Appendix A: Details of the Prevention Board

POLICE & CRIME COMMISSIONER FOR LEICESTERSHIRE

STRATEGIC PARTNERSHIP BOARD

PAPER MARKED

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Report of	**OFFICE OF POLICE & CRIME COMMISSIONER**
Subject	**PREVENTION BOARD**
Date	**TUESDAY 5 NOVEMBER 2019**
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1. Purpose

1.1. This report proposes the establishment of a Prevention Board to replace the existing People and Place Board as a sub-group of the Strategic Partnership Board (SPB).

2. Context

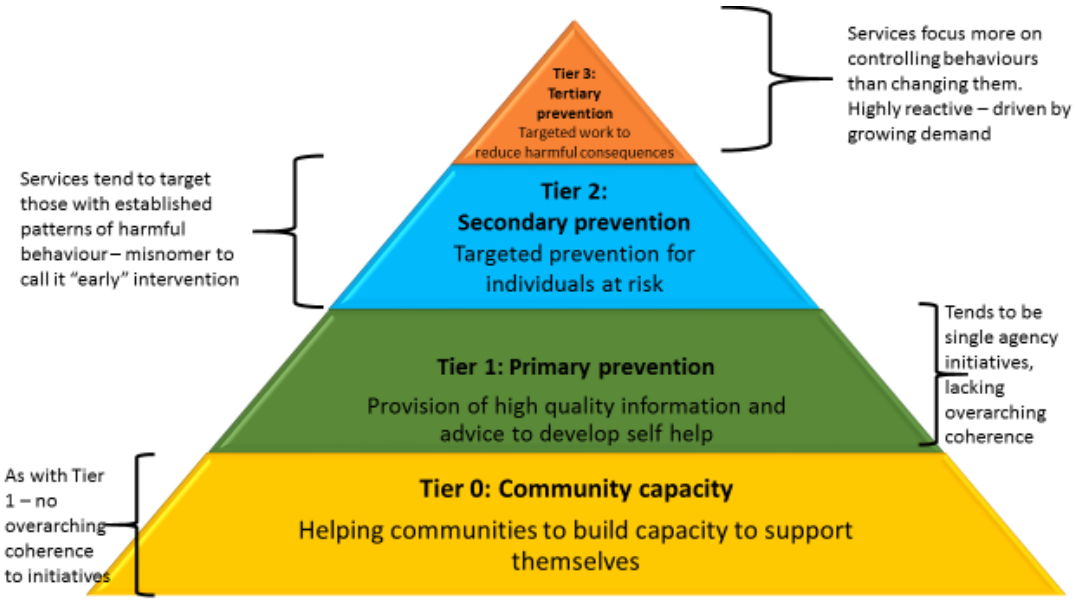
2.1. The People and Place Board was established as one of the original sub-groups of the SPB under the existing terms of reference. The People and Place Board established the People Zones initiative and oversaw its implementation. The terms of reference of the People and Place Board included a focus on “preventing” harmful behaviours and this was part of the rationale for the People Zones.

2.2. Since then two further developments have led to the proposals contained in this paper. The first is the establishment of the Violence Reduction Network (VRN), which is built around the Public Health Model, following on from the success of applying that methodology in Scotland. The second is the development of an operating model for People Zones, which argues that the original model was too broad and requires simplification in order to maximise agency and community commitment. The original methodology for People Zones was entirely consistent with the Public Health Model, albeit not clearly articulated in that format

