HAVERING'S JOINT STRATEGIC NEEDS ASSESSMENT (JSNA) 2011/12

SUMMARY

1. Introduction

Joint Strategic Needs Assessment (JSNA) uses evidence to assess the health and wellbeing needs of local people and make evidence based recommendations for commissioning. JSNA has been a statutory responsibility for Councils and Primary Care Trusts since 2008, and recent legislative proposals (in Healthy Lives, Healthy People; The Public Health White Paper) further strengthen the future role of the JSNA, and place duties on other partners e.g. Clinical Commissioning Groups to be involved. From April 2013, it is also proposed that responsibility for the majority of local health improvement functions will transfer from primary care trusts to local authorities.

Havering's JSNA was first produced in 2008. A JSNA refresh was then completed in 2010. Following this refresh, the Shadow Health and Wellbeing Board agreed that Havering's JSNA should move away from being a static document (which becomes out of date very quickly as new data is released), and move towards being a more "live" collection of data, information and resources to support decision making and commissioning.

There are two elements to Havering's 11/12 rolling programme of JSNA:

A) JSNA Data. In 2011, Havering's JSNA datasets were made available for the first time on Havering's data intelligence hub www.haveringdata.net. Here a range of data about health and wellbeing in Havering can be accessed by partners, with tables, charts and maps available. In 2011, a JSNA webpage was also developed which is hosted on the hub at http://www.haveringdata.net/research/jsna.htm.

B) JSNA chapters. Following the 2010 refresh, there were a number of topics that were chosen to have further in depth needs assessments carried out. These build on the 2010 JSNA refresh and would include looking at areas such as service provision and gaps (which the previous refresh did not consider as it considered a wider range of topics at a higher level). The topics identified were: dementia, obesity, cardiovascular disease, cancer, smoking and breastfeeding.

C) A demographics update was also included and needs assessment work taking place on domestic violence was incorporated into the JSNA programme. Chapters on keeping people out of hospital, vulnerable children and young people and supporting vulnerable adults and older people are currently in development in phase 2 of the 2011/12 JSNA programme.

A small JSNA project team of existing staff (from the Council, NHS ONEL and GP Consortia representatives) was established in 2011 to take forwards this work. For each of these topics, a standard needs assessment template was used to ensure that the same key questions were answered for each topic.

- The release of a new JSNA data inventory in late 2011 means that the future approach to the JSNA will need to be considered by the JSNA project team and Health and Wellbeing Board to ensure that new data and guidance is incorporated in future.

2. DEMOGRAPHICS UPDATE

- Havering has 236,100 residents and 243,508 people are currently registered with GPs in Havering

- 23% of the population are aged 0-18, 36% of the population are aged 50+ and 21% of the population are of retirement age
- It is estimated that by 2016, Havering's population will have grown by 5.4% (12,699 people) and by 11.5% (27,095 people) by 2021, a faster growth than the London average
- Havering is ranked 177th overall out of 326 local authorities for deprivation (1st being most deprived, 326th being least deprived), however there are pockets of deprivation
- It is estimated that around 12% of Havering's working age population are of non white ethnicity, however the school census reported that nearly 23% of school pupils in Havering were from non white ethnic groups
- The expected increase in the number of elderly residents in Havering is predicted to result in larger numbers of residents experiencing cardiovascular diseases (CVD), cancer, respiratory illnesses (e.g. bronchitis and pneumonia), dementia, osteoporosis (and fractures due to falls), incontinence and hearing impairment. This is likely to increase demand on health and social care services e.g. prescribing of statins (for cardiovascular diseases), hospital admissions these conditions and demand for health and social care services to help manage long term conditions
- Health services are the top priority for local people in making the Borough a nice place to live, followed by clean streets and the level of crime
- Road and pavement repairs were the top priority for improvement for local people.

3. OBESITY (Chapter lead: Fran Parry)

3.1 What Is The Level of Need in Havering?

- It is estimated that 27.3% of adults in Havering are obese. This is higher than the England average of 24.2% and the London average of 20.7%
- Although there are pockets of high obesity prevalence across the borough, it tends to be clustered in the north and south of the borough, and in the less affluent wards of Gooshays, Heaton and South Hornchurch
- 12.1% of reception year children in Havering are obese, with this figure rising to 21.3% for year six children
- Childhood obesity in Havering is more prevalent than in other similar locations, and obesity in reception year appears to be increasing over time

3.2 Current Service Provision in Havering

- Services for preventing and treating obesity in Havering include universal services such as leisure facilities and Havering active campaign, targeted services such as the national child measurement programme and breastfeeding support, and specialist services such as obesity medication, the MEND programme (for ages 7-13) and bariatric surgery.

