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Better health, lower crime

a briefing for the NHS and partner agencies

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Crime is a health issue. It affects the health of our communities and individuals within them directly and indirectly. Crime against health service staff, patients and property diverts resources away from service provision.

Reducing crime benefits health services. The current approach to crime reduction emphasises partnership working at a local level. Crime and disorder reduction partnerships are keen to work with health agencies. This briefing outlines:

- **Why?** The reasons for health services to take crime seriously and become involved in crime reduction.
- **Who?** The crime reduction context and the agencies that work in it.
- **How?** Plans to help you get started on partnership working to reduce crime.

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Nacro also publishes a practical guide for community safety practitioners on working in partnership with health agencies. *Safe and healthy* is available free from the Nacro website (www.nacro.org.uk/publications) or from the address on the back cover.



changing lives
reducing crime

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Crime and health

- Crime has both direct and indirect effects on health.
- The results of crime divert resources away from service provision.

The issue of crime and its relation to health has been a focus of discussion and research for some time.¹ It is an issue at the levels of public health policy, service delivery and clinical practice.

Crime affects health in a number of ways, directly, indirectly and by influences on the health care system. Crime affects health:

- **Directly**, eg through violence, injury, rape and other offences against the person.
- **Indirectly**, through the psychological and physical consequences of injury, victimisation and isolation because of fear. These effects persist across time.
- As a **determinant** of illness, along with poverty and other inequalities, which

increase the burden of ill-health on those communities least able to cope.

- By **reducing the effectiveness of our health care systems** through violence against staff, damage to patients and property, and revenue lost in replacement, liability/risk, repair and security.
- By **preventable health burdens**, such as alcohol-related crime, motor vehicle incidents and drug dependency.

The best piece of work in this area in recent years is that of Robinson *et al.* (1998) who conducted a feasibility study for the Northern & Yorkshire NHS Regional Office. They concluded that there is a general awareness of the impacts of crime on the health of individuals and on the NHS, but that, although NHS agencies are becoming increasingly involved, 'these concerns and initiatives do not seem to be supported by much information, research or policy.'

¹ Robinson *et al.* (1998), McManus (2000a)

The direct effects of crime on individual and public health

2 Golding (1997)

3 WHO (1999)

4 ONS (2000a)

5 ONS (2000b). All figures based on late extracts from Registrar General's dynamic mortality database.

6 PAHO/WHO (1996)

7 With the exception of victims of hate crimes, as studies into hate crimes against lesbians and gay men, and black and minority ethnic communities demonstrate.

- **Crimes that impact directly on health include:**
 - violence
 - homicide
 - dangerous driving
 - drug and alcohol abuse
- **The effects can be both immediate and long-term.**

The most obvious categories of crime that have a direct effect on health are:

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

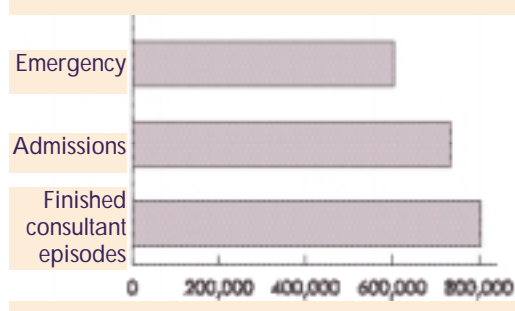
Others include drug and alcohol related problems, and long-term physical or psychological disability from injuries, muggings, etc.

Violence is and remains a major public health issue in the UK and internationally.² The World Health Organisation report that interpersonal violence is the third most common cause of death and the ninth most common burden of disease for males and females aged 15–44 in European Region High Income Countries. Unipolar depression, alcohol dependence, road traffic injuries and drug dependence rank first, second, third and seventh respectively in burden of disease for the same age group.³

Excluding road traffic accidents, the *Hospital Episode Statistics* for England show that there were 804,253 finished consultant episodes relating to interpersonal violence and incidents of undetermined intent (including suicide) in 1998/99. These took up 5,138,984 bed days⁴ (see Figure 1).

Of these episodes, 413,591 (51.5 per cent) were male; 374, 375 (46.5 per cent) were aged 16–59. This pattern may vary locally – the collection of such information is required by the strategic framework for health authorities and NHS Trusts laid down by HSC 1999/244 and the guidance to which it

Figure 1 Number of hospital episodes 1998–1999



in turn refers, including the NHS performance framework (HSC 1999/078).

Of 16,201 deaths from external causes in England and Wales in 1998, 64 per cent were among males. 3,041 were due to road traffic accidents, 5,302 were due to suicide, 694 homicide and 1,837 were injury undetermined whether accidentally or purposely inflicted⁵.

In addition to these most obvious effects, there are a range of other longer-term issues for which figures and costs are more difficult to estimate. Some of these were highlighted by the World Health Organisation in 1994.⁶ They include:

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

The risk of crime to health falls disproportionately across genders and social classes. Males are at greater risk of being killed than females at all ages, but females suffer more severe long-term psychiatric and other consequences.⁷ Death rates from young men are increasing and males are still at greater risk of being killed than females at all

ages. This represents a significant burden to health service investment, since the typical consequences of violent injury may necessitate input from a range of sources.

A study of two NHS Trusts was undertaken for this briefing. We looked at the long-term consequences on injuries from violence and asked the Trusts to identify the specialties who would be involved with:

- intracranial injury
- open wounds, (both among the most common violence related injuries)
- a rape victim (whether male or female)

The results are shown in Table 1.

Long-term persistent pain without injury (causalgia) and other complications (both physical and psychological) frequently occur in people who have been victims of violence, even after their wounds have healed.⁸

Guidance has been issued to the NHS in how to estimate the costs of crime to the NHS but it is clear that such work is a major undertaking.

Crime also has major effects on health through drug and alcohol use:

- alcohol- and drug-driven crime
- accidental injury
- poisoning
- adverse reaction to drug use
- a range of long-term effects

Table 2 provides an illustration of the various effects.

There has been major concern about homicide and suicide by people with mental illness. The *Confidential Inquiry* reported recently⁹. that, over an 18-month period from 1998–1999, 718 convictions for homicide were notified from the homicide index. The ratio of males to females was 9:1; this increased to 25:1 in the 10–19 age group. Most victims of homicide are young men. Ten per cent of perpetrators were found guilty of manslaughter or infanticide on grounds of diminished responsibility; six per cent were committed to psychiatric hospital. While the

8 Skevington (1995)
9 NCI (1999)

Table 1 A selection of specialties involved in treating different types of injury from violence

Function/speciality	Intracranial injury	Open wound	Rape
Paramedic	Yes	Yes	Possible
Porter	Yes	Yes	Yes
Nurse specialists / nurse practitioners	Yes	Yes	Yes
Nursing staff	Yes	Yes	Yes
Accident & Emergency	Yes	Yes	Yes
Vascular surgery	Yes	Yes	
Genito-urinary medicine			Yes
Obstetrics & Gynaecology			If female
Neurology	Yes	Yes	Yes
Neuropsychology	Yes	Yes	
Psychology	Yes	Yes	Yes
Anaesthetist	Yes	Yes	Possible
Pain control	Yes	Yes	Possible
Intensive care/high dependency	Yes	Yes	Possible, depending on severity
Registrar	Yes	Yes	Yes
Psychiatry	Yes	possible	Yes
Clinical Psychology	Yes	Yes	Yes
Physiotherapy	Yes	Yes	Possible
Occupational Therapy	Yes	Yes	Possible
Outpatient clinics	Yes	Yes	Yes
Radiology	Yes	Yes	Yes
Renal / Urology		Possible	Yes
Community Nurses / CPN	Possible	Possible	Possible
Health Visitor	Possible	Possible	Possible
General Practitioner	Yes	Yes	Yes
Pharmacist	Yes	Yes	Yes
Social Services (hospital social worker, Home Care, Child Care)	Possible	Possible	Possible