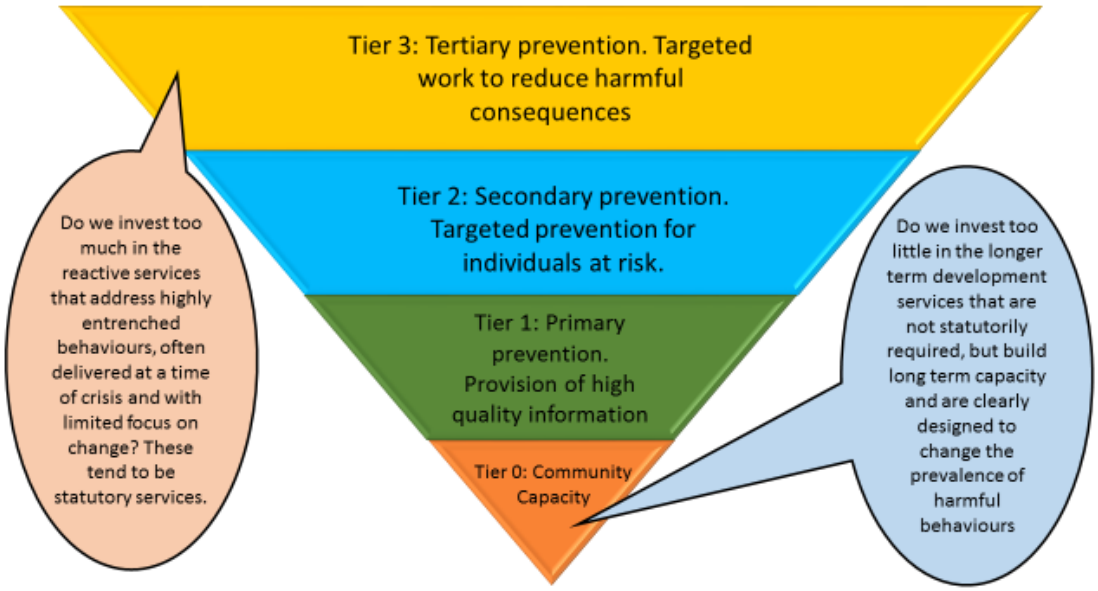
3. The Existing Landscape

3.1. As mentioned above, the Public Health Model is central to the development of the VRN. It is a simple model that is easily understood and accepted by practitioners across the public service sector and could provide a focal point for the development of shared strategies.

3.2. In developing the VRN the team has undertaken a preliminary analysis of the existing delivery arrangements across Leicester, Leicestershire and Rutland (LLR) that are relevant to the behaviour of violence and in line with the Public Health Model. This assessment has highlighted some strengths and weaknesses in the existing service delivery arrangements. These are highlighted in the diagram below.



3.3. In terms of investment, it could be argued that the triangle is currently upside down, with most of the investment going into services that have very limited prospect of achieving long term changes in patterns of harmful behaviour across the communities of LLR. This is depicted in the diagram below.



3.4. The emerging hypothesis is that our capacity to "prevent" harmful behaviours over the longer term is inhibited by the challenge of building the lower tiers of the Public Health Model to the degree that is required. On top of this "prevention" in the higher tiers is limited because the majority of services tend to have a greater focus on "controlling" behaviour rather than enabling the rehabilitation of those who exhibit the behaviour and a tendency to focus on individual "perpetrators" rather than considering the wider network of individuals they interact with and influence.

3.5. Indeed austerity may have exacerbated the problem from a public health perspective, as the higher tiers tend to be statutory and crisis based: the core elements of demand; whilst the lower tiers tend to be non-statutory and longer term. In periods of retrenchment it is inevitable that services will be more narrowly focussed and those that are not statutorily required and do not satisfy immediate demand will experience higher levels of disinvestment. The analysis suggests that this approach merely drives more and more short term crisis based services, whilst doing nothing to stem the long term flow of demand.

3.6. The preliminary VRN service mapping exercise suggests that services at tiers 2 and 3 currently have a very limited focus on prevention. The services most likely to respond to violent behaviour in adults are police, EMAS, A&E, probation and prison. The police response is not designed to change the behaviour of the individual perpetrator and police training does not focus on rehabilitative interventions. Leicestershire Police has invested in services such as Braunstone Blues and People Zones and has developed a Serious Harm Reduction Unit to focus on longer term initiatives as well as building its neighbourhood policing capability. But the response to individual incidents is largely to apprehend and convict the perpetrator.

3.7. EMAS and A&E tend to respond to the "victims" of violent behaviour rather than the perpetrators, albeit the distinction between victim and perpetrator can become blurred in some types of violent incident. The prison service clearly works directly with perpetrators of violence and delivers some services to impact on the attitudes underpinning the behaviour. Nevertheless, the recent crisis of mushrooming violence within our prisons does not suggest that violence prevention will blossom in that environment. Indeed the consultant supporting the development of the VRN described prison as reinforcing the very trauma that underpins violent behaviour.