3.3 Gaps in Knowledge and Service Provision in Havering

- Limited information about the number of expectant mothers in Havering who are overweight (a risk factor for the child becoming overweight)
- Lack of information about what local people think about obesity and what services they would like to see in the Borough
- No targeted community obesity prevention or weight management services for children under the age of seven
- No weight management programmes designed for adolescents
- There are no NHS funded community weight management programmes for adults in Havering (although commercial programmes available at a cost)

3.4. Obesity: for decision makers and commissioners to consider:

- Undertake community engagement with local stakeholders
- Commission an NHS funded weight management programme for Havering.
- Ensure that women who are pregnant or trying for a baby are supported to achieve a healthy weight before or after the birth: either through the provision of a NHS funded weight management service, a specialist service, or support from health professionals
- Continue investment in the assessment, treatment, and prevention of childhood obesity: Continue to commission the MEND programme, promote breastfeeding, work with early years settings and schools to act as environments that promote healthy weight
- Reduce the obesogenic nature of the environment in Havering: Options for future work here include improving housing, providing options for active travel, and working with local businesses to improve the food environment

4. SMOKING (Chapter lead: Clare Ebberson)

3.1 What Is The Level of Need in Havering?

- Between 20.6% and 20.8% of the adult population in Havering are estimated to be current smokers, with is similar to the London and England averages
- There are estimated to be wide variations in smoking prevalence within Havering, with this ranging from 10.1% in some small parts of Havering to 36.6% in other small areas
- 13.6% of women in Havering are smokers at the time when they give birth, which is similar to the national average and means around 377 babies a year are born in Havering where the mother has smoked during pregnancy
- The rate of smoking related deaths in Havering is not significantly different from the England average, however around 418 Havering residents a year die from smoking related causes
- There were around 1,128 hospital admissions (per 100,000 population aged 35+) attributable to smoking in Havering in 2009-10. This is a lower admission rate than the national and London averages.

3.2 Current Service Provision in Havering

A range of smoking cessation services are available in Havering, including:

- A stop smoking specialist service (Borough wide), which includes stop smoking support to those at Queen's hospital, and targeted stop smoking services aimed at expectant mothers and at cardiac rehabilitation patients
- A stop smoking service is also delivered by specific pharmacies and GP practices directly (GPs and pharmacists can also refer to the specialist stop smoking service)

Trading standards also carry out a range of actions to regulate the sale of tobacco, including:

- A Challenge 21 scheme for tobacco, test purchasing exercises, working with local businesses to remove tobacco vending machines, work to reduce proxy sales of tobacco and regulation of illicit tobacco and tobacco advertising.

3.3 Gaps in Knowledge and Service Provision in Havering

- There is currently not a stop smoking champion at Queen's hospital. Stop smoking champions are supported by the British Thoracic Society to take actions such as leading on developing smoking cessation policy in local hospitals

- Currently only a small proportion of women receive carbon monoxide testing as part of their ante-natal appointments
- There are limited initiatives taking place in Havering targeted at preventing children and young people from beginning to smoke e.g. media campaigns or including smoking cessation in the school curriculum (however enforcement action aimed at deterring underage sales of tobacco is taking place)
- There is no smoking cessation strategy in Havering

