Good Practice Briefing

HEALTH & VAWG

Contents

Introduction

ASCENT - Support services to organisations

Ascent is a partnership within the London Violence Against Women and Girls (VAWG) Consortium, delivering a range of services for survivors of domestic and sexual violence, under six themes, funded by London Councils.

ASCENT – Support services to organisations, is delivered by a partnership led by the Women's Resource Centre (WRC) and comprised of five further organisations: AVA, IMKAAN, RESPECT, Rights of Women, and Women and Girls Network.

This second tier support project aims to address the long term sustainability needs of organisations providing services to those affected by sexual and domestic violence on a pan-London basis.

The project seeks to improve the quality of such services across London by providing a range of training and support, including:

- Accredited training
- Expert-led training
- Sustainability training
- Borough surgeries
- BME network
- One-to-one support
- Policy consultations
- Newsletter
- Good practice briefings

Good practice briefings

The purpose of the good practice briefings is to provide organisations supporting those affected by domestic and sexual violence with information to help them become more sustainable and contribute with making their work more effective.

For more information, please see:

www.thelondonvawgconsortium.org.uk

London VAWG Consortium

About this briefing

This briefing aims to provide women's voluntary sector organisations with the information they need to' make the case' for being commissioned by local health commissioners.

For the past fifteen years or so as violence against women and girls (VAWG) has increasingly attracted the attention of statutory agencies, it has been principally framed as a criminal justice issue. This may be one of the reasons that the health sector has been slow to respond but there are some hopeful signs that this may finally be shifting.

Key aspects of the NHS reforms include:

- Creation of the **NHS Commissioning Board** to allocate resources and provide commissioning guidance
- Creation of **Clinical Commissioning Groups** (CCGs) to take over responsibility for commissioning local services from PCTs
- Abolition of **Primary Care Trusts** and **Strategic Health Authorities** and the introduction of Health and Wellbeing Boards, with the function to encourage integrated commissioning
- Development of **Monitor** as the economic regulator for all NHS funded services
- The **Care Quality Commission** will continue to act as the quality inspectorate across health and social care and well register services to ensure quality standards are maintained
- Creation of local **Healthwatch** organisations and **Healthwatch England** to gather and represent the views of patients

Health and Wellbeing Boards, structured to bring all parts of the local health and care system together to improve commissioning and achieve better health outcomes, have a significant role to play. Recent changes to the health and care system present new opportunities for effective strategic collaboration at the local level between health and wellbeing boards, community safety partnerships and other local partners, to improve the health and wellbeing of those affected by violence.

School nurses who work with children and young people aged 5 to 19 provide early help and universal public health services. Children transition from being supported by the health visiting service to the school nursing service at the age of 5 and subsequently transition into adult services at 19. School based interventions can be effective in targeting and supporting children at risk.

Example of a health project addressing VAWG: IRIS

Identification and Referral to Improve Safety (IRIS) is a general practice based domestic violence and abuse training, support and referral programme for primary care staff and provides care pathways for all adult patients living with abuse and their children. IRIS is centred in partnership work between primary care and specialist third sector agencies to deliver essential services and close the historical gap between the two sectors. Ultimately IRIS improves the quality of care for patients experiencing domestic violence and fulfils the moral, legal and economic case for addressing domestic violence

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

The new health architecture structures provide new challenges and opportunities for those working to end violence against women and girls (VAWG). New structures, processes and accountability requirements provide the opportunity to engage with health services, including public health who are increasingly aware of the need to VAWG as an underlying determinant of health and wellbeing. The drive to increase co-operation between health and social care to provide greater joined-up service provision may also prove beneficial to specialist VAWG organisations who are skilled in taking holistic approaches..

The **National Association for Voluntary and Community Action** published three research briefings (April 2014) that explored local charities and voluntary organisations attitudes and experiences of local health organisations.

Key findings from the research were:

1. **JSNAs**

There is a mixed picture in terms of voluntary organisations feel their views and those of their beneficiaries influenced and impacted upon local priorities. Some local relationships are in their early stages of development, although others report feeling excluded from the development of JSNA or that involvement has been largely symbolic and so has little impact.

2. **Healthwatch**

Overall the view is positive. The majority of respondents stated that they are engaged at least to some extent with Healthwatch and a significant proportion feel the views of their beneficiaries are represented.

3. **CCGs**

Results suggest that there is considerable variation between CCGs, even within single counties. Respondents repeatedly stressed that work with CCGs is in its early days and were, on the whole, positive about developments. However, responses highlight that there remains a significant proportion of organisations that have not been able to engage with CCGs, and which feel their beneficiaries' needs and views are not taken into account.

