



## **Safe and healthy**

*A guide to partnership between health authorities and  
community safety partnerships*

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*This is a practical guide for community safety practitioners who are looking to work in partnership with health agencies. It covers:*

- *Why – the reasons for partnership with health agencies*
- *Who – the main players in the NHS and their responsibilities*
- *How – a plan to help you work together effectively*

### **Contents**

2	Introduction	10	Useful contacts and sources of information
2	Why should health services and crime and disorder partnerships work together?	11	Bibliography and further reading
4	Partnership working with health services: making it work	11	Footnotes
4	Health agencies: who's who and what they do		
6	A plan for involving local health agencies in your community safety partnership		
9	The way forward		

*This guide is for members of crime and disorder reduction partnerships wishing to work more closely with local health agencies. Nacro also publishes Better health, lower crime: a briefing for the NHS and partner agencies, generously supported by the King's Fund, which briefs health service professionals on why and how they should be working with community safety partnerships to reduce crime. If you would like copies to give to your local health service colleagues, please contact David Mullett, Publications Officer, Nacro Crime and Social Policy Section, 237 Queenstown Road, London SW8 3NP; t 020 7501 0555; f 020 7501 0556; e david.mullett@nacrocsp.org.uk.*

## Introduction

In recent months 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. The developing Health Action Zone programme can be added to this list. 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. It starts by summarising some of the reasons why such partnership work should be developed. We then give a brief guide to NHS jargon for non-health professionals and finish by giving practical suggestions on how such partnership might be achieved. For best results, you should use this briefing in tandem with our briefing for health professionals, *Better health, lower crime* (details on p. 1).

Health is not just about treating illnesses; the health system is not just about the NHS. Local Authorities have a public health role through its environmental health, social services and public protection functions. Public health is about the prevention of risks to the well-being of our community. This involves a range of activities from controlling unsafe goods and services to reducing inequalities in health caused by lack of access to services, disadvantage and the social, psychological, economic and physical effects of crime and disorder. In this sense, promoting good public health is a function for all statutory agencies involved in crime and disorder partnerships. The issue of 'health inequalities' has become a major theme in public policy over the last four or five years. The Acheson Report (*Report of the Independent Enquiry into Inequalities in Health*, HMSO, 1998) highlighted the links between health inequalities and crime by recommending the 'development of policies to reduce the fear of crime and violence, and to create a safe environment for people to live in.'<sup>1</sup>

This recommendation takes forward the recognition that healthy neighbourhoods and communities are safer neighbourhoods and communities. From this point of view the White Paper *Saving Lives: Our Healthier Nation* (Department of Health, 1998) recognised the importance of what is often called the 'Healthy Settings Approach': working in settings like the workplace and neighbourhoods to improve health. There are important and natural links here between community safety strategies and Health Improvement Plans (which Health Authorities must produce.)

In the narrow sense of the word, the health services within the NHS are there to; make people better – to treat them when they are injured or ill; and prevent and reduce ill-health. 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.

But the health service also 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.

Reducing crime and improving public health go hand-in-hand: a safer community is a healthier community. Partnership working benefits both community safety practitioners and health professionals. As the white paper on health, *Saving Lives: Our Healthier Nation* puts it, we need to work together to 'bridge the gap between the most deprived neighbourhoods and the rest of England; and in all the worst neighbourhoods, to achieve ... less crime [and] better health.'

## Why should health services and crime and disorder partnerships work together?

The reasons why health services should be more closely engaged in the work of their local crime and disorder reduction partnerships 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 (nervous system, liver, alcohol poisoning, etc)

Recent government policy and legislation has focused on the need for local agencies to work in partnership. There is an important benefit to be gained from this: the fact that there are tremendous opportunities to re-invest resources currently wasted as a result of crime in other parts of the public health system.

## *The negative effects of crime on public health*

The most obvious categories where crime has a direct impact on health are:

- interpersonal violence and injuries
- road traffic accidents through dangerous driving
- homicide

There are others. These include:

- drug and alcohol-related problems
- long-term physical or psychological disability from injuries, muggings, etc

Violence is and remains a major public health issue in the UK and internationally.<sup>2</sup> Interpersonal violence is the third most common cause of death and ninth most common cause of illness or disease for males and females aged 15–44 in European Region High Income Countries.<sup>3</sup> Homicides are mainly committed by young men; drugs and alcohol are often a contributory factor.