3.4. Smoking: for decision makers and commissioners to consider:

- Develop a local smoking cessation and tobacco control strategy outlining actions partners will take to address these areas (consideration of a sector wide strategy with Borough sections to reflect local delivery arrangements)
- Stop smoking service to deliver further level 1 stop smoking training to health professionals, particularly community midwives and ante-natal workers.
- Increase the proportion of expectant mothers who receive carbon monoxide testing as part of their discussions about tobacco exposure at ante-natal hospital appointments. Identify resources to purchase additional CO monitoring equipment to enable this.
- Trading standards to continue to gather and act on intelligence about illicit tobacco and underage sales, and to continue test purchasing and retailer education
- Trading standards to continue to work with local retailers to implement changes to legislation around tobacco sales including the ban on tobacco vending machines and new legislation on displaying and packaging of tobacco
- Work with Basildon Havering and Redbridge University Trust to identify a stop smoking champion to participate in the British Thoracic Society programme, and promote smoking cessation within Queen's and King George's hospitals
- Identify a forum where local partners can work together to address smoking cessation
- Continue to work with GPs and pharmacists to ensure that local people receive a consistently high level of smoking cessation support from across the Borough (stop smoking team)
- Identify resources with which to work partners to implement interventions to prevent young people from beginning smoking. In line with NICE guidance, such interventions could include ensuring anti-smoking activities and information are part of the school curriculum, and supporting schools to develop anti-smoking policies
- Further work to take place to embed smoking cessation into care pathways so that smoking cessation is discussed at each stage of the patient's journey (this could include reminders to health professionals by electronic prompts etc)
- Consider raising awareness of the smoking cessation support available to young people aged under sixteen in specific hard to reach groups (e.g. young people in care). Consider investigating whether all local pharmacies are aware of the smoking cessation support available to these aged below sixteen.

5. DEMENTIA (Chapter lead: Alice Williams)

3.1 What Is The Level of Need in Havering?

- It is estimated that around 3,050 people in Havering (aged 65+) currently have dementia
- This is predicted to rise to 4,691 by 2030, with Havering having a greater number of residents with dementia than the majority of other London Boroughs
- The recorded number of people with dementia in Havering is significantly lower than the expected number, suggesting that more than 2,000 local people are living with undiagnosed dementia
- Around 60 people in Havering are estimated to be affected by early onset dementia (age 30-64)
- It is estimated that around 63% of those with late onset dementia live in private homes in the community, and around 37% live in care homes

3.2 Current Service Provision in Havering

- There are a range of services for people with dementia in Havering provided by a number of different organisations including health, social care, the Alzheimer's Society and Age Concern Havering
- Non dementia specific services which may be accessed by people with dementia include: GPs, the community mental health team for older people, community care services, telecare, home care reablement service and the collaborative care team (psychiatric liaison for older people, based in hospitals)
- Dementia specific services in Havering include a memory service, a dementia advisory service, dementia home support service, dementia clubs, a dementia café, a peer support group, a group for younger people with dementia, a carer's lunch club and guide me/me time sessions for carers. There are also dementia specific places in many nursing and residential care homes in the Borough

3.3 Gaps in Knowledge and Service Provision in Havering

- Generally poor recording of incidences of dementia e.g. in hospital admissions and social care. This means there is a lack of information about activity, costs and outcomes of many services accessed by those with dementia
- Lack of awareness of the current dementia pathway

3.4. Dementia: for decision makers and commissioners to consider:

- Continue to improve collection, data sharing and quality of dementia information, including communication and sharing of best practice around dementia locally
- Continue dementia awareness work to include a) consider extending this to include awareness of the early signs of dementia and how to seek help b) improve the range of information available to those with dementia and their families
- Work with GPs around dementia training/diagnosis particularly focusing on GP practices with a large gap between expected and recorded dementia prevalence
- Develop further education sessions for families about how to support someone with dementia

- Consider commissioning additional short respite breaks for carers of those with dementia to meet demand, and improving access to current respite breaks
- Develop a new training strategy/pathway for those working with and supporting people with dementia (to incorporate the findings of the care homes audit)
- Work with public health to review other pathways (e.g. stroke, learning disabilities etc) to ensure they incorporate opportunities to aid prevention through early identification of dementia risk factors

6. CARDIOVASCULAR DISEASE (CVD) (Chapter lead: Aslam Baig)

3.1 What Is The Level of Need in Havering?

- Around a third of deaths in Havering are caused by CVD, a large proportion of which are deaths from Coronary Heart Disease and Strokes
- However overall, mortality from CVD in Havering is lower than the England average, but above the London average
- There are nearly twice as many male deaths from CVD in Havering as in women (this is also the case in London and England)
- For many types of CVD, including heart failure and atrial fibrillation, the prevalence (among those registered with GPs) is lower than the England average but above the London average
- However, 13.5% of those registered with GPs in Havering have hypertensive disease. This is higher than the London (10.9%) and England (13.4%) figures, with Havering having the highest prevalence of hypertension out of the London Boroughs
- There are inequalities in cardiovascular health in Havering. Those who live in less affluent areas of Havering are more likely to die from CVD, and those registered at the most "deprived" GP practices were 55% more likely to have hypertension, 36% more likely to have congestive heart failure and 70% more likely to have coronary artery disease than those registered at the least "deprived" GP practices
- 8% of hospital admissions in Havering in 2010/11 were due to circulatory disease (around 7,000 admissions), however this was a lower rate than in England or London overall in 2009/10