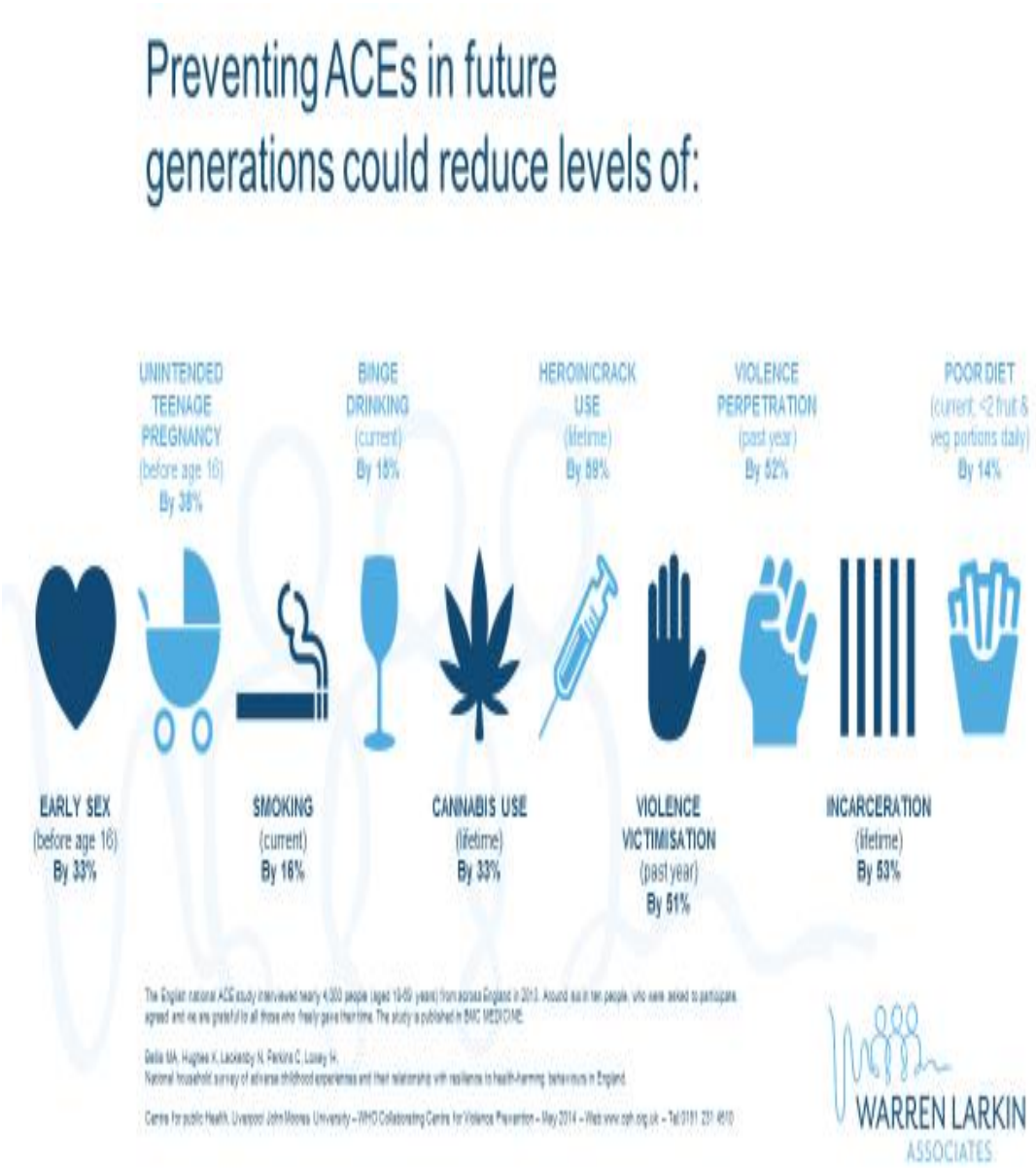
3.8. The probation service probably has the largest focus on rehabilitation of all these services, but has undergone major organisational upheavals in recent years, with more to come. Even then that service is arguably more focussed on controlling the behaviour of those who pose a threat to public protection rather than investing in their long term rehabilitation. It clearly does not routinely work across the network of individuals who are influenced by perpetrators and therefore obviously cannot impact on the inter-generational nature of these behaviour patterns.

3.9. The response from the Youth Offending Service for younger perpetrators of violence may provide a more promising focus on rehabilitation as well as a willingness to engage with the wider network of individuals who influence and are influenced by the individual. This approach is likely to have a longer term effect, but the truth is that the vast majority of perpetrators are in the higher age range.