In addition to these most obvious effects, there are a range of other longer-term ones for which figures are more difficult to estimate. Some were highlighted by the World Health Organisation in 1994.<sup>4</sup> They include:

- long-term effects of injury and violence, including self-harm, eating disorders, stress, poor wound healing, decline in health and permanent disability
- mental health problems, including self-harm, eating disorders, stress, poor wound healing, decline in health and permanent disability
- psychiatric and psychological consequences of repeat victimisation and hate crimes, including self-harm, eating disorders, stress, poor wound healing, decline in health and permanent disability

There is ample evidence about the long-term physical and psychological deterioration of those who suffer stress, fear of crime and repeat victimisation.<sup>5</sup> For instance, long-term persistent pain without injury (causalgia) and other physical and psychological complications frequently occur in people who have been victims of violence after the wounds have healed.<sup>6</sup>

Crime also has major effects on health through drug and alcohol use. This ranges from alcohol and drug-driven crime to accidental injury, poisoning and adverse reaction to drug use and a range of long-term effects.

## *The indirect effects of inequalities*

People living in disadvantaged circumstances can expect to experience more disability and illness. 10 per cent of communities – those already most badly affected by

health inequalities and poverty – suffer 40 per cent of crime. The same 10 per cent of communities feature on surveys of the worst levels of mental health, employment opportunity, educational attainment and economic success. Health inequality, social exclusion, poverty and the effects of crime are all intertwined. As Recommendation 13 of the *Report of the Independent Inquiry into Inequalities in Health* says: the ‘development of policies to reduce the fear of crime and violence, and to create a safe environment for people to live in.’

The Acheson Report in 1998 summarised and enhanced the growing trend of evidence on indirect effects of crime and health inequalities.<sup>7</sup> *Reducing Inequalities in Health* went on to state that the New Deal for Communities, Single Regeneration Budget and the national drugs strategy were all areas of action on health and crime.<sup>8</sup> Building stronger communities is part of this – as it is part of crime reduction, because stronger communities are (generally) safer communities.

## *The effects of crime on NHS resources*

Based on government statistics, treating crime-related illness and injury costs the NHS between £1.1 and £2.3 billion per year.<sup>9</sup> (However, it should be noted that this is a crude estimate only and it would require much greater work to produce an accurate figure.) Robinson *et al.* report that in Greater London the health related cost of crime could be £189 million per annum.

This does not include the costs to the NHS in terms of property damage, risk, liability or injury to staff. No reliable figures are available for this but estimates vary between £300 million and £678 million per annum.<sup>10</sup>

It is obvious that crime has an effect on the health system. The NHS Executive estimates that approximately 65,000 violent incidents against NHS staff are recorded every year.<sup>11</sup> The costs in sick pay, trauma to staff and colleagues, impaired patient care and fees for legal action has to be diverted from providing services.

Even a small reduction in crime would save the NHS tens of millions of pounds per year.

## *The legislative and policy framework*

There is a clear legislative and policy framework for NHS and other partners to work together on crime and health. Police, local authorities and the NHS can be brought together to form powerful alliances for action.

Working together to tackle problems, involving local communities and achieving Best Value in doing so are all key policy principles in community safety. So too is ensuring the widest and most comprehensive action to tackle the range of problems facing our communities. The same is true of the NHS. The new policy framework

for the NHS requires the NHS and other agencies to work together for better public health in its widest sense.

Health Authorities and NHS bodies<sup>12</sup> have raised the point that there is no guidance to the NHS in the form of a Health Service Circular on Health and Crime, and therefore the NHS finds it difficult to find a role for itself in this area. You may well find this used as a reason to resist closer partnership working.

This, however, is not a sustainable argument. The generic policy framework clearly requires action on health inequalities and has demonstrated that there are links between poor health and crime. Specific examples include:

- *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 work on crime and disorder. These objectives can all be found on the *Our Healthier Nation* website. ([www.doh.gov.uk/ohn.htm](http://www.doh.gov.uk/ohn.htm)). Taking action to reduce alcohol-related ill-health can be linked to reducing alcohol-related violence.
- Guidance has been issued in relation to Youth Offending Teams and NHS responsibilities: HSC 1998/177 requires health authorities in conjunction with local authorities to discuss 'the availability of, and access to, health services relevant to preventing young people offending or re-offending.'

