

## **Commissioning report**

### **Kent and Medway IDVA provision**

**June 2012**

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## Background

The Kent and Medway Domestic Abuse Strategy Group have recognised for some time that funding arrangements for IDVA services have not been stable or coherent.

Fizz Annand has been commissioned to undertake two pieces of work for the Domestic Abuse Task and Finishing Group in relation to IDVA provision specifically in Kent and Medway. Firstly, to complete a needs assessment focussing on IDVA provision and how the capacity and coverage can be improved upon in the current economic climate; Secondly, following on from the needs assessment, to draft this commissioning report with recommendations to address the identified problems around funding and coverage of IDVA provision across Kent and Medway.

The needs assessment has been completed and focussed on IDVA provision specifically however a number of issues which are relevant to the wider domestic abuse support system were flagged up and are addressed to a certain extent in the recommendations.

### National policy background

The Home Office strategy document '*Call to end violence against women and girls: Taking action – the next chapter (2012)*' was an update which underlined the key themes of prevention, provision of services, partnership working, better justice outcomes and risk reduction which formed the main thrust of the Coalition Government's approach. It makes clear what is expected from local areas and partners. Of particular relevance to the Kent and Medway situation is the guiding principle that adequate levels of support should be made available where violence occurs. This principle should be demonstrated by the achievement of the following outcomes:

- Domestic abuse victims receive a good and consistent level of service wherever they live.
- Statutory agencies and NGO's get the response right the first time
- High quality commissioning processes and service provision at a local level

The Coalition Government has made clear that it is committed to devolving power, resources and accountability to local areas to decide their own priorities and how they deliver on these. Home Office part-funding for local IDVAs and MARAC co-ordinators will continue until the end of the spending review period (March 2015), although relatively little (£44k from Home Office and £73k from Ministry of Justice) of this funding has been received in Kent & Medway.

Reforms to policing, the NHS, public health arrangements and to the way victims' services more generally are commissioned locally, will lead to a shift in accountability for services to support the victims of domestic abuse.

Local area structures are changing: new Health and Wellbeing Boards are being established, and Police and Crime Commissioners will take responsibility for commissioning the bulk of victims' services from 2014. **The Government want to ensure that services to victims of violence against women and girls are protected and enhanced** under these new structures.

The Victims' Strategy *Getting it right for victims and witnesses* was launched in January 2012 subject to consultation. The strategy seeks to increase the sums of money available for practical support and advice for victims. It includes proposals to transfer responsibility for commissioning the majority of victims' services from central government to Police and Crime Commissioners. It is proposed that a

proportion of the additional income raised from offenders through the Victim Surcharge and other financial impositions will go to services for victims of domestic and sexual violence. The new arrangements for commissioning of services for victims should therefore ensure that the needs of victims of domestic abuse are taken into account.

The *Troubled Families programme*, launched in December 2011, commits the government to working with local areas to turn around the lives of 120,000 troubled families by the end of the Parliament. Based on past evidence it is expected a significant proportion of these families would suffer domestic violence problems.

## Executive summary of needs assessment and equity audit

### Prevalence, costs and expenditure

In Kent and Medway there will have been 54,773 ( $\pm$  11,000) women or girls (16-59) who have experienced domestic abuse in the last year.

Statutory responsibilities in relation to survivors of domestic abuse and their children are limited, to domestic homicide, child protection and patient safety. However, domestic abuse has been identified as a main driver for violent crime in Kent and Medway and a significant driver for the numbers of children using Specialist Children's Services.

The financial cost to local partners in Kent and Medway associated with this level of domestic abuse is ~£321million.

The total cost burden to different sectors can be split organisationally as shown below:

DOMESTIC VIOLENCE PROPORTIONATE COSTS MODEL		
Cost to Kent & Medway	Sector	Detail
£69m	health & mental health costs	Acute services (A&E), primary care, mental health treatment.
£44m	criminal justice costs	Policing, courts, prisons, probation
£8m	costs to social services	Safeguarding children, looked after children
£200m	other areas such as civil legal, housing etc.	Refuge, housing advice and support, housing services, legal advice re options and disposals,
<b>£321m</b>	<b>Total</b>	

The Health sector and the Criminal Justice System shoulder the greatest financial costs of domestic violence as single systems and stand to receive the greatest financial benefits of any prevention function that IDVA services deliver.