3.10. The pattern emerging from the early VRN analysis is that the top two tiers of the Public Health Model are unlikely to generate long term changes in the pattern of behaviour and the bottom two tiers are insufficiently developed to build long term community resilience. There are some very promising initiatives in the bottom two tiers, including the development of Local Area Co-ordinators in the county, street based youth work, and the generic vulnerability checks undertaken by fire officers. Whilst these sorts of initiative will undoubtedly have some positive impact, they clearly have not contained the growing levels of serious violence as highlighted in the analysis presented to the Board on 6 September 2019.

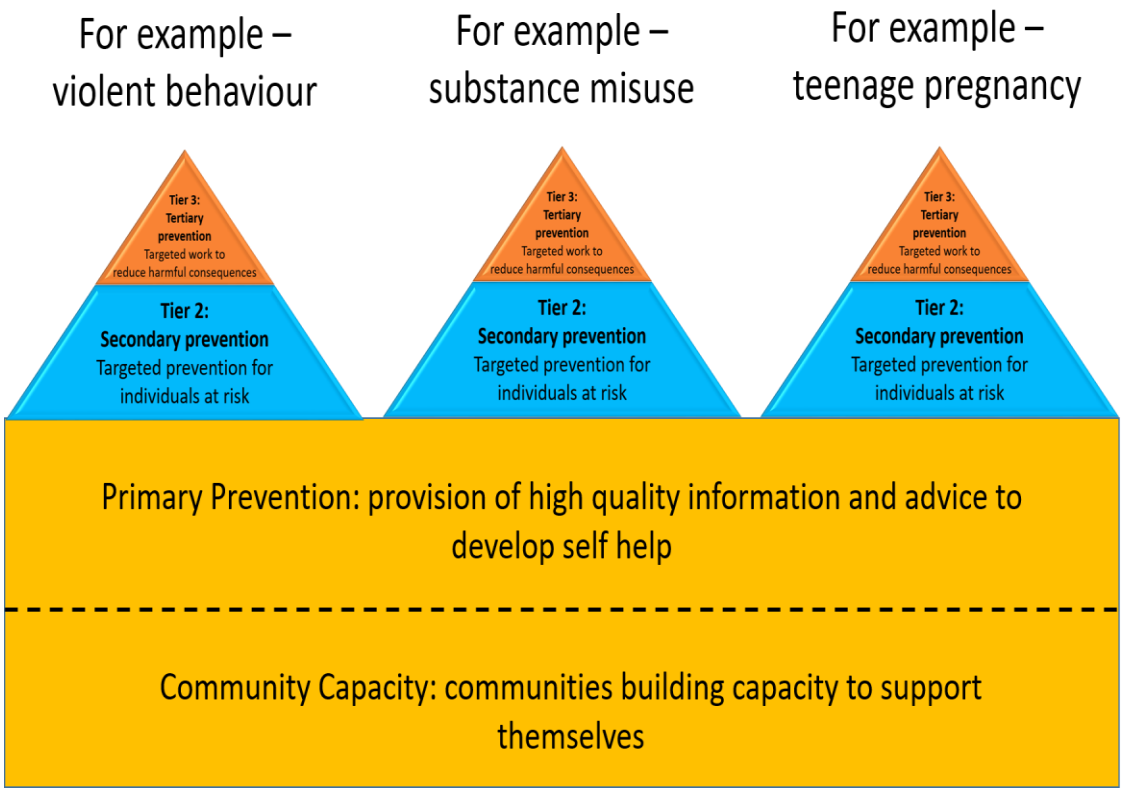
4. A Different Perspective on the Public Health Model

4.1. We tend to address harmful behaviours individually as though each one has unique drivers and perpetrators and victims. But the reality is that certain communities tend to exhibit patterns of multiple deprivation resulting in a myriad of harmful behaviours. Recent analyses of Adverse Childhood Experiences (ACEs) demonstrate that higher levels of trauma in early life are very closely correlated with a range of negative behavioural outcomes. At the same time it implies that making an impact on one behaviour, could have a wider impact on other harmful behaviours. This generic impact is highlight in the diagram below.



4.2. However, the ACE analysis also suggests that patterns of harmful behaviour have a long gestation period and are established over many years. Essentially the behaviour is a "symptom" of long term deprivation. This makes the behaviours very difficult to change once they are entrenched. All the indications are that investing early in building resilience to the causes of the behaviour in the first place is a more profitable route to pursue; therefore investing in tiers 1 and 2 of the public health model.