There are some good examples of practice where *Saving Lives: Our Healthier Nation* targets and community safety aims have been combined:

- Teignbridge Borough Council and South & West Devon Health Authority are providing a skills programme for young people designed to reduce risk from accidents, improve hazard awareness, tackle peer pressure and improve safety.
- Redbridge & Waltham Forest Health Authority is leading the 'Health Ladder to Social Inclusion' SRB project, in association with its local authority partners. This project aims to regenerate the local area and reduce health inequalities, disadvantage and crime in the process.
- The Better South Derbyshire Group is working to address health inequalities and reduce crime and disorder victimisation with black and minority ethnic communities in South Derbyshire.
- In Brighton & Hove a unit is being set up to tackle hate crime. The unit will include members from the police, NHS, local authority and community representatives, including black and minority ethnic communities, women's agencies and the lesbian and gay population.

There is a major focus on the NHS playing a part to address health within the wider system of all public services, and a new culture of partnership and efficiency is promoted. Specific statutory duties on the NHS in this area include:

- Section 22 of the NHS Act 1977, as amended by Section 28 of the Health Act 1999 imposes a duty to support and co-operate with local authorities. Co-operation here will underpin the duty to co-operate under S5(2) of the Crime & Disorder Act 1998.
- Specific arrangements that will enable joint financial investment are outlined in Sections 30 and 31 of the 1999 Act. This will underpin joint work in relation to local crime strategies.
- The National Performance Assessment Framework supports comprehensive NHS response to crime and disorder. This can be linked to Best Value frameworks in local authorities and the police.
- Guidance on managing violence against staff was issued to Health Authorities and NHS Trusts in HSC1999/226 and HSC 1999/229.

### Partnership working with health services: making it work

Engaging with health services can be a challenging experience. It is not always obvious where contacts should be made and who has the power to do what; and different cultures can make it seem like health professionals are talking a different language from community safety practitioners. The following sections give some help on how the process of engagement can be made smoother and more effective – starting with a little jargon-busting for non-health professionals.

### 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. Its structure is partly dictated by history and partly dictated by successive reorganisation. The latest reorganisation sought to redress what was often regarded as a 'postcode lottery' in services and promote a more strategic perspective.

The **Department of Health** (DoH) sets health policy and the **NHS Executive** (an executive agency of the DoH) puts it into practice.

The NHS Executive is responsible for performance management of the NHS and the overall staffing, funding and running of it. The NHS Executive also has **eight regional offices**, which equate roughly to

Government Regional Offices. Each regional office performance monitors Health Authorities locally as well as having regional public health and research & development functions. These offices replaced the old Regional Health Authorities in 1996.

At local level (District) **Health Authorities** have a statutory duty to identify the health needs of local people and make arrangements for services to be provided by NHS trusts, primary care and other agencies, including voluntary agencies and health authorities (see below for a discussion of the functions of these various agencies). You may have heard of 'commissioners' or 'purchasers' in health discussions. This is a shorthand way of referring to what Health Authorities do: they commission or purchase services from providers. A board of executive directors appointed by the chair of the health authority and non-executive directors appointed by the government runs each health authority. The chair is a non-executive post. Each Health Authority has a chief executive and a director of public health. Health Authorities will also be responsible for supporting the development of Primary Care Groups and allocating resources to them, setting local targets to drive quality and working in partnership with other agencies.

There are also a number of **Special Health Authorities** across England & Wales that handle specific functions:

- The **National Blood Authority** has responsibility for blood transfusion and the quality of blood.
- The **National Institute for Clinical Excellence** was set up in 1999 to promote quality of treatment, technology and cost-effectiveness in NHS services. It gives advice on best practice to health authorities and primary care groups/trusts provider agencies, patients and their carers.
- The **Commission for Health Improvement** was also set up in 1999. It is an independent inspectorate and is charged with ensuring that policies and guidance are followed and standards met.
- The **Health Development Agency**, which was set up in 2000 to replace the **Health Education Authority**, exists to research and collate evidence on what works in improving public health and provide advice on best practice.

