Police and Crime Commissioner priorities and linkages with Health and Wellbeing.

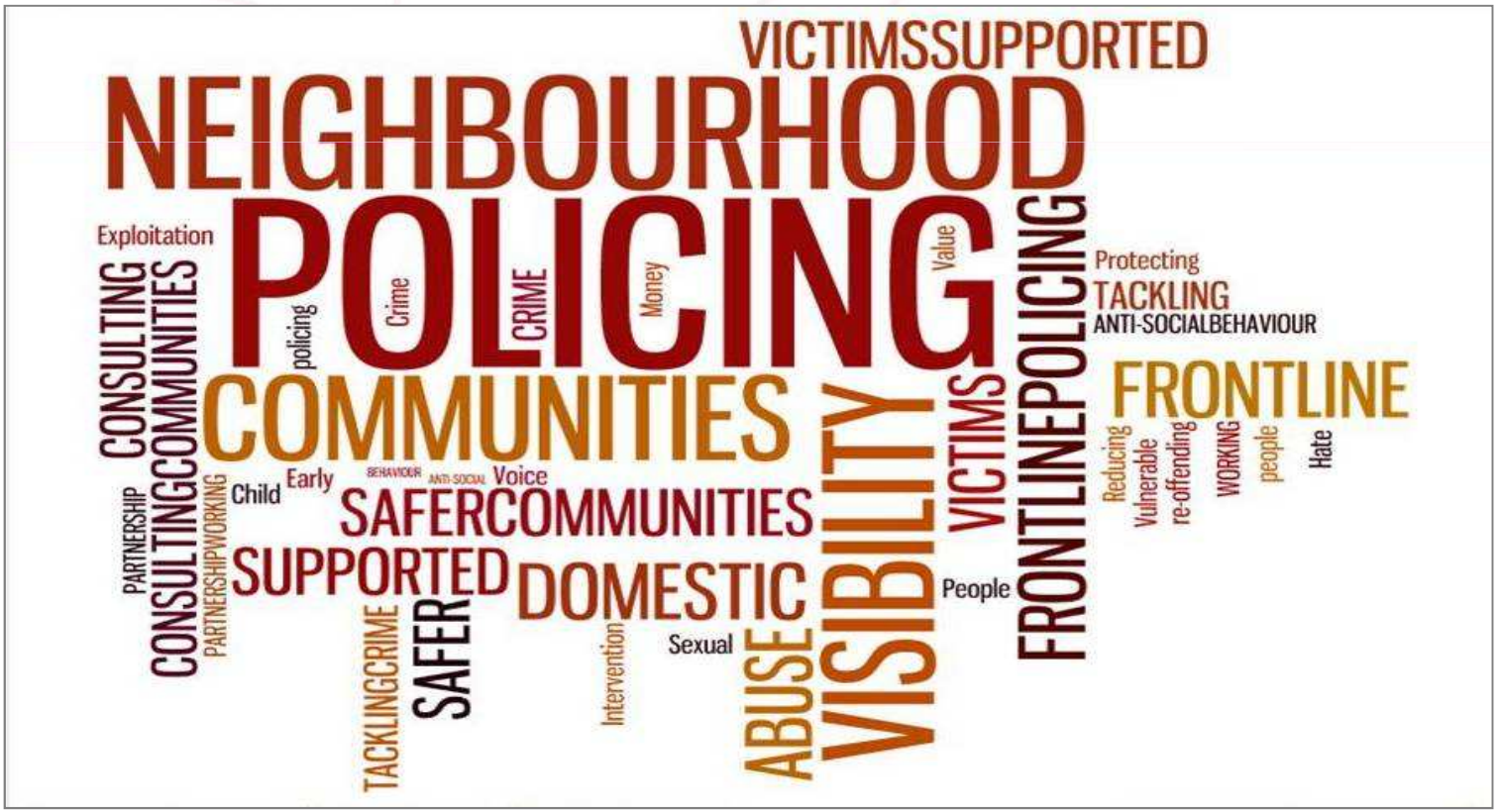
Mike Lock

Senior Strategic Advisor

Role of Commissioner

- Secure the maintenance, efficiency and effectiveness of the constabulary.
- Appoint and dismiss the Chief Constable
- Hold the Chief Constable to account
- Set the precept and to be responsible for the operational policing crime budget
- Set out a five-year Police and Crime Plan
- Contribute to the National Strategic Policing Requirement
- Work with partners to tackle crime and disorder
- Contribute to an efficient and effective criminal justice system.
- Make grants to organisations aside from the police, including but not limited to CSPs.

Police and Crime Plan



Strategic Aims

- **RE-ASSURE** our communities – improve trust and confidence in policing.
- **REDUCE** crime
- **REDUCE** re-offending
- **WORK TOGETHER** with partners to deliver better services and ensure that resources are used effectively.