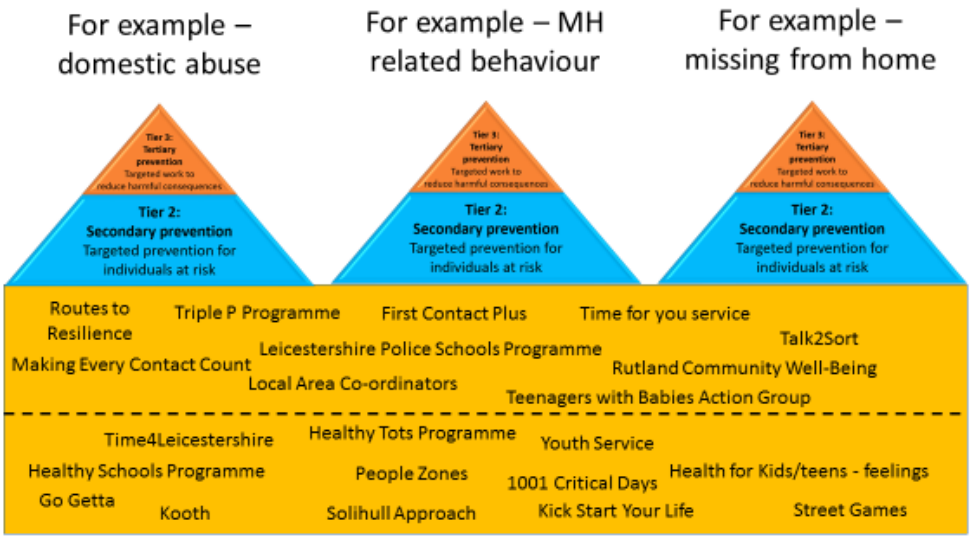
4.3. Investing in the lower tiers of the Public Health Model has the added advantage of being non-behaviour specific. If we build resilience to one form of harmful behaviour we are likely to build resilience to them all. In this sense the Public Health Model is more like a Toblerone than a triangle as depicted in the diagram below.



4.4. On this basis we could establish a model wherein the lower tiers are seen as generic and developed collaboratively across public service agencies, whereas the higher two tiers are targeted more specifically at individual behaviours as indicated in the diagram above. This approach can build upon existing initiatives across LLR, some of which have been mapped by the VRN work. The approach would also enable a much higher level of collaboration across public services than has been possible to achieve hitherto.

4.5. At present, insofar as we develop initiatives at the lower tiers, some of them are developed to address specific behaviours rather than building wider resilience in our young people and local communities. For instance many violence reduction units outside of LLR are targeting schools and local communities to promote messages in relation to knife crime/serious violence. If we adopted this behaviour-specific approach for each of the harmful behaviours we want to focus on, the schools and communities would be inundated and there would be a risk of conflicting messages resulting in confusion. The proposed approach is more generic, developing some core messages to promote and build a wider level of overarching resilience to a range of harmful behaviours. Reassuringly this is the approach adopted by Leicestershire County Council via their successful Youth Endowment Award programme to be delivered in schools by Barnardo's.

4.6. The diagram below is drawn from the preliminary VRN mapping and gives an indication of the sorts of existing resources that are available in local communities at tiers 1 and 2 (no distinction is made between those tiers in the diagram). Clearly the community itself is the source of many other resources to enable resilience building.



5. A Worked Example – Mental Health

5.1. The proposed methodology has already been tested via some work already undertaken in the area of mental health. Mental health issues are referred to in the Police and Crime Plan as an area of vulnerability that generates very reactive work for the police and other agencies, without delivering long term benefits.

5.2. The Proactive Vulnerability Engagement Team (PAVE) was established via the OPCC's Strategic Partnership Development Fund (SPDF) to develop an enhanced response to frequent callers to emergency services with complex issues of vulnerability. As part of the recent review the scope and remit of PAVE was considered alongside the services offered by Leicestershire Partnership Trust and by Primary Care services and other organisations to support this cohort of people. What has emerged is a proposed holistic approach to these individuals that draws on services and support at all levels of the Public Health Model. The proposals will be considered at a special leaders' event on 25 November and is described more fully in a separate paper to this meeting of the SPB.

5.3. However, the key ingredients are that a key behaviour was identified – low level mental health generated demand for emergency services; a collaborative analysis was undertaken and an inter-agency strategy developed to address the behaviour. This is the approach proposed for other behaviours that have yet to be defined.