(Further information: http://navcanews.tumblr.com/post/80563401896/navca-publishes-health-survey-findings)

Health professionals can play an essential role in responding to and helping prevent further VAWG by identifying, intervening early, providing treatment and information and referring patients to specialist services. The health service is in a unique position to help women and girls who experience gender based violence to get the support they need because:

- The NHS is a universal, non-stigmatised service
- Health professionals have regular contact with individuals over their life course
- Women and girls are more likely to make contact with the health service than other statutory agencies
- Uniquely, health professionals may see women and girls in a state of undress which may reveal injuries usually covered by clothing

Whilst it is important that health professionals improve their responses to VAWG, this will usually mean that they will want to refer to a local specialist agency. It is worth knowing that the NHS is also the statutory agency which spends the most on dealing with the impacts of VAWG: impacts that can be prevented and / or reduced by the provision of appropriate specialist services. Estimated costs of VAWG to the London economy alone (including health services, loss of economic output and emotional costs) is £1.5 billion annually (Home Office 2009) with £3.42 million of this being the cost to the health service alone. The provision of specialist VAWG services have the potential to save the NHS a lot of money and as public services are increasingly put out for open tender, specialist services have much to offer.

(Some) impacts of VAWG on health

VAWG is linked to a wide range of negative health outcomes and is a risk factor for a wide range of both immediate and long-term conditions. Health impacts can be physical such as bodily injuries, chronic pain, neurological symptoms, gastrointestinal disorders, gynaecological problems and increased cardiovascular risk. Women and girls may also be depressed, self-harm, have post traumatic stress disorder (PTSD), anxiety, insomnia, increased substance use and suicide ideation. Cessation of abuse does not necessarily mean that mental health problems cease as well and if left unaddressed can become chronic conditions.

Less well recognised are health problems that arise as a consequence of coping strategies such as alcohol or drug use, eating disorders or self-harming. Neglectful self-care is also common amongst abused women and girls due to feelings of poor self-worth. Experiences of abuse can lead to the development of phobias. For example, for a women or girl who has been sexually abused, lying down with a strange person leaning over you who is at best going to cause discomfort and possibly pain, can be extremely frightening. As such, some health appointments such as dental and gynaecological checks may be avoided.

Example of a health project addressing VAWG: Nia

The Emma Project is a unique refuge and outreach service for women who have experienced domestic and sexual violence and who also use substances problematically.

The women who enter the refuge usually have long histories of abuse and disadvantage for example childhood abuse, domestic and sexual violence in their relationships, exploitation through prostitution including coercion and control by pimps, drug dealers, and people traffickers. They may have physical and mental health problems and complex needs including dial diagnosis, learned survival and coping strategies which can lead to difficulties in them accessing and benefitting from services, criminal records, experience of street homelessness and frequently been excluded from other services, including refuges.

We offer a high and specialist level of staffing which means that we are able to work with women who still use drugs and/or alcohol problematically; this is essential because leaving a violent relationship is a time of crisis and for many women this is not the best time to address substance use issues effectively. Most other refuges require women to be drug free to use the service. Our aim is to provide a safe place that accepts women as they are whilst supporting them to identify goals and find ways of moving forward and away from the multiple harms with which they live.

We also help agencies supporting women with problematic substance use to better meet their needs and provide training on violence against women and problematic substance use.

Why is VAWG a public health problem?

VAWG is a gendered issue (this is now even recognised by the World Health Organisation) and has significant and major long-term health consequences for women who have experienced, or are experiencing, VAWG and for their children who witness it. Much VAWG could be prevented and it is here that public health has a significant role to play. Additionally, VAWG is linked to health inequalities (a key priority for Public Health). Public health also has responsibility for commissioning sexual health services, alcohol and drug services, prevention campaigns on injury prevention and public mental health services all of which are key areas of interest for specialist VAWG services.

Key documents you may find useful to quote:

- Alberti Review: Commissioned by the previous Government, this assessed the health sectors response to VAWG. It contains a series of recommendations for the NHS to better support victims of violence. (http://www.health.org.uk/media_manager/public/75/external-publications/Responding-to-violence-against-women-and-children%E2%80%93the-role-of-the-NHS.pdf)

- Sexualisation of Young People Review: This review examined how sexualised images and messages may be affecting the development of children and young people and influencing cultural norms. The review also examines the evidence linking the sexualisation of young people with violence. (http://webarchive.nationalarchives.gov.uk/20100418065544/http:/homeoffice.gov.uk/documents/Sexualisation-of-young-people.html)

