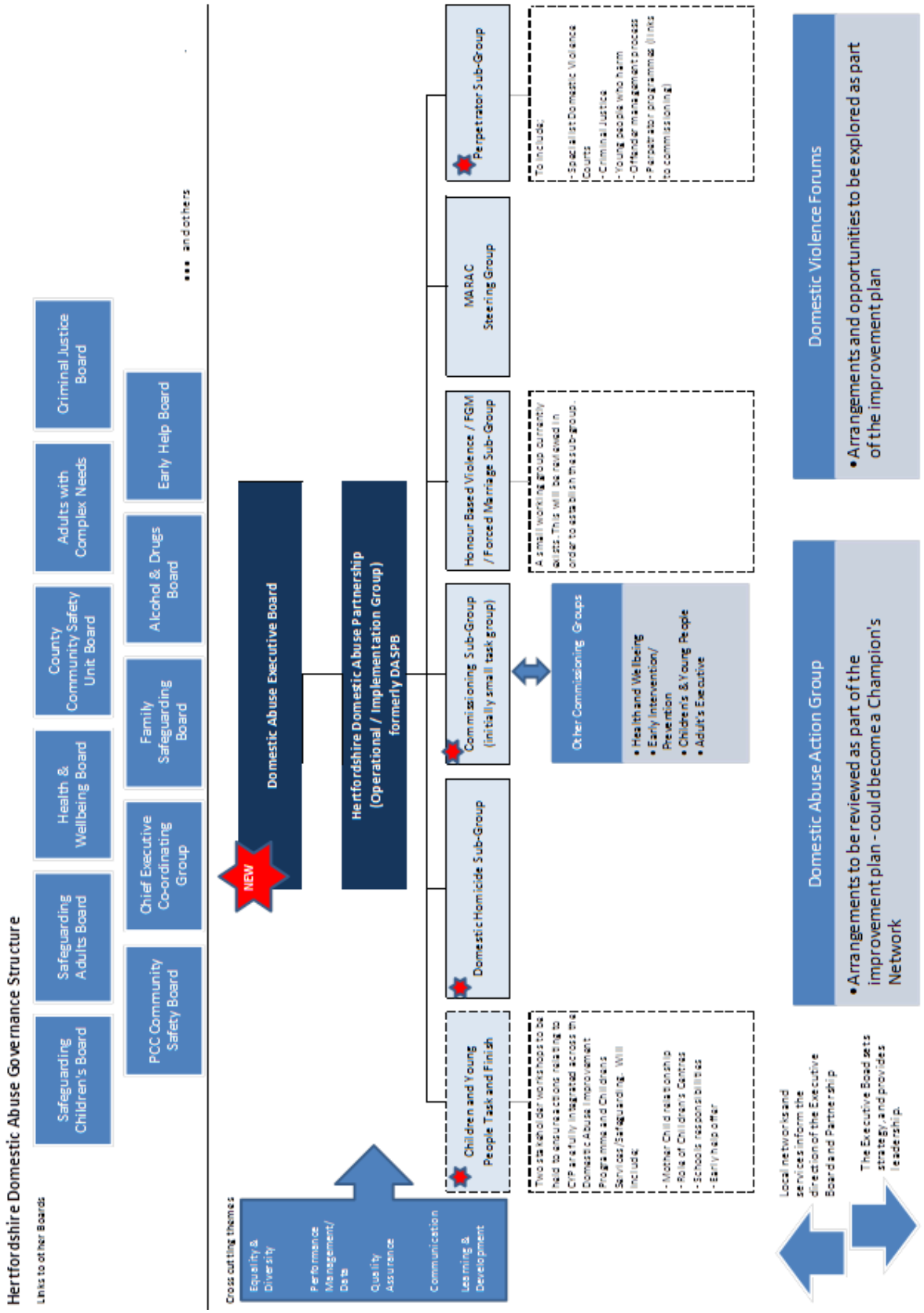
Acronyms or terms used. eg:

Initials	In full
IDVA	Independent Domestic Violence Advisor

Attachments & appendices:

Appendix 2 full version - Domestic Ab

Appendix 1 – Domestic Abuse Governance Structure



Appendix 2 – Draft Domestic Abuse Strategy

Please see separate attachment for full version of the strategy.

A copy of the strategic framework and a summary of commitments are included below.

Strategic overview

Our vision **Women, children and men in Hertfordshire are kept safe from domestic abuse and have opportunities leading to healthy and happy lives.**

Strategic Aim		Outcomes
Prevent	***Prevent domestic abuse from happening in the first place by challenging the attitudes and behaviours which foster it, and intervening early where possible to prevent it.***	Victims, perpetrators and their children are identified early by a wide range of frontline practitioners and partner agencies.
		Communities understand what domestic abuse is, and know how to respond.
		Increased reporting of domestic abuse to police and fewer repeat victims of domestic abuse each year.
Protect	***Reduce the risk to victims and ensure that perpetrators are held to account.***	Children and young people at risk of harm are identified and referred appropriately.
		Victims are safer and have improved resources to remain safe.
		Victims have increased access to justice.
		Perpetrators of domestic abuse are supported to change their behaviour.
Provide	***Work in partnership to provide appropriate levels of support where abuse occurs***	Victims receive responsive services and risks of further abuse are mitigated.
		All identified victims are offered an equally accessible service which meets their needs.
		Victims report improved health, wellbeing and resilience.

Our aims and plans – Draft Domestic Abuse Strategy

Summary of commitments

AIM 1 – PREVENT - *To prevent domestic abuse from happening in the first place by challenging the attitudes and behaviours that foster it, and intervening early where possible to prevent it.*

We will;

1. raise awareness of domestic abuse and the support available to victims and perpetrators amongst professionals who work in universal services (such as hospitals, doctors and teachers)
2. conduct a partnership wide training needs analysis
3. understand, coordinate and quality check the training offered across Hertfordshire
4. introduce outcomes for learning and development
5. build capacity for innovation, learning and development across the partnership
6. continue to deliver domestic abuse campaigns across Hertfordshire to raise awareness
7. maintain and further promote the Hertfordshire Sunflower services and branding e.g. website, helpline, drop ins, IDVA, and SARC services
8. work with children & young people to provide information & general awareness through schools & other young people's services including the teaching of the importance of healthy relationships

AIM 2 – PROTECT *- Reduce the risk to victims and ensure that perpetrators are held to account.*

We will;

9. ensure roles are clear for MARAC core group members and their deputies, and that effective induction arrangements are in place
10. continue to review sample police incidents and the use of the Domestic Abuse Stalking and Harassment (DASH) risk assessment tool, and audit MARAC cases to identify risks
11. continue to undertake focussed self-assessments in line with local MARAC principles
12. ensure that the important role of Housing Associations and Registered Social Landlords is reflected in MARAC arrangements
13. develop web-based information systems to be used across MARAC agencies
14. encourage all agencies to use the SafeLives Domestic Abuse Stalking and Harassment (DASH) tool to ensure consistency in risk assessment, and quality assure the process

15. further review MARAC co-ordination capacity levels to ensure robust administration arrangements
16. produce multi-agency quality standards for domestic violence courts to include services to the victim and a pre-court programme
17. drive improvements in line with the detailed Perpetrator/Specialist DA Court implementation plan
18. develop a consistent approach for the management and assessment of domestic abuse perpetrators and promote the safety of victims
19. contribute to the development of effective prevention strategies to ensure that potential domestic abuse perpetrators are identified early and offered opportunities to change
20. support the effective sharing of information to ensure effective multi-agency risk management
21. develop an evidence led approach to the commissioning and provision of services for domestic abuse perpetrators
22. advise on how front line workers can be appropriately trained to identify, engage and manage perpetrators of domestic abuse and work with key agencies to contribute to protecting victims and safeguarding children and vulnerable adults
23. improve mechanisms for sharing the learning from DHRs, including how the learning is embedded into practice
24. implement operational DHR pathways across agencies
25. develop, agree and implement a protocol and process for Quality Assurance
26. identify central coordination of DHRs and establish robust systems to track the outcomes

AIM 3 – PROVIDE *- Work in partnership to provide appropriate levels of support where abuse occurs*

We will;

27. conduct a full options appraisal of service provision and gaps
28. develop an Integrated Commissioning Plan, leading to a clear framework for a Hertfordshire core 'offer'
29. research and consider the use of a data-monitoring tool for overseeing service delivery against the outcomes we expect to see including through commissioned arrangements
30. design and commission the new service model contract for the IDVA Service (high risk victims service)
31. agree IDVA Service phase two funding and service modelling in order to commission an enhanced IDVA service (medium risk victims service)
32. design and agree a model for accommodation based services including timelines and funding

33. commission new service arrangements for perpetrator services
34. pathways for support - review current 'offer for Hertfordshire', and agree future service delivery model/funding
35. children's support - review current arrangements to support children including community based interventions, the identification of opportunities and gaps, and clarify future needs and actions
36. community support - evaluate current services to support victims in the home and commission future services as appropriate
37. community support services – identify gaps and opportunities, and implement actions to strengthen service responsiveness across care, support and community services
38. develop clear approaches for ensuring the service user voice influences service design plans
39. explore the introduction of a champion's network
40. use the results of our local multi-agency self-assessment against the HM Government: FM/HBV Guidance to determine service priorities for the partnership and commissioning arrangements
41. raise awareness among the public and professionals/agencies focusing on health agencies and children's services including schools to recognize, provide information and give a route to seek help
42. provide training for the agencies' staff to recognize, report and refer
43. develop and agree clear care pathway from initial identification shared by all agencies
44. access to appropriate services for support and actions - reducing or protecting from risk of/harm
45. work with faith leaders to raise awareness within vulnerable communities and develop positive relationships.
46. work with the charity Barnado's to ensure that we are doing all we can to help eradicate the illegal practice of female genital mutilation

Appendix 3 - Phased Timeline for Domestic Abuse Commissioning Activity (short, medium, long term)