Strategic Priorities

- **Defend Frontline Policing**
- **Champion the Rights of the Victim**
- **Protect Vulnerable People**
- **Promote Targeted Initiatives to Contribute to Tackling Crime and Re-Offending**

Partner Organisations

- Local Authorities and Public sector bodies
- Lancashire Criminal Justice Board (CPS, HMCTS, Probation, Youth Justice, HMPS, Police, Victim Support)
- Lancashire Community Safety Strategic Group
- Community Safety Partnerships
- Health and Wellbeing Boards
- Children and Young People's Trusts
- Safeguarding Children's and Adults Boards
- Youth Justice Management Boards
- Pan /Lancashire Strategic Boards and Commissioning Groups

Significant health inequalities exist amongst offenders and ex-offenders

In the week following their release:

- - female prisoners are 69 times more likely to die than females in the general population
- -male prisoners are 29 times more likely to die than males in the general population.
- -It is estimated that up to 30 per cent of offenders have a learning difficulty/disability.
- - Among children and young people in custody:
- - over 75 per cent have serious difficulties with literacy and numeracy
- - over 30 per cent have a diagnosed mental health problem
- - more than 30 per cent have experienced homelessness
- - over 30 per cent of young women and over 25 per cent of young men report a long-standing physical complaint

Significant Health Inequalities exist amongst offenders and ex offenders

- 24 per cent of prisoners with a drug problem are injecting drug users. Of these, 20 per cent have hepatitis B, and 30 per cent have hepatitis C.
- Among female prisoners, 40 per cent have a long-standing physical disability, and 90 per cent have a mental
- health or substance misuse problem.
- Less than 1 per cent of ex-offenders living in the community are referred for mental health treatment.
- In prisons, the smoking rate is as high as 80 per cent – almost four times higher than the general population.
- 63 per cent of male prisoners and 39 per cent of female prisoners are hazardous drinkers.

Improving the wider determinants of health

Objective

Improvements against wider factors which affect health and wellbeing and health inequalities

Indicators

1.1 Children in poverty 1.2 School readiness1.3 Pupil absence1.4 First time entrants to the youth justice system 1.5 16-18 year olds not in education, employment or training1.6 Adults with a learning disability / in contact with secondary mental health services who live in stable and appropriate accommodation† *(ASCOF 1G and 1H) 1.7 People in prison who have a mental I illness or a significant mental illness 1.8 Employment for those with long-term health conditions including adults with a learning disability or who are in contact with secondary mental health services *(i-NHSOF 2.2) ††(ii-ASCOF 1E) ** (iii-NHSOF 2.5) †† (iii-ASCOF 1F) 1.9 Sickness absence rate1.10 Killed and seriously injured casualties on England's roads1.11 Domestic abuse 1.12 Violent crime (including sexual violence) 1.13 Re-offending levels1.14 The percentage of the population affected by noise 1.15 Statutory homelessness 1.16 Utilisation of outdoor space for exercise / health reasons 1.17 Fuel poverty1.18 Social isolation † (ASCOF 1I)1.19 Older people's perception of community safety.*

Health improvement

Objective

People are helped to live healthy lifestyles, make healthy choices and reduce health inequalities

Indicators

2.1 Low birth weight of term babies
2.2 Breastfeeding
2.3 Smoking status at time of delivery
2.4 Under 18 conceptions
2.5 Child development at 2 – 2 ½ years
2.6 Excess weight in 4-5 and 10-11 year olds
2.7 Hospital admissions caused by unintentional and deliberate injuries in children and young people aged 0-14 and 15-24 years
2.8 Emotional well-being of looked after children
2.9 Smoking prevalence – 15 year olds (Placeholder)
2.10 Self-harm
2.11 Diet
2.12 Excess weight in adults
2.13 Proportion of physically active and inactive adults
2.14 Smoking prevalence – adults (over 18s)
2.15 Successful completion of drug treatment
2.16 People entering prison with substance dependence issues who are previously not known to community treatment
2.17 Recorded diabetes
2.18 Alcohol-related admissions to hospital
2.19 Cancer diagnosed at stage 1 and 2
2.20 Cancer screening coverage
2.21 Access to non-cancer screening programmes
2.22 Take up of the NHS Health Check programme – by those eligible
2.23 Self-reported well-being
2.24 Injuries due to falls in people aged 65 and over.

Health protection

Objective

The population's health is protected from major incidents and other threats, whilst reducing health inequalities.

Indicators

3.1 Fraction of mortality attributable to particulate air pollution**3.2** Chlamydia diagnoses (15-24 year olds)**3.3** Population vaccination coverage**3.4** People presenting with HIV at a late stage of infection**3.5** Treatment completion for TB**3.6** Public sector organisations with board approved sustainable development management plan**3.7** Comprehensive, agreed inter-agency plans for responding to health protection incidents and emergencies.