Table 2 Examples of the relationship between health and crime in individuals

Example	Short-term	Long-term
Rape	Physical trauma, sexually transmitted diseases, fear, panic, anxiety, depression, neurosis, agrophobia, withdrawal, self-hate, nightmares.	Post-Traumatic Stress Disorder, persistent flashbacks, predisposition to STDs and cervical cancer, avoidance of sex, nightmares, seeking sexual victimisation, alcohol and drug problems, low self esteem, self-harm, insomnia, low concentration, avoidance of invasive procedures from dentistry and surgery to genito-urinary investigations, disturbance in menstrual cycles.
Stabbing	Physical trauma, risk of infections (eg gangrene), anxiety, fear, panic.	Post-Traumatic Stress Disorder, panic, anxiety, repeat infections and lowered resistance to disease at site of stabbing, problems with organs stabbed, persistent pain, phantom stabbing.
Mugging of an elderly person	Physical trauma, compound trauma through broken bones or joints or other weakened parts of the body, increased healing time, ulcerating wounds through poor immune function, psychological stress, insomnia.	Deterioration in coping skills, wounds and injuries at higher risk of re-opening or recurring through knocks/ bumps. Increased risk of falling, poor coping skills, poor hygiene, deterioration in psychological coping, isolation, fear, undernourishment, cutting off from the rest of the world, depression, anxiety, increased admission to social or hospital care.

Information about rape taken from: Estrich, Susan, (1987) *Real Rape*, Cambridge, Mass: Harvard University Press; Herman, JL (1992) *Trauma and Recovery*, New York: Basic Books; Koss, MP *et al* (1994) "Detecting the scope of rape: a review of prevalence research methods", *Journal of Interpersonal Violence*, 8, 198-222; Koss, MP *et al* (1994) "The global health burden of rape", *Psychology of Women Quarterly*, 18, 509-537.

prevalence of mental health problems among perpetrators of homicide is an issue, homicide among young men in general is the most pressing public health issue. The majority of homicides are committed by young men who are unmarried and/or unemployed; drug and alcohol misuse is a commonly occurring factor. Violence and drug and alcohol use are significant priorities for a public health response to homicide, and more pressing than mental illness in relation to homicide.

24 per cent (over 1,000 people) of suicides had been in contact with mental health services in the year preceding death. Hanging was commonest in men; drug overdose among women. The commonest drug of overdose is of drugs prescribed to treat mental disorder. Depression, schizophrenia, personality disorder and drug/alcohol misuse were the commonest diagnoses among suicides. 63 per cent had a history of self harm and 19 per cent

had a history of violence. The public health issues here are self-evident.

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 partnership working on mental health issues between all the relevant agencies in a crime and disorder reduction partnership. The same can be said for violence.

The indirect effects of crime and health inequalities on individual and public health

- Stress, fear of crime and repeat victimisation lead to ill health.
- There is a strong correlation between poor health, high levels of crime and poverty.

In the UK death rates at all ages are two to three times higher among disadvantaged social groups than affluent ones. There is ample evidence about the long-term physical and psychological deterioration of those who suffer stress, fear of crime, repeat victimisation and poverty.¹⁰ 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; they disproportionately affect those least able to resist the health consequences.

In addition, smoking – one of the major public health challenges to the UK – is disproportionately represented in the proportion of the population already hardest hit by health inequalities.¹¹ A recent review¹² found that prisoners, offenders and ex-offenders are disproportionately represented among smokers.

We have already seen that there is a steep gradient in homicide for younger men, and that violence and drug or alcohol use are indicated in a significant proportion of cases. In 1991–93, men aged 20–64 in social class V (unskilled, SMR 300) were 12 times as likely to be killed as those in Social Class I (professional and managerial, SMR 25).¹³ The Acheson Report in 1998 summarised and enhanced the growing trend of evidence on indirect effects of crime and health inequalities.¹⁴ *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.¹⁵

The setting up of Health Action Zones under guidance EL (97) 65 stated that Health Action Zones would seek:

‘to bring together all those contributing to the health of the local population to develop and implement a locally agreed strategy for improving the health of local people. On 30 September, the Prime Minister subsequently announced that up to ten HAZs would be set up from 1 April 1998. Health Action Zones have key objectives of reducing health inequalities, improving services and securing better value from the total resources available. Partnership will be a key means of achieving these objectives. Bids will therefore need to be submitted with the explicit support of a consortium of local bodies committed to those objectives and with a vision and a programme to address them.’

This recognised the major benefits which multi-agency approaches to tackling health inequalities could have. The Healthy Settings concept, which had been given impetus in this policy, was developed by *Saving Lives: Our Healthier Nation*.¹⁶ This addresses the fact that people identify with the places they live. Neighbourhoods provide important opportunities for tackling the range of health-worsening variables:

4.34 People relate closely to their neighbourhoods, and are likely to be healthier when they live in neighbourhoods where there is a sense of pride and belonging. Evidence, particularly from the World Health Organisation, shows how social cohesion and strong social networks benefit health.

4.35 The Neighbourhood Renewal Policy Action Team set up by the Social Exclusion Unit and headed by the Department for Culture, Media and Sport has found that

10 Benzeval *et al.* (1996), Gowman (1999)

11 Dept of Health (1999a and 1999b)

12 McManus (2000b)

13 Rooney and Devis (1999)

14 DoH (1998)

15 DoH (1999c) p. 24

16 DoH (1999d)

participation in arts and sport can promote social cohesion by building strong social networks. Health action zones, healthy living centres and family doctor practices all offer the potential to promote active lifestyles to benefit local communities.

4.36 The close link between regeneration and health is reflected in our *New Deal for Communities* initiative – a key part of our work to turn around our most deprived neighbourhoods. Under it we have set up a new fund, worth £800 million over three years, to help improve the poorest neighbourhoods and encourage local people and agencies – public, private and voluntary – to work together to overcome the problems of multiple deprivation and to make a lasting improvement to their neighbourhoods.’

This policy context supports joined-up action to address the issues of health and health determinants together with crime and disorder. There are significant opportunities to

address the relationships between health, health behaviour and crime at both an individual and a community level.

Neighbourhoods and conurbations that are identified as being likely to benefit from interventions aimed at improving health directly (eg drug or coronary heart disease programmes) and indirectly (eg addressing determinants of ill-health through regeneration schemes) would benefit from working to address crime and factors affecting criminality simultaneously. Potential programmes for action include ones targetted at young people (to reduce disaffection, etc) and those that address the needs of elderly and disabled people who are afraid of crime (eg combining care and security schemes, and seeking to reduce isolation in areas of high fear of crime).

One such scheme is run in Exeter. The police, with funding from the NHS, run an exercise and community fitness scheme for young people. It addresses both health behaviours and disaffection and criminality.

The effects of crime on the health system

- It has been estimated that the NHS spends over £1 billion per year on treating the victims of crime.
- Crimes against staff, patients and NHS property divert resources away from patient care.

Robinson *et al.*¹⁷ report estimates that injury from crime in the US in 1987 resulted in an estimated US\$10 billion in health-related costs. An additional US\$6.8 billion a year is spent on mental health-related costs of crime. UK studies are reported at costing £5,200 per in-patient, with an average length of hospital stay of 12 days. Based on the *Hospital Episode Statistics* figures reported earlier for bed days related to crime and disorder, a crude estimate of crime related costs to the NHS would be between £1.1 and £2.3 billion, though this would require much greater work to produce a robust figure. Robinson *et al.* report that in Greater London the health-related cost of crime could be £189 million per annum.