**Primary care** is the range of services provided in the community through **GPs** and **Health Centres**. This includes practice nurses and very often a range of services from district nursing, through travel clinics, child clinics and ante-natal services, to some kinds of community chiropody and dentistry for specific groups such as elderly people. Until recently some GPs held their own budgets. They were called 'fundholders.' The 1999 Health Act abolished fundholding. **NHS Walk-in**

**Centres** around the country are also part of the primary care network.

The recent reorganisation created new bodies called **Primary Care Groups (PCGs)** and **Primary Care Trusts (PCTs)**. PCGs are mandatory and universal: every area is covered by one. A PCG covers a number of local GP practices in an area (usually covering an area with a population of about 100–200,000) and has a governing body which includes community nursing and social services representatives as well as GPs. PCGs can contribute to the Health Authority's Health Improvement Plan and take responsibility for the budget for healthcare in their part of the Health Authority's area. They can themselves commission services from relevant NHS Trusts. They must also monitor performance and seek to integrate services, as well as having clear arrangements for public involvement.

PCTs are essentially a development from PCGs. They have greater independence than PCGs (although they still remain accountable to the Health Authority) and combine the strategic functions of PCGs with the provider functions of NHS Trusts for some kinds of service. About 70 per cent of areas have expressed an interest in bidding to become PCTs.

**NHS Trusts** are found in almost all areas. They offer a general range of services to meet most people's needs. Most Trusts provide either acute (eg general hospital) services or community and mental health (eg drugs, community health, health visitors, etc) services. Some Trusts provide services across the range. **Ambulance services** are also NHS Trusts. Some trusts are regional or national centres for more specialised care, such as coronary care or neurosciences.

*Which health agencies should you be talking to?*

To work effectively with the NHS, community safety partnerships need to involve people at a strategic level (ie health authorities, PCTs and PCGs), as well as have a way of feeding into provider agencies (NHS Trusts, GPs, etc.) Involvement at a locality level for district nurses might be suitable where front-line practitioners are discussing specific problems. At the level of a Responsible Authority Group, involvement is likely to be needed from the Chief Executive or Director of Public Health of the Health Authority, or from the Chief Executive of appropriate PCGs/PCTs.

*The policy framework*

To add to the complexity, there are also a range of national and local policy frameworks. Crime and disorder work can benefit from rigorous thought and analysis of NHS policy.

## The national policy framework

Apart from the significant amount of reorganisation which has been driven by National Level including the white paper *The New NHS* (DoH, 1999) and *The NHS Plan* (DoH, 2000) there are a range of new policy frameworks:

- **The New NHS** and the **NHS Plan** drive structure and strategic organisation for the NHS
- **Saving Lives: Our Healthier Nation** drives public health aims for action by the NHS and partners on areas such as mental health and accidents.
- **National Priorities Guidance** is issued annually. It gives the NHS lead responsibility on developing primary care, coronary heart disease, cancer and other issues, and joint lead with social services on mental health services and reducing inequalities in health.
- **National Service Frameworks** establish national standards for services in order to improve quality and reduce unacceptable variations in standards of care and treatment. They already exist for mental health, cancer and coronary heart disease and will be produced for more areas (including elderly people) in coming years.
- The **National Framework for Assessing Performance** stipulates arrangements for assessing performance in providing services.
- A range of **Health Service Circulars** and other documents (available from the Department of Health website: [www.doh.gov.uk](http://www.doh.gov.uk)) stipulate policy requirements on specific issues. The key circulars that are relevant to crime and disorder are listed in the **References and further reading**.

All of these areas should feed into local policy: each section of the NHS has a duty to ensure they follow this guidance where applicable to them.

## The local policy level

Each local Health Authority must set a **Health Improvement Plan** (HimP), which Primary Care Groups and Primary Care Trusts can contribute to and must work within. The HimP must take account of national guidance and targets (*Our Healthier Nation*, etc) as well as local priorities. The HimP is the primary health strategy document for any local area.

Primary Care Groups are responsible for developing **Primary Care Investment Plans** (PCIPs). These documents give a baseline requirement for infrastructure, workforce issues, and community and secondary level services in GP practices. They also include plans for new services.