6. Alignment with Health

6.1. The worked example described above, and other complex behaviours that the Prevention Board is likely to address, are bound to have a health component. The solutions identified will only be effective if they align with the strategic initiatives of the Clinical Commissioning Groups (CCGs) and local health providers.

6.2. In order to promote this alignment it is proposed to take this paper to the Health and Well-Being Boards that cover Leicester, Leicestershire and Rutland (LLR) and to align work between the SPB sponsored Prevention Board and the Unified Prevention Board that is building a similar health-based preventive approach across Leicestershire, and any equivalent forums in other jurisdictions across LLR.

6.3. Taking this a step further there will always be considerable overlap between the issues addressed by SPB and those taken forward by Health and Well-Being Boards. Bearing this in mind it is proposed to establish an annual joint forum, wherein overlapping issues are identified and considered. The proposal for this will be developed more fully and brought before a future meeting of the SPB.

7. Alignment with Place

7.1. The diagram in 4.6 above demonstrates that there is already quite a lot of activity going on in tiers 0 and 1, but this varies considerably by place. Many of the programmes referred to in 4.6 are commissioned by Leicestershire County Council, which may partly reflect the knowledge base of the person who did the preliminary VRN mapping – but it may also demonstrate that there is variation in provision between upper tier local authority areas. Clearly there may also be variations between lower tier authorities, but that is more difficult to map at this stage because of the resources available for mapping and because of the overlapping provision offered by Leicestershire.

7.2. Nevertheless the Board does need to understand the variations in provision by place in order to know where to target services and stimulate community resources, including the deployment of a revised People Zone methodology. The proposal is for the Board to develop its own expectations of what is required at tiers 0 and 1 in order to facilitate the prevention of harmful behaviours, and to put in place arrangements to review and monitor this. In the first place the review and monitoring can be undertaken at upper tier level.

8. Alignment with the VRN

8.1. The methodology described for the Prevention Board entirely accords with the approach adopted by the VRN. In essence violence is one of the harmful behaviours that the Prevention Board will be concerned with. The work that the VRN undertakes to enhance tiers 1 and 2 of the Public Health Model across LLR will provide immediate benefits to the VRN and any work that the Prevention Board commissions to address other harmful behaviours will have similar synergistic effects.

8.2. Bearing this in mind the VRN and the Prevention Board need to work particularly closely and need to align their programmes. Wherever possible agencies will ensure that membership of the Boards is held in the same person. Over the longer term it may be that the two Boards are brought together as one, but in the short term, the funding requires the VRN to be a separate Board and its pioneering development probably requires dedicated commitment from each agency. This will be reviewed over time.

9. Implications for the Prevention Board

9.1. Translating this into the development of a multi-agency Prevention Board the remit of that Board would be to do the following:

9.2. Identify the harmful behaviours that it chooses to prioritise. This exercise will be undertaken in collaboration with initiatives in the health world, such as via the Unified Prevention Board and the Health and Well-Being Boards as well as taking account of the emerging developments in Primary Care Networks.

9.3. Review existing preventive work undertaken at Tiers 2 and 3 for each of the prioritised harmful behaviours, leading to recommendations for change and the preparation of a multi-agency strategy to enhance the achievement of preventive initiatives.

9.4. Build a self-assessment toolkit for individual agencies to enhance the quality of their work on prevention. This will include the testing of the toolkit with individual agencies to ensure its

efficacy.

9.5. Map and co-ordinate initiatives to build Tiers 1 and 2 of the Public Health Model. This will be done across LLR identifying gaps either geographically or in specific elements of the preventive model, with an emphasis on generic initiatives that are not specific to individual behaviours. .

9.6. Identify specific geographical communities where resilience is particularly low and undertake work to enhance the resilience of those communities using the revised methodology for People Zones, which is attached at Annex B.

9.7. This approach will complement the work being undertaken by the Violence Reduction Network, which is currently engaged in each of the activities identified above, albeit focussed on serious violence.

9.8. A proposed Terms of Reference for the Prevention Board is attached at Annex A.

10. Recommendation

10.1. The Board is asked to agree to the establishment of the Prevention Board to replace the People and Place Board, in line with the Terms of Reference contained in Annex A.

Annex A: Terms of Reference for the Prevention Board

The Prevention Board: Terms of Reference

1. Purpose

1.1. The primary purpose of the Prevention Board is to develop strategies to prevent harmful behaviours by deploying the Public Health Model.

