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Community safety practice briefing

Primary Care Trusts as responsible authorities

A guide for Crime and Disorder Reduction Partnerships

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The mailing is just one part of our work on community safety. Nacro works with local people, practitioners and inter-agency partnerships to reduce crime levels, lessen the fear of crime and regenerate communities.

Our research, our work with Government and our experience of delivering services at a local level give us an excellent national perspective on what works in community safety and how to adapt and apply this at a local level. Community safety practitioners from a range of community safety partnerships use this expertise at every stage of partnership development. More information is available from the address below.

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The Police Reform Act 2002 gave to Primary Care Trusts (PCTs) responsible authority status in relation to Crime and Disorder Reduction Partnerships (CDRPs). This guide has been written to help CDRPs prepare for this responsible authority status and work more closely with local health agencies.

This briefing applies to England only. Nacro Cymru has published a separate briefing for Welsh agencies. To obtain copies, please contact Nacro Cymru on 01792 450870.

A fuller version of this briefing, containing more information on the structure of the Health Service, will be available from the Nacro website (www.nacro.org.uk) from Summer 2003.

Contents

2	<i>Introduction</i>
2	<i>Why should health services and Crime and Disorder Reduction Partnerships work together?</i>
3	<i>Health agencies: who's who and what they do</i>
5	<i>Information sharing</i>
5	<i>Useful contacts and sources of information</i>
8	<i>Bibliography</i>
8	<i>Footnotes</i>

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Introduction

The role of the NHS in crime reduction has been increasingly highlighted by the work of Youth Offending Teams, Drug Action Teams and Domestic Violence initiatives. These initiatives have shown not only the links between health and crime but also the potential for involving health agencies in partnerships that aim to reduce crime.

This briefing has been written for community safety practitioners who want to bring their local health services more closely into partnership, and help prepare for the Responsible Authority status which Primary Care Trusts will have to exercise following the Police Reform Act 2002.

There are many ways of approaching the concept of health. It is not just absence of disease, but includes a state of physical, psychological and social wellbeing.¹ A range of issues from poor housing to high neighbourhood physical disorder, being a victim of crime and poor access to health care because of the impact of crime on the NHS system can all have an effect on health at individual and population levels.² As part of the restructuring of our public services, an increasing emphasis has been placed on all those services which have a role in improving health – in all its senses – at a population level.

The NHS has a responsibility, with other statutory agencies, for health in its widest sense: public health. The term 'public health' essentially refers to the general state of the population's health, both mental and physical. This is where there is a clear crossover with crime. The poorest communities are likely to have the worst public health as well as high crime. And crime and fear of crime are significant contributory factors to poor public health.

This provides a natural set of policy links and opportunities for action between public health and community safety. Reducing physical disorder in an area will have a health impact as well as a crime and disorder impact.³ There are, similarly, a number of parallels between the process of determining local needs and responding to them.

This framework provides a number of opportunities for action. Reducing crime can help the health services: fewer violent crimes mean fewer resources have to be used on treating the victims and the long-term psychological and physical consequences of crime on health can be reduced.

Why should health services and Crime and Disorder Reduction Partnerships work together?

There are a number of reasons why health services should be more closely engaged in the work of their local crime and disorder reduction partnerships. They include:

- Crime and health are linked both directly and indirectly. Reducing crime improves public health.
- Reducing fear of crime among elderly people can reduce isolation and improve their mental health, as well as saving long-term care beds.
- Early intervention with victims of hate crime and domestic violence reduces long-term physical rehabilitation costs and mental health costs, especially if it targets and prevents repeat victimisation.
- Crime costs health services hundreds of millions of pounds every year and takes resources from patient care.
- Violent crime against health care staff costs upwards of £300 million a year and reduces the effectiveness of health care services.
- Reducing alcohol-related crime reduces injury and alcohol-related harm.
- Violence related injury is expensive to treat: an alcohol related glass injury can cost up to £180,000 to treat, involving as many as 48 different professionals.

The legislative and policy framework

The Police Reform Act 2002 has made some significant changes to the law, which affect how the NHS at local level will need to relate to the CDRP.

Section 97 of the Police Reform Act 2002 amended the Crime and Disorder Act 1998 to specify that responsible authorities shall include Primary Care Trusts.

Section 98 of the Police Reform Act also gave the Secretary of State new powers⁴ to order that two or more CDRPs effectively combine as if they were one, if s/he 'considers it would be in the interests of reducing crime and disorder, or of combating the misuse of drugs, to make the order'.