Other plans also exist. They include: **Local Drug Action Strategies**, **Community Care Plans** and **Children's**

**Service Plans**. All these plans should be developed jointly between Local Authorities, Health Authorities and other relevant agencies.

A significant range of opportunities has been created by the recent changes in policy and legislation. The Health Act 1999, for example, allowed a range of joint arrangements to be developed between local authorities and health authorities. These replaced the old Joint Consultative Committees. Examples of this in practice are:

- In Herefordshire a single person is Chief Executive of the Health Authority, Director of Housing and Director of Social Services.
- In Manchester the Health Authority produced an analysis of crime and health in its area and has identified a range of action and opportunities for the NHS in partnership with other agencies. (See **Case Study** below.)

A number of **Health Action Zones** (HAZs) have been established in England. These were intended to be an opportunity for inter-agency action at local level. While the HAZ programme may prove to be groundbreaking, the principles underpinning HAZs (direct, local, multi-agency, strategic action to improve health and reduce inequalities) should already be contained in HimPs (see the DoH Circular *HC1999/244*). In reality, many commentators suggest the HAZ initiative is largely unnecessary except as a means of directing funding to areas of particular need: the lack of a Health Action Zone should not in any way hinder inter-agency involvement.

We have already seen that Health Authorities are to provide strategic leadership in partnership with NHS Trusts, Primary Care Groups and Primary Care Trusts. This is important in the crime and disorder framework and should end the perceived fragmentation and dissonance within the NHS that often greets other agencies trying to get NHS commitment to a programme of policy or action on crime and disorder. A useful approach for many local crime and disorder partnerships to take would be to work jointly with their Regional Crime Director and Regional NHS Executive to develop a strategic approach. This enables good practice to be shared across the region.

## A plan for involving local health agencies in your community safety partnership

There are several key steps in getting NHS involvement in crime and disorder reduction strategies. Many of them are applicable to all partners but some are specific to local health agencies only. (More detailed plans for health agencies are included in our briefing *Better health, lower crime*; the two plans should be used in tandem. For how to obtain copies, see front cover.) We have summarised the steps in the following table.

	<b>Getting started</b>	<b>Steps for the NHS</b>	<b>Steps for partner agencies</b>
<b>Clarification of roles and contribution</b>	<ul style="list-style-type: none"> <li>• Get to know legislative framework.</li> <li>• Each agency brainstorms internally, then together.</li> <li>• Understand relationships between crime and health at preventive, remedial, strategic and individual levels.</li> <li>• Agree framework between partners for taking issues forward.</li> </ul>	<ul style="list-style-type: none"> <li>• Develop a list of key points and area of action.</li> <li>• Study the issues and the contribution of health services to partnership.</li> <li>• Include crime and health issues in strategic framework for all partner agencies.</li> </ul>	<ul style="list-style-type: none"> <li>• Develop a list of where existing policies and strategies link with health issues, as an agenda for discussion.</li> <li>• Conduct regular Best Value benchmarking against other partnerships.</li> <li>• Learn from Drug Action Team and Social Services joint working experience.</li> </ul>
<b>Enable health agencies to contribute</b>	<ul style="list-style-type: none"> <li>• A person with lead responsibility should be appointed from the local health services. (This should be someone senior enough to take decisions.)</li> <li>• Get co-ordination and agreement across all local health agencies.</li> <li>• Develop framework for sharing information.</li> </ul>	<ul style="list-style-type: none"> <li>• Set up a working group (NHS Health &amp; Crime Task Group) to coordinate the work of various local health agencies.</li> </ul>	<ul style="list-style-type: none"> <li>• Brief NHS agencies and key internal stakeholders on what has been achieved to date.</li> <li>• All partners produce a detailed continuous improvement plan.</li> <li>• Work with health agencies to incorporate this plan into the commissioning process and performance frameworks.</li> </ul>
<b>Auditing</b>	<ul style="list-style-type: none"> <li>• Carry out a rapid review of research and evidence to assess what can be done.</li> <li>• Carry out a rapid review of what is already being done.</li> <li>• Create a joint working party on health and crime auditing issues.</li> </ul>	<ul style="list-style-type: none"> <li>• Carry out effectiveness audits.</li> <li>• Conduct an epidemiological study or confidential inquiry into areas of specific interest.</li> <li>• Link GIS systems for health and crime planning.</li> </ul>	<ul style="list-style-type: none"> <li>• Carry out detailed research on the agencies links with health aspects of crime and disorder..</li> </ul>
<b>Target setting and strategic planning</b>	<ul style="list-style-type: none"> <li>• Include local health targets and strategy in crime reduction strategy.</li> <li>• Include a health section in audit and strategy.</li> <li>• Commit to Best Value/ Business Excellence as a framework.</li> <li>• Health agencies include statement on developing the plan in PCIP, Himp, SSAF and JIP.</li> <li>• Design strategy to take forward cross-cutting review that includes health agencies.</li> </ul>	<ul style="list-style-type: none"> <li>• Use the NHS Health &amp; Crime Task Group to help develop the health section of the strategy.</li> <li>• Combine mechanisms for community consultation on crime and health.</li> </ul>	<ul style="list-style-type: none"> <li>• Focus on themes for specific action and purchasing each year.</li> <li>• Review progress jointly with partners and realign NHS purchasing plans.</li> </ul>