The above figure 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.¹⁸

The effect of crime on the health system is clear. The NHS Executive estimates that approximately 65,000 violent incidents against

NHS staff are recorded every year.¹⁹ The NHS must divert resources from service provision to pay for sick pay, trauma to staff and colleagues, impaired patient care and fees for legal action. Much more work needs to be done on this; a framework was issued under guidance EL 1997 (40) to NHS agencies. The response to this imperative to collect costs of crime within trusts and health authorities is, however, low. To date, no national report seems to have been collated and published. A survey of 50 health authorities and Trusts showed that only 15 were actively collating data on the costs of crime.

Key action and information sources

- HSC 1999/226 and HSC 1999/229 provide information and guidance on crime against NHS staff. NHS agencies can use existing IIP, clinical governance and health & safety programmes to address these issues.
- NHS and other agencies (such as Social Services and voluntary agencies) can benefit from a shared approach to staff safety, risk reduction and dealing with perpetrators.
- Nacro can provide advice on reducing risk to NHS premises and staff. (Contact details on back cover.)

17 Robinson *et al.* (1998)

18 Based on a telephone survey of NHS agencies.

19 NHS Executive (2000)

Crime reduction: the context²⁰

20 Much of the information in this section is taken from the Home Office Crime Reduction website (www.crimereduction.gov.uk).

- **Current crime reduction policies rely on partnerships at a local level.**

The **Crime and Disorder Reduction Act 1998** forms the basis of the crime reduction context. (You may also find this area referred to as community safety; for the purposes of this briefing community safety and crime reduction are the same thing.) According to the Home Office, ‘the purpose of the Act is to tackle crime and disorder and help create safer communities. It reflects a number of underlying themes:

- The purpose of the youth justice system is to cut offending. Action must be taken quickly to nip youth offending in the bud.
- The police and the local authority – with the whole community – must establish a local partnership to cut crime.
- Local authorities and other public bodies must consider the crime and disorder implications of all their decisions.’ (You may find this referred to as ‘mainstreaming’.)

The main point of contact for health agencies will be local **crime and disorder reduction partnerships**, which were established by the Act in every area of England and Wales. They have to include representatives from the police, local authorities, probation service and health authorities, and may include representatives from the voluntary sector, and local residents and businesses. These partnerships:

- Establish the levels of crime and disorder problems in their area by carrying out a crime audit. They then consult widely with the local population to make sure that the partnership’s perception matches that of local people, especially hard-to-reach groups.
- Devise a **strategy** containing measures to tackle priority problems. This includes targets and statements of who is responsible for meeting the targets. Strategies last for three years and must be kept under review by the partnership.

The first strategies were published by 1 April 1999. The next strategies are due to be published by 1 April 2002.

The government’s **Crime Reduction Programme** is running for 3 years from April 1999. It is taking an evidence-based approach to reducing crime in England and Wales. (Separate arrangements apply to Scotland and Northern Ireland.) The programme is focused on obtaining evidence on what methods, employed by the police and their crime and disorder partners, are the most effective in tackling crime and its causes. The knowledge gained will contribute to reversing the long-term growth rate in crime and ensure that the greatest impact for the money spent can be achieved. The CRP is comprised of a series of diverse initiatives each supporting a range of projects on the ground. Projects which are successful will form the basis of future mainstream programmes; those which are not will be dropped.

Each regional government offices in England has a small Home Office team dedicated to supporting the Crime Reduction Programme, as well as doing other work on crime and crime reduction. Regional **Crime Reduction Directors** are based in the government office in each English region, plus one in Wales who works from the Welsh Assembly. Their responsibilities include: championing the partnerships by helping them to cut crime locally and strengthen their links with central government; and building strong working relations with all the key members of the partnerships in their region.

The **Crime Reduction Strategy** published on 29 November 1999, sets out the government’s approach to crime reduction. It includes current policies as well as what will happen in the medium term. It summarises the approach in seven main areas (raising the performance of the police and the crime and disorder reduction partnerships; reducing burglary and property crime; tackling vehicle crime; dealing with disorder and anti-social

behaviour; dealing effectively with young offenders; dealing effectively with adult offenders; helping victims and witnesses). It is not intended to provide a comprehensive list of all crime reduction initiatives, nor is it the final word on crime reduction policies.

The government has set **Crime Reduction Targets** for all police authorities and police forces on domestic burglary and vehicle crime. In addition, five forces are being asked to set a target for robbery.

You may also come across other crime reduction agencies such as:

- The **Youth Justice Board** is responsible for: advising the Home Secretary on the operation of the youth justice system in delivering its aim of preventing offending by young people; monitoring the operation and performance of the youth justice system, including the youth court, the work of the youth offending teams (see below) and the delivery of secure accommodation; advising the Home Secretary on drawing up standards for the work of youth offending teams and juvenile secure estate, monitoring

and publishing performance indicators; and identifying and disseminating good practice, including commissioning research and providing grants for developing best practice.

- **Youth Offending Teams** (YOTs) are made up of representatives from local authorities, education authorities, social services, the police, probation services and health authorities. They are responsible for providing youth justice services in their area for children and young people aged 10 to 17. They are also expected to carry out work to prevent offending in this age group.

To complete the picture, there are a number of voluntary agencies working in the crime reduction. The most well-known are probably Neighbourhood Watch and Victim Support. **Nacro** (the publisher of this briefing) is the principal independent organisation in England and Wales working to prevent crime and resettle offenders. We work with partners at national, regional and local levels to develop and implement effective strategies for tackling crime.

Crime reduction: finding out more

The Crime and Disorder Act 1998 www.hmso.gov.uk/acts/acts1998/19980037.htm

Guide to the Act www.homeoffice.gov.uk/cdact

Crime and disorder reduction partnerships www.crimereduction.gov.uk/partnerships2.htm

Crime Reduction Programme www.crimereduction.gov.uk/crimered.htm

Crime Reduction Strategy www.homeoffice.gov.uk/crimprev/crssummary.htm

Crime Reduction Targets www.homeoffice.gov.uk/webwork/crimtarg.htm

Nacro www.nacro.org.uk

Youth Justice Board www.youth-justice-board.gov.uk

Youth Offending Teams www.homeoffice.gov.uk/cdact/yotcirc.htm

Partnership working: the legislative and policy framework

21 DoH (1999d)

22 SEU (2000)

23 SEU (2000)

- **There is a clear legislative and policy framework for NHS and other partners to work together on crime and health.**
- **The NHS, police and Local Authorities can be brought together to form powerful alliances for action on crime reduction.**

England and Wales are witnessing the most significant development in public health since the 1846 Public Health Act – the development of an integrated strategy for the health of the public. Public health is seen rightly as consisting of a number of elements, including:

- the reduction of crime
- the ability to work
- access to good health care and other services
- better life options

Every agency has a part to play in this agenda of restructuring and regeneration in the most deprived communities.

The policy agenda in local government and the police has changed considerably in recent years, following the publication of the Government's Crime Reduction Strategy and the introduction of the Crime & Disorder Act 1998. Working together to tackle problems, involving local communities and achieving Best Value are all key policy principles. So too is ensuring the widest and most comprehensive action to tackle the range of problems facing our communities. These principles have been underpinned by Best Value and other performance monitoring frameworks (including the NHS Performance Assessment Framework). The reinvestment in the strategic role of local health authorities (and the strategic role of Primary Care Groups and Primary Care Trusts), the end of the internal market and an increased emphasis on the wider social and economic aspects of health all create a climate that nurtures work on health and crime.

The new policy framework for the NHS requires the NHS and other agencies to work together for better public health in its widest sense. The policy framework for public health highlights the need for multi-agency response and makes it clear that health inequalities, social exclusion, crime and unemployment are all public health issues in the widest sense.