3.2 Current Service Provision in Havering

Current services in Havering relating to CVD *prevention*:

- NHS Health checks, stop smoking services, physical activity and obesity services

Current services in Havering to *support* people with CVD:

- Primary care anti-coagulation monitoring service, a stroke liaison nurse, a community diabetes service (including diabetes self management education courses), a community heart service (for those with heart failure), a community rehabilitation service (neurological) and community matrons (support those with two or more long term health conditions)

3.3 Gaps in Knowledge and Service Provision in Havering

Key gaps in knowledge and service provision include:

- Limited information is available about how hard to reach groups are affected by CVD e.g. homeless people and economically disadvantaged communities
- There are variations in primary care on key Quality and Outcomes Framework (QOF) outcomes and reasons for this need to be assessed

- There is a need to understand and address the reasons for the extensive variation of general practice identification and care for people with hypertension, atrial fibrillation and heart failure
- There is need to identify further local cost-effective interventions to prevent CVD e.g. increasing physical activity and improving diet
- A way of assessing the impact of the lifestyle interventions discussed with individuals as part of the NHS health checks should be introduced
- A recent review of the Post-Acute Stroke Rehabilitation Services in Havering recommended that the service be extended in order to resolve unmet need with the Early Supported Discharge (ESD)
- An overall review and evaluation of the existing treatment and services for cardiovascular diseases would help to pinpoint gaps in service delivery

3.4. CVD: for decision makers and commissioners to consider:

- Further roll out the NHS health checks programme across Havering for the 40-74 age group, particularly focusing on high risk groups and those that are hard to reach, including those that may not visit a GP
- Ensure that resources and funding are available for targeted primary and secondary prevention of CVD in Havering e.g. weight management programmes, stop smoking services and exercise and dietary advice services
- Work with primary care to improve the approach for identifying individuals with CVD to enable the gap between reported and expected numbers on disease registers to be reduced.
- Consider developing a CVD strategy for Havering including a service review (to include review of tertiary services and cardiac and stroke rehabilitation)
- Continue to work closely with partners such as North East London Cardiovascular and Stroke Network, BHRUT and ONEL Community Services to contribute to the development of cost effective, high performing models of care for areas such as atrial fibrillation, chest pain and cardiac diagnostics
- Work with community pharmacy to improve compliance with medication

7. Breastfeeding (Chapter lead: Heather Yuregir)

3.1 What Is The Level of Need in Havering?

- Around 67% of women in Havering breastfeed their babies at birth (partially or totally), which is lower than the London (86%) and England (73%) averages
- By 6-8 weeks after birth, this has dropped to 34% of women breastfeeding in Havering, which is still lower than the England average of 45%
- 87% of local mothers had decided on a feeding method before even becoming pregnant and of those that did not breastfeed, the most common reason for this was it being easier as family, friends or partner could help with bottle feeding

3.2 Current Service Provision in Havering

Current service provision includes breastfeeding support as part of ante-natal classes and routine ante-natal care, and also breastfeeding specific services such as:

- Breastfeeding social marketing campaign, breastfeeding friendly scheme (where local premises sign up as places where breastfeeding is welcome) which 44 local premises have signed up to, breastfeeding peer support and a schools breastfeeding awareness pilot (5-10 schools taking part)

3.3 Gaps in Knowledge and Service Provision in Havering

- The breastfeeding support service is currently only able to support 8-10 mothers a month as it is run by a small number of volunteers
- There is not enough provision of free ante-natal classes in Havering for all expectant mothers to be able to attend. Information about which mothers are not receiving any ante-natal support and which are purchasing private ante-natal support is not currently available
- Information about whether women in Havering breastfeed has not been collected completely in the past

3.4. Breastfeeding: for decision makers and commissioners to consider:

- Introduce staff training programmes about breastfeeding to ensure consistent messages about breastfeeding are being delivered by different groups of professionals
- Expand the peer support programme, so a greater number of women are supported to breastfeed
- Continue Havering's social marketing campaign promoting breastfeeding and extend this to further areas of Havering
- Increase the number of locations which are participating in the breastfeeding friendly scheme
- Continue to work with GPs to improve the quality of the breastfeeding data
- Further work with acute units to ensure breastfeeding is supported, including a review of the provision of ante-natal classes and breastfeeding support included in these