1.2. The Public Health Model adopted by the Prevention Board is presented in the diagram below

1.3. Harmful behaviours are defined as any behaviour which undermines the safety and well-being of the whole community of LLR or of specific communities within LLR. There is also an expectation that the harmful behaviours to be addressed by the Prevention Board will demonstrate high levels of complexity, requiring inputs from a range of agencies. Harmful behaviours which fall within the remit of single agency would not normally be addressed by the Prevention Board.

1.4. However, the Board will define the behaviour it is addressing as specifically as possible. For instance, crime is a behaviour, but it is not a single behaviour: it takes myriad different forms requiring a multiplicity of responses. However, domestic violence is a sub-group of crime, enabling more detailed analysis of the patterns and causes in order to develop effective preventive strategies. More specifically the Board could focus on specific types of domestic violence, or even domestic violence within specific communities.

1.5. Whatever behaviours the Prevention Board chooses to address, its aim is to minimise the expression of each behaviour, albeit recognising that the positive changes may be realised over a long time period.

2. Approach

2.1. As mentioned above, the Prevention Board will deploy the Public Health Model in addressing the targeted behaviours. More specifically this means the following:

2.2. A recognition that the targeted behaviour is usually a symptom of more long term causes and that the aim of the Board is to understand and address the long term causes, whilst also deploying strategies to minimise the expression of the behaviour in the short term.

2.3. In order to understand the causes the Board will have to analyse the behaviour in detail and draw conclusions from the data. This requires the Board to have an analytical capability at its disposal and it is assumed that each agency will contribute its own data to achieve that analysis.

2.4. In order to identify the targeted behaviours, the Board will maintain an issues log, which all members will contribute to. This will record the behaviours that members consider cause the most significant harm to the community (or specific communities) of LLR. The issues in the log will be reviewed in order to prioritise the targeted behaviours.

2.5. The key output of each targeted behaviour will be an inter-agency strategy to minimise the future expression of the behaviour. As a minimum the strategy will identify the required inputs at each tier of the Public Health Model, specifying any particular communities (geographic or non-geographic) where additional inputs are required.

2.6. The strategy will also identify any policy enablers that can be introduced and the anticipated alignment with other local and national strategies. The strategy will also clarify how it will monitor the behaviour over time.

2.7. Insofar as the strategy requires significant deployment of multi-agency resource and/or significant changes in multi-agency policy then the strategy will reported to the SPB for approval and may be monitored and reported at SPB level.

2.8. The Board may choose to develop enablers in order to achieve generic reductions in harmful behaviours, without focussing on a specific behaviour as described above. For instance, the Board may choose to invest in the development of community leadership skills, recognising that community leadership will facilitate the achievement of the Public Health Model.

2.9. Community leadership will also facilitate the sort of local intelligence that will enable the Board to focus on behaviours that are relevant to local communities. In this respect it would be helpful to have input from relevant community leaders on the Board.

2.10. Similarly the Board may recognise that its success is highly dependent on the achievement of a multi-agency data analytical capability, supported by effective data sharing arrangements. This may be difficult to achieve without investment.

2.11. Bearing in mind the potential for investment, the Board may also choose to develop a capability for accessing funding opportunities.

2.12. Finally, the Board will also require a horizon scanning capability in order to be aware of key developments in effective practice, new initiatives at national or local level, national and local strategies and patterns of change in harmful behaviours at a national and local level.

3. Schedule

3.1. The Board’s initial schedule of development will be:

3.2. Establish membership and meeting arrangements

3.3. Establish processes for collecting and monitoring issues

3.4. Agree minimum dataset for monitoring patterns of harmful behaviour, this will include the reporting of issues from local communities

3.5. Agree arrangements for horizon scanning

3.6. Identify harmful behaviours to focus on

3.7. Analyse and develop multi agency strategies for harmful behaviour(s)

3.8. Monitor and review ongoing patterns of harmful behaviour

4. Membership

4.1. Upper Tier Local Authorities

4.1.1. Public Health
4.1.2. Social Care

4.2. Police – strategic lead for Prevention/Neighbourhood Policing

4.3. OPCC – chief executive

4.4. Lower Tier Local Authorities – strategic lead for community safety

4.5. Representative from Public Health England

4.6. Representative from Clinical Commissioning Groups

4.7. Representative from University Hospitals Leicester

4.8. Representative from Leicestershire Partnerships Trust

4.9. Representative from EMAS

The representatives from health will ensure that the work of the Prevention Board is informed by developments within each of the organisations described above, as well as the Health & Well-Being Boards across LLR and the Unified Prevention Board in Leicestershire. Representatives will also be familiar with the development of Primary Care Networks and the Mental Health Partnership Delivery Programme Board. Representatives will also ensure that the work of those organisations and partnerships is informed by the work of the Prevention Board.