<b>Culture and delivery</b>	<ul style="list-style-type: none"> <li>• Ensure the production of joint information and training strategies and protocols.</li> <li>• Ensure that clinical governance frameworks in local health agencies take crime and disorder into account.</li> </ul>	<ul style="list-style-type: none"> <li>• Ensure a diversity of professions is represented on the working group to produce an holistic response to health and crime.</li> </ul>	<ul style="list-style-type: none"> <li>• Use staff training and information systems to reinforce the message of partnership working to improve health and reduce crime.</li> </ul>
<b>Evaluation</b>	<ul style="list-style-type: none"> <li>• Evaluate outcomes and processes of current provision and planning.</li> </ul>	<ul style="list-style-type: none"> <li>• Health services to include outcomes and processes within Performance Assessment Framework.</li> </ul>	<ul style="list-style-type: none"> <li>• Conduct multi-agency partner evaluations of work done.</li> </ul>

### **Mental illness: a model for partnership working**

The Report of the Confidential Inquiry made a number of recommendations for action on preventing homicide and suicide by people with mental illness. These recommendations cover a multi-agency approach to:

- prevention
- diagnoses
- screening
- suitable assessment
- ongoing support
- after-discharge care
- care planning

It is clear from this report that there are significant opportunities for work on mental health related and on violence and drug/ alcohol use between all the relevant agencies in a Crime & Disorder Partnership.

### **Target alignment**

*Our Healthier Nation* sets the following targets:

- reducing the death rate from suicide and undetermined injury by 20 per cent
- reducing deaths from accidents by 20 per cent and serious injuries by 10 per cent
- reducing death rates from heart disease, stroke and related illnesses among people aged under 75years by at least 40 per cent (which in practice will involve lessening the abuse of alcohol, drugs and tobacco)

These provide an immediate starting point for co-operation between Drug Action Teams, crime and disorder reduction partnerships and the NHS. The work of Drug Action Teams themselves in taking forward the national drugs strategy provides another area for immediate co-operation.

## 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*.<sup>13</sup> HSC 1998/177 requires local authorities and Health Authorities to facilitate 'arrangements for the sharing of information among professionals and agencies'. These arrangements include a new statutory power.

While NHS agencies are still acting with caution on information sharing, multi-agency partnerships in Surrey County Council and in Dudley in the West Midlands have already carried out such work.

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

1. Which information will be shared? Which victims, offences, offenders and situations?
2. Will the information be anonymised or not?
3. Why is information being shared? What are the reasons for sharing? What are the reasons for not sharing?
4. Who gives and receives the information?
5. How will the information be shared? Will there be informal arrangements, a protocol, or joint training and ownership?
6. 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.

### The way forward

Public health is seen rightly as consisting of a number of elements, including the ability to work, access to good health care and other services, better life options and – last but not least – crime reduction.

The previous section has shown that the NHS policy framework is well suited to action with other public sector agencies – including crime and disorder reduction partnerships. Where the local health agencies are not closely involved in partnership working, both sides are – as this briefing has shown – missing out.

### Case study: Cardiff

The Cardiff Violence Prevention Group estimated that only 25 per cent of violent offences resulting in NHS treatment in their area were recorded by police, and that 30 per cent of those injured in assaults who receive NHS treatment develop serious psychological problems. A strategy was developed to respond to this and is still ongoing. Initial results indicate that reporting of violent offences to police has increased to 50 per cent.