Financial information about what is being spent, by whom and to what effect has been previously lacking. This combined with the historical lack of robust activity and performance data has meant assessment of value for money has not been attempted.

In total around £611k is expected to be spent on IDVA services in 2012/13. Multiple council funding streams contribute to an overall expenditure of £190k from councils. A significant amount of funding for IDVAs comes from charitable sources, accessed by the provider agencies themselves (189k). Relatively little (30k) comes from the Criminal Justice System (police specifically) and zero directly from Health although it should be noted that Health are partners in Community Safety Partnerships and therefore indirectly have an involvement in the 39k that CSPs contribute. Children's services fund some DV services but not any IDVA posts directly

Funding sources	Expected IDVA funding 2012/13 (£000's)
Charitable funding sources	189
Medway council, Districts and KCC	190
Community Safety Partnerships	39
Central government departments	118
Housing associations	45
Children's services	0
Police	30
Health	0
<b>Total</b>	<b>£611,000</b>

Financial costs associated with this group of victims are particularly high for the health service and criminal justice system and failing to address high risk cases is expensive for the public purse. The charity Co-ordinated Action Against Domestic abuse (CAADA), calculates that **the direct costs of an average 'high risk' victim to statutory agencies is a minimum of £10,000 per year.**

**The actual cost of providing an IDVA for a high risk victim of domestic abuse is around £500 (<£1000 per successful outcome where all forms of abuse cease).**

**The costs vs. benefits ratio of IDVA provision is therefore 1:10 in cases where all abuse ceases.**

### **The current IDVA system and recent changes**

Kent and Medway Independent Domestic Violence Advisor (IDVA) services are a key element of the Coordinated Community Response to domestic abuse. They are part of a much wider system of services which make up a network of support. There is a small but reliable evidence base which shows that IDVA services can have a dramatic impact on reducing rates of re-victimisation and improve the safety of adult victims and their children.

Kent and Medway IDVA provision has historically been funded locally from public bodies such as district council CSPs, children's services, central government departments and local police, and from a range of charitable organisations, mainly with one off or short term funding. Ten separate providers operate IDVA services across the county. The provision varies in terms of both quality and capacity from one district to another and is not targeted at areas where most need, demand or the widest gap in provision is identified.

Whilst numbers of identified high risk cases presented at MARACs has increased by 25-33% per year, recent cuts in available funding have resulted in a significant drop in number of IDVAs from 23.1 f.t.e. to 16.84 f.t.e. in 2012/13; a 27% drop in IDVA numbers.

**Districts which will be least well served by the remaining IDVA provision in 2012/3 will be Dartford, Gravesham, Dover, Shepway and Ashford. In addition there is a gap in court IDVA support in Dover, Shepway and Ashford.**

A lack of standardised monitoring data has hampered a complete analysis of demand and activity, however it can be established that the current arrangement will not meet demand furthermore it is clear current resources are not equitably distributed in each district as needed.

### **Recommendations**

It is recommended that partners invest in a more strategic IDVA service, jointly funded and jointly commissioned, which would help to address the need for sustainability, more flexibility, better value for money, improved data for monitoring and planning purposes, and more consistent standards and processes.

A contract for a Kent and Medway-wide, sectorised (by MARAC area) service should be tendered which would also be able to address some of the other key gaps in the current service arrangement such as a single point of contact phone line and a lower tier of support for medium risk clients and volunteer domestic abuse (DA) support where appropriate.

Whilst improvements can be achieved by this kind of strategic commissioning approach to IDVA type services, it is also clear that the wider system of Domestic Abuse support services would benefit from a similar approach to needs assessment i.e. Clarifying what services are in place, where, identifying all funding streams, identifying overlaps, duplications and gaps in services, pooling resources and jointly commissioning agreed priorities that are flexible and sustainable and that meet assessed needs.