The Police Reform Act also makes a number of potentially substantial changes in relation to drugs. Notwithstanding the existence of local Drug Action Teams (DATs) in England and

Drug and Alcohol Action Teams in Wales, the Police Reform Act 2002, Section 97, amends the Crime and Disorder Act 1998 to state that the responsible authorities for each Local Government area in England shall:

- Produce an audit of crime and disorder and a crime reduction strategy.
- Produce an audit of drug misuse and a drug misuse reduction strategy. Guidance is still awaited on how this will be implemented.

Other parts of the generic policy framework clearly require action on health inequalities and demonstrate that there are links between poor health and crime:

- Saving Lives: Our Healthier Nation states its aims as being the improvement of health and reduction of health inequalities, and sets targets to prevent up to 30,000 untimely and unnecessary deaths by 2010.
- The Mental Health, Accidents and Coronary Heart Disease and Stroke (alcohol and tobacco) aims can be related to crime reduction work. These objectives can be found on the Our Healthier Nation website (www.ohn.doh.gov.uk/). Taking action to reduce alcohol related ill-health can be linked to reducing alcohol-related violence.
- Guidance has been issued on Youth Offending Teams and NHS responsibilities: HSC 1998/177 requires health authorities to discuss with local authorities 'the availability of, and access to, health services relevant to preventing young people offending or re-offending.'

Health agencies: who's who and what they do

The National Health Service was set up in 1948. It is the largest organisation of its kind in Europe. As such, it is extremely complex, costs £50 billion per annum to run and has been reorganised many times over the past 50 years. At the time of writing, Government intends to increase real spending on the NHS by up to 43% over 5 years.⁵ Profound structural and organisational change is accompanying this. NHS structure is partly dictated by history and partly dictated by successive reorganisation. The latest reorganisation brought about Primary Care Trusts,⁶ who will be the key agencies at local level with whom CDRPs will need to liaise. The reorganisation sought to redress what was often regarded as a 'postcode lottery' in services and promote a more strategic perspective, increase the importance of primary care and empower front line staff.

Primary Care Trusts

Apart from now becoming responsible authorities for the purposes of the Crime and Disorder Act 1998,⁷ PCTs:

- Have a statutory duty to identify the health needs of local people.
- Plan for delivering healthcare services to meet the needs and improve the health of the local population.
- Work with and commission NHS trusts, primary care and other agencies, including voluntary agencies and local authorities to deliver these.

A board of executive directors (made up from PCT senior staff) and non-executive directors (appointed by the government who may include local councils) runs each PCT. The chair is a non-executive post.

Each PCT has a chief executive and a director of public health (some PCTs share a Director of Public Health). PCTs will also be responsible for setting local targets to drive quality and working in partnership with other agencies to deliver the NHS Plan, which is set by the Dept of Health. Many PCTs are coterminous with local authorities, but many are not. Some PCTs cover two or more local authorities.

Which health agencies should you be talking to?

To work effectively with the NHS, CDRPs need to involve people at a strategic level in PCTs, usually at Director of Commissioning or Director of Public Health level, as well as have a way of feeding into provider agencies (NHS Trusts, GPs, etc.). There is a clear agenda for collaboration:

- Helping the PCT to exercise its function as a responsible authority.
- Auditing the skills, knowledge, expertise and support the NHS can bring to the partnership, and vice versa.
- Ensuring that Local Delivery Plans and Crime and Disorder Reduction Strategies are aligned. (Addressing the public health and community safety issues of alcohol, or domestic violence, might provide a good starting point.)
- Ensuring that the Drugs Audits and Strategies result in a balanced strategy for response to drugs in an area, and that the responsible authorities ensure the work done by DATs over the preceding years is reflected in the strategy.⁸

- From a perspective that public health and community safety have strong overlaps, working to ensure each mainstreams the ethos of the other.

Involvement at a locality level for district nurses might be suitable where front-line practitioners are discussing specific problems.

A useful means of liaising with the NHS may be to ask the NHS to handle internal liaison between NHS agencies and have one key representative. This may be most useful where, for example, one CDRP covers two NHS trusts, a PCT and several other agencies.

The Health and Social Care Act 2012 ss 7-10⁹ established a right for 'top-tier' local authorities (ie councils that are Social Services Authorities) to exercise scrutiny over NHS agencies through its scrutiny function. This is discussed in more detail in the on-line version of this briefing. Local elected councillors have the power to question the chief executive of the local primary care trust about their plans and decisions, and to consider local health issues (eg the health impact of an issue) and make recommendations to the NHS. The Overview and Scrutiny Committee can make recommendations and revisit them in the future. The NHS must give good reason if it declines to accept or act on any recommendation made. A range of provisions exist in the draft guidance.¹⁰ Using a scrutiny exercise to apply the

principles of mainstreaming (s.17, Crime and Disorder Act 1998) to NHS and NHS and Local Authority Joint Services may be extremely valuable, but CDRPs should ensure that is a means whereby the local authority and NHS together explore how they can all benefit the wellbeing of their population.