- A Bitter Pill to Swallow: A report on a series of survivor focus groups on their experiences of health services (http://wnc.equalities.gov.uk/work-of-the-wnc/violence-against-women/news-and-updates/309-a-bitter-pill-to-swallow-report-from-the-wnc-focus-groups.html)

- World Health Organisation, Global and regional estimates of violence against women: Prevalence and health effects of intimate partner violence and non-partner sexual violence: This report states that VAWG is a 'global health problem of epidemic proportions'. (http://www.who.int/reproductivehealth/publications/violence/9789241564625/en/)

The report was published alongside new clinical and policy guidance for health professionals: (http://www.who.int/reproductivehealth/publications/violence/9789241548595/en/)

- National Institute for Health and Care Excellence (NICE), Domestic violence and abuse - how services can respond effectively (http://guidance.nice.org.uk/PH50)

Example of a health project addressing VAWG: What works? LifeWorks

Since 2008, St Mungo's LifeWorks programme has provided face-to-face psychotherapy to around 200 service users regardless of their mental health diagnosis, including psychosis and personality disorders, or active substance use. Of the LifeWorks clients willing to share their history, 66% had histories of chronic trauma including sexual, emotional and/or physical abuse as children and high levels of early loss of primary caregiver. 24% had been in care and 43% had been in prison.

Clients are offered up to 25 weekly sessions of individual psychodynamic psychotherapy. These are 'client led', with clients talking about emotional issues (such as relationship breakdown and bereavement), rather than 'needs led' (talking about substance use and non-engagement with services).

Evaluation of the LifeWorks project has found that:

• 75% of clients showed an improvement in mental well-beingg

• Impact on a wide range of health and social outcomes :e.g. increased uptake of appropriate health treatment, reduced use of emergency services, and 42% of LifeWorks clients were in employment or training placements by the end of the therapy

• Higher take-up and completion rates and more recovery outcomes than the IAPT programme (Improving Access to Psychological Therapies) despite working with chronically excluded adults with complex needs.

For more information, see http://tinyurl.com/cpte2mn

In 2002, Richardson et al estimated that almost one in six women accessing GP services in the last year were victims of domestic violence whereas later studies found that in populations of women attending GP surgeries, the number who had experienced domestic violence in the past year ranged from 6-23%, and lifetime prevalence ranged from 21-55% (Hegarty, 2006).

Women accessing GP services may typically complain of disorders such as: chronic pelvic pain, STIs, recurrent UTIs, poorly controlled asthma and diabetes, fibromyalgia, medically unexplained symptoms, chronic fatigue syndrome, depression, post-traumatic stress disorder, substance misuse, alcoholism, or low self-esteem (Golding, 1999; Coker, 2000; Campbell, 2002; Bonomi, 2009). Domestic abuse in pregnancy is associated with intrauterine growth retardation, miscarriage and premature labour (Murphy, 2001). Women reporting domestic violence are 32 times more likely to be afraid of their partner than women not reporting domestic violence (Bradley et

al, 2002). Women experiencing VAWG are 'frequent attenders' of health services and require wide-ranging medical care, but they may also be likely to miss appointments regularly (Davidson et al, 2001). Children witnessing domestic violence may later present with developmental problems and long-term mental health, educational and social sequelae (Attala, 1995; Kitzmann, 2003; Bair-Merritt, 2006).

In one study, the rate of lifetime depression among childhood rape survivors was 52% compared to 27% among non-victims. (Saunders et al 1999) and survivors of childhood sexual abuse have also been shown to be at greater risk of problem alcohol use and eating disorders later in life (Galaif et al 2001; Wonderlich et al (2001).

Substance use is commonplace among women involved in prostitution: in one study 87% of women used heroin (Hester & Westmarland 2004) and more than half the women involved in prostitution, both on-and off-street, have been raped or seriously assaulted and at least 75% have been physically assaulted by a pimp or punter (Home Office, 2004)

Example of a health project addressing VAWG: Solace

Violence against women and girls is a direct cause of mental, physical and emotional ill-health, disability and even death. The Counselling service at Solace Women's Aid works with women who present with Post Traumatic Stress Symptoms including Re-experiencing (flashbacks, pro-longed psychological distress), Avoidance (distressing thoughts, triggers), Negative Conditions and Mood (persistent and distorted sense of self-blame), Arousal (sleep difficulties, hyper vigilance).

Many clients use self-harming techniques such as cutting and problematic use of substances to cope with the enduring impact of the abuse. The Rape Crisis counselling service found 78% of women assessed had attempted or thought about taking their own life.

The impact of engaging with counselling (1 to1 and group) has excellent outcomes including reduction in PTSD symptoms, depression, anxiety & isolation scores, increases in self-esteem, confidence and coping mechanisms and physical health. Many clients are referred to us by IAPT services, GP's, Personality Disorder Clinics and Mental Health services. 94% of clients accessing our group services had reduced attendance at A&E.