## Scope of needs assessment and commissioning report

This report and the needs assessment aim to provide partner organisations with sufficient background information and analysis on which to justify and agree priorities, identify likely funding bodies and take commissioning decisions.

**The main aim of the commissioning recommendations is to simplify and rationalise the commissioning and delivery of IDVA services and ensure they are more sustainable in the future.**

It is envisaged that a considerable amount of planning, work and effort will be needed from partner organisations to make the recommended changes and it is crucial that a senior level *Domestic Abuse Champion* takes responsibility for driving the change processes in 2012/13 and onwards into the following years, as changes are embedded.

In many areas of public services there is an increasing need for commissioning across public bodies. In considering options for improvement to the current IDVA provision an approach based on elements of *a guide to commissioning for maximum value*<sup>1</sup> has been used; the principles of which are around clarity about what changes or outcomes are needed and incorporating social, economic and other costs and benefits into decision making. In doing so it is hoped that contributions to change can be harnessed from multiple parties, both funders and providers. There are opportunities to collaborate at a funding, strategic and provider level. The approach also takes account of the potential impact of expenditure on areas of interest to various parts of the public sector.

**Spending on IDVA or other Domestic Abuse support services is justified by the current need shown in the needs assessment and the benefit (reducing re-victimisation) which will reduce a future need to intervene and further expenditure on health, crime and other social issues.**

## Current IDVA funding arrangements

Accurate financial information has been difficult to obtain however a spreadsheet showing the total funding has been drawn up. The difficulties appear to have been around funders not having detailed records of what or who exactly they fund and no central financial recording, as well as somewhat vague grants being given to organisations for DV work generally, which then is difficult to attribute to IDVA work specifically as providers use grants fairly flexibly.

As mentioned in the needs assessment providers spend significant amounts of energy and time making funding bids to various potential charitable and public sector sources. This has resulted in a substantial charitable input to the funding framework which supplements the public funds which are largely short term or one off funding 'pots'.

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1 Prepared by the Social Return on Investment (SROI) Network as part of the National Programme for Third Sector Commissioning for LGA.

Some funding from public sector (police, CSP etc) has been described as being awarded in a 'hand to mouth' fashion in as much as it comes as one-off payments from organisational under-spends and as such there is little ongoing commitment and often only serves to temporarily 'prop up' an agency in financial difficulty or at risk of losing posts.

## Options considered

During the process of developing the needs assessment and commissioning report, a range of options have been discussed and considered. These are summarised below.

Option	Potential advantages	Potential disadvantages/risks	Recommended?
<p>1. <u>Do nothing new</u></p> <p>Leaving third sector IDVA providers to pursue funding for themselves, as they have historically, from a range of funding 'pots' on an ad hoc basis.</p>	<p>No financial risks to public sector organisations in terms of commitment to funding services.</p>	<p>Services will continue to reduce in size as funding streams shrink or cease whilst numbers of reported incidents continue to rise. <b>Capacity to support victims will reduce and risk of escalation of abuse in cases where victims are unable to gain support could have serious consequences (violence, homicide, health issues, child protection) as well as the increased costs associated with managing these cases.</b></p> <p>No strategic coverage or standardisation of quality.</p> <p>No activity data or shared performance framework.</p> <p>Potential reputational risks to commissioning organisations if no action is taken to address needs.</p>	<p>No</p>
<p><u>Costs</u></p> <p>Estimated additional immediate costs to partners Zero, however there would be financial implications of managing increasing numbers of cases in generic services.</p>			
<p><b><u>Recommended short term option (2012/13)</u></b></p> <p>2. <u>Fund extra IDVA capacity in areas with biggest gap in provision.</u></p> <p>i.e. Dartford, Gravesham, Dover, Shepway and Ashford to cover expected MARAC numbers for North and South Kent MARACs.</p> <p>Total 5 community + 1 court IDVA.</p>	<p>Relatively small extra cost ensures a minimum cover is provided to areas of highest demand and clients at highest risk.</p>	<p>This measure would only provide a short term fix and would do nothing to make the system work better or become more sustainable in the longer term.</p>	<p>Only as a short term measure in 2012/13</p>