Healthcare public health and preventing premature mortality

Objective

Reduced numbers of people living with preventable ill health and people dying prematurely, whilst reducing the gap between communities

Indicators

4.1 Infant mortality* (NHSOF 1.6i)4.2 Tooth decay in children aged 54.3 Mortality rate from causes considered preventable ** (NHSOF 1a)4.4 Under 75 mortality rate from all cardiovascular diseases (including heart disease and stroke)* (NHSOF 1.1)4.5 Under 75 mortality rate from cancer* (NHSOF 1.4i)4.6 Under 75 mortality rate from liver disease* (NHSOF 1.3)4.7 Under 75 mortality rate from respiratory diseases* (NHSOF 1.2)4.8 Mortality rate from communicable diseases4.9 Excess under 75 mortality rate in adults with serious mental illness* (NHSOF 1.5)4.10 Suicide rate4.11 Emergency readmissions within 30 days of discharge from hospital* (NHSOF 3b)4.12 Preventable sight loss4.13 Health-related quality of life for older people4.14 Hip fractures in people aged 65 and over4.15 Excess winter deaths4.16 Estimated diagnosis rate for people with dementia (NHSOF 2.6i)

Improving the wider determinants of health

Objective Improvements against wider factors that affect health and wellbeing and health inequalities

Indicators

- Children in poverty
- Pupil absence
- First-time entrants to the youth justice system
- 16-18 year olds not in education, employment or training
- People in prison who have a mental illness or a significant mental illness
- Killed and seriously injured casualties on England's roads
- Domestic abuse
- Violent crime (including sexual violence)
- Re-offending levels
- The percentage of the population affected by noise
- Statutory homelessness
- Older people's perception of community safety

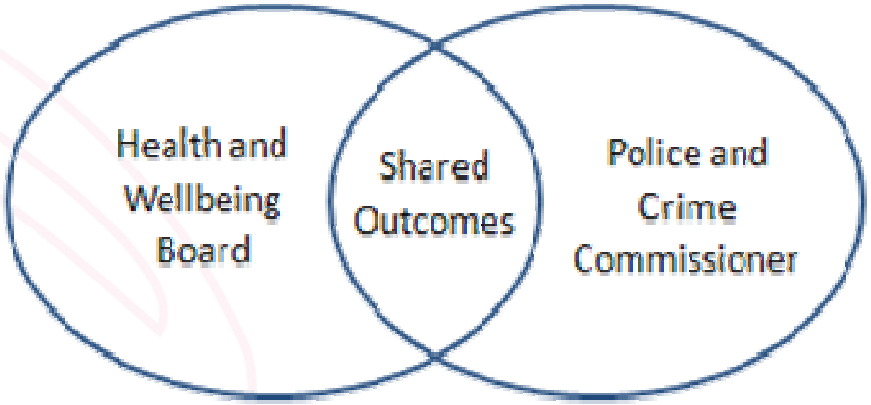
Health Improvement

Objective People are helped to live healthy lifestyles, make healthy choices and reduce health inequalities

Indicators

- Low birth weight of term babies
- Under 18 conceptions*
- Child development at 2-2½ years (under development)
- Hospital admissions caused by unintentional and deliberate injuries in children and young people aged 0-14 and 15-24 years
- Emotional well-being of looked after children
- Self-harm
- Successful completion of drug treatment
- People entering prison with substance dependence issues who are previously not known to community treatment
- Alcohol-related admissions to hospital
- Self-reported wellbeing

Potential shared outcomes across the Outcomes Frameworks



- Public health outcomes framework for England, 2013/2016
- NHS Outcomes Framework 2014/15
- Adult Social Care Outcomes Framework2014/15
- Outcomes aimed at Children and Young People

Health and PCC Commissioning functions

Clinical commissioning groups (CCGs)	NHS Commissioning Board (NHSCB)	Local authorities	Police and Crime Commissioner
• health services for adults and young offenders serving community sentences or completing custodial s sentences on licence, supervised by the local probation trust. • emergency care, including 111, A&E and ambulance services, for prisoners and detainees • mental health services, including assessment at arrest and advice to courts (as well as psychological therapies) • treatment services for children, Including child and adolescent mental health services (CAMHS) • treatment for mental ill health, including community sentences with a mental health treatment requirement • alcohol health workers in a variety of healthcare settings • promoting early diagnosis, as part of community health services and outpatient services • drug misuse advice and treatment in the community, which may form part of other healthcare contacts.	• primary care, including mental health, secondary care, drug and alcohol treatment services • health services (excluding emergency care) and public health services for people in prisons and other custodial settings (adult prisons, young offender institutions, juvenile prisons, secure children's homes, secure training centres, immigration removal centres, police custody suites) • public healthcare for people in prison and other places of detention. • sexual assault referral services (SARCs) • mental health interventions provided under GP contract • some specialised mental health services. • secure psychiatric services • brief drug, alcohol misuse and tobacco control interventions in primary care.	• drug misuse services, prevention and treatment • alcohol misuse services, prevention and treatment • local tobacco control a activity, including stop smoking services, prevention activity, enforcement and communications • sexual health advice, prevention and promotion • mental health promotion, mental illness prevention and suicide prevention • local programmes to address inactivity and other interventions to promote physical activity • adult and young people's social care services • vulnerable adult accommodation services.	• Tackling Crime and Reoffending: • Community Victim Services including crime and ASB incidents • Restorative Justice • Community Action Fund