All figures relate to 2013/2014 annual data.

Helpful research findings

- People affected by violence are far more likely to experience poor physical and mental health than the general population.
- Early intervention is the most effective way to tackle the negative health and wellbeing impacts of violence and save local healthcare costs.
- Coordination across local services is necessary to address the complex needs of those at risk of causing violence, at risk of experiencing violence, and victims of violence.
- Effective joint strategic working between health and wellbeing boards and community safety partnerships will support improved local commissioning to achieve better health outcomes for those affected by violence.
- Experiences of violence and abuse are strongly related to subsequent mental health difficulties and the services people need and use.
- Six distinct groups in the population were identified through analysis of data from the Adult Psychiatric Morbidity Survey (APMS) on reported experiences of violence and abuse in childhood and adulthood. Three quarters of the population had little experience of violence or abuse, but the remaining quarter consisted of people with five distinct profiles of violence and abuse. Each group was different in terms of their socio-economic circumstances, health, mental health and use of treatment and services. Poverty, disability, poor health and health risk behaviours were much more common in those groups characterised by extensive violence and abuse.
- 1 in 25 of the population (around 1.5 million adults) have experienced extensive forms of both physical and sexual violence, with an abuse history extending back to childhood. Nearly everyone in this group had, at some point in their life, been pinned down, kicked or hit by a partner. Half had been threatened with death. Most had been sexually abused as a child and some severely beaten by a parent or carer. Many had also been raped as an adult. Over half the members of this group had a common mental disorder such as clinical depression or anxiety. However, only 10% were in receipt of counselling or a talking therapy.
- A further group – representing 1 in 50 of the population – are characterised by their experience of extensive physical violence and coercive control by a partner (but not by other kinds of abuse). They also had very high levels of common mental disorder. Analysis shows an extremely strong relationship between partner violence and mental health which has received little attention.

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

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

Why focus on Women?

It's evidence-based

The evidence shows women's health needs are different: for example, they suffer more from poverty, gender inequality, gender-based violence and mental health problems. The World Health Organisation recognises that domestic and sexual violence is more often experienced by women and recommends that woman-centred care is essential to meet their needs.

It's better service provision

Reducing health inequalities is one of the NHS's top five priorities. Investment decisions based on women's specific health needs are a practical, cost-effective way of delivering the NHS Social Inclusion Agenda. For example, the cost of violence against women and girls to the NHS is around £1.2 billion a year; domestic abuse alone costs an additional £176 million a year in mental health services, while each rape costs in total around £96,000. The return on investment on prevention is therefore significant: for example, low-cost community-based based support services (such as refuges or rape crisis centres) can reduce the demand on GP services, A&E and admissions to hospital. Around 50% of women who use mental health services have experienced violence and abuse and the figure is still higher for women involved in the criminal justice system.

It's better community engagement

JSNAs need to be rooted in communities, reflecting their priorities. Women are under-represented in high-level decision-making resulting in inadequate knowledge of their specific needs. The valuable intelligence on service users' needs that is collected by the health and social care voluntary and community groups that work with women and girls must feed into JSNAs. This will help health and wellbeing boards understand what assets and resources local communities can offer to help meet local needs and improve health and well--being outcomes.

Adapted from 'Better Health for Women: how to incorporate women's health needs into Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies', Women's Health Equality Consortium, January 2013.

Gaps identified in research that women's services could meet:

- Mental health professionals: People who have experienced extensive physical and sexual violence are far more likely than those with little experience of violence or abuse to have a common mental disorder, psychosis, PTSD or an eating disorder. Effectively supporting survivors of violence and abuse should be 'core business' for mental health services.

- Health care commissioning: Despite being 15 times more likely to have multiple mental disorders, people with extensive experience of physical and sexual violence were just four times more likely to discuss their mental health with a GP and only three times more likely to access community mental health services. Only 10% were receiving any kind of talking therapy. However, they were 12 times more likely to have spent time as an in-patient on a mental health unit.

- Crisis and emergency services: Suicide attempts are 15 times more likely among people who have experienced extensive physical and sexual abuse. They are also 5 times more likely ever to have self-harmed than those with little experience of abuse. A&E staff, paramedics, police and fire officers are likely to encounter survivors of violence and abuse at their most distressed.

- Public Health: Sexual and domestic violence are major public health issues. Violence and abuse are experienced in all socio-economic groups but those with the most extensive experience are more likely to also have to cope with disability, low-income and the challenges of poorer health, housing and neighbourhoods. The evidence clearly links the experience of extensive physical and sexual abuse with alcohol dependency, smoking, and obesity.