Service Area	PHASE 1 –Short term By April 2016	Phase 2 – Medium term 2016/17	*Phase 3 – Longer term* *2017/18 – 2019/20*
IDVA			
IDVA	Existing funding levels unchanged Improve existing contract monitoring and quality assurance arrangements Service delivery Model/outcomes reviewed Agree additional funding 2016 and ongoing from 2017 Tender information Go Live (March 2016)	Autumn 2016 - New service model contract commences with initial increase in staffing levels(phase 1 for high risk visible victims only) Confirm any additional funding for longer term based on needs analysis. Note: to explore longer term funding options with any identified efficiencies through the refuge redesign	April 2017 - Implement full IDVA staffing levels (phase 2 for high and medium risk visible victims)
Accommodation			
Refuges	Improve existing contract monitoring and quality assurance arrangements Vary existing contracts to enhance current offer to a 24/7 service Agree new model for service delivery (to include floating support services). Note: SafeLives specification already developed for Refuge Provision Confirm funding levels for 2017	January 2016 – pre engagement with providers to start to redesign services for April 2017	April 2017 - New Accommodation Service Model Go Live
Community Services			
Perpetrator programmes	Existing perpetrator service continued with additional funds (until January 2016)	Existing perpetrator service continued and expanded Review of perpetrator outcomes and best practice approaches (via Perpetrator sub group) Agree additional funding for any new service requirements for 2017/18+ based on needs analysis	April 2017 - Implement new service arrangements

Service Area	PHASE 1 –Short term By April 2016	Phase 2 – Medium term 2016/17	*Phase 3 – Longer term* *2017/18 – 2019/20*
Pathways for Support	Review current 'offer for Herts' Agreement for future service delivery model including additional funding requirements	June 2016 -Implement new service arrangements in parallel to IDVA Phase 1 launch(to ensure pathways are clear for different thresholds for support)	
Children's Support	Review current 'offer for Herts' including community based solutions (incl links with Children's and Young People Sub Group) Identify efficiencies and/or additional needs /resources. Note: to explore longer term funding options with any identified efficiencies through the children's safeguarding team	TBA subject to Safeguarding Team review outcomes	
Community Support	Evaluate current service options for victims at home/community based. Identify efficiencies and/or additional needs /resources	TBA subject to review outcomes	April 2017 - Fully reviewed service offer to Go Live (aligned to refuge redesign to ensure offer is complementary)

Hertfordshire Domestic Abuse Partnership

Hertfordshire Domestic Abuse Strategy 2016-2019

DRAFT

Breaking the cycle

Foreword

Domestic abuse is unacceptable yet it continues to be a serious issue for many of our residents. It is estimated that one in four women and one in six men will experience domestic abuse at some point in their lifetime. More victims in Hertfordshire are coming forward to report abuse and demand on services for perpetrators is also increasing. Our services need to be responsive at the earliest opportunity, and balanced with prevention activities designed to stop abuse from happening in the first place.

The SafeLives review of Hertfordshire's domestic abuse commissioned services 2014/15 acted as a catalyst for change in the way that local partners work together to tackle domestic abuse. Although the review found some good practice in Hertfordshire, it was clear that partners and stakeholders could do more to improve the services in responding to the issue. Since then, a range of statutory agencies have worked together with representatives from housing and the voluntary and community sector to improve partnership working and decision making in tackling domestic abuse and protecting victims. A focussed improvement programme with support from SafeLives, and new governance arrangements are now in place together with a clear plan for the commissioning of domestic abuse services.

We want women, children and men in Hertfordshire to be kept safe from domestic abuse and have the opportunity to lead healthy and happy lives. We want to achieve this by;

- preventing domestic abuse from happening in the first place by challenging the attitudes and behaviours which foster it, and intervening early to prevent it.
- reducing the risk to victims and ensuring that perpetrators are held to account.
- working in partnership to provide adequate levels of support where abuse occurs

This strategy sets out what we, as a partnership, want to achieve over the next three years. We want to better co-ordinate services based on individual need and risk, and put greater emphasis on prevention, sustained recovery and early intervention. We will do this by reviewing our services to ensure that they meet user needs, and offer the best value for money through joint commissioning and partnership working.

Domestic abuse is a complex and challenging issue which can wreck lives, and devastate families. No agency has single statutory responsibility for domestic abuse, and so it follows that the key to achieving our strategy lies in the hands of partnership working. Together we will break the cycle of abuse.

Richard Thake
Executive Member for Community Safety
Hertfordshire County Council

David Lloyd
Police and Crime Commissioner
for Hertfordshire

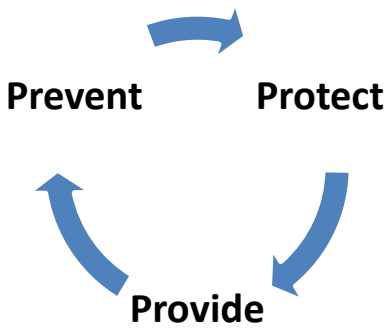
Contents

Strategic overview

Our vision

Women, children and men in Hertfordshire are kept safe from domestic abuse and have opportunities leading to healthy and happy lives.

Strategic Aim		Outcomes
Prevent	***Prevent domestic abuse from happening in the first place by challenging the attitudes and behaviours which foster it, and intervening early where possible to prevent it.***	Victims, perpetrators and their children are identified early by a wide range of frontline practitioners and partner agencies.
		Communities understand what domestic abuse is, and know how to respond.
		Increased reporting of domestic abuse to police and fewer repeat victims of domestic abuse each year.
Protect	***Reduce the risk to victims and ensure that perpetrators are held to account.***	Children and young people at risk of harm are identified and referred appropriately.
		Victims are safer and have improved resources to remain safe.
		Victims have increased access to justice.
		Perpetrators of domestic abuse are supported to change their behaviour.
Provide	***Work in partnership to provide appropriate levels of support where abuse occurs***	Victims receive responsive services and risks of further abuse are mitigated.
		All identified victims are offered an equally accessible service which meets their needs.
		Victims report improved health, wellbeing and resilience.



Introduction

The Hertfordshire Domestic Abuse Strategy sets out our vision, aims and objectives for dealing with domestic abuse, and the outcomes we expect to see as a result. It includes our commissioning strategy for Hertfordshire which aims to assist agencies to deliver appropriate and joined up service responses for victims and perpetrators. It is vital that services are informed and developed by what victims and perpetrators say is important to them, and we want people affected by domestic abuse to play an active role in influencing design.

The key Hertfordshire priority groups intended to benefit from this strategy are:

- victims and survivors of domestic abuse
- children and young people who have witnessed or experienced domestic abuse
- perpetrators of domestic abuse
- partner agencies involved in supporting adults, children and young people affected by domestic abuse

What is Domestic Abuse?

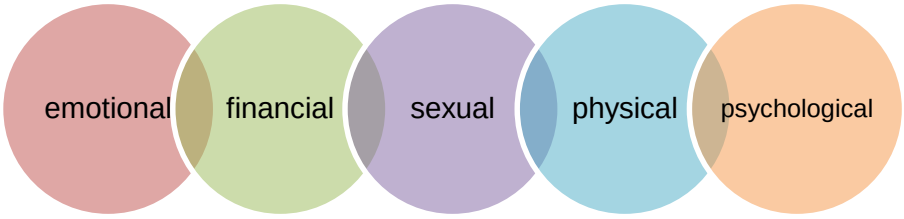
National statistics tell us that;

- domestic abuse accounts for 1 in 5 of all violent crimes
- one in four women and one in six men experience domestic abuse over their lifetime
- 1.2 million women and 700,000 men experience a form of domestic abuse every year
- on average, victims experience 50 incidents of abuse before receiving effective support

Home Office definition

Domestic abuse

"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:



Controlling behaviour

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

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 it is clear that victims are not confined to one gender or ethnic group[1]

Whilst the government definition of domestic violence and abuse applies to young people aged 16 and above, it is critical to acknowledge that domestic abuse can have far reaching impacts on children and young people under 16 who are often caught up in the abuse carried out in the household.

[1] Home Office (2013) *Information for Local Areas on the change to the Definition of Domestic Abuse* https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/142701/guide-on-definition-of-dv.pdf

National Context

Domestic abuse can affect anybody, regardless of their gender or sexual orientation, and it occurs across all of society, regardless of age, race, religion, wealth or geography. The evidence for improving the response to domestic abuse is overwhelming;

Key statistics
Every minute, police in the UK receive a domestic assistance call – yet only 35% of domestic violence incidents are reported to the police [2]
1 in 4 women and 1 in 6 men endure violence from a partner, ex-partner / family member during their adult life in England and Wales – equivalent to 1.2 million women and 784,000 men (16-59 years old) in 2012/13[3]
Between six and ten percent of women suffer domestic violence in a given year[4]
Victims of domestic violence are more likely to experience repeat victimisation than victims of any other type of crime
Two women are killed every week in England and Wales by a current or former partner[5]
Domestic abuse commonly takes place in a household with children and young people. We know that witnessing domestic abuse can be particularly traumatic for children. A minimum of 750,000 British children and young people a year (around 6.5%) are witnesses to domestic abuse and around 30% of domestic abuse begins or escalates during pregnancy.[6]

Hertfordshire Context

This strategy is informed by the SafeLives review and the Joint Strategic Needs Analysis (JSNA) completed in 2015[7]. Our key JSNA findings included;

1	The majority (79.6%) of known victims in Hertfordshire are female with the highest number of reports coming from those aged between 21 and 30
2	Hertfordshire has seen a significant increase in the number of victims aged between 61 and 70 and those between 16 and 20 over the three year period 2012/13-2014/15
3	Children were known to present in the house in 28% of all reported domestic abuse crimes and incidents in 2014/15, and recorded as a witness to the abuse in 15% of all reported domestic abuse crimes and incidents in 2014/15
4	Domestic abuse reporting peaks at weekends in Hertfordshire when support services for victims are often unavailable
5	The rate of domestic abuse per head of population in Hertfordshire is higher in areas of multiple deprivation

[2] Stanko, 2000 & Home Office, 2002
[3] Ranford et Al 2012
[4] Council of Europe, 2002
[5] Homicide Statistics, 1998
[6] Home Office 2010
[7] The full JSNA and summary is published on the HCC website with the draft Domestic Abuse strategy

6	Hertfordshire Constabulary recorded alcohol as an aggravating factor in over 27% of all domestic abuse incidents in 2014/15
7	The average annual caseload for the Hertfordshire Independent Domestic Violence Advisor (IDVA) service is double the national recommended level *(January 2015)*
8	There is no on-going commitment or approach to services for perpetrators, and only one commissioned pilot perpetrator programme based in Stevenage

We have already responded to some of these findings by;