### Case study: Manchester

Manchester's Crime and Disorder Executive Partnership Group includes the Health Authority. An analysis conducted for the audit showed that in the year 1998/99 there were nearly 8,000 woundings (12 per cent of recorded crime) and 1,525 domestic assaults (87.5 per cent of which were carried out by men). This provided some immediate focus for action on health and crime over and above drug and alcohol issues.

In addition, a report to the Health Authority identified that the impact of crime on mental health included 1,000 cases of crime-related Post Traumatic Stress Disorder and 1,100 GP consultations for acute reaction to stress. There had also been 1,283 violent incidents against NHS staff in 1999/2000. In May 2000 the Partnership agreed a proposed framework to reduce street violence. This impacted on Accident & Emergency, alcohol services, Transport, licensing and education services and was a cross-cutting strategy.

In this approach a baseline audit was conducted that addressed health issues as part of the context of crime and disorder, and sought to find a solution with health agencies as partners. It had strategic ownership from health and other partners and demonstrated a degree of political will, strategic intent and understanding based on health services research methods.

## Useful contacts and sources of information

The **Cardiff Violence Prevention Group** is a group 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  
02920 742442  
Shepherdjp@cardiff.ac.uk.

**Department of Health.** The website contains information, and DoH documents and circulars.  
Richmond House  
79 Whitehall  
London SW1A2NL  
020 7210 4850  
www.doh.gov.uk

The **Health Development Agency** 'is a special health authority that aims to improve the health of people in England – in particular, to reduce inequalities in health between those who are well off and those on low incomes or reliant on state benefits'.  
Trevelyan House  
30 Great Peter Street  
London SW1P 2HW  
020 7222 5300  
www.hda-online.org.uk

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

The **Institute of Healthcare Management** provides information on healthcare management and up to date information on changes in policy.  
7-10 Chandos Street  
London W1M 9DE  
020 7460 7654  
www.ihm.org.uk

The **King's Fund** is a source of policy and research information.  
11-13 Cavendish Square  
London W1G 0AN  
020 7307 2400  
www.kingsfund.org.uk

The **NHS Confederation** is a bit like an NHS version of the Local Government Association. It produces some useful briefing papers and is a source of useful information.  
26 Chapter Street  
London SW1P 4ND  
www.nhsconfed.net

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.doh.gov.uk/ohn.htm

## Bibliography and further reading

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## Footnotes

1 DoH (1998) Recommendation 18.

2 Golding (1997)

3 WHO (1999)

4 Pan American Health Organisation (1996)

5 Benzeval et al. (1996); Gowman (1999)

6 Skevington (1995)

7 DoH (1998)

8 DoH (1999c). Page 24.

9 Based on the *Hospital Episode Statistics* figures for bed days caused by crime-related illness and injury and UK studies reporting that an in-patient costs £5,200 to care for over an average length of hospital stay of 12 days.

10 Based on a telephone survey of NHS agencies.

11 NHS Executive (2000)

12 McManus (2000)

13 NHS Executive (1999)

*If you would like further advice on engaging health services in community safety, please contact Jim McManus, Nacro Crime and Social Policy Section, 237 Queenstown Road, London SW8 3NP; t 020 7501 0565; f 020 7501 0556; e jim.mcmanus@nacrocsp.org.uk*

### **Crime and Social Policy Mailing**

This briefing is part of the free Crime and Social Policy Mailing from NACRO. If you do not already receive this mailing and would like to add your name to our mailing list, please write to Crime and Social Policy Mailing, Nacro Crime and Social Policy Section, 237 Queenstown Road, Battersea, London SW8 3NP

### **NACRO's 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, with an emphasis on tackling issues such as anti-social behaviour, racially motivated crime and mainstreaming for sustainable solutions.

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:

- Developing and implementing Crime and Disorder Strategies
- Involving communities
- Monitoring and evaluation
- Research
- Training
- Developing and managing projects

For more information contact Chris Fox, Nacro Crime and Social Policy Section, 237 Queenstown Road, Battersea, London SW8 3NP; t 020 7501 0562; f 020 7501 0556.