Source: *Violence, abuse and mental health in England;* NatCen, CWASU, DMSS (2013)

Example of a health project addressing VAWG: Women and Girls Network

Women and Girls Network (WGN) is a pan-London organisation our overall aim is to promote, preserve and restore the mental health and well-being of women and girls who have experienced gendered violence. *IPAMO (house of healing) Honouring Resilience Restoring Lives* is *a* specialist provision providing support to women from refugee and asylum seeking communities. Many of the women have fled war torn countries where they have witnessed genocide of their families and communities; been subjected to state persecution and torture; have experienced gang rape; forced to become child soldiers; trafficked into prostitution. Women typically present with complex trauma manifestations and pronounced mental health difficulties such as severe depression, PTSD, sleep/ eating disorders and myriad of health problems. Once in the UK their trauma is further exacerbated by multiple and high levels of discrimination, poverty, stigmatisation, isolation, lack of adequate support services contributing to escalating levels of stress. WGN has developed a creative and innovative solution to increasing accessibility to counselling for women from asylum/ refugee communities. The IPAMO project provides an accredited counselling training programme for women from asylum/ refugee communities, who once qualified provide specialist culturally and linguistically sensitive counselling service to women from asylum / refugee communities with experiences of gendered violence. This enables women to recover from previous trauma and support their transition into UK life. The added benefit of the project supports the development and increases capacity for the whole community.

Commissioner information needs[1]

The guidance below provides some pointers on the type of information a commissioner of healthcare services would be looking for in determining whether to invest in a scheme or service.

General

1. The NHS landscape has changed considerably with the implementation of the Health and Social Care Act 2012. There are a range of new organisations with

[1] Quoted with permission from: Jude Carey, Management Fellow, Centre for Academic Primary Care, Bristol University Nov 2013

different remits, budgets and core responsibilities. The King's Fund have created a short animation which neatly explains the new NHS landscape: http://www.kingsfund.org.uk/projects/nhs-65/alternative-guide-new-nhs-england

2. Find out which is the most appropriate commissioning organisation for the service being offered. This will vary from area to area and depending on the service might include Clinical Commissioning Group, Local Area Team (NHS England) or Local Area Authority. Be aware that commissioning responsibilities might be held jointly between organisations or be commissioned by more than one organisation.

3. Find out the commissioning priorities for this organisation and try and identify ways in which your service aligns with these.

4. Try and identify a champion within the organisation (who has power and influence) this may not always be the person who is responsible for commissioning in this area. Have a conversation to assess the appetite and potential level of support in the organisation for your service.

5. Find out what the commissioning process is for this organisation. Most will have an annual cycle of investment planning and allocation. Find out what the timescales and processes are and who can make application(s). Usually each organisation will have specific forms for completion: outline business case, full business case etc that will be required to be completed at particular times of the year.

6. If your approach falls outside this planning cycle then find out if there is any in year ad hoc allocation of funding that you can apply for.

7. Don't produce a very lengthy document. You need to be comprehensive in your information provision but succinct. Demonstrate a case for investment, include an evidence base, anticipated outcomes, how this will be measured and what the benefits and costs involved are.

Approaches regarding existing services – making a case for increased investment

Where a service is already in existence and you are making a case for increased investment you would want to demonstrate the following:

1. If possible demonstrate the effectiveness of the service by providing outcomes of a formal service evaluation.

2. Provide information on the existing service which demonstrates the value and effectiveness of the service and makes a robust case for continued /increased investment.

3. Provide data that is relevant to the area. Some comparison with national data may be helpful but focus on the local as that is what the Commissioner will be interested in.

4. Most contracts will have a requirement around performance monitoring included and this data is useful for including in a business case.

5. Outline the costs of the service and if additional investment is required provide a rationale for this, including a breakdown of the costs.

6. Outline the impact of the service on the wider health system e.g. reduced emergency admissions; a X% reduction in GP appointments (and how these figures / estimates have been reached).