‘4.47 Local decision-makers must think about the effect which their policies may have on health and in particular how they can reduce health inequality. In most cases this will require a change in the way that health authorities, local authorities and other local agencies see their role. They will in future need to act much more as health champions at local level and ensure that health is on the agenda of all local organisations and agencies outside the health field. An important part of this role will be to encourage all local agencies to make local health impact assessments when planning investment in, for example, amenities, buildings or local communities and in the location of services.’²¹

Both *Saving Lives: Our Healthier Nation* and *The National Strategy for Neighbourhood Renewal: A Framework for Consultation*²² highlight the need to:

‘Bridge the gap between the most deprived neighbourhoods and the rest of England; and in all the worst neighbourhoods, to achieve lower long-term worklessness; less crime; better health; and better educational qualifications.’²³

The following *Our Healthier Nation* targets are relevant to this process:

- 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 75 years by at least 40 per cent (which will involve work on alcohol, drug and tobacco issues)

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.

Recommendation 13 of the *Report of the Independent Inquiry into Inequalities in Health* recommends the ‘development of policies to reduce the fear of crime and violence, and to create a safe environment for people to live in.’ A recent report²⁴ makes clear that the New Deal for Communities, Crime Reduction Strategy and Single Regeneration Budget programmes are public health interventions requiring the co-operation of all agencies.

This framework is clearly underpinned by the legislation. The Crime & Disorder Act 1998, s.5 requires responsible authorities (local authorities and police) to develop crime reduction strategies for their areas. It is clear from the letter and spirit of the legislation that the co-operation and involvement of NHS bodies is crucial to the success of such a strategy. The Crime and Disorder Act 1998, s.5(2) requires responsible authorities to co-operate with health authorities, and requires health authorities to co-operate with responsible authorities in the development of strategies. NHS Trusts have a similar duty to cooperate placed on them by s.5 (2)(c) of the Act. Under s.5(3), registered medical practitioners and bodies that represent them must be invited to participate by crime and disorder reduction partnerships. MISC (98) 26 from the Department of Health sent the act and guidance on information exchange to health authorities and trusts. Guidance on calculating the costs of crime was also issued to NHS Trusts in 1997.

In recent months the role of the NHS in crime reduction has been highlighted by the work of Youth Offending Teams, Drug Action Teams and Domestic Violence initiatives, as

well as the developing Health Action Zone programme.

A suitable framework is provided by the existing policy and legal framework for assessment of health need and co-operation between Health and Local Authorities. S.28 of the Health Act 1999 provides that it is the duty of each Health Authority to prepare a Health Improvement Plan for their area, and the duty of Primary Care Trusts and NHS Trusts to participate in this process. (Local authorities have a similar duty to participate.) This reinforces the existing duty placed on health agencies and local authorities under the NHS and Community Care Act to assess the health and social care need of their areas, and to co-operate in doing so. Moreover, s.27 of the Health Act 1999 amended s.22 of the NHS Act 1977 to read:

‘(1) In exercising their respective functions NHS bodies (on the one hand) and local authorities (on the other) shall co-operate with one another in order to secure and advance the health and welfare of the people of England and Wales.

(1A) In this section ‘NHS body’ means:

- (a) a Health Authority;
- (b) a Special Health Authority;
- (c) a Primary Care Trust; or
- (d) an NHS Trust.’

These arrangements have recently been given impetus in guidance to Health Authorities and Trusts HSC 1999/244 (LAC (99) 39 to Local Authorities). Specific guidance was issued to Health Authorities and NHS Trusts on managing violence against staff in HSC 1999/226 and HSC 1999/229; this guidance required targets for reduction of violence.

The legislative and policy context leaves no reasonable excuse for failing to develop strong health improvement programmes that include action on crime and disorder. Likewise, there is no reasonable excuse for crime and disorder reduction partnerships failing to incorporate health agencies fully.

24 DoH (1999c)

Working to reduce crime: the NHS policy framework

25 NHS Executive (1999a)

26 McManus (2000c)

27 NHS Executive (1998)

28 DoH (2000a)

- NHS bodies have a clear framework for working on health and crime.
- NHS bodies should use the national performance framework²⁵ outlined below to implement their work on health and crime.

Some Health Authorities and NHS bodies have raised the issue that there is no guidance to the NHS in the form of a Health Service Circular on health and crime.²⁶ Therefore, the argument runs, it is difficult for the NHS to find a role for itself.

This is not a sustainable argument. The generic policy framework clearly requires action on health inequalities and has demonstrated 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 aims for mental health, accidents and coronary heart disease and stroke (alcohol and tobacco) can be related to work on crime and disorder (see below).

In addition, some specific guidance has been issued in relation to Youth Offending Teams and NHS responsibilities in HSC 1998/177, which 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'.

The Health Improvement Programme for the NHS started with the publication of *The New NHS: Modern, Dependable*²⁷ and continued with the recent publication of *The NHS Plan*.²⁸ The Health Improvement Programmes will build on existing local planning and respond to the *National Priorities Guidance* and *Saving Lives: Our Healthier Nation*. Local authorities and health authorities together will develop Joint Investment Plans for Local Authorities and

will contribute to Health Improvement Plans, Service and Financial Frameworks, and assessment of health care need. HSC 1999/244 *Planning for Health Care* outlined in detail how this framework would work.

There are several key points to be noted about the new policy framework for the NHS that are relevant to work on crime reduction:

- 1 Albeit in different language from that of local government, it embodies the principles of Best Value, which are readily applicable to crime and disorder work:
 - **Challenge** What is the purpose of a specific activity? Why is it provided?
 - **Consult** What do the community think?
 - **Compare** How effective is it compared to other activities?
 - **Compete** How can it be made more effective and efficient?
- 2 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 being promoted.
- 3 The involvement of communities in the planning and delivery of health care interventions is a major priority for the years to come. This is a key aspect of community safety work.
- 4 Health authorities are to provide strategic leadership in partnership with NHS Trusts, Primary Care Groups and Primary Care Trusts. This should end the current situation, where other agencies involved in crime and disorder reduction partnerships feel that strategy development is hindered by fragmentation and dissonance within the NHS.
- 5 NHS agencies have a statutory duty to support and co-operate with local authorities under s.22 of the NHS Act 1977, as amended by s.28 of the Health Act 1999. Co-operation here will underpin the duty to co-operate under s.5(2) of the Crime and Disorder Act 1998.
- 6 There are specific arrangements that will

enable joint financial investment outlined in Sections 30 and 31 of the 1999 Act. This will underpin joint work in relation to local crime reduction strategies.