Option	Potential advantages	Potential disadvantages/risks	Recommended?
<p><u>Costs</u>            Estimated extra costs to partners approximately £240,000</p>			
<p>3. <u>Bolster current arrangement</u></p> <p>Fund 13 IDVAs, one per district including Medway to supplement current provision and provide a minimum level of cover/capacity for each district plus 3 court IDVAs as per suggestion in KCJB report 26<sup>th</sup> September 2011 plus one new court IDVA for Dover, Ashford, Shepway.</p>	<p>Overall capacity of IDVA system would be boosted.</p>	<p>Takes no account of differential demand and need for flexibility to provide service where most needed.            Does not address need to improve data, performance framework, standardisation of processes and other qualitative issues.</p>	<p>No</p>
<p><u>Costs</u>            Estimated additional cost to partners £730,000</p>			
<p><b><u>Recommended long term option (2013/14 onwards)</u></b></p> <p>4. <u>Pool resources and strategically, jointly commission IDVA services</u></p> <p>Pool current public sector funding to IDVAs and bid for funds to supplement this to Police Crime Commissioner and Health and Wellbeing Boards. Jointly, strategically commission an IDVA service across Kent and Medway based on identified levels of need and demand, and allowing flexibility to address areas of highest demand.</p>	<p>Would provide better value for money due to lower overheads, management and on costs, better flexibility, coherent monitoring, provide a core funding basis on which bids could be made for charitable or 'match' funding from elsewhere. A more standardised approach could be used and gaps addressed such as the need for a single</p>	<p>Potential for loss of some smaller, local third sector services along with associated experienced/trained staff.            Potential loss of charitable contributions to IDVA services.</p>	<p>Yes</p>

Option	Potential advantages	Potential disadvantages/risks	Recommended?
<p>Ensure services are aligned with MARACs rather than districts and target high risk clients. Use longer term contracts/agreements so services can plan and develop. e.g. 3 year contracts with potential for extension. Invite consortia bids. Commission for outcomes rather than posts. Encourage providers to continue to access charitable funds to supplement the core, IDVA service dealing with high risk clients. Develop the outreach and volunteer base across the county and Medway to provide a more appropriate level of support for cases which are not high risk. Clarify the model of the domestic abuse support system – ensuring generic workers are contracted, trained, confident and supported to identify and address needs of victims, referring on to limited specialist services as appropriate and IDVA services are targeted on high risk cases.</p>	<p>point of contact. Existing providers could take the opportunity to merge or become partners.</p>		
<p><b>Costs</b>            Estimate of costs to partners</p> <p>To commission a community IDVA service with a capacity for 1300 clients (from expected MARAC figures) would cost £650,000. An estimate of £500 per client unit cost has been used as per national research literature. An additional £40,000 per court IDVA (4) would require £160,000 (£810k grand total).</p>			

Option	Potential advantages	Potential disadvantages/risks	Recommended?
<p>A Pooled fund should be created specifically for jointly commissioning strategic IDVA provision. If current levels of council, CSP and police funding can be maintained and pooled (259k) this leaves £551,000 to be funded from PCC and HWBs.</p> <p>If the 'proportionate costs model' shown on page 3 were applied to the total amount required the split between Health, CJS and Social services would be 7:4:1 i.e. Health £321k:CJS £184k:Social services £46k</p>			