Commissioning should take a 'whole systems' approach that has four key stages:

Key stage	What does this involve?
Analysis	• Understanding and evidencing the needs of service users • Identifying unmet needs • Understanding and mapping who delivers services • Identifying gaps in service provision and considering how these gaps can be addressed • Being clear and defining outcomes to be delivered **What you can do:** • Provide evidence of the needs of your service users, identifying those that are unmet. Demographic data will be needed. • Promote your service to Commissioners • Suggest outcomes for services via networks and local partnerships such as your Health & Well-being Board • Suggest monitoring requirements for contracts

Planning	• Consideration of how to fund those services required to meet outcomes. • Developing the approach required to secure the outcomes. **What you can do:** • Develop a concise explanation of your model of work • Gather evidence to support your model
Sourcing	• Securing the most appropriate provider(s) to deliver the outcomes **What you can do:** • Gather feedback from service users • Prepare material for bids that demonstrates the impact you have on health outcomes. Try insofar as possible to make these both hard and cost-effective outcomes. • Eg 80% of women feel safer after engaging with our service is weaker evidence than 60% of women stopped using anti-depressants after engaging with our service.
Monitoring and Review	• Assessing performance against original objectives and identifying changes to inform future commissioning and outcomes **What you can do:** • Remain in regular contact with the commissioner / contract manager. Let them know of successes and discuss any problems with them as early as possible.

Extra top tips

- Health really cares about evidence based data, preferring, if at all possible a randomised control trial and academic-level, peer reviewed research / evaluations.

- Time poverty is a constant feature of many parts of the NHS so emphasise it if your project will save NHS staff time. If your project practice changes by health staff, you will need to explain how this can be done within existing time constraints.

- Use your Health & Well-Being Board to raise VAWG issues in a range of services: dental services, sexual health services, reproductive rights services. You may be able to influence the contract requirements of services that are commissioned.

Legal framework for women only services[2]

The Equality Act 2010 makes it clear that women-only services are legal and appropriate in certain contexts; it is still legal and appropriate for public authorities to fund (and provide) female-only services. The Government and public bodies are also bound by international agreements to protect women only services. The Convention for the Elimination of all forms of Discrimination Against Women (CEDAW) was established by the United Nations in 1979.[3] Unlike domestic UK and European legislation on sex discrimination and equal treatment, the Convention is solely concerned with the position of women. The Convention places obligations on Government's to eliminate discrimination against women. As a signatory to CEDAW the UK Government must fully implement the Convention, to ensure the practical realisation of equality between women and men. In relation to the interpretation and application of the Equality Duty CEDAW/C/GBR/CO/7 (26th July 2013, p3, point 17) recommends that:

> 'Use the Public Sector Equality Duty (PSED) review to ensure that gender equality is properly prescribed for public authorities, including the application of the principle of substantive equality.'

The substantive equality is based upon the principle that discrimination is socially constructed and is not a natural principle of human interaction, recognising the need for concerted action against inequality and the institutional mechanisms that perpetuate it. Substantive equality promotes:

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[2] 'The Equality Act should not be interpreted to mean that both sexes should be treated the same. Single sex services are permitted where it can be shown to be the most effective way of providing those services or where the service is needed by one sex only.' Equality Act 2010, Schedule 3, Part 7.

[3] http://www.wrc.org.uk/resources/tools_to_engage_and_influence/working_internationally/about_cedaw.asp

- Equality of opportunity through law, policy programme and institutional arrangements
- Equality of access by eliminating all obstacles that prevent access to opportunities and taking positive steps to ensure the goal of equality is achieved
- Equality of results

With specific reference to funding of women/women only services CEDAW/C/GBR/CO/7 (p3, point 21) recommends:

> ‘Mitigate the impact of austerity measures on women and services provided to women, particularly women with disabilities and older women.’
>
> ‘Review the policy of commissioning services where it may undermine the provision of specialised women's services.’

Reproduced from ‘Women-only services: Making the case’, Women’s Resource Centre 2011 http://thewomensresourcecentre.org.uk/wp-content/uploads/Making-the-case-for-women-only-July-2011.pdf

The following tables provide information about the key local health bodies and individuals that have a role in planning and commissioning interventions and services to address violence against women and girls, and the ways in which to engage with and influence them.

Who	Roles and responsibilities	Engagement
Health and Wellbeing Board (HWB) HWBs comprise: • representatives from the Clinical Commissioning Group • Directors of Public Health, Children's Services and Adult Social Care • local HealthWatch. In addition many HWBS: • will be chaired by the Leader of the Council or another senior council member, and • include other council members. Some HWBs have invited voluntary sector representatives, although the selection criteria vary greatly.	HWBs are a high level strategic partnership working in each upper-tier local authority. HWBs are responsible for producing the Joint Strategic Needs Assessment (JSNA), which will form the basis of the Joint Health and Wellbeing Strategy (JHWS). The JHWS will support HWB members to plan the delivery of integrated local services and collectively address the underlying determinants of health and wellbeing which cross traditional service boundaries. As such, HWBs should take account of other existing commissioning streams, and consider joint commissioning that will benefit from multi-agency working, e.g. reducing crime and re-offending or child/adult safeguarding. The agenda of HWBs, and thus the JSNA and JHWS, incorporates wider determinants of health and wellbeing, including housing, education and the environment. For instance, health-based IDVAs that provide early intervention in high-risk cases of domestic violence can have a positive impact on victims' health and wellbeing as well as potentially reducing the burden on social services and the police by increasing safety and reducing revictimisation through referral to the MARAC. HWBs should ensure that public health and preventive strategies are aligned with health and social care commissioning plans.	Identify members of HWB – do you already have contact with any members? Do you have contacts you can use to be introduced to members you do not know? Provide information for local authority officers and HWB members about VAWG locally – use data from police, MARACs and service providers to highlight prevalence and what it means for commissioning services. Find out who represents the voluntary sector on the HWB Ensure the HWB has a written public engagement or stakeholder strategy – how can VAWG survivors and service providers feed into the development of the HWBs?