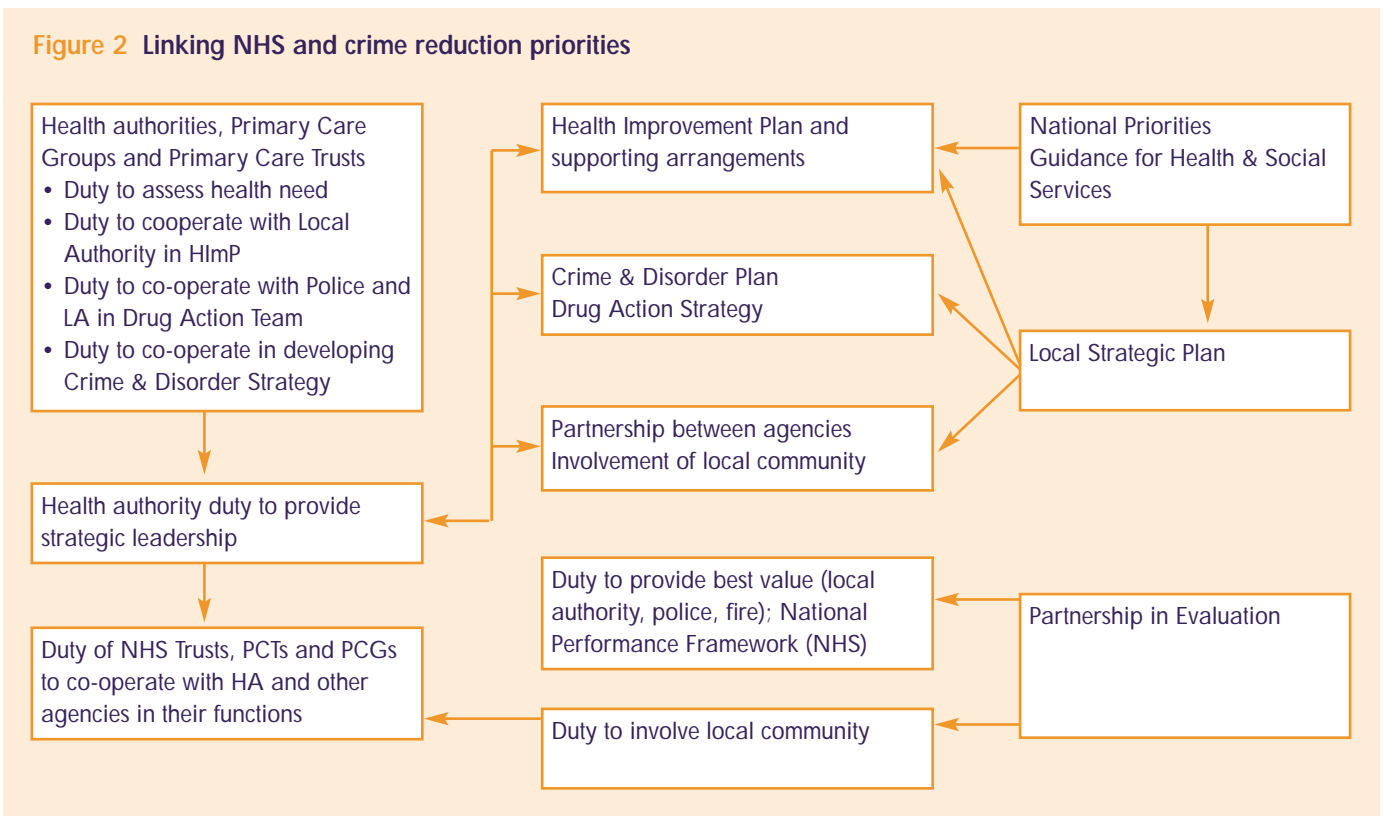
- 7 The National Performance Assessment Framework supports comprehensive NHS response to crime. (This is explored further below.)
- 8 Clinical Governance provides an opportunity to ensure that linkages between the care a person receives, implications about crime and disorder, and best possible practice are achieved. Clinical audits should conduct cross-cutting reviews. Clinical protocols and governance arrangements should develop standards for: sharing information; considering the global needs of

the patient; considering which agencies can support and help; and requiring best practice by staff.

Figure 2 outlines the way in which the new policy framework within the NHS can work with the policy framework in other public services to support the policy objectives of social inclusion, community involvement and action on health inequalities and crime.

The NHS policy framework is therefore well suited to aligning action with other public sector agencies and can, with creative thought, enable effective partnership on action across a range of issues. This will ensure better use of resources and more comprehensive action. NHS agencies that do not participate in crime and disorder reduction partnerships are losing out.

Figure 2 Linking NHS and crime reduction priorities



Getting started: assessing the issues

■ In order to get the most out of crime and disorder reduction partnerships, health agencies need to clarify who does what internally.

There are several key steps in getting NHS involvement in crime reduction strategies:

- 1 Clarify the NHS roles and the role of other partners according to the national policy framework.
- 2 Clarify the NHS and other agency contributions.
- 3 Clarify the NHS internal structure:
 - Public Health
 - Commissioning
 - Personnel/HR
 - Risk

- 4 Implement a whole-system approach, with liaison between:
 - HAs
 - Trusts
 - PCGs
 - PCTs
 - other providers
- 5 Use NHS commissioning, contracting, performance and public health frameworks, such as:
 - National Service Frameworks
 - National Priorities Guidance
 - NHS Plan
 - Local HImPs, etc
 - Clinical Governance
 - National Performance Framework

There are also a range of other steps which can and should be taken. These are set out in the plan below.

Getting started: a suggested plan for Health Authorities

	Early stages	Mature stages	Continuous improvement
Clarification of roles and contribution	<ul style="list-style-type: none"> • Know legislative framework. • Role definition within NHS. • Brainstorming within each partnership agency. • Brainstorm together. • Understand relationships between crime and health. • Agree framework between partners for taking issues forward. 	<ul style="list-style-type: none"> • Epidemiological studies of issues and contribution to crime and disorder partnership. • Inclusion of crime issues in strategic framework for all agencies. 	<ul style="list-style-type: none"> • Audit and consult with community and partners. • Conduct regular Best Value benchmarking against other partnerships.
Clarify internal structure	<ul style="list-style-type: none"> • Appoint lead responsibility (someone who can make decisions). 	<ul style="list-style-type: none"> • Co-ordinate working group between various parts of the NHS. 	<ul style="list-style-type: none"> • Include internal structure in performance reviews.
Get whole NHS system working	<ul style="list-style-type: none"> • Get co-ordination and agreement across NHS purchaser, Trusts and PCGs/PCTs. • Develop framework for sharing information for a) audit planning and b) Caldecott work. • Do a cross-cutting analysis of how the NHS Performance Framework can apply at all levels. • Coordinate NHS representation on partnership. 	<ul style="list-style-type: none"> • Assess the need for communication and involvement structures across various NHS agencies and sectors. • Possibly use IIP or existing liaison mechanisms as mechanism for communication and assessment. 	<ul style="list-style-type: none"> • Produce a detailed continuous improvement plan. • Incorporate into commissioning process and performance frameworks.

Commitment	<ul style="list-style-type: none"> Attend partnership. Statement about development of plan in PCIP, HImP, SSAF and JIP. Design strategy to take forward cross-cutting review of performance framework application. 	<ul style="list-style-type: none"> Develop and include detailed plans in HImP, JIP, SSAF and PCIP. 	<ul style="list-style-type: none"> Take part in crime and disorder partnership's continuous improvement cycle.
Partnership	<ul style="list-style-type: none"> Key regular person to attend partnership from public health or commissioning function of health authority. Educate other partners in the contribution, needs and priorities of NHS. Ensure internally whole system approach is started (liaison with NHS trusts, PCGs/PCTs, etc) as suggested above. 	<ul style="list-style-type: none"> Place public health and needs assessment functions of HA at disposal of the crime and disorder partnership. Develop an NHS Health & Crime task group comprising PCGs/PCTs/ Providers and aspects of the HA/ FHSA function. Use this group to develop NHS providers responses. 	<ul style="list-style-type: none"> Alignment of targets between crime and disorder strategy and HImP, etc.
Audit	<ul style="list-style-type: none"> Rapid review of research and evidence to assess what can be done. Rapid review of what is being done/purchased. 	<ul style="list-style-type: none"> Epidemiological studies, health needs analysis. Effectiveness audits and realignment of purchasing plans. Link with GIS systems for health planning. 	<ul style="list-style-type: none"> Detailed epidemiological research aligned to health aspects of crime & disorder strategy for locality.
Alignment	<ul style="list-style-type: none"> Inclusion of what is being done in Jimp, HImP, SSAF and JIP and in local crime and disorder partnership's strategy. 	<ul style="list-style-type: none"> On basis of audit evidence and effectiveness reviews realign services commissioned to meet needs identified. 	<ul style="list-style-type: none"> Development of health inequalities approach to factors predisposing individuals to criminality.
Target setting & strategic planning	<ul style="list-style-type: none"> Inclusion of what is being done in Jimp, HImP, SSAF and JIP. Include a health section in local crime & disorder audit and strategy. Commit to Best Value/ Business Excellence as a framework. 	<ul style="list-style-type: none"> Health aspects of crime & disorder strategy included in local crime and disorder partnership's strategy. Use the NHS Health & Crime task group referred to help develop. 	<ul style="list-style-type: none"> Focus on themes for specific action and purchasing each year. Review progress jointly with partners and realign purchasing plans.
Culture & delivery	<ul style="list-style-type: none"> Ensure the production of joint information and training strategies and protocols. Ensure that clinical governance frameworks take crime & disorder into account. 	<ul style="list-style-type: none"> Ensure a diversity of professions is represented across PCGs, PCTs, NHS Trusts and other providers work to produce holistic response to health and crime. 	<ul style="list-style-type: none"> Use staff training and information systems.
Risk	<ul style="list-style-type: none"> Develop a risk minimisation plan for staff at risk, violent patients, crime against NHS. Inclusion of risk to staff and patients from crime in IIP and existing plans. 	<ul style="list-style-type: none"> Divert monies otherwise spent on risk into evidence-based purchasing of services. Develop risk strategies for managing crime by staff and patients. 	<ul style="list-style-type: none"> Review and realign services based on evaluation.
Commissioning	<ul style="list-style-type: none"> Inclusion of Crime & Disorder co-operation and information protocol requirements in contracts for service. Cross-cutting best value style audit of how crime and health impacts on all aspects of the Health Improvement Plan and the framework for services and clinical governance. 	<ul style="list-style-type: none"> Realignment of commissioning intentions to take account of impact of crime on health. 	<ul style="list-style-type: none"> Align planning and auditing processes between HImP, Crime & Disorder Strategy, etc. Inclusion of crime and disorder work into all parts of Performance and planning system (HImP to Clinical Governance measures).
Evaluation	<ul style="list-style-type: none"> Evaluate outcomes and processes of current provision and planning. 	<ul style="list-style-type: none"> Include within Performance Assessment Framework. 	<ul style="list-style-type: none"> Conduct multi-agency partner evaluations of work done.