## Recommended commissioning options (Option 2 and Option 4) in more detail

1. Option 2. Partners should pool resources to make short term, 'in year' funding available for 2012/13 to existing providers in MARAC areas where current capacity of IDVAs does not meet the need of MARAC referrals as shown in the needs assessment. These areas are Dartford, Gravesham, Dover, Shepway and Ashford . In total 5 community + 1 court IDVA at a rate of £40,000 per IDVA. £240,000 in total.
2. Option 4. Identify and pool public sector resources as of 2013/14 to create a strategic IDVA budget.
  - a. Some funding sources which have been identified in 2012/13 will be absorbed into the PCC budget and therefore will need to be flagged, 'pooled' and retained for the strategic IDVA budget in the following years.
  - b. Negotiation will need to be undertaken with other police, district and Medway budget holders so that other existing IDVA funding streams from the districts and Medway can be added to the 'pool' in 2013/14
  - c. Identify senior level Domestic Abuse champions (one 'health' and one 'CJS') to approach PCC and Health and Wellbeing boards with a business case, based on the IDVA needs assessment and commissioning report, for supplementing the identified existing funds to strengthen IDVA provision in a strategic manner.
  - d. Jointly commission a Kent and Medway-wide IDVA and Outreach service. Avoiding the current multiple agency arrangement, cutting overheads, management costs and on costs.
  - e. Specify acceptable levels of on costs/overheads in tender documentation.
  - f. Specify the capacity required as per the needs assessment and standards required. Include a single point of contact as a requirement.
  - g. Develop the volunteer based, less costly, DV outreach support services for medium/lower risk cases within the specification and exploiting the third sector's ability to attract charitable funding sources and 'match funding'.
  - h. Ensure specification for service is sectorised rather than district based to allow flexibility in provision and covers IDVA, outreach and volunteer based support services.
  - i. Consider using a 'sustainable commissioning model'<sup>2</sup> where commissioners specify outcomes required, and potential bidders describe how they will deliver and develop services to achieve target outcomes within the available budget.
  - j. Give notice to existing agencies as soon as possible and inform them of the approach that will be taken. Tender, welcoming consortia bids so existing agencies can partner up, merge or work with other agencies and present a more cost effective, sustainable approach demonstrating the cost benefits of collaboration and clear management structures and accountability.

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<sup>2</sup> Sustainable commissioning model developed by NEF/LB Camden. See 'Commissioning for maximum value', LGA.

3. Partners should consider which organisation is best placed to jointly commission new IDVA services on behalf of all contributing partners. KCC commissioning team may be appropriate leaders in this respect given their expertise and experience in joint commissioning and the alignment between their existing responsibilities (drugs and alcohol and supporting people) and domestic abuse.
4. Undertake a similar needs assessment approach for the wider Domestic Abuse services system and consider a more strategic commissioning based approach using a wider needs assessment, across the board, to develop a robust 'model' of service which clearly prioritises key elements of the Combined Community Response. Identify duplications and areas where funding can be released to contribute to the strategic approach to commissioning services across Kent & Medway (IDVA and other)
5. Ensure that IDVA and DV needs assessments inform the strategic assessment for the Police and Crime Plan once Police and Crime Commissioners are in place. Equally, ensure that the Joint Strategic Needs Assessment which informs Health and Wellbeing Boards commissioning priorities, includes a comprehensive section on domestic abuse and its impact on health inequalities.

## Influencing potential funding bodies

### Police and crime commissioners (PCCs)<sup>3</sup>

In November 2012, voters will go to the polls to elect Police and Crime Commissioners (PCCs) for the first time. The election of Police and Crime Commissioners will mean changes in the structures of partnerships. Commissioners will be given a range of funding streams. It will then be up to them to decide what community safety related services they want to commission in their area which should be based on the pledges and priorities on which they were elected.

The PCC will have similar functions to police authorities, one of which will be to work with partners and fund community safety activity to tackle crime and disorder.

In the first instance the PCC will inherit the existing staff that directly supports the police authority. The current chief executive of the police authority will become the chief executive of the PCC's staff. The staff of the police authority will be transferred to work for the PCC just after the election, and it is with these individuals that the Kent and Medway Domestic Abuse Strategic Group (KMDASG) should invest time and effort raising awareness of DV and IDVA in particular, prior to the election in order to bear fruit once the PCC is in place. Although these staff could be replaced by the PCC, it is likely that in the early days of the PCC's regime they will have a key role in the induction of the PCC, briefing them on key issues, and introducing them to key partners and the wider community safety landscape. Forging strong relations over the next year with these police authority staff will be an important task in order to be well placed to work closely with the PCC from the outset.