Local policy level

Each PCT must set a Local Delivery Plan,¹¹ which relevant agencies can contribute to. This must take account of national guidance and targets (Our Healthier Nation, etc) as well as local priorities. The Plan is the primary health strategy document for any local area. Plans should, as a matter of good practice, reflect appropriate CDRP priorities and vice versa. Health inequalities targets within these Plans may be relevant to CDRPs and other agencies involved in the criminal justice system.

The NHS should be represented at CDRPs for two purposes. The first, obviously, is as a Responsible Authority through the PCT, sharing the duties of producing the audit and strategy, and implementing these.

The second is to look at the relationships between crime and disorder and health. These have been discussed in McManus

Table 1 Examples of analysing impacts of crime and disorder on health

	Material	Psychological
Individual	<ul style="list-style-type: none"> ● Repeat victimisation for domestic violence impacts on physical and mental health. What can the NHS do to reduce this? 	<ul style="list-style-type: none"> ● Psychological trauma from burglary on elderly people can impact on their wellbeing and independence, and increase demand on care services. What can the NHS and CDRP do together to prevent repeat victimisation and consequent costs on care services?
Environmental	<ul style="list-style-type: none"> ● Repeat victimisation for domestic violence may be made more difficult to reduce because of the way services are configured. What can the NHS do to resolve this? ● High crime and disorder in a neighbourhood can reduce access to health care because NHS premises and staff are attacked or vandalised. What can the CDRP do to help the NHS remain a presence in the area? ● Where is there crossover between Crime and Disorder Reduction Strategies and those parts of Local Delivery Plans that relate to health inequalities? 	<ul style="list-style-type: none"> ● High physical disorder and crime rates in an area can impact on people's psychological wellbeing. To what extent can an LSP's regeneration initiative both reduce crime and physical disorder, and address fear of crime and mental health?

(2001). There are many areas where the Local Delivery Plan and CDRP Strategy can overlap. A useful way of looking at these is outlined in Table 1.

Information sharing

Section 115 of the Crime & Disorder Act discusses the issues about sharing of information. The Confidentiality Issues Section of the NHS Executive has issued guidance to Health Authorities and Trusts in the form of the Crime & Disorder Act 1998: Protocols. HSC 1998/177 requires local authorities and Health Authorities to facilitate 'arrangements for the sharing of information among professionals and agencies'. Most recently, a key target arising from Shifting the Balance of Power¹² has been to deliver an Information Governance Strategy. Strategic Health Authorities will be closely involved in this work but it will affect the whole NHS.¹³ Information Governance includes confidentiality, access, law and ethics. It will have profound implications for how CDRPs liaise with NHS agencies over information and the Caldicott Guidance¹⁴ (every PCT and NHS Trust will have someone responsible for handling this, known as a Caldicott Guardian) governs sharing information. There is still some way to go to build trust in NHS agencies over sharing of information, despite recent case law.¹⁵

A strategy for starting work on effective protocol development would involve an NHS agency in going through the following process internally and with partner agencies:

- Which information will be shared? Which victims, offences, offenders and situations?
- Will the information be anonymised or not?
- Why is information being shared? What are the reasons for sharing or not sharing?
- Who gives and receives the information?
- How will the information be shared? Will there be informal arrangements, a protocol, or joint training and ownership?
- Compare the result with legal precedent, existing good practice and other areas.

In particular, it is essential to think about how to minimise the problem by using creative solutions. For example, the Cardiff Violence Prevention Group has designed a form to enable local Accident & Emergency departments to contribute to crime audits, by obtaining consent from the patient when the data is collected.

Table 2, on the next page, outlines what data can be obtained from what parts of the NHS.

Useful contacts and sources of information

The **NHS Confederation** is a bit like an NHS version of the Local Government Association. It produces useful briefing papers and is a source of useful information.
www.nhsconfed.net.

The **Department of Health** website contains information, and DoH documents and circulars.
www.doh.gov.uk

The **National Electronic Library for Health** provides a key resource for accessing publications, relevant information and other sources on health issues. It provides free access to the Cochrane Library of evidence-based practice and sections on Health Needs Assessment.
www.nlh.nhs.uk

The **Our Healthier Nation** website contains information on Our Healthier Nation action, a database of projects, links to good practice and Health Action Zones.
www.ohn.doh.gov.uk

The **King's Fund** is a source of policy and research information.
www.kingsfund.org.uk

The **Health Development Agency**
www.hda-online.org.uk

The **Institute of Healthcare Management** provides information on healthcare management and up to date information on changes in policy.
www.ihm.co.uk

The **Health Service Journal** is available weekly in newsagents or online.
www.hsj.co.uk

The **Cardiff Violence Prevention Group** is made up of representatives from the NHS and other agencies. It produces detailed intelligence on the health effects of violence and hate crime from Accident & Emergency data, as well as evaluations of the impact of CCTV, etc. Contact Professor Jonathan Shepherd; tel 02920 742442; email Shepherdjp@Cardiff.ac.uk.