Using the NHS Performance Assessment Framework

- **NHS agencies need to develop an understanding of how:**
 - **The NHS Performance Assessment Framework can be applied to managing their contribution to crime reduction.**
 - **The Best Value process relates to the crime and disorder reduction partnership process and how it relates to their own work on crime reduction.**

Not many people outside the NHS understand the NHS Performance Assessment Framework. At first sight, it seems to be a world away from the Best Value regimes which local authorities and police authorities are required to follow. This is an undoubted stumbling block to closer partnership working, especially when given the huge work programmes required to bring the framework into being effectively, and the fact that, as a culture of 'Best Value' in local authorities and police authorities develops, it will increasingly be applied to assess the commitment of partners to, and their success in, reducing crime and disorder.

NHS Agencies therefore need to develop an understanding of how:

- The NHS Performance Assessment Framework can be applied to managing their contribution to crime reduction work.
- The Best Value process relates to the partnership process and how it relates to their own work in crime and disorder.

The NHS Performance Assessment Framework

The inclusion of actions related to crime and disorder in the Health Improvement Plan is the most obvious way in which the Performance Assessment framework can be used.

The Health Improvement Plan can also be used to develop arrangements for service and financial frameworks and relating the costs of

crime, and activity to prevent it, to baseline financial frameworks, waiting lists and emergency pressures at peak times (eg Christmas and New Year for alcohol-induced injury and road traffic accidents).

The following sections cover some other ways in which the Performance Assessment Framework can be used.

Annual accountability agreements

The health authority and Primary Care Groups should include in this agreement:

- work on crime and disorder
- inclusion of data supply and information sharing
- development of an NHS framework for working on crime reduction.

Accountability for delivering the crime aspects of the Health Improvement Plan should be developed here.

Service agreements

These are important for specifying key targets and objectives consistent with the Health Improvement Plan. Each service agreement could include:

- arrangements for data sharing
- agreements of the impact of the service on crime and disorder and how the service can respond in terms of staff, resources and patients/users
- how the service interacts with other agencies and systems

High-level indicators

The following indicators can help monitor progress on crime and disorder:

- deaths from all causes (people aged 15-64)
- deaths from all causes (people aged 65-74)
- suicide rates
- deaths from accidents

Fair access and effective delivery

NHS agencies could look at ways in which the standards for effective delivery of health care impact on offenders or victims of crime and disorder:

- How often are victims of crime and disorder subject to inappropriately used surgery?
- Are they getting fair access?
- What are the acute and chronic management arrangements for victims of crime?
- What are the links to clinical governance, to ensure that practitioners detect and appropriately support/refer on victims of crime?

A specific policy on victims of crime could be developed within a Service Framework.

Best Value²⁹

Best Value was introduced as a means of ensuring the best quality of service is provided in the public sector. Its basic principles are that Best Value authorities (police and local authorities) should undertake Best Value assessments of everything they do. These are guided by the Four 'C's':

- **Challenge** Why is this provided? Why must we provide it? What are its benefits?
- **Compare** How do others do it? What are their arrangements and performance outcomes?
- **Consult** What do our stakeholders and patients feel?
- **Compete** How can we do better?

Apart from the obvious NHS community involvement and consultation requirements, which could be significant assets to crime reduction partnerships in the audit/strategy process, there are a number of ways in which this can be used.

The NHS Performance Assessment Framework can fit within a Best Value process. By carrying out the processes necessary to implement the Framework, the purpose and performance has been challenged,

arrangements for performance comparisons and competitions have been made, and (based on continuous consultation) improvement is expected within a national framework that allows comparisons and competition for excellence.

In community safety, too, there are links. NHS agencies could usefully ask themselves the following questions as a background to crime reduction work. Agencies undertaking this process should remember that Best Value aims to deliver step change, not small scale improvement.

- **Challenge** What do we do that impacts on crime and disorder? How does it impact? What can we do? Whose role is it?
- **Compare** What are other agencies doing about it? What are other NHS agencies doing? How are they better or worse? What comparisons can we make?
- **Consult** What do other agencies think? What about our staff and patients? What are the views of the local agencies already working on crime and disorder?
- **Compete** How can we do better? What internal and external arrangements are needed?

The process of answering these questions will help you understand the current policy challenge in community safety: mainstreaming. Section 17 of the Crime and Disorder Act 1998 requires a local authority to take into account the effects of all its functions on crime and disorder. A number of different ways of addressing this are developing and most local authorities seek to implement mainstreaming as a principle across partnerships.³⁰

The next sections of this briefing will support an NHS agency in developing a robust strategy which takes account of the ethos of mainstreaming, the key principles about how crime and disorder affects health, and seeks to provide a means of synchronising Best Value with the NHS Performance Assessment Framework.

²⁹ Nacro will be producing a briefing on Best Value in mid-2001, which NHS agencies should read to understand the links between best value and community safety. It will be available on the Nacro website: www.nacro.org.uk

³⁰ Nacro has produced a briefings and tools on mainstreaming. These are available from the address on the back cover of this briefing.

Developing an internal strategy for a whole system approach

- **There are three stages to maximising the effectiveness of health agencies' contribution to crime reduction:**
 - 1 Sort out the internal systems and frameworks.**
 - 2 Look at the links between strategies and agencies.**
 - 3 Look at the functions and themes for delivering on crime reduction.**

Taking further the suggested whole system approach work outlined in para 6 there are a number of stages which need to be done to achieve this:

- 1 Get the internal systems and frameworks sorted out.
- 2 Look at the links between strategies and agencies and improve them if necessary.
- 3 Look at the functions and themes for delivering on crime reduction to produce a tangible result.

Another way of putting this is:

- 1 Ensure that internal systems (services which help the NHS conduct its business) are able to work on community safety issues properly.
- 2 Do the same for customer-facing services such as Accident & Emergency.

This helps to build a strong strategy.

Health authorities, NHS Trusts, PCGs and PCTs need core internal functions. These include:

- policy
- audit
- financial planning
- legal advisers
- board services
- health and safety
- personnel

All of these can help provide a framework for a whole-system approach to community safety. It's similar to building a house:

- Getting the internal framework right, to suit the agency, is like putting up the girders and laying foundations. These need to be appropriate to your authority and use the services available.
- Delivering on themes such as housing, etc is like putting the bricks and roofing on. These need a sound internal structure to operate solidly.
- Links with other strategies, departments and agencies is about the services and utilities. Without these the house is isolated and cannot relate to the rest of the world or deliver a safe environment.