- expanding the perpetrator pilot programme across the county and establishing a *Perpetrator and Specialist Domestic Abuse Court* working group to make recommendations on effective practice and provision
- increasing resources in the IDVA team to reduce caseloads, working more closely with the service provider to manage existing arrangements, and securing future funding to expand the high risk service to victims
- working more closely with service providers to improve 'out of hours' access arrangements
- working with stakeholders to identify opportunities to enhance services for children and young people experiencing domestic abuse, with recommendations to be formally made to the Hertfordshire Safeguarding Children Board

The JSNA makes a series of recommendations which we have used to inform the plans outlined in this strategy. These are;

1	All interventions for prevention and protection need to be based on evidence of what works, taking into consideration cost effectiveness, national and local research, to ensure that resources are targeted where they will make the greatest impact
2	Full participation of all key providers and stakeholders is necessary to ensure effective services, robust referral pathways and successful outcomes for victims of domestic abuse
3	Domestic abuse services need to be available and accessible for all levels of victim risk and potential harm
4	Services need to provide support for the whole family, in particular linked services for victims and their children
5	Commissioning arrangements should be underpinned by a clear commissioning strategy that is supported by key Boards and multi-agency structures to ensure services are targeted to reduce incidence, increase prosecution rates and address fully the impact on those affected
6	Formal multi-agency child protection arrangements must include attendance and participation of family members, local partner agencies and organisations, including child protection conferences
7	Domestic abuse provision e.g. IDVAs and refuges, need to be accessible at the weekend (peak times of reported offending)
8	Prevention and protection strategies and services need to consider targeting hot spot areas, including areas of deprivation
9	Formalised arrangements for direct referrals between domestic abuse services and sexual health, alcohol, substance misuse and mental health services need to be established along with assessment of need for further related service provision

10	Commission an IDVA service that meets national guidelines on safe caseloads to ensure the needs of Hertfordshire residents are met within the context of strategic priorities
11	Increase provision for perpetrators in Hertfordshire (based on level of risk and evidence of what works)
12	Domestic abuse information, advice and campaigns should be consistent across prevention, protection and service provision
13	Establish an outcome focussed performance framework with data collection specified in contracts
14	Facilitate ongoing involvement for people affected by domestic abuse in the development of the future strategy and commissioning approach
15	A strategic approach to training and development of professionals is required, including an approach for housing workers, so that all front line workers are able to identify the signs of domestic abuse and know how to respond.

Strategic framework

We used the Government's action plan, A Call to End Violence Against Women and Girls, to inform our local strategy and have put robust governance arrangements in place to ensure that agencies are held to account for its delivery. Our strategy is based on the findings of the SafeLives review and our local JSNA and covers services for all victims and perpetrators of domestic abuse. We acknowledge that the Government is (at the time of writing), refreshing its action plan and this will be reflected in our approach going forward.

Vision, aims and outcomes

Our vision is that women, children and men in Hertfordshire are kept safe from domestic abuse and have opportunities leading to healthy and happy lives.

This is supported by the three key aims of prevention, protection and service provision.

We aim to;

1. *Prevent domestic abuse from happening in the first place by challenging the attitudes and behaviours which foster it, and intervening early where possible to prevent it.*
2. *Reduce the risk to victims and ensure that perpetrators are held to account.*
3. *Work in partnership to provide appropriate levels of support where abuse occurs*

Our priorities (objectives) are to;

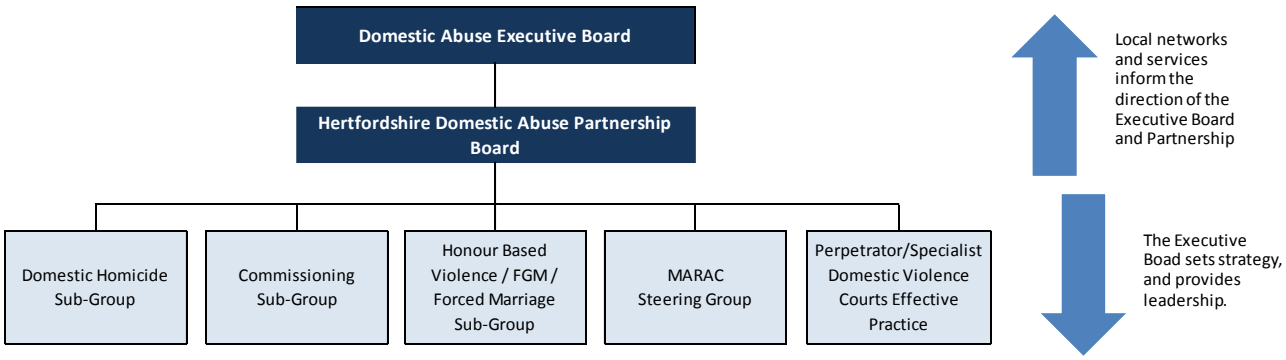
i. Target work on education, prevention and training
ii. Identify, assess and reduce risk to victims
iii. Protect victims via intervention
iv. Provide appropriate support for adults, children and young people suffering from domestic abuse

Through our work we want to achieve the following key outcomes;

Key outcomes	
1	Victims, perpetrators and their children are identified early by a wide range of frontline practitioners and partner agencies
2	Communities understand what domestic abuse is and know how to respond
3	Increased reporting of domestic abuse to police, and fewer repeat victims of domestic abuse each year
4	Children and young people at risk of harm are identified and referred appropriately
5	Victims are safer and have improved resources to remain safe
6	Victims have increased access to justice
7	Perpetrators of domestic abuse are supported to change their behaviour.
8	Victims receive responsive services and risks of further abuse are mitigated
9	All identified victims are offered an equally accessible service which meets their needs
10	Victims report improved health, wellbeing and resilience

Governance and structures

We have improved our partnership governance arrangements in order to ensure that decisions about domestic abuse in Hertfordshire are better co-ordinated and prioritised. We introduced a new Domestic Abuse Executive Board in 2015 and established a number of supporting working groups to help develop strategy and deliver action plans



The direction of the domestic abuse strategy is set by the Hertfordshire Domestic Abuse Executive Board, and delivered via the Partnership Board and supporting sub-groups. The Executive Board is chaired by the Hertfordshire County Council Director of Children's Services and comprises senior directors from a range of agencies, and representatives from the housing, and voluntary and community sector. It is also responsible for scrutinising existing arrangements, and securing the funding necessary to ensure service user needs are met.

The Hertfordshire Domestic Abuse Partnership Board is an operational board responsible for overseeing the delivery of the domestic abuse strategy and plans. The board is chaired by the Hertfordshire Constabulary Detective Chief Superintendent for Safeguarding and comprises the chairs of each of the sub-groups plus representatives from the Clinical Commissioning Groups, the Police and Crime Commissioner, Districts and Hertfordshire County Council.

The Boards are supported by five (operational) sub-groups which reflect the main areas of activities in our plans. These are;

- Domestic Homicide Reviews
- Multi-Agency Risk Assessment Conferences
- Commissioning
- Perpetrators/Domestic Violence Courts effective practice
- Honour Based Abuse

There are six Domestic Abuse Forums in Hertfordshire. These forums are district based and work at a local level to increase awareness of domestic abuse and improve services and responses. They provide an opportunity to bring together a mix of key leads and service providers from within each local community safety partnership working directly with those affected by abuse in order to inform local and countywide practice and partnership working.

The Hertfordshire Domestic Abuse Action Group brings together the chairs of each of the Domestic Abuse Forums together with a range of key representatives from statutory, voluntary and community organisations and local specialist services. Its purpose is to share intelligence, knowledge and good practice to inform need and support local and countywide plans.

This network of domestic abuse professionals is key to ensuring strategic direction and plans are informed by local knowledge and good practice. We are currently considering how the introduction of a champion's network model in Hertfordshire could further support these partnership arrangements, particularly with the voluntary and community sector.

Accountability

Hertfordshire Safeguarding Children Board is the key statutory mechanism for agreeing how the relevant organisations in Hertfordshire will work together to safeguard and promote the welfare of children, and ensuring that this work is effective. One of the board's key themes is around priority areas of risk to children and young people from domestic abuse and female genital mutilation.

Hertfordshire Safeguarding Adults Board (HSAB) is a multi-agency partnership, as required by the Care Act 2014, with representation from the organisations and constituencies that work with and support adults at risk in our community. The HSAB is the key body for the coordination of the activity of the various organisations, statutory, independent and voluntary, in Hertfordshire to safeguard and promote the welfare and wellbeing of 'adults at risk' and for seeking assurance that this work is effective. One of the Board's strategic objectives is to raise public, professional and political awareness of the safeguarding adults agenda across Hertfordshire including awareness around domestic abuse.

The Health and Wellbeing Board brings together the NHS, public health, adult social care and children's services, including elected representatives and Hertfordshire Healthwatch, to plan how best to meet the needs of Hertfordshire's population and tackle local inequalities in health. The board has nine priorities, three of which directly link to preventing domestic abuse from happening and reducing the harm that it causes. These are;

- reducing the harm caused by alcohol
- helping all families to thrive, and
- improving mental health and emotional wellbeing

Some senior members of the Safeguarding Boards and the Health and Wellbeing Board are also members of the Domestic Abuse Executive Board. This helps to ensure that appropriate links are made between work areas, and domestic abuse is prioritised in plans.

Performance

We recognise that we have some way to go before we are fully able to monitor all domestic abuse services to ensure that they are as effective as possible. A substantial amount of data is collected about the services we provide but this is not necessarily done in a consistent way across agencies. We want to improve some of the processes and systems we use to collect data and are in the process of developing a new performance framework. We are working towards a new set of measures and indicators that we will use to determine whether our strategy and plans are proving successful and these are included as an appendix. We are in the process of determining a baseline, or starting point, for each area.

Equality Statement

This strategy acknowledges that domestic abuse can affect people regardless of factors including age; ethnicity; religion or belief; disability; sexual orientation; and gender. An Equality Impact Assessment in line with the Equality Act 2010 has been undertaken to inform the development of this plan and determine the impact and mitigations needed to provide equitable support for diverse groups. The equality impact assessment will be updated based on new intelligence provided as part of the domestic abuse strategy consultation. We have identified the following patterns in relation to specific groups most likely to be affected by domestic abuse either as victims or perpetrators;

- the majority of known victims, 79%, are female
- the average age of all known victims is 36.5 years
- The percentage increase in known male victims is 82%.
- 84.3% of known perpetrators were male and the average age for perpetrators is 34
- the percentage increase in known female perpetrators over the last three years is 53%
- where known, the ethnicity of victims and perpetrators is predominantly White-North European
- there is generally under-reporting from a range of victims from different equality groups including but not limited to people with a disability, who are LGBT (Lesbian, Gay, Bisexual or Transgender), in a same sex relationship, or from a Black or Minority Ethnic (BME) background.