Clinical Commissioning Group (CCG) CCGs are formed from groups of practices (currently called clusters). Each practice nominates a commissioning lead who will be their CCG representative. This may or may not be a GP. The CCG are overseen by a governing body comprising: • the chair • an accountable officer • a chief finance officer • at least two lay people • a secondary care doctor • a registered nurse A small staff team delivers the CCG work programme. Staff may be transferred from the old PCTs or this may be contracted out to the private sector.	CCGs are a statutory body with statutory commissioning rights and responsibilities. There is a legislative framework guiding aspects of the functioning of CCGs, but each CCG will decide how they will operate in practice. CCGs must adhere to several duties in undertaking their work: • they must have due regard to their local JSNA and JHWS when developing commissioning plans. HWBs can refer the plans back to the CCG if they are not in line with the JHWS. • they must have due regard to the need to reduce inequalities in the access to, and the outcomes of healthcare • they must exercise their functions with a view to securing the integrated provision of services where they consider this would reduce health inequalities Whilst this means CCGs will be encouraged to take a broader, more holistic approach to addressing the healthcare needs of the local population, CCGs will be monitored by the NSHCB, and will need to demonstrate how they are meeting NHS outcomes (a summary is on p.8) so will remain clinically focussed. CCGs will fund some services through grant-type contracts, but will also use the 'any qualified provider' model of purchasing healthcare for patients. Service providers need to become a preferred supplier in order for their service to be purchased by GPs. This will be particularly relevant for services that provide	Find out how the CCGs are running in your area – do you know anyone who is a member? Is there a GP lead for domestic or sexual violence in your area? Are they a member of the CCG? If not, can they put you in contact with someone who is? Find out what are priorities for GPs and CCGs in your area Offer to speak at a CCG meeting – be prepared to keep it very brief, focused on how addressing VAWG meets their outcomes, and have something to offer (a referral pathway, service leaflets) Find out if your CCG plans on having voluntary sector representatives. It is not mandatory but some areas are involving the voluntary sector in different ways – how can service providers and survivors have a voice in your CCG? Investigate the process for becoming a preferred supplier in your area

	counselling and therapy to survivors whose services may be purchased if general counselling (IAPT) is not appropriate. CCGs may also adopt a social prescribing model to address 'softer' outcomes such as increasing exercise and reducing isolation in people with long-term conditions rather than only funding clinical care pathways. In some areas consortia of smaller organisations have been funded to provide these services or activities	Find out how your CCG plans to commission for softer outcomes
Healthwatch	Under the Health and Social Care Act 2012, there is a legal requirement to involve local people in the development of the JSNA and the JHWS. The primary source of involvement will be Healthwatch organisations. Health England, the national body, will gather and analyse information from local services to inform the planning and delivery of services at a national level. Locally, there will be a Healthwatch organisation covering each local authority area. Local Healthwatch organisations have taken on the work of Local Involvement Networks (LinKs) and: • have the power to enter and view services • influence how services are set up and commissioned by having a seat on the HWBs • provide information, advice and support about local services. • provide a complaints advocacy service from 2013 to support people who make a complaint about services. • report concerns about the quality of healthcare to Healthwatch England and further the Care Quality Commission. By law, they will have to listen to Healthwatch and respond to its concerns	Learn more about Healthwatch and find your local LinKs/Healthwatch at http://www.healthwatch.co.uk/ Find out how service providers and users can be involved in your local Healthwatch Join the Healthwatch online community to keep up to date with developments. To register email healthwatch@nunwood.com