Some or all of the above needs to be in place in order to have a good infrastructure for a corporate approach to mainstreaming and community safety. They are the minimum standards and provide a foundation on which to build action across themes.

Putting links in between internal systems and customer-facing systems is essential to any whole-system approach. There are several ways to develop links across functions and agencies, and across internal departments. They include using SRB.

Any proposed strategy should properly identify:

- the issues across all functions
- what the community safety contact points are
- how these link to other departments and strategies

A suggested matrix for commencing this process is shown on page 21, with some initial themes.

Internal services: how can they help

Function	How it can help
Legal Advisers and Risk Policy	<ul style="list-style-type: none"> • Looking at immediate legal liabilities and the scope of these including risk from patient injury, medical negligence, staff injury, damage to property, etc. • Prioritising the legal risk to the agency and securing immediate action. • Legal implications of policy stance. • Legal implications of inactivity/resistance.
Board Services	<ul style="list-style-type: none"> • Committee cycles and reporting systems. • Organising seminars for Executive and Non-Executive Directors. • Scrutiny of committee reports for community safety friendliness. • Establishing a community safety scrutiny reporting system (ie under new proposals the HA must attend a local authority scrutiny committee twice yearly and elected members should ask questions about community safety.)
Personnel	<ul style="list-style-type: none"> • Including community safety in relevant job descriptions, so that staff give it priority. • Corporate staff training. • Induction training on community safety. • Inclusion of community safety information and awareness as a key strategy within Investors in People process and standards.
Health & Safety / Occupational Health	<ul style="list-style-type: none"> • Violence against staff policy and monitoring. • Safe working systems and standards (eg from violence protection to security for female staff).
Finance	<ul style="list-style-type: none"> • Planning resources. • Inclusion of strategies to reduce the cost of crime in all contracts.
District Audit	<ul style="list-style-type: none"> • Advice, agreement, support and letter to Chief Executive on progress expected and desired. • Performance indicators support.
Corporate Policy	<ul style="list-style-type: none"> • Corporate policy statement and framework.
Equal Opportunities	<ul style="list-style-type: none"> • Corporate Policy on crime affecting specific populations e.g. race, gender, sexuality.
Performance Framework Team	<ul style="list-style-type: none"> • Apply Best Value mechanism and use the spirit of Section 17 of the Crime & Disorder Act 1998.

Putting in links across strategies

Community Care Plan Children's Plan Special Needs Housing Strategy Health Improvement Plan Health Action Zone Plan SRB Plan New Deal for Communities Plan	<ul style="list-style-type: none"> • An opportunity to see how the agency's services, combined with those of other agencies, can make an impact on community safety across a specific theme (eg elderly and vulnerable, other vulnerable adults, children at risk, unemployed young people, etc).
Complaints system	<ul style="list-style-type: none"> • Information on complaints relevant to community safety which could help the authority improve its performance. • Other data from complaints can help build up a picture of patterns of success or failure in community safety relevant issues. (Eg how well does the PCG/PCT/NHS Trust respond to trauma in victims of mugging? What arrangements for holistic care and onward referral exist? What prevention support can be given to help stop repeat victimisation?)

Patient-facing services

Function	Community safety issues	Inter-departmental/agency issues
GUM		
A & E		
Geriatric Care		
Mental Health		
Health Promotion		
Health Visitors		
CPN Services		
Family Planning		
Child Health		

Analyse what the direct, indirect and determinant community safety issues are, using the matrix above. You could also use the **Problem analysis triangle** (Figure 3 right).

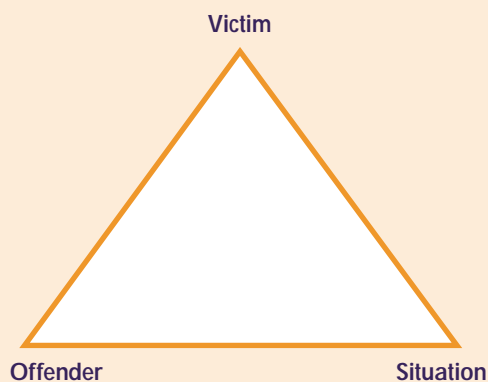


Figure 3 Problem analysis triangle

Information sharing

- **Partnerships work best when partners share information.**
- **The legislative framework of the NHS and crime and disorder reduction allows for effective information sharing.**
- **Information-sharing procedures and protocols should be clearly laid down right from the beginning of the partnership process.**

Sharing information is an extremely important part of making a crime and disorder reduction partnership work. Data (both anonymised and individual) needs to be shared between agencies to facilitate crime audits, strategy development and, sometimes, direct intervention (as in the case of Anti-Social Behaviour Orders, court reports, drug testing and treatment orders, and other kinds of interventions).

This is nothing new: effective information sharing lies at the heart of the changes brought in by the NHS and Community Care Act 1990. Joint training and information projects across the country have created useful models of sharing information about services, service users, and likely demand and need.

Section 115 of the Crime and Disorder Act grants the power to share information that can identify people. The issue of sharing information that identifies individuals has always been the cause of some disquiet within the NHS, since there is both a strong culture of confidentiality and a traditional presumption that the law underpins this. Indeed, with the Venereal Diseases Regulations 1974 and 1991, specific measures and prohibitions were put in place to protect the identity and well-being of those accessing NHS services.

In some places, though, the culture of confidentiality has become one of secrecy. A mistrust of other agencies sometimes underpins this. Agencies can also be sensitive to the information they hold being criticised as poor. The NHS is still responding to legislation

on access to health and medical records; the lessons and principles developed in this work need to be carried over into developing effective information sharing within the context of the Crime and Disorder Act 1998.

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*³¹ (HSC 1998/177). This guidance, although useful, takes a cautious approach to sharing information and should be read in conjunction with HSC 2000/009, which discusses the protection and use of patient information within the context of the Data Protection Act 1998. This circular gives a four-point action plan for Chief Executives and a three-point action plan for Data Protection Officers.

The principles underlying the common law duty of confidence in dealing with information are contained in HSG (96) 18.

The assumption in many authorities³² is that there is an unacceptable risk in disclosing information; for this reason, many NHS agencies have been reluctant to become involved in crime and disorder reduction partnerships. Practice suggests, however, that the vast majority of information to be shared is in the form of anonymised data from Accident & Emergency Departments or Drugs Clinics.³³ Refusing to share information carries its own risks: not just the possibility of judicial review, but also the mistrust and consequent refusal to co-operate that is the common reaction of other agencies when they feel that NHS agencies are being obstructive.

The risk of not effectively addressing this problem, therefore, is just as great as the risks from inappropriate information-sharing. An effective, shared system of developing a uniform approach will make the life of NHS and other agencies involved in crime and disorder reduction partnerships much easier.

31 NHS Executive (1999b)

32 McManus (2000c)

33 McManus (2000c)

Getting started

Every partnership needs to develop an information-sharing protocol. This will involve the NHS; indeed, the local authority can invoke the statutory duties of co-operation laid down by the NHS Act 1977, the Health Act 1999, the NHS and Community Care Act 1990 and the Crime and Disorder Act 1998 to enforce such involvement. If NHS agencies enter the partnership late, they may find an existing protocol that is almost unworkable. This can hamper the effective working of inter-agency relationships and the partnership itself. It is therefore important that NHS agencies enter into partnership working at as early a stage as possible.