The **UK Public Health Association** brings together people from all agencies and disciplines (local authority, NHS, education, etc) with an interest in public health. They organise regional and special interest networks and an annual forum.
www.ukpha.org.uk

Table 2 What information can CDRPs access from which parts of the NHS?

Agency	Data that could be obtained
Ambulance NHS Trust / Service	<ul style="list-style-type: none"> ● Emergency calls ● Ambulance callouts ● Violent incidents against ambulance staff and resources ● Injuries related to night-time economy
Accident & Emergency. See Sivarajasingam, V et al. (2002) for a fuller discussion.	<ul style="list-style-type: none"> ● Violent injuries ● Domestic violence ● Elderly people - falls ● Young people - injuries ● Drug related poisoning deaths ● Drug related attendances ● Alcohol related attendances
Drugs agencies	<ul style="list-style-type: none"> ● Numbers of persons attending using which substances ● Age distribution, gender, types of substances
Acute Health Services NHS Trusts / Foundation Hospitals	<ul style="list-style-type: none"> ● Attacks on staff ● Crime on NHS property and estate ● Hospital episodes related to violence or crime, drugs or alcohol (ICD-10 codes)
Children & Adolescent Mental Health Services	<ul style="list-style-type: none"> ● Drugs and young people ● Abuse caseloads
Psychology Services	<ul style="list-style-type: none"> ● Caseload of victims of injury/violence or harassment

<p>Community and Mental Health NHS Trust</p>	<ul style="list-style-type: none"> ● Mentally disordered offenders ● Dual diagnosis ● People with learning difficulties (vulnerable to assault, sexual assault, etc) ● Attacks on staff ● Crime on NHS property and estate
<p>Public Health Function (PCT in England, Local Health Boards in Wales)</p>	<ul style="list-style-type: none"> ● Surveillance data on health inequalities ● Public health common data ● Surveillance of specific diseases of interest (eg Hepatitis C in drug users) ● Drug misuse database figures from the regional drugs misuse database
<p>Health Promotion</p>	<ul style="list-style-type: none"> ● Access to research on specific communities of interest or identity (gay and bisexual men, young people, sex workers)
<p>Primary Care Trusts (England)</p>	<ul style="list-style-type: none"> ● Information on assaults on GP and primary care staff (health visitors, etc) ● The NHS is also responsible for leading on prison health care and as such information on planning for needs of prisoners released from custody (eg drug use needs, mental health needs, etc) could be important in promoting resettlement planning as a community safety activity.
<p>Workforce Development Confederations</p>	<ul style="list-style-type: none"> ● Information on training and induction for staff ● HR plans for the NHS and Social Care

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Footnotes

1 DoH (1998)

2 DoH (1998)

3 In fact a whole field has grown up around health and social impact analysis.

4 Essentially by amending Section 5(1) of the Crime and Disorder Act 1998 by inserting Subsections 1A and 1B.

5 Raftery (2003)

6 DoH (2001a, b & 2002)

7 Police Reform Act s.97 and s.98

8 Guidance is still awaited on how the drugs strategies are to be produced, and much will depend on how these sit with (or indeed replace) the DAT Plans produced by Drug Action Teams, and the role of agencies such as the Drugs Prevention Advisory Service (Home Office) and the National Treatment Agency (NHS).

9 With an amendment made by the NHS Reform and Health Care Professions Act 2002.

10 Dept of Health, Draft Guidance, 2002. www.doh.gov.uk

11 The following Health Service Circulars HSC 1998/121, 1998/129, HSC 1998/167, HSC 2002/007 and LAC (98) 23 are also relevant.

12 DoH (2001a)

13 www.doh.gov.uk/ipu/stbop/governance.htm

14 www.doh.gov.uk/ipu/confiden
See Also CI (2000)8 on casework information needs in the criminal justice systems.

15 McManus (2001) summarises case law on NHS information sharing. Sharing of anonymised data is recognised by the Courts as a free good.

Nacro has wide experience of working with local partnerships that are engaging health services more closely in community safety. If you would like further information on the services we offer, please contact us at the address on the front cover of this briefing.