The strategy recognises that domestic abuse:

a) is generally under-reported, and that Hertfordshire encourages all those who are experiencing abuse to come forward. Therefore in the short term, increases in the reported level of domestic abuse could signify success in increasing disclosure and not necessarily an increase in actual levels

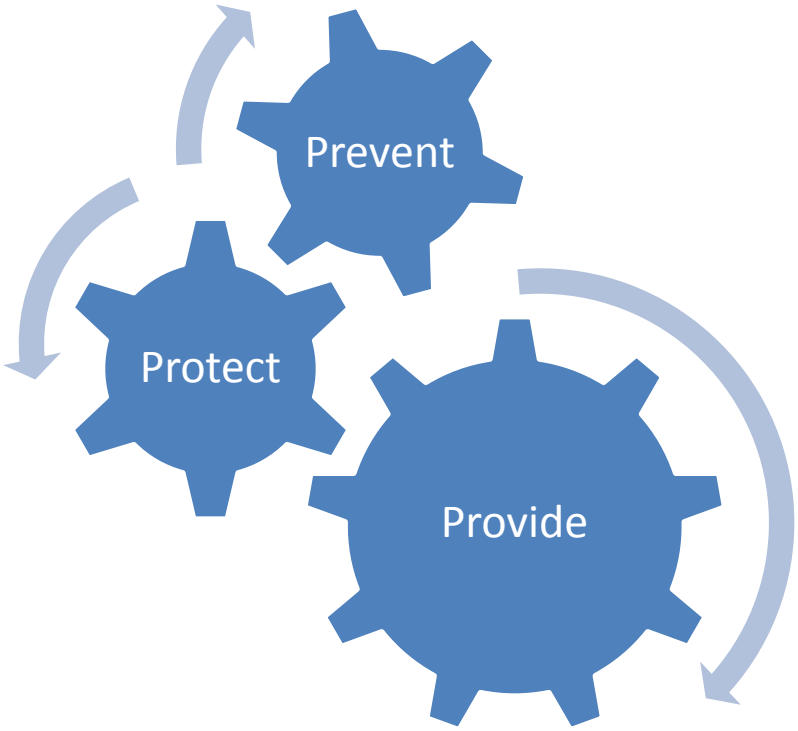
b) data indicates that it is predominantly but not exclusively the abuse of women by their male partner or ex-partner. Hertfordshire will take account of this data when anticipating the volume of need while remaining committed to meeting the needs of all equality groups

c) causes significant harm to children in the household and impedes effective parenting. Hertfordshire's response will therefore aim to strengthen partnership working between adults' and children's services to meet the needs of all family members

d) also occurs between other family members

e) requires specific procedures and practices if it is to be tackled effectively.

Our aims and plans



AIM 1 – PREVENT

To prevent domestic abuse from happening in the first place by challenging the attitudes and behaviours that foster it, and intervening early where possible to prevent it.

Outcomes we want to achieve

- Victims, perpetrators and their children are identified early by a wide range of frontline practitioners and partner agencies
- Communities understand what domestic abuse is and know how to respond
- Increased reporting of domestic abuse to police, and fewer repeat victims of domestic abuse each year

Outcomes for domestic abuse victims and perpetrators are better if the risk of, or actual, abuse is recognised quickly. Even though Hertfordshire has seen a steady and positive increase in reporting over recent years, many victims are often reluctant to come forward and the true extent of the problem is unknown.

Parental problems such as mental illness, alcohol and drug misuse, and domestic abuse are all known to increase the likelihood of children experiencing emotional abuse and neglect, particularly when they appear in combination.

Where parents have complex multiple problems, including those arising from trauma in their own childhoods, earlier intervention needs to be sufficiently intense and holistic in order to break cycles of domestic abuse and overcome its impact.

Sharing information about multiple needs is vital and we do this in a number of ways including through our Multi Agency Risk Assessment Conferences and in our multi-disciplinary Family Safeguarding Teams and more broadly through making effective use of the powers that exist to enable public and voluntary organisations to share information.

We need to ensure that;

- A core offer is in place across the County; communicated and understood by all partners.
- Clarify early help pathways for domestic abuse from information support and guidance to more direct interventions
- Identify and agree approved evidenced based interventions which would support families to break the cycle of generational domestic abuse
- Promote an understanding of delivery mechanisms for domestic abuse support across multi-agency partners
- Roll out risk assessment tools for those at risk of domestic abuse

Multi-Agency Safeguarding Hub (MASH)

The MASH brings together Police, Probation, Health Visiting and Children's Services staff, working together as a team, to share information and decision making about the best way to safeguard and meet the needs of vulnerable children in Hertfordshire including those experiencing domestic abuse.

The Hertfordshire MASH went live in July 2015 and deals with contacts and referrals sent by members of the public and professionals to Children's Services for a safeguarding response. Where the MASH team consider that the child's welfare will be better met by early help services, they will ensure referrals get to the most appropriate teams and will inform referrers the outcome of their request for a safeguarding assessment.

Learning and Development

Victims of domestic abuse come into contact with a wide range of services, so there are many opportunities for public sector professionals to spot early indications of abuse. Intervening early to reduce violence and abuse against adults and children not only protects them from immediate harm but can have longer-term benefits such as reducing:

- the number of people requiring treatment for mental health problems such as depression;
- risky health issues such as alcohol and drug abuse and smoking, as well as obesity;
- gynaecological and sexual health problems;
- incidence of family breakdown;
- number of looked-after and missing children;
- incidence of teenage pregnancy;
- poor educational attainment and behavioural problems, absenteeism and school drop-out

Professionals in universal services cannot and should not replace the function of specialist services, but they do need to be able to understand, engage and think professionally about the children, young people and families they are working with. They need to understand the circumstances of families at the point they seek help, or when they are identified as needing help whilst using a service (such as health or education services). People working with families, such as children's centre staff, teachers, social workers, doctors and healthcare staff, Jobcentre staff and housing professionals, who pick up on signs of domestic abuse need to have a clear route to signpost victims, perpetrators and children. These front-line staff should have access to training which enables them to identify domestic abuse and to support people to access further support.

We intend to conduct a countywide, multi-agency workforce audit to aid development of training frameworks, core competences and improved training coordination across all business areas.

To enable us to do this we are engaging with Learning and Development leads to formulate and better understand what the local Learning and Development landscape looks like and developing a tool for adoption and roll-out across the domestic abuse, safeguarding and Early Help multi-agency workforce throughout Hertfordshire.

We will

- raise awareness of domestic abuse and the support available to victims and perpetrators amongst professionals who work in universal services (such as hospitals, doctors and teachers)
- conduct a partnership wide training needs analysis
- understand, coordinate and quality check the training offered across Hertfordshire
- introduce outcomes for learning and development
- build capacity for innovation, learning and development across the partnership

Case study:
Healthy Relationships: Healthy Baby Programme – *Stefanou Foundation*

The Stefanou Foundation, a Hertfordshire-based charity, has invested its philanthropic resources to develop the innovative Healthy Relationships: Healthy Baby Programme (HRHB) and launched it in Hertfordshire. The programme offers expectant mothers and fathers the range of support they need to bring an end to domestic abuse, overcome trauma and give their babies the best start in life. The programme supports the family until the baby is two years old.

The design of the programme has been informed by the separate evidence bases of effective interventions for families, infants and children, for early and earlier intervention, for those who experience and use domestic violence and abuse.

These evidence bases were brought together to build the intervention strategy, define the cohort who could benefit most, drive programme design and operational arrangements, identify the outcomes being sought and commission its evaluation.

A key facet of the HRHB model is the way it is integrated with, and embedded into, multi-agency services and systems. As one of the UK's two host localities for the first two prototype projects, Hertfordshire's local government, health, police and probation services have worked closely with the Stefanou Foundation to help develop the programme. The programme was launched in April 2015 and the Hertfordshire HRHB team are co-located with the Stevenage Thriving Families Team.

Our partnership with the Stefanou Foundation, together with the academic research evaluation of the HRHB prototype project should give us vital learning about working with whole families at an earlier stage in the trajectory of domestic abuse to break the cycle, overcome and avoid the impact of domestic abuse on adults and especially on children.

Case study:
Police training

Hertfordshire police undertook significant training in domestic abuse via its pilot training program, domestic abuse matters - 25 days of action, provided through the national college of policing. During this training 1,400 Hertfordshire police officers were trained in Domestic Abuse. The aim was to get a critical mass of staff to create a substantial culture and attitude change and improve their skills to offer the best services to victims, offenders and their children.

Hertfordshire has trained 200 coaches to create a network of domestic abuse coaches who share best practice. Delegates were trained in coercive control, trauma bonding, perpetrator behaviour, evidence gathering, and safety planning.

The training received high praise from a breadth of people who attended. With the roll out of body worn video, officers can also record an initial account of the incident from the victim and, where appropriate, capture what has happened. The evidence is more graphic and can also be viewed by the court instead of reading a written statement.

Communications and awareness

Raising awareness of domestic abuse is essential to increasing confidence in victims and perpetrators to come forward to ask for support. We want to target work on education, prevention and training so that all residents experiencing domestic abuse, or likely to, understand what it is and know what to do.

One way to reduce the impact of domestic abuse is to educate and inform young people, preferably before they enter into a relationship. The raising of awareness for both boys and girls at an early age should also reinforce the unacceptability of any forms of abusive behaviour, which may assist in reducing the victims and perpetrators of the future and ensuring the future well-being of our young people.

Schools and colleges have a crucial role to play in helping children and young people to develop healthy relationships, deal with their emotions and challenge the way in which some young people behave towards each other. Preventative work around domestic abuse in the school setting is important to reach the next generation early, to mould attitudes and teach young people that domestic abuse is never acceptable.