4.10. Fire – strategic lead for community safety

4.11. Probation – strategic lead for community safety

4.12. VCSE representative(s)

4.13. Academic representative(s)

4.14. Community leaders

4.15. Academic bodies

Annex B: Summary of Revised Operating Model for People Zones

Changes to People Zone Methodology

1. Background

1.1. The People Zones' methodology was launched in 2018 to support the work of the SPB. It has operated in three communities across LLR.

1.2. An evaluation is currently taking place and will be reported back to the Prevention Board, if the SPB agrees to establish it. An evaluation methodology has been prepared by Loughborough University.

1.3. A revised operating model has been developed by an independent body (Process Evolution) drawing on the feedback from participants. However, the revised model was developed prior to introduction of the Violence Reduction Network and the broad acceptance of the Public Health Model as the approach to adopt.

2. Learning

2.1. The concept of the People Zones has been wholly supported and still aligns very well with the key strategic drivers around which it was established.

2.2. Community leadership has been strong in two of the three People Zones and the initiative has had a positive impact in embedding and enhancing that leadership.

2.3. The initiative has stimulated activities at the local level including the ability to leverage funding in support of work in schools, drug treatment and other local services.

2.4. The initiative has stimulated commitment from the sporting bodies across LLR, with a range of sporting activities undertaken in each zone to engage young people.

2.5. The initiative has had a positive impact in promoting more collaborative working across agencies at the PZ level.

2.6. The initiative has built a creative relationship with the Community Payback scheme delivered by the Community Rehabilitation Company, wherein local people/agencies can identify sought after environmental improvements that can be addressed by Community Payback.

2.7. Despite these and other positive benefits there are areas that require further development as follows:

2.8. The People Zone initiative was intended to be cost neutral. This has been hard to realise in practice and has put pressure on three organisations in particular to maintain the work: the OPCC; the relevant local authorities; and the police. From the perspective of the OPCC three individuals within the office have taken responsibility for delivering the OPCC commitment to each PZ, on top of their other duties. This has been very difficult to sustain for a small organisation, particularly as staffing changes and new commitments, such as the VRN, have occurred.

2.9. The methodology for defining the target behaviour has been unclear and the target behaviours have arguably been too broad. This reflects the fact that the particular areas were chosen because of the high levels of multiple deprivation that were evident in those

communities. Bearing this in mind it has been difficult to focus on a single behaviour as there are so many issues to address, but without focussing on a single behaviour it is hard to demonstrate progress.

2.10. Although some agencies have made a strong commitment to the approach, others have more reserved, leaving gaps in the effective deployment of services.

2.11. Community leadership has been very limited in one of the PZs and is still developing in the others. Community leadership is clearly a key element of the model, but requires greater stimulation at the start of a PZ in order to be effective.

3. Proposed Developments

3.1. The fundamental proposal is that the PZ methodology is enhanced to provide a tool for the Prevention Board to deploy in particular geographic communities (at present the PZ methodology is not adapted for non-geographic communities, although this could be a future development) in line with the Prevention Board approach described above. Specifically this means that the Board will analyse a harmful behaviour and in doing so will identify any particular geographic communities wherein the harmful behaviour is especially prevalent. As part of its strategy for addressing the behaviour the Board will commission a PZ in a specified community or communities.

3.2. In order to do this the current revision of the operating model will be completed to achieve the following:

3.3. A more robust process for agreeing agency and community commitment at the outset of establishing a PZ, with the expectation that the PZ will only go ahead once the commitment is achieved.

3.4. A more robust process for defining roles within the PZ, particularly focussing on a lead role for agencies, a lead role for the community and a co-ordinator role. The expectation is that a co-ordinator will be a funded position.

3.5. The development of a practical toolkit that can be used by community leaders and agencies at the local level. This is currently underway, building on the initial toolkit that was prepared.

3.6. Adoption of the Public Health Model as part of the operating model. This will enable the local delivery team to focus on the management and rehabilitation of individuals exhibiting a very specific harmful behaviour at the top end of the model, whilst building more generic community resilience at the bottom end.