Health Issues for the OPCC

1. Health Inequalities with a particular focus on victims and offenders

2. Mental Health Crisis Care Concordat – Improving outcomes for people experiencing mental health crisis. Local areas to make sure that:

- Health-based places of safety and beds are available 24/7
- Police custody should not be used because mental health services are not available and police vehicles should also not be used to transfer patients.
- Timescales are put in place response from health and social care workers.
- Information sharing so they can receive the best care possible.
- In areas where black and minority ethnic groups have a higher risk of being detained under the Mental Health Act, this must be
- A 24-hour helpline should be available for people with mental health problems and the crisis resolution team should be accessible 24 hours a day, 7 days a week.

3. Early Intervention and Early Support

4. Addressing unmet physical and mental health needs for young people and adults involved with the criminal justice system.

5.Supporting interventions for adults and young people to address substance misuse use impacting upon crime reduction and reoffending

6. Substance misuse harm reduction (including both legal and illegal drugs and alcohol) and the relationship with crime reduction and the night time economy

7.The provision of improved services for victims who require specialised support services (including domestic abuse, sexual violence, child sexual exploitation and other groups with significant vulnerabilities

8. Sexual Assault Referral Centre, Police Custody Healthcare and Custodial health care provision transfer to NHS England

Moving Forward together

- How we work together
- Identifying and agreeing our joint priorities
- Sharing data and information
- Achieving shared outcomes
- Pan Lancashire / Constabulary wide delivery
- Relative size of budgets
- Commissioning together for Combined effect

Ten questions about working in partnership with PCC and CJS

1. Do board members have an awareness and understanding of the positive local health outcomes linked to improving the health of people in contact with the CJS, including offenders and those at risk of offending or re-offending as well as victims?

2. Does the board have a good understanding of how current investment in the health of people in contact with the CJS is deployed, and the levels of access this provides?

3. Is there a local needs assessment incorporated into JSNAs that identifies the health and social care needs of people in contact with the CJS?

4. Do local commissioning plans explicitly recognise the service needs of offenders and ex-offenders including health and re-offending prevention services?

5. Is there a coherent and agreed partnership strategy with CJS agencies for offender and ex-offender health?

6. Do health and wellbeing board members recognise that new ways of partnership working are required and has consideration been given to how partnership links with local CJS agencies can be strengthened?

7. Is integrated care for people in contact with the CJS commissioned through providers and other organisations with clear shared priorities and vision?

8. Are primary care services aware of the wider needs of people in contact with the CJS and are they able to signpost and refer for example, for housing, employment, benefits etc.

9. Are offenders supported to maintain continuity of health and social care from prison to community?

10. Is there active engagement with different local community groups in contact with the CJS, including offenders and those at risk of offending or re-offending as well as victims?

Ten questions CJS agencies should ask about working in partnership with health and wellbeing boards

1. Do you understand how JSNAs and JHWSs and commissioning plans fit together in the new local health and care system

2. Do you know how to input into and influence JSNAs and JHWSs?

3. Has the health and wellbeing board been made aware of the responsibilities across the local CJS for delivery of local offender and ex-offender health outcomes?

4. Is key evidence (including quantitative data and analysis, and qualitative information) on health and health inequalities among people in contact with the CJS, shared with the health and wellbeing board and member organisations?

5. Do CJS agencies share an awareness and acceptance of the benefits of integrated planning, commissioning and delivery of health and care services across the CJS?

6. Is there a coherent and agreed partnership vision across local CJS agencies for offender and ex-offender health priorities and outcomes that can be shared with the health and wellbeing board?

7. Are all CJS partners open and willing to explore new ways of partnership working?

8. Are local CJS leaders clear about their roles and responsibilities in terms of fostering joint working between CJS agencies and the health and care system at local level?

9. Are CJS agencies willing and able to align their priorities for delivering improved health outcomes in the CJS with those of JHWSs

10. Is there recognition of the benefits from strong and effective leadership, able to influence and motivate across organisational boundaries to translate locally agreed health and wellbeing priorities into action?