8. CANCER (Findings incorporated from 2010 Annual Public Health Report, Chapter lead: Mark Ansell)

3.1 What Is The Level of Need in Havering?

- Overall, the incidence (new cases) of cancer in Havering is lower (better) than the national average
- Nonetheless, high numbers of Havering residents are diagnosed with and die from cancer each year; due in part to the older population. This will increase even further as the population continues to get older
- Breast, bowel, and lung cancer are the most common cancers in women in Havering, and prostate, lung and bowel cancer are most common in men
- The prevalence of risk factors for cancer among Havering's population are similar to or greater than (in the case of obesity) the national average. There is low awareness among Havering residents that diet and obesity increase the risk of cancer
- Overall, cancer mortality rates in Havering are similar to the national average
- However, for those who do have cancer in Havering, cancer survival is not improving and is significantly worse than the national average
- The *number* of people living following a diagnosis of cancer has still increased in Havering however, as a result of population ageing and improvements in survival
- There is evidence of inequalities in Havering regarding mortality rates and the prevalence of lifestyle related risk factors associated with levels of socioeconomic disadvantage

3.2 Current Service Provision in Havering

- There are existing strategies to reduce the prevalence of some risk factors for cancer including obesity and harmful alcohol consumption but there are gaps, notably smoking
- Existing strategies are increasingly dated, and management arrangements do not reflect the establishment of the Health and Wellbeing Board.
- Local smoking cessation services are available and have consistently met the targets set for them, but further improvements should be possible
- Screening programmes for breast and cervical cancer are well established and uptake is relatively good
- There is a newly established screening programme for bowel cancer, and uptake is encouraging but further improvement is needed
- A social marketing campaign to raise public awareness is underway but has still to be evaluated. This aims to address the low awareness of Havering residents of some of the signs and symptoms of cancer in Havering
- The available information suggests that overall, the referral practice of local GPs when patients present with symptoms suggestive of cancer is relatively good; but there is variation at individual practice level
- Performance at BHRUT regarding the timeliness of 1st consultant contact following referral with suspected cancer (2 week wait) is very good
- The timeliness of subsequent treatment (31 and 62 day standards) is good but could be improved
- The limited information available about treatment outcomes suggest outcomes achieved at BHRUT are in line with national averages
- There is a need nationally to increase access to optimal treatment; including radical surgery and radiotherapy which are linked to better survival
- Patient experience of care in Havering is relatively poor
- Too many people dying of cancer do so in hospital
- There is some evidence of inequalities in access to services regarding both the prevention and treatment of cancer
- Rates of emergency admission and lengths of stay in Havering are relatively high which may in part explain why expenditure on cancer in Havering is higher than the national average

3.3 Gaps in Knowledge and Service Provision in Havering

- Cancer survival in Havering is worse than the national average and late presentation by patients with symptoms of cancer to their GP is the most likely cause
- Further improvement is needed to make cancer treatment in both Havering and England as good as the best available internationally
- With regard to survival, increased access to surgery and radiotherapy is likely to have most impact
- Better information is needed to monitor access to effective treatment in general but also for older people who, based on national data, may be missing out
- Existing strategies to help Havering residents live healthier lives are incomplete or need updating, to ensure residents are supported to reduce avoidable lifestyle risk factors for cancer
- Management arrangements for all such strategies need to be amended to reflect the leadership role of the newly established Health and Wellbeing Board
- There are no NHS weight management services in Havering and smoking cessation services could be more effective

- Patient experience at BHRUT and London generally is poor and needs improvement
- Too few people are able to die at home and end of life care needs improvement

3.4. Cancer: for decision makers and commissioners to consider:

- A comprehensive programme to improve cancer survival in Havering is needed including action to:
  - Raise public awareness of the signs and symptoms of cancer.
  - Further improve the competence and capacity of local GPs to identify and promptly refer patients with symptoms suggestive of cancer.
  - Maintain the current excellent performance regarding waiting times between referral of patients with suspected cancer and first consultant contact (2 week waits).
  - Improve access to optimal treatment, particularly radiotherapy and surgery.
  - Ensuring that older people benefit from these developments.
  - Maximise uptake of cancer screening, particularly the newer bowel screening programme.
- The Health and Wellbeing Board should oversee the development and implementation of strategies, underpinned by credible plans, to make healthy living the 'norm' in Havering.
- Evidence based, community weight management services should be commissioned for Havering residents
- Smoking cessation services should be re-commissioned to increase their impact and cost effectiveness; ensuring equitable access to disadvantaged groups with greatest need.
- Action is needed to identify the ongoing needs of cancer survivors and how they can be met; involving relevant 3rd sector groups.
- Opportunities to minimise rates of unplanned hospital admission and reduce lengths of stay should be exploited. Greater use of laparoscopic surgery should be an early priority.