We will

- continue to deliver domestic abuse campaigns across Hertfordshire to raise awareness
- maintain and further promote the Hertfordshire Sunflower services and branding e.g. website, helpline, drop ins, IDVA, and SARC services
- work with children & young people to provide information & general awareness through schools & other young people's services including the teaching of the importance of healthy relationships

Case study:
Herts Sunflower

Hertfordshire has a large and varied number of services, to support victims. These services are collectively known as and represented by the overarching 'Herts Sunflower' branding across the county.

Herts Sunflower provides information and support services for everyone affected or concerned by domestic abuse in Hertfordshire.

Services include:

- Independent Domestic Violence Advisers
- Multi-Agency Risk Assessment Conferences (MARACs)
- Sexual Assault Referral Centre (SARC)
- Specialist Domestic Violence Courts (SDVCs)
- Herts Sunflower Drop-in Services

The Herts Sunflower partnership is underpinned by the Herts Sunflower website, and the Hertfordshire Domestic Abuse Helpline. The website – www.hertssunflower.org – is a 'one stop' shop of information about services and support available for victims, friends and families of victims, professionals and perpetrators of domestic abuse. The website has a directory of services and provides an online reporting facility, so that non-emergency incidents can be reported directly to the police or to an independent domestic violence advisor (IDVA).

Hertfordshire Domestic Abuse Helpline –

08 088 088 088

- provides a free, confidential and sensitive resource service to those affected by or concerned about domestic abuse. It is currently staffed by trained volunteers from 10am-10pm, Monday – Friday. We want to expand the hours that the helpline is available in order to better meet service user needs.

Hertfordshire Domestic Abuse Helpline

Many victims agonise on the question of seeking help and are often deterred from approaching the 'authorities'. The Hertfordshire Domestic Abuse Helpline was established 13 years ago by the County Community Safety Unit for this very reason, and the public link with 'the authorities' subsequently weakened by converting it into a Charitable Trust. The Helpline provides an easily accessible and untraceable point of contact for the victim or other concerned individuals or members of the family to voice their concerns and to seek help. There is no charge to the caller and crucially, the Helpline number does not show up on their telephone bill so they can, if they wish, remain anonymous and their cry for help kept secret. The Helpline acts as the gateway to more than 200 services and can also direct victims needing urgent assistance to the IDVA service or a refuge.

The term 'gateway' is an apt description of our position between those who work and campaign to bring domestic abuse into the light, and those who provide support services to victims, create perpetrator programmes, and prosecute offenders. We also advise on the availability of services to workers and professionals who come into contact with domestic abuse. It is necessary work, as evidenced by the 6% increase in calls in 2014-15 over the previous year and our increasing need to use the services of Language Line as our communities continue to become more diverse. We are constantly looking to expand the service.

AIM 2 – PROTECT

Reduce the risk to victims and ensure that perpetrators are held to account.

Outcomes we want to achieve

- Children and young people at risk of harm are identified and referred appropriately
- Victims are safer and have improved resources to remain safe
- Victims have increased access to justice
- Perpetrators of domestic abuse are supported to change their behaviour.

We want to identify, assess and reduce risks for victims as early as possible, and protect victims by intervening appropriately when necessary. The safety of the victim is of paramount importance and it is essential that we have robust and consistent risk assessment processes in place, and that these are used as widely as possible.

We are keen to develop a family centred and consistent approach to effective perpetrator justice with clear, safe, and supportive mechanisms to ensure that the victim's voice is heard. A recent report by the Centre for Justice Innovation calls for greater use of specialist courts, including those focusing on domestic abuse. The Better Courts: a Blueprint for Innovation report[8] notes that despite a 34 per cent rise in domestic abuse incidents reported to the police since 2007, victims are often reluctant to testify with many finding the system confusing and intimidating.

Whilst justice for victims of domestic abuse is essential, it needs to be delivered alongside appropriate support for perpetrators in order for them to change. Admitting there is a problem is a necessary but often difficult first step for many perpetrators. Once they have accepted that their behaviour needs to change, we offer support via perpetrator programmes and a range of intervention services.

We want to better understand what works and will set out our proposals for effective practice for perpetrators and the courts later this year.

Case study:
My Life – Watford Women's Centre

'My Life' is a 10 – 12 week domestic abuse awareness and personal development programme for women who have experienced domestic abuse in their adult relationship. Typically a group will consist of up to fourteen women, and is led by two trained female facilitators (one of whom is a counsellor), and a crèche is ideally provided. Women can self-refer onto the programme or be referred by social workers, health visitors, family support staff, and GPs. The first step is usually a one-to-one appointment to assess current risk and suitability for the programme.

A combination of presentations, group discussion, individual and group exercises are used including Protective Behaviours and risk assessments. Women set their personal goals and have individual learning plans. The programme is evaluated through self-assessment, and review.

Whilst attending a programme women often make decisions to seek legal and housing advice, start one-to-one counselling or look at support services for their children as a result of their increased awareness and confidence.

[8] Centre for Justice, December 2015

The aim is that women who have completed the My Life programme will be recognise and identify their experiences of abuse

- recognise how domestic abuse impacts on children and parenting
- identify support systems and feel less isolated
- develop their confidence in making safe choices and decisions about their future
- demonstrate their knowledge of their rights to access other support and information
- recognise and indicate their feelings
- "put light back in their lives", and ''find me again'' (quotes from women who completed the programme)

During 2015, six programmes were delivered, two of which were held in other areas of the County.

Multi-Agency Risk Assessment Conferences (MARACs)

MARACs are multi-agency meetings where statutory and voluntary agency representatives share information about high risk victims of domestic abuse in order to produce a co-ordinated action plan to increase victim safety. Over 1,300 cases of domestic abuse were heard by MARACs in Hertfordshire in 2014/15 and this figure continues to rise during the current year.

We made several improvements to our MARAC arrangements in 2015. We;

- appointed a senior lead from Hertfordshire Constabulary to chair the MARAC steering group and ensure that it remains a priority amongst partnership agencies
- identified common improvement areas via independent MARAC observations
- reviewed the steering group terms of reference and action plan, and implemented quality assurance arrangements for MARACs
- started to review the MARAC operating and information sharing protocols in order to agree a clearer framework for operating MARACs in Hertfordshire
- established the strategic lead, and core/deputy core group members for agencies and ran training sessions

Key priorities

We will

- ensure roles are clear for MARAC core group members and their deputies, and that effective induction arrangements are in place
- continue to review sample police incidents and the use of the Domestic Abuse Stalking and Harassment (DASH) risk assessment tool, and audit MARAC cases to identify risks
- continue to undertake focussed self-assessments in line with local MARAC principles
- ensure that the important role of Housing Associations and Registered Social Landlords is reflected in MARAC arrangements
- develop web-based information systems to be used across MARAC agencies
- encourage all agencies to use the SafeLives Domestic Abuse Stalking and Harassment (DASH) tool to ensure consistency in risk assessment, and quality assure the process
- further review MARAC co-ordination capacity levels to ensure robust administration arrangements

Hertfordshire Constabulary's Domestic Abuse Investigation & Safeguarding Unit (DAISU)

The new Domestic Abuse Investigation and Safeguarding Unit (DAISU) opened its doors on the 11 January 2016. Based at Hatfield Police Station, DAISU is a county-wide team which deals with intimate relationship domestic abuse across all risk levels, so-called honour based abuse and forced marriage. DAISU operates from 7am to 11pm seven days a week.

The implementation of DAISU follows a review of domestic abuse services in Hertfordshire, and a similar structure has been implemented in a number of forces across the country. This more streamlined, end to end service will enable the Constabulary to tackle domestic abuse and its aftermath for those most at risk of serious harm, with the objectives of improving service to victims, reducing repeat victimisation, and increasing our expertise in dealing with domestic abuse.

Perpetrators and Specialist Domestic Violence Court Effective Practice

In 2015 we established a Perpetrator and Specialist Domestic Violence Court working group in order to develop an evidence led, multi-agency approach to tackling domestic abuse perpetrators including prevention, provision of services, management and assessment.

In order to design and deliver services, we need to;

- understand perpetrator behaviour
- identify risk factors likely to be criminogenic
- target risk factors and multiple needs
- use responsive behavioural techniques at the appropriate intensity
- ensure that therapy is sensitive and constructive

So far we have;

- Developed a set of approval criteria which will be used to approve domestic abuse programmes
- Expanded the perpetrator pilot programme in Stevenage to become a countywide service operating out of three bases in areas of highest risk
- Introduced a female perpetrator pilot scheme using the expertise, experience and established infrastructure of the Watford Women's centre and Herts Women's Centre in Stevenage to develop a unique female focused programme that will tackle the underlying causes of female instigated abuse
- Worked with the Stefanou Foundation as a host authority for their new whole family programme that integrates perpetrator support, victim support and parenting support for both parents

We will

- produce multi-agency quality standards for domestic violence courts to include services to the victim and a pre-court programme
- drive improvements in line with the detailed Perpetrator/Specialist DA Court implementation plan
- develop a consistent approach for the management and assessment of domestic abuse perpetrators and promote the safety of victims
- contribute to the development of effective prevention strategies to ensure that potential domestic abuse perpetrators are identified early and offered opportunities to change

- support the effective sharing of information to ensure effective multi-agency risk management
- develop an evidence led approach to the commissioning and provision of services for domestic abuse perpetrators
- advise on how front line workers can be appropriately trained to identify, engage and manage perpetrators of domestic abuse and work with key agencies to contribute to protecting victims and safeguarding children and vulnerable adults

Case study:
Operation Acorn

Operation Acorn is the Stevenage community safety partnership's response to domestic abuse which aims to break the cycle of persistent offending by providing appropriate support and alternative measures. The programme also aims to provide enhanced protection and respite for vulnerable victims of domestic abuse. The initiative targets offenders by using the successful processes of Integrated Offender Management, partnership working and legislation, to reduce repeat offending and subsequently keep victims safe.

High risk domestic abuse offenders are asked if they wanted to change their behaviour. If they agree, offenders are tagged with a GPS "Buddi" monitoring system. During the initial pilot, twenty offenders worked with police and partner agencies and several were accepted on to a perpetrator programme as well as receiving support for drugs rehabilitation where required. The project is also working closely with housing providers to support appropriate moves where required. This is a new approach to tackling domestic abuse by addressing the issues that have led to the abusive behaviour and trying to prevent further offending.