Perhaps of most interest is that the PCC will inherit all grant funding previously awarded to CSPs from government. The PCC will be responsible for setting the force budget, making community safety grants, and setting the local precept. The community safety fund, which will have been reduced by 60 per cent from April 2012, will be paid to PCCs from April 2013 at the latest, alongside funding such as the Home Office elements of drug intervention programme money as well as funding for services to address violence against women and girls. It is likely that any ring-fencing around these grants will be removed, enabling the PCC to deal with a truly pooled budget, giving them maximum flexibility to tackle the issues relevant to their community.

The KMDASG will need to identify a Domestic abuse champion to bid for funding from the PCC if the option of jointly commissioning a strategic IDVA service is taken up. If it is, the onus will be on the bidder to provide an outcomes-based, well evidenced business case in support of their request for funding, the IDVA needs assessment will provide essential information in this respect.

By establishing a framework by which activity is commissioned jointly and procured where necessary through a single portal (e.g. KCC Service improvement department, Commissioning team), partnerships can make significant savings. Provided formal agreements are in place between partnerships in advance of offering services, this should be attractive to a PCC; it excuses them the task of recruiting and providing for their own commissioning and procurement service, and also brings the PCC closer to the council's community safety partnerships when it comes to decision-making about commissioned services.

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<sup>3</sup> From: *Police and crime commissioners: a guide for councils*, LGG Sept 2011 & *Police and crime commissioners: a guide for community safety partnerships*, LGA, Feb 2012.

## Health and Wellbeing boards

Health and wellbeing boards will be a forum for key leaders from the health and social care system to work together to improve the health and wellbeing of their local population and reduce health inequalities.

Health and wellbeing boards will be operating in *shadow* form during 2012-13. Boards will take on their statutory functions from April 2013. Each top tier and unitary authority will have its own Health and Wellbeing Board. Board members will collaborate to understand their local needs, agree priorities and enable commissioners to work in a more joined up way. The aim is that patients and the public should experience more joined-up services from the NHS and local councils in the future.

The idea behind health and wellbeing boards is to strengthen working relationships between health and social care, and encourage the development of more integrated commissioning of services. Health and wellbeing boards will have strategic influence over commissioning decisions across health, public health and social care. This is key to the joint commissioning approach recommended in this report.

Boards will bring together clinical commissioning groups and councils to develop a shared understanding of the health and wellbeing needs of the community. They will undertake the Joint Strategic Needs Assessment (JSNA) and develop a joint strategy for how these needs can be best addressed. It is essential therefore that there is a well researched and coherent section which addresses domestic abuse, as this document will guide commissioning decisions. The JSNA will include recommendations for joint commissioning and integrating services across health and care.

The Health and Social Care Bill mandates a minimum membership of:

1. one local elected representative
2. a representative of local Healthwatch organisation
3. a representative of each local clinical commissioning group
4. the local authority director for adult social services
5. the local authority director for children's services
6. the director of public health for the local authority

To bolster chances of domestic abuse services being prioritised it will be necessary to raise members awareness of the issues, the impact of domestic abuse on health inequalities, and costs/benefits of domestic abuse support services particularly IDVAs, outside of the board meetings, as well as formally via the JSNA.

A bid for funding from the Health and Wellbeing boards will be required if the option of jointly commissioning a strategic IDVA service is taken up. If it is, the onus will be on the bidders to provide an outcomes-based, well evidenced business case in support of their request for funding, the IDVA needs assessment will provide essential information in this respect and should help to inform the JSNA which will inform the commissioning priorities of the Health and Wellbeing boards.

## Conclusion

To conclude, it is clear the current IDVA funding arrangement is unsustainable if adequate support is to be available to victims of domestic violence into the future. There is no quick or cheap fix to this long standing problem.

Better value for money in publicly funded services is a priority for national and local policymakers and the longer term commissioning approach described in the recommendations of this report provides an opportunity to invest in strategically commissioned services which have the potential to save money longer term for all strategic partners.

The recommended long term approach requires leadership and willingness to pool funds, as well as a strategic commissioning approach and an increase in investment.