Nb. The Director of Public Health's Annual Report for 2010 (published autumn 2011) focuses on cancer and should be referred to as the JSNA "chapter". There is no additional separate JSNA chapter on cancer. The report can be found online here: http://www.hspnetwork.org.uk/HaveringHealthReport2010/

9. DOMESTIC VIOLENCE (DV; Chapter lead: Victoria Hill)

3.1 What Is The Level of Need in Havering?

- Around 5,460 women and girls in Havering are estimated to experience DV every year. Actual figures may be higher than this as these estimates do not include men experiencing DV
- 4,880 women and girls annually are also estimated to experience sexual assault, and 9,670 to experience stalking in Havering
- It is estimated that the cost of responding to DV in Havering is £23.3million annually (not including the human and emotional costs)
- Over 1000 cases of DV were supported by Havering DV services in 2010/11

- Havering has the 8th lowest rate of DV offences and incidents (per 1000 population) out of the 32 London Boroughs
- Over a third of domestic violence in Havering takes place at the weekend, and 1 in 10 cases occurs between midnight and 1am

3.2 Current Service Provision in Havering

Services for those experiencing DV in Havering are delivered by a range of organisations such as Women's Aid and include:

- Refuge accommodation for 23 families, floating support for women and men in the community, children's refuge and community services, a drop in service, support groups, a counselling service, a helpline (including an on call 24 hour service for emergencies), skills and training support, an Independent Domestic Violence Advocate (who supports risk of harm cases) and the East London rape crisis centre (not Havering specific)
- In 2010/11, Havering's Women's Aid supported 1192 women, 539 children and 20 men
- A MARAC (multi agency risk assessment conference) also operates locally. (where partners co-ordinate services for the highest risk DV cases to prevent repeat cases of DV) and supported 112 people experiencing DV in 2011/12

3.3 Gaps in Knowledge and Service Provision in Havering

- Referrals from health services including GPs to DV services are extremely low and currently regular information from DV services on health referrals is not captured
- Little feedback has been collated from local service users on their views on how services are supporting them and what improvements are required
- Intelligence on the incidence and nature of issues such as prostitution, sexual violence, trafficking, forced marriage, honour based violence and female genital mutilation in Havering is currently lacking
- An outcome monitoring framework needs to be agreed and implemented by all DV services in Havering
- Little information is currently shared about children in contact with social care who are experiencing DV

3.4. Domestic Violence: for decision makers and commissioners to consider:

- Update and publish a DV and violence against women and girls strategy for Havering
- Engage GPs in the coordinated response to DV, to improve practice and generate referrals. Consider commissioning a pilot of Project IRIS with GPs, to improve primary care response to patients who are experiencing domestic violence
- Ensure appropriate agencies and representatives attend the MARAC. Continue to improve the collation and analysis of MARAC data to understand the needs of those experiencing domestic violence and to align services accordingly
- Work with health and social care to improve the availability of local DV data. Currently most local data on DV is provided by the police and including information from other partners would improve local intelligence on the prevalence of DV. There is also a need for local partners to begin to record information about areas such as forced marriage, honour based violence and female genital mutilation.
- Develop further joint commissioning for domestic violence/violence against women and investigate the need for specialist services e.g. care for those girls and women affected by female genital mutilation or sexual violence
- Consider holding a DV awareness campaign locally

- Consider introducing DV performance indicators into the contracts of health service providers
- Consider commissioning specialist support services for families where DV has been identified e.g. a family DV support worker
- Consider how the East London rape crisis centre will be commissioned in the future and what resources will be available to support this commissioning (from March 2012 funding from the Mayor of London ceases)
- Develop a process with DV services for recording referrals received from health services to better understand health involvement in responding to DV
- Domestic Violence Forum to work with Havering Magistrate's Court to improve management of domestic violence cases, including information sharing, tracking of results and listing of cases to help support services attend court and support victims
- Partners to explore the use of Barnardos Risk Assessment Matrix in conjunction with the MARAC risk assessment tool