Potential subjects are identified through a risk matrix and are deemed to be high risk to a vulnerable victim. Each subject is then assessed for suitability for either:

- Engage - support through Offender Management Programmes, drug rehabilitation, alcohol groups, Hertfordshire Change programme, Buddi Tag programme, housing and probation, or
- Catch and Convict - if targets are unwilling to engage, they are treated as Prolific and Priority Offenders. Their full criminality is reviewed and opportunities are taken to catch, convict and remand/suitable conditions, to ensure the safety of victims.

During recent months, there has been one repeat offence out of 31 offenders that have been reviewed within the project. This is a significant decrease for Stevenage, having constantly appeared with several offenders in the top ten for Hertfordshire police for repeat offenders and victims.

Case study:
Herts Change – Perpetrator programme

The pilot Herts Change Project works with perpetrators of domestic abuse in a group work setting, and offers an integrated support service for their victims.

Clients undergo an initial assessment of suitability for the programme, which is determined by the client's motivation to change, accountability for their actions and awareness of the harm caused. In addition, consideration is given to the client's mental health, substance misuse and risk posed. For clients lacking motivation to address

their abusive behaviour, assessors offer further assessment sessions and adopt a motivational interviewing approach to encourage and motivate clients into considering change. Whilst on programme, monthly case management meetings are held to review risk levels and create action plans to ensure the safety of the victim and children is maintained. Additional reviews are held within 24 hours of risk alerts being received by the Service Manager.

The pilot programme has been very successful so far with the majority of victims reporting that they feel safer and have not experienced physical violence since their partner completed the programme. Before the programme 54% of women reported that their children were frightened of the perpetrator, this reduced to 34% on completion of the programme. Following the programme qualitative interviews highlighted most women reported more freedom, less anxiety and less fear.

Making the change

When parents A and B were referred to the service, the family had 'broken down', they were living separately and struggled to communicate. The children were subject to Child in Need plans due to the emotional impact of witnessing domestic violence between their parents. Dad completed the full programme and Mum engaged with the support service. Since completion the family are now reunited, the children are no longer open to Children's Social Care and there have been no further reports of domestic violence. The social worker said "the Change project has had a huge impact on this family, it has enabled Dad to identify his behaviour and to make the changes to reintegrate into the family home, he has been able to rebuild his relationship with his children and his partner".

Domestic Homicide Reviews

Domestic Homicide Reviews are one way to improve responses to domestic abuse and aim to prevent what happened to the victim happening to others. They try to ensure that public bodies like social services, councils, police and other community based organisations understand what happened that led to the death and identify where responses to the situation could be improved. From this, the public bodies hope to learn all the right lessons including those which impact how they work together.

Domestic Homicide Reviews are part of the Domestic Violence, Crime and Victims Act 2004 and became law from 13 April 2011. They do not replace but are in addition to the inquest or any other form of inquiry. Reviews are undertaken by District Community Safety Partnerships.

Hertfordshire has had eight locally based and lead DHRs - whereby the permanent or most frequented address of a victim prior to their death was within one of the 10 local Community Safety Partnership areas since the implementation of related legislation in 2011[9], all involving female victims. In addition to the eight Hertfordshire-based DHRs, there are a further five DHRs in other parts of the country whereby the scope of these has identified a history within Hertfordshire, and past involvement with Hertfordshire agencies.

In 2015 we established a Domestic Homicide Review sub-group to oversee, monitor and scrutinise countywide arrangements for DHRs. We have;

- agreed consistent pathways for DHR operational arrangements across Hertfordshire with Community Safety Partnerships

[9] Domestic Violence, Crime and Victims Act (2004), Section 9: effective 13th April 2011

- identified a number of common themes arising from DHRs and agreed a series of actions
- started to implement a process for collating lessons learned

We will

- improve mechanisms for sharing the learning from DHRs, including how the learning is embedded into practice
- implement operational DHR pathways across agencies
- develop, agree and implement a protocol and process for Quality Assurance
- identify central coordination of DHRs and establish robust systems to track the outcomes

Support for victims

We want victims to be safer, and better resourced to remain safe. We want to improve the experience of victims using the courts system so that they feel confident to testify, and empowered to make decisions about their future.

During 2015 the Police and Crime Commissioner created the Beacon Victim Care centre in order to provide all victims of crime with a single point of access where the right information and advice is available and at a time suitable for them. In order to meet with the requirements of the EU directive and 2015 Code of Practice for Victims of Crime, the Beacon Victim Care Centre is:

- free of charge
- confidential
- non-discriminatory (including being available to all regardless of residence status, nationality or citizenship)
- available whether or not a crime has been reported to the police
- available before, during and for an appropriate time after any investigation or criminal proceedings

beacon Hertfordshire victim care centre

Case study: Beacon

Responding to the PCC Victims' Voice consultation, a number of victims of domestic abuse provided invaluable insight into their experiences while awaiting justice.

Many victims expressed satisfaction with a service empowering victims and helping individuals regain their confidence and self-esteem. However, for some, the criminal justice system seemed daunting and where receiving timely and accurate information problematic. In extreme cases, some victims had been left chasing agencies for information and on occasion, victims felt they were the only person who knew what other partner agencies were doing. Poor coordination of services can not only lead to additional anxiety and stress at an already difficult time but disengagement from the criminal justice system altogether.

The Beacon Victim Care centre has been created to provide all victims of crime with a single point of access where the right information and advice is available and at a time suitable for them. This includes victims of domestic abuse and where Beacon has a role in coordinating support with more

specialist agencies, as well as providing emotional and practical services for victims, including access to the Hertfordshire Home Security Service.

A key partner is Victim Support who provide trained specialist Domestic Abuse volunteers to support those victims designated as ‘standard’ risk.

All of the Domestic Abuse Volunteers have received SafeLives approved domestic abuse training, which enables them to support victims who are regarded as being both standard and high risk. The training is comprehensive and equips the volunteers with the skills and knowledge needed to provide effective support to victims of domestic abuse, including how to complete the SafeLives risk assessment questionnaire and undertake safety planning, all of which are reviewed periodically by a trained manager.

An important role for Beacon is to ensure that victims of crime have access to support services irrespective whether they have reported the crime to police (or other competent authority). This is a requirement of the European Parliament (2012) Directive 2012/29/EU on the Minimum standards on the rights, support and protection of victims of crime. Therefore victims can contact Beacon direct confident in the knowledge that their needs will be addressed and where direct links with other statutory partners and VCSE sector have been developed to ensure effective support packages are available.

Beacon Victim Care Centre is your gateway to victim services available in Hertfordshire.

If you have been unfortunate enough to have been a victim of crime, you can speak with a member of our victim service team on ***03000 11 55 55.***

You can also speak directly to Victim Support on ***08 08 16 89 111.*** *All calls are treated in the strictest of confidence.*

AIM 3 – PROVIDE

Work in partnership to provide appropriate levels of support where abuse occurs

Outcomes we want to achieve

- Victims receive responsive services and risks of further abuse are mitigated
- All identified victims are offered an equally accessible service which meets their needs
- Victims report improved health, wellbeing and resilience

Domestic abuse can happen to anyone at any point of their life irrespective of their gender, sexual orientation or background. It often has a serious and long lasting effect on families, with victims of domestic abuse often becoming repeat victims or sometimes perpetrators themselves. It is therefore essential that Hertfordshire offers a wide range of services that can cater for individual needs at the same time as delivering good value for money.

We want to break the cycle of domestic abuse. This requires us to ensure that there is the right balance of investment between prevention, protection and provision, and also understand what it takes to break the cycle through our earlier and later interventions.

Commissioning services

The design and supply, or commissioning, of domestic abuse services is the largest area of our strategy. We know from the SafeLives review that Hertfordshire was below the national average in terms of spend on specialist services and we have now started to put a three year funding and commissioning timetable in place. During 2015 we;

- established a domestic abuse commissioning partnership sub-group with representation from key agencies, and appointed a senior Domestic Abuse Commissioning Manager
- conducted a mapping exercise of domestic abuse services in Hertfordshire
- identified current secure funding and confirmed this via a Memorandum of Agreement with the Executive Board
- agreed commissioning priorities and a short, medium and longer term commissioning timetable for service redesign
- developed a Joint Strategic Needs Assessment so that we can make better informed decisions about the types of services we need
- started a process of engagement with current service providers to identify opportunities to ‘add value’ to the current offer prior to formal procurement processes being undertaken
- agreed additional funding requirements for the high risk IDVA service, and developed a procurement timetable
- held a number of workshops with refuge providers to enhance partnership working and service options for victims which has led to an agreement to open service access at the evenings and weekends subject to voids
- secured funding to ensure that the *Herts Change* pilot perpetrator programme is expanded and continues to operate whilst work takes place on how we identify effective practice and treatment for perpetrators in the future
- grant funded a female perpetrator pilot programme

We will

- conduct a full options appraisal of service provision and gaps
- develop an Integrated Commissioning Plan, leading to a clear framework for a Hertfordshire core 'offer'
- research and consider the use of a data-monitoring tool for overseeing service delivery against the outcomes we expect to see including through commissioned arrangements
- design and commission the new service model contract for the IDVA Service (high risk victims service)
- agree IDVA Service phase two funding and service modelling in order to commission an enhanced IDVA service (medium risk victims service)
- design and agree a model for accommodation based services including timelines and funding
- commission new service arrangements for perpetrator services
- pathways for support - review current 'offer for Hertfordshire', and agree future service delivery model/funding
- children's support - review current arrangements to support children including community based interventions, the identification of opportunities and gaps, and clarify future needs and actions
- community support - evaluate current services to support victims in the home and commission future services as appropriate
- community support services – identify gaps and opportunities, and implement actions to strengthen service responsiveness across care, support and community services
- develop clear approaches for ensuring the service user voice influences service design plans

Partnership approach

There are an enormous number of dedicated stakeholders and professional front line staff working to prevent domestic abuse from happening in the first place, and providing support when it does. The Hertfordshire Domestic Abuse Partnership seeks to bring together representatives from statutory agencies, housing and the voluntary and community sector to improve partnership working, communication and decision making. We want to work with as many organisations as possible to ensure that people living and working in Hertfordshire understand what domestic abuse is and how to respond. We will only achieve our intended outcomes by working together, particularly with the universal services residents use on a daily basis such as schools, hospitals and GPs.