Director of Public Health (and public health teams)	The changes in the structure of health and social care have raised the profile of public health, with responsibility for addressing public health moving from PCTs into the local authority. Public health focuses on prevention rather than cure, and on the wider determinants of health such as the environment and poverty. Recent governments have highlighted the critical role of public health in reducing health inequalities between different groups, which is also a key outcome for this government. The Director of Public Health will prepare an annual report giving an overview of local public health issues and actions to address health inequalities. They will pay attention to the health status of vulnerable groups – the greatest users of social services whose health is sometimes overlooked, for example older people, people with mental health problems and could include survivors of violence against women and girls. In addition, the local authority is responsible for commissioning, among others: • sexual health services • alcohol and drug services • obesity and community nutrition initiatives • public mental health services • prevention campaigns on cancer, long-term conditions, injury prevention	Find out how public health is incorporated into your local authority – are they a single team or mainstreamed into other teams? Find out who the Director of Public Health and lead public health officers are Prepare information about VAWG in relation to the public health outcomes (see below)

Outcomes frameworks

In making the case for HWB and CCGs to address VAWG, it is useful to understand what outcomes they are working towards. There are three outcomes frameworks (the NHS, Public Health and Adult Social Care) that will play a central role in the planning, commissioning and delivery of health and social care services.

The NHS

1) Preventing people from dying prematurely including from cardiovascular, respiratory or liv disease and cancer; reducing premature death people with serious mental illness and learni difficulties, babies and young children
2) Enhancing quality of life for people with long-ter conditions – people feeling supported, improvi functional ability, reduce time spent in hospital
3) Help people recover from ill-health or injury including recovery from trauma
4) Positive experience of care
5) Protecting people from harm – specifically medic accidents, safety of maternity services, safe care children in acute settings

Public Health

1) Improving the wider determinants of health – includes domestic abuse and violence crime (including sexual violence), statutory homelessness, sickness absence rate, pupi absence
2) Health improvement – includes low birth weight hospital admissions as a result of self-harm alcohol-related hospital admissions
3) Health protection – includes air pollution chlamydia in young people, HIV
4) Healthcare public health and preventing premature mortality – infant mortality from causes considered preventable, cardiovascular/liver/respiratory disease and cancer, suicide

Adult social care

1) Enhancing quality of life for people with care and support needs – enabling people to have control of their support; people can participate in their family, social and work life
2) Ensuring people have a positive experience of care and support – including have a choice of support and being treated with dignity
3) Delaying and reducing the need for care and support – focus on earlier diagnosis, intervention and reablement;
4) Safeguarding adults whose– everyone enjoys physical safety and feels secure; protection from avoidable harm, disease and injury; support to manage own risks

Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies

The Joint Strategic Needs Assessment (JSNA) and Joint Health and Wellbeing Strategy (JHWS) process provides an ongoing local mechanism for development of integrated multi-agency approaches to tackle violence. Local authorities and CCGs have statutory duties to develop JSNAs and JHWSs to be discharged through the health and wellbeing board.

The aim of the JSNA is to assess the needs and assets of the local population in order to improve the physical and mental health and wellbeing of communities and to reduce health inequalities within and between communities. Incorporating women's health needs within JSNAs and JHWSs will be an important part of each process.18 Since research evidence shows significant health and wellbeing inequalities are experienced by local communities where there are high levels of violence, it is important a local needs assessment for people who are at risk of causing violence, at risk of experiencing violence, and victims of violence, be incorporated in the JSNA.

JSNAs will underpin JHWSs and together these will drive local commissioning priorities, policies and practices. Whilst JHWSs are strategies to meet the needs identified in JSNAs they should not seek to cover everything but prioritise areas where the board members can take collective action and make the biggest impact. JSNAs and JHWSs are the key mechanisms by which health and wellbeing boards will engage with their local partners and hold each other to account for actions agreed in relation to violence.

Unplanned hospital admissions are very expensive – in one area an unplanned hospital admission costs c.£17,000 which is the same as the annual per capita allowance for health services in that area. If you can show that your intervention reduces unplanned hospital admissions, you'll be well on the way to gaining Commissioners' interest!

Additional resources

Women's Health and Equality Forum: http://www.whec.org.uk/wordpress/ - The Women's Health and Equality Consortium (WHEC) is a partnership of women's charity organisations, all of who share common goals of health and equality for girls and women. Produces a regular newsletter and briefings.

AVA: http://www.avaproject.org.uk/our-projects/health-project.aspx - Contains lots of free resources – including a free e-learning module - about health and VAWG with a particular emphasis on substance use and mental health.

www.ccrm.org.uk: This website is updated monthly with any new guidance, policies, research, toolkits and other resources and on all aspects of addressing domestic violence and has specific sections on health.

Search for other examples or submit your project to the NICE implementation database: http://www.nice.org.uk/usingguidance/sharedlearningimplementingniceguidance/shared_learning_implementing_nice_guidance.jsp