This strategy recognises the importance of working in partnership across agencies to facilitate joint commissioning arrangements and deliver preventative, effective and co-ordinated domestic abuse services. Partners are committed to;

- *Ensuring the Hertfordshire Joint Commissioning Strategy is underpinned by the development of personalised and needs led services*
- *Implementing a risk management approach to target resources effectively to those most in need*
- *Developing effective partnerships between statutory services and voluntary and community networks to maximise service solutions*
- *Effective and consistent monitoring and data analysis to identify and respond to trends*
- *Best practice and lessons learnt from domestic homicide reviews influencing the direction of travel.*

Case study: Family Safeguarding Teams

The County Council was awarded the highest grant to local authorities in the UK from the government's Children's Social Care Innovation Programme (£4.86 million) to revolutionise children's social care in Hertfordshire. The money funds a ground-breaking change in the way we approach child protection and improve the lives of vulnerable families. It is a completely new way of working for social workers, cutting down on red tape and freeing them up to spend more time with families. The funding has enabled us to press ahead with plans to improve the health, education and wellbeing of more than 1,000 of our highest risk children and families, and we hope it will become a model for other areas.

We have extended the work of our safeguarding teams across the county to include substance misuse workers, community psychiatric nurses, and domestic abuse specialists all trained in new ways of supporting families. The safeguarding teams work alongside schools, children's centres, health visitors, police officers and the voluntary sector to make sure children in Hertfordshire have the opportunity to live in a caring home where they can thrive and prosper.

Multi-disciplinary teams are trained to use the same evidence and practice approach and engage families far more in analysing their own issues and designing their own work plan. Service user feedback has been extremely positive to date and some examples of the work we have done are;

Case 1 - A mother and child, who was on a Child Protection Plan, had moved out of the family home following a violent incident. The victim was determined that she would 'not let him get away with it' this time and reported the incident to the police. Through dedicated case work, she was able to identify negative areas of her relationship, and desirable and healthy areas of relationships that were missing in her own.

She admitted that during her relationship she had experienced mostly negative emotions and felt guilty. We worked with her to help her put strategies into place that would raise her mood, think of positive actions to protect herself and reduce her feelings of isolation. In her last session she demonstrated a clear understanding of domestic violence and its impact. She shared knowledge gained from sessions with her family and felt confident in using the information given to her to make informed choices regarding future relationships and the impact on her child.

Case 2 - A mum of two children, one of which was on a Child Protection Plan, was initially reluctant to recognise that her relationship had been abusive. She felt that the abuser was a good Dad and that other women experienced 'real abuse'. She felt guilty for breaking up the family and the possible impact on the abuser. Over time she recognised a number of areas where she had experienced abuse, and admitted that she felt powerless to prevent actions which caused her stress in relation to her abuser. Following a violent incident in the family home she contacted the Police to make a statement and gained a non-molestation order against the abuser.

With this order in place, she became much more confident. She spoke of needing time for herself and to socialise, and discussed the necessity in future to make safe choices with partners. She became more organised and spoke about her future in a positive way without her former partner. She was able to demonstrate change as she considered her future and her ability to focus on the needs of her children and protect them from witnessing confrontations between her and her ex-partner.

Adults with complex needs

The Adults with Complex Needs project was established in 2014 and seeks to explore the following theory:

If agencies in Hertfordshire pool resources and work more closely together to identify and deliver services to adults with complex needs and chaotic lifestyles, they will be able to achieve a more cost effective service and deliver interventions, solutions or improvements which are more customer focussed and effective.

Adults with complex needs experience multiple issues, such as mental health needs, drug and alcohol dependency or a lack of stable housing, and are frequent users of high costs services. Research identified that 20 of the most frequent users of services cost in excess of £1.4million over two years to the public sector. Anecdotally, many of these individuals were victims of domestic abuse and almost all had had multiple, negative interactions with the police.

The project is supported by a partnership of key service providers, including health, police, districts and boroughs and community organisations. Following in depth research, partners have committed over £350,000 per year to deliver two pilots in Hertsmere and Three Rivers to test the theory above.

The pilot service offers personalised support, working towards individuals goals which lead individuals to stronger relationships, appropriate accommodation and meaningful occupation. Through the pilot it is anticipated that partners will be able to share learning with other practitioners and that, in the longer term, evaluation will influence strategic commissioning.

Our aim is to demonstrate that by working more intensively and preventatively with individuals, we will not only generate sustainable outcomes, but reduce the cost of service use. To do so, we offer support built on personal goals, community based recovery plans and dedicated key worker support.

Refuge

Refuges provide a safe sanctuary for victims in immediate danger while they make supported decisions about their future. Hertfordshire has maintained Refuge provision levels over the last decade, and agencies and providers are working closely together to consider opportunities for enhancing existing services, and designing future accommodation models.

Opportunities for short and medium term

- Case studies showcasing ‘social value’ to highlight the wider benefits and contribution to society
- Service provision for male victims via floating support services
- Service access to be provided out of hours and weekends (a refreshed protocol to be developed between refuges and the constabulary)
- Refuge involvement in workforce learning and development to raise awareness of the service offering

Refuge Service Opportunities for the future accommodation model

- Provision of a ‘crash pad’ facility – a service for 1 - 7 days only
- Outreach provision across all districts
- Service provision for male victims and young people of transition age
- Exploration of reciprocal service access arrangements with border local authorities

Service users' voice

Consultation with service users in developing our plans and services is critical to ensuring that we design responsive services that meet the needs of the whole community. Responses to the recent victims' voice survey and the SafeLives review victims consultation have been used to shape this strategy and our commissioning plans. We want to improve existing arrangements and will consider the use of service user panels in our commissioning plans, and work with the voluntary and community sector in particular to ensure that both victims and perpetrators continue to have their say.

People just point the finger and assume the man is the protagonist and offender.

I was continuously made to feel like I was the offender

There needs to be better support for victims of drink and drugs, and better understanding of domestic violence.

Everything was done to protect the offender's rights

You should have more places for victims and their children

If I'm not privy to this vital information how am I able to keep myself and my daughter safe?

They always focussed on me but I wasn't the problem.

The police were really helpful. They explained MARAC to me and kept me updated.

I am a jealous person; I wanted my girlfriend with me all the time. Now I have lost her because of my behaviour. The (Herts Change) programme helped me to understand how that affected her, maybe if I had done this course sooner we would still be together.

I didn't call the police because in the country I grew up in they wouldn't help, and I didn't know what to expect.

When things are bad you don't know what to do. You need someone calling you, being understanding and giving you options.

Service user feedback 2014/15

Champion's network

We will review the role of the Domestic Abuse Action Group in light of becoming a 'champion's network'.

Only by ensuring professionals have a sound and common understanding of domestic abuse – its dynamics and impact – and the ability and capacity to work more effectively, can we begin to ensure the safety of victims. A champions' network enables this by coordinating the dissemination of improved understanding that ensures consistent, quality and timely information.

'Champions' are equipped with the skills and knowledge to support internal and external structures and inter- and intra-agency partnerships by providing advice and guidance where domestic abuse is a concern, and assisting colleagues to navigate access to appropriate services.

They would also have enhanced knowledge of how other services can assist in cases

and help signpost others to the right agency or service. Network membership is likely to include representatives from:

- Nursing / Health visiting
- Domestic abuse outreach services
- Community Safety Officers
- Substance Misuse Workers
- Social Workers
- Police Officers/PCSOs
- Relationship Therapists
- Family Support Workers
- Sexual Health Workers

The Champions' network could be supported by a 'closed' / members only web-based forum and a programme of cyclical and regular training, network meetings and events, and bulletins.

Honour Based Abuse including Forced Marriage and Female Genital Mutilation

The National Police Chief's Council definition of Honour Based Abuse is;

"A crime or incident which has or may have been committed to protect or defend the honour of the family and/or community".

It is a form of domestic abuse which is perpetrated in the name of so called 'honour'. Relatives and acquaintances that do not abide by the 'rules' set for them are then punished for bringing shame on the family or community. Common triggers for honour based abuse can include having a boyfriend or girlfriend, rejecting a forced marriage, pregnancy outside of marriage, interfaith relationships, seeking divorce, and inappropriate dress or make-up.

We know that our front line professional staff may have limited opportunities to speak to potential victims of honour based abuse, forced marriage and female genital mutilation which means that *all* professionals need to be aware the issues, how to identify when it might be happening and what to do. If the victim is allowed to walk out of the door without support being offered, that one opportunity might be lost.

Forced marriage is a criminal offence and statutory agencies and institutions where victims may be accessible need to work together to increase awareness and support for these victims. We know that despite the recorded numbers, forced marriage still remains a hidden practice, as many more cases remain unreported.

There are multi-agency services available but work needs to be done to align this with the statutory requirements on dealing with forced marriage and honour based abuse.

Partnership agencies need to work together to;

- Develop and embed clear care pathways
- Focus on raising awareness within health agencies and schools to recognise, prevent and refer
- Work with communities to increase an awareness of support that is available for victims and an individual's right to choose

we will;

- use the results of our local multi-agency self-assessment against the HM Government: FM/HBV Guidance to determine service priorities for the partnership and commissioning arrangements

we will;

- raise awareness among the public and professionals/agencies focusing on health agencies and children's services including schools to recognize, provide information and give a route to seek help
- provide training for the agencies' staff to recognize, report and refer
- develop and agree clear care pathway from initial identification shared by all agencies
- access to appropriate services for support and actions - reducing or protecting from risk of/harm
- work with faith leaders to raise awareness within vulnerable communities and develop positive relationships.
- work with the charity Barnado's to ensure that we are doing all we can to help eradicate the illegal practice of female genital mutilation

Local commissioning priorities

Based on local information reviewed in the JSNA and findings from the SafeLives review, a range of key issues have been identified and used to inform the commissioning strategy and timetable for future activity. These include the following:

1. *There is evidence that domestic abuse victims require services to be developed through integrated pathways and approaches.*
2. *In meeting the needs of the whole community, there is inconsistent and minimal intelligence in relation to the needs of and impacts for people with specific and multiple equality characteristics (as outlined in the Equality Act 2010).*
3. *Due to limited monitoring and fragmented approaches to commissioning existing services, there is the need to implement an integrated outcomes focused framework for measuring progress against future strategic delivery.*
4. *Professionals working in services across statutory services and within community settings need to better understand how to recognise and report domestic abuse.*
5. *Targeted awareness raising and effective communications outlining both the victim and professional pathways are needed to support early intervention and / or ensure victims receive timely access to appropriate information, guidance and specialist support.*
6. *The experiences and involvement of victims including children, as well as perpetrators needs to directly influence service design and delivery. This is not routinely currently evidenced.*
7. *Risk management is key – services offered to victims must strike a balance between prevention and risk.*
8. *There is the need for a clear 'pathway' for victims that triages support*
9. *IDVA services need to be sustainable and have a presence in a wider range of community settings to maximise reach*
10. *Service interventions need to incorporate 'minimum standards' in line with best practice*
11. *Secure funding is needed to sustain service viability and responsiveness*
12. *More support is needed to respond to peaks in demand i.e. weekends and evenings*

Commissioning Principles

The following four thematic areas will underpin the future commissioning principles;

1. Early intervention and prevention

- Victims receive clear and co-ordinated, accessible information, advice and signposting
- Children receive educational support to develop healthy relationships
- Priority is given to getting children back into education if moving into refuge or short term accommodation
- Service provision balances risk and prevention

2. Services are responsive

- Professionals from partner agencies recognise signs of abuse
- Agencies provide a safe environment for disclosures to be made
- Identification of abuse and disclosures result in timely and appropriate referrals through integrated pathways
- Victims are listened to and services are needs-led for men, women and children
- Best practice interventions are identified and utilised with perpetrators
- Appropriate types of support are available out of hours and at weekends

3. Services meet the needs of the whole community

- Service developments are underpinned by robust equality impact assessments
- There is ongoing and targeted engagement with communities at a local level to build trust and develop future services
- A ‘no wrong door’ is developed across agencies
- Services have a ‘whole family’ approach

4. Effective governance and partnership arrangements underpin commissioning

- Services are underpinned by national accreditation ensuring minimum quality standards are met
- Needs analysis for commissioning options is based on a risk management approach
- An outcomes focussed performance framework will be used to measure progress against delivery of the strategy
- Commissioned services receive routine contract monitoring, seeking evidence of social value, value for money and positive outcomes for victims and people affected
- Service solutions will focus on developing sustainable partnerships, including between commissioned, non-commissioned services, local and national agencies

Risk factors

Risk factors that might prevent the commissioning strategy from being realised include;

- A lack of engagement and timely 'buy in' from key service providers including education links
- Insufficient and insecure funding arrangements
- Commissioning decisions being made outside of a joint commissioning and multi- agency approach
- Inconsistent application of contract management and quality assurance oversight of services
- Unclear pathways across partner agencies
- A lack of understanding of domestic abuse in communities and with practitioners

We will mitigate these risks by;

- Consulting with key agencies to inform decision making – and sharing a timetable of core commissioning activity
- Developing robust business cases outlining projected needs and cost implications
- Underpinning the commissioning strategy with a commitment to multi-agency working
- Developing proportionate approaches for contract monitoring and quality assurance – and developing overarching KPI's
- Developing and communicating practitioner and victim referral pathways for support
- Developing and implementing a communications strategy to assist with victims recognising the signs of abuse, referral routes to services and what support is available to meet their needs.
- Ensuring practitioners have appropriate workforce development interventions

Legislative framework

In shaping this strategy, we have taken into account a number of sector specific legislation and publications including:

On the 25th of November 2010, to mark the International Day for the Elimination of Violence against Women, the Coalition government launched a paper outlining their ambition and guiding principles to tackle violence against women and girls.	In November 2013, the government announced their intention to roll out nationally both domestic violence protection orders and the domestic violence disclosure scheme across England and Wales from March 2014.
In 2011, Domestic Homicide Reviews (DHRs) were established on a statutory basis under section 9 of the Domestic Violence, Crime and Victims Act (2004). This provision came into force on 13th April 2011. Locally, the District Community Safety Partnership is responsible for determining whether such a review should take place in the event of a death, establishing a review and overseeing subsequent reports and actions.	In March 2013, the coalition government introduced a change in the definition of domestic violence and abuse. It was widened to include young people aged 16 to 17 and coercive control – a pattern of controlling behaviour. The decision followed a consultation that saw respondents call overwhelmingly for this change
In November 2012 the Protection from Harassment Act 1997 was updated by provisions made in the Protection of Freedoms Act 2012, creating 2 new offences for stalking. The new offences were made under sections 2A and 4A of the 1997 Act and cover: stalking, stalking involving fear of violence or serious alarm and distress. The amendments also set out new police powers to enter and search premises (on provision of a warrant – section 2B) in relation to these offences.	Domestic Violence Protection Orders (DVPOs) are a new power introduced by the Crime and Security Act 2010, and enables the police to put in place protection for the victim in the immediate aftermath of a domestic violence incident. Under DVPOs, the perpetrator can be prevented from returning to a residence and from having contact with the victim for up to 28 days, allowing the victim a level of breathing space to consider their options, with the help of a support agency. This provides the victim with immediate protection. If appropriate, the process can be run in tandem with criminal proceedings
The Domestic Violence Disclosure Scheme (DVDS) introduces a framework with recognised and consistent processes to enable the police to disclose to the public information about previous violent offending by a new or existing partner where this may help protect them from further violent offending. The DVDS introduces two types of process for disclosing his information. The first is triggered by a request by a member of the public (right to ask‘). The second is triggered by the police where they make a proactive decision to disclose the information in order to protect a potential victim (‘right to know‘). Both processes can be implemented within existing legal powers.	FGM has been a specific criminal offence in the UK since 1985 when the (UK-wide) Prohibition of Female Circumcision Act (“the 1985 Act”) was passed. The Female Genital Mutilation Act 2003 (“the 2003 Act”) replaced the 1985 Act in England, Wales and Northern Ireland1. It modernised the offence of FGM and the offence of assisting a girl to carry out FGM on herself while also creating extra-territorial offences to deter people from taking girls abroad for mutilation. To reflect the serious harm caused, the 2003 Act increased the maximum penalty for any of the FGM offences from five to 14 years’ imprisonment.

APPENDIX 1 - Domestic Abuse Strategy – Draft Outcomes Framework

Strategic Aim		Strategic Objectives	Outcomes	Indicators/Measures
Prevent	*Prevent domestic abuse from happening in the first place by challenging the attitudes and behaviours which foster it, and intervening early where possible to prevent it.*	Target work on education, prevention and training	Victims, perpetrators and their children are identified early by a wide range of frontline practitioners and partner agencies	• Number of victims engaged by referral route • Duration of abuse by referral route • Number of victims engaged as % of referrals • Number of perpetrators engaged by referral route • Number of perpetrators engaged as a % of referrals • Number of perpetrators not in the criminal justice system
			Communities understand what domestic abuse know how to respond	• Number of educational preventative programmes • Training provided and numbers of front-line practitioners attending • Number of domestic abuse campaigns delivered • Prevalence of domestic abuse incidents in ethnic minority communities
			Increased reporting of domestic abuse to police, and fewer repeat victims of domestic abuse each year	• Number of domestic abuse homicides • Number of domestic abuse incidents (crime and non-crime) • Repeat victim rate
Protect	*Take action to reduce the risk to victims and ensure that perpetrators are brought to justice.*	Identify, assess and reduce risk to victims	Children and young people at risk of harm are identified and referred appropriately	• Number of children of victims engaged • Number of victims with children for whom key support was provided • Number of young victims and percentage of repeat victims • Number of young perpetrators and percentage of repeat perpetration • Number of support services for young people who have experienced domestic abuse including those who may be at risk of becoming perpetrators
			Victims are safer and have improved resources to remain safe	• Timely sharing of relevant information across agencies via MARAC • Percentage of Domestic Abuse victims at MARAC who are repeat victims • Cessation in all types of abuse • Reduction in risk of further harm • Sustainability of any reduction in risk • Victim reported changes to feelings of safety

Strategic Aim		Strategic Objectives	Outcomes	Indicators/Measures
		Protect victims via intervention	Victims have increased access to justice	• Number of report to police made • Percentage of cases where charges brought • Cases where CPS proceeded with the case • Cases where there was a successful prosecution • Number and proportion of positive disposals • Victims supported by the case worker with civil orders
			Perpetrators of domestic abuse are supported to change their behaviour	• Effective completion of behaviour change programmes • Increased rate of rehabilitation amongst offenders
Provide	*Work in partnership to provide appropriate levels of support where abuse occurs*	Provide adequate support for adults, children and young people suffering from domestic abuse	Victims receive responsive services and risks of further abuse are mitigated	• Number of victims and repeat victims • Percentage of victims accessing support • Number of perpetrators and repeat perpetrators • Number of victims requiring relocation • Number of victims able to remain in their own homes where it is safe and appropriate to do so • Number of children accessing or using Outreach support services • Number of victims accessing or using Outreach support services • Number of 16 and 17 year olds who are victims of Domestic Abuse accessing Outreach services • Number of 16 and 17 year olds who are victims of Domestic Abuse accessing Refuge services • Percentage of beds occupied in Refuges (Adults) • Percentage of beds occupied in Refuges (Children)
			All identified victims are offered an equally accessible service which meets their needs	• Number of victims referred to the service • Number of repeat referrals to the service • Number of victims unable to be contacted or refusing support • Number of victims proactively contacted • Number of victims provided information and advice only • Number of victims engaged (a case is opened and tracked) • Demographic and equalities data on intake • Victims engaging with recovery programme or other therapeutic services • Victims for whom an exit review was completed.
			Victims report improved health, wellbeing and resilience	• Victim reported quality of life improvements • Victim reported confidence in accessing support • Victims accessing health & wellbeing advice and support

Glossary of terms

Term	Definition
BME	Black and Minority Ethnic
DA	Domestic Abuse
DHR	Domestic Homicide Review
FGM	Female Genital Mutilation
HBA/V	Honour Based Abuse / Violence
HSCB	Hertfordshire Safeguarding Children Board
HSAB	Hertfordshire Safeguarding Adults Board
FGM	Female Genital Mutilation
FM	Forced Marriage
IDVA	Independent Domestic Violence Adviser
JSNA	Joint Strategic Needs Assessment
MARAC	Multi-Agency Risk Assessment Conference
MASH	Multi-Agency Safeguarding Hub
SARC	Sexual Assault Referral Centre
SDVC	Specialist Domestic Violence Court