Ideally, a working group on information sharing should be established for the entire NHS within a crime and disorder partnership area (local government district or county). This group should seek to develop a uniform set of policy arrangements that link information-sharing to both clinical governance within the NHS and the crime and disorder reduction partnership. This should be led by the Health Authority, PCT or PCG in the appropriate area, and include all NHS providers and the commissioners. The guidance should include:

- a description of duties and obligations containing:
 - who is responsible for deciding within each provider unit about disclosure
 - who they are to consult and why
 - how to seek consent and what to do when consent is not forthcoming
 - how to make a decision that takes account of legal obligations under statute, common law
- obligations to the patient and the case for disclosure in the public interest
- the impact of professional ethical principles on this (eg BMA Code, UKCC/RCN Codes, etc)
- a flowchart summarising this process and the decisions to be made
- a means of recording and demonstrating this including a checklist of the various stages
- a means of checking and validating this
- a set procedure for gaining consent or dispensing with obtaining consent
- a designated person within each NHS Trust, PCG, PCT, Health Authority and Primary Care Practice/Unit.
- a means of keeping a record about the disclosure

34 McManus (2000c)

35 Mackay *et al.* (1994)
paras 436-452 and 480-482.

Sharing anonymised information

The sharing of anonymised information has been going on between NHS agencies for many years, for example in Clinical Audit, epidemiological profiles for public health reporting and the conduct of research sanctioned by research ethics committees. Some NHS Trusts are still anxious about this, however.³⁴ A number of NHS Trusts operate on the principle that sharing patient information, even if anonymised, is unlawful because it will enter the public domain.

The remainder of this section summarises legal judgements on the sharing of anonymised information.

Source Informatics Ltd wanted to collect data on prescribing habits and asked pharmacists to provide it, using some of the information on prescription forms. The Department of Health advised in a policy document that even when such information is anonymised, the duty of confidentiality remains. Source Informatics failed in Judicial Review but the Court of Appeal held recently (*R v Department of Health, ex parte Source Informatics Ltd* [2000] 1 All ER 786) that ‘in a case involving personal confidences, the disclosure of information by the confidant would not constitute a breach of confidence provided that the confider’s identity was protected.’ In other words, the sharing of information which does not identify the person was permissible because ‘the law was concerned only to protect the confider’s privacy, and it was immaterial that the disclosed information was not in the public domain.’

The Court of Appeal specifically considered the obligation of confidence owed by health professionals to patients.³⁵ For a breach of confidence to have occurred, the three principles outlined in *Saltman Engineering Co Ltd v Campbell Engineering Co Ltd* (1948) [1963] All ER 413 must be met, namely:

- 1 The information itself must have the necessary quality of confidence about it (ie it can identify the person or can be identified with the person giving it).
- 2 The information must have been imparted in circumstances importing an obligation of confidence in either common or statute law.
- 3 There must be unauthorised use of that information to the detriment of the party communicating it.

In cases where information is anonymised

for research or audit purposes, where there is no quality of confidence about the information it can be freely shared. This applies even if the information, when linked to the aspects of it which can identify a person, imposes an obligation of confidence. Good practice would suggest that the protocol developed for the NHS should consider what kinds of data are held and what steps need to be taken to make patient identifiable data ‘shareable’ for the purposes of these principles.

The Court of Appeal held in the Source Informatics case that the ‘patient did not have a proprietary claim to the prescription form or the information it contained, and he therefore had no right to control its use provided that his privacy was not put at risk.’ In the case of sharing data from Accident & Emergency Departments, Drug Clinics, Regional Drug Misuse databases and other NHS records, the question of whether a patient has proprietary claim to the information usually does not arise, since it is common custom and practice for such information to be used internally for research, audit and management purposes.

The real barriers to sharing anonymised information are not legal: they are cultural and organisational and reveal an unwillingness to share.

Sharing personalised information

Sharing personalised information is far more complex and, on the whole, likely to be less frequent and routine than the sharing of anonymised data for audit purposes. Section 115 of the Crime and Disorder Act 1998 provides that:

‘**115** (1) Any person who, apart from this subsection, would not have power to disclose information –

(a) to a relevant authority; or

(b) to a person acting on behalf of such an authority;

shall have power to do so in any case where the disclosure is necessary or expedient for the purposes of any provision of this Act.

(2) In subsection (1) above ‘relevant authority’ means-

(a) the chief officer of police for a police area in England and Wales;

(b) the chief constable of a police force maintained under the Police (Scotland) Act 1967;

- (c) a police authority within the meaning given by section 101(1) of the Police Act 1996;
- (d) a local authority, that is to say –
- (i) in relation to England, a county council, a district council, a London borough council or the Common Council of the City of London;
- (ii) in relation to Wales, a county council or a county borough council;
- (iii) in relation to Scotland, a council constituted under section 2 of the Local Government etc. (Scotland) Act 1994;
- (e) a probation committee in England and Wales;
- (f) a health authority.’

This clearly provides that NHS agencies may disclose information to the health authority, police or local authority for the purposes of the Act. This means providing personalised or anonymised information relevant to obtaining any of the range of orders (Anti-Social Behaviour Orders, Drug Testing and Treatment Orders, orders on young people, etc). It could also apply to information where victims are identified to a partnership wishing to target, for example, repeat victims of racial, domestic or homophobic violence; or when the partnership has made a commitment in its strategy to contact individuals who repeatedly present to Accident & Emergency services.

This kind of sharing raises both legal and ethical issues, but the Act provides an empowerment to share information. The Act does not provide a statutory obligation; rather, it gives a statutory justification and power to disclose when the conditions for disclosure in the statute and otherwise established in law are met.

According to the Act these conditions are that:

- There are no statutory restrictions on disclosure³⁶ (eg those provided by the Human Fertilisation and Embryology Act 1990, the Venereal Diseases Regulations 1974, the Computer Misuse Act 1990 or the Venereal Diseases Directions 1991).
- The subject of the information has been informed of the proposed disclosure and has consented to it.
- On balance, there is an overriding public interest in the disclosure.

In addition, the requirements of the Data Protection Act 1998 must be met. These requirements have been dealt with elsewhere in detail (see eg ‘www.doh.gov.uk/dpa98’, which is supplied in support of the principles

³⁶ This itself is a matter of debate. DoH guidance suggests that the statutory restriction outweighs the empowerment provided by the 1998 Act. Others are of the opinion that s.115 takes precedence. To safeguard against risk legal advice should be sought while developing a protocol.

outlined in HSC 2000/009) and those developing protocols should consult these and the NHS Information Authority's Action Plan (www.standards.nhsia.nhs.uk/sdp) for further information.

Judgements on sharing personalised information should be made on a case-by-case basis, informed by a policy and set of protocols that have been agreed with the crime reduction partnership and apply to all NHS agencies in an area. Specific measures to protect people from crime could probably be justified by the public interest, but such decisions would clearly need to be supported by a policy framework.

Some health authorities and NHS agencies have argued that information-sharing protocols should not be developed on the basis that the public interest argument for disclosure is not significant or overwhelming. This would be a mistake, because:

- 1 S.115 of the 1998 Act is based on the principle that sharing information to reduce, prevent or otherwise deal with crime and disorder is in the public interest. The presumption that sharing information is in the public interest has been increasingly growing in practice among partnerships.
- 2 Existing policy guidance and legal precedent indicate that the issue of public interest needs to be taken seriously.

Guidance from the General Medical Council³⁷ and the Department of Health³⁸ both consider that disclosure to prevent or detect 'serious' crime falls within a public interest justification. The GMC Guidance states serious crimes:

'in this context, will put someone at risk of death or serious harm, and will usually be crimes against the person, such as abuse of children.'

This kind of arrangements exists already in many Area Child Protection Protocols; partnerships could find much to learn from practice in this field.

The Department of Health Guidance states (para 5.8) that:

'passing on information to help tackle serious crime ... may be justified if the following conditions are satisfied:

- i) without disclosure, the task of preventing, detecting or prosecuting the crime would be seriously prejudiced or delayed
- ii) information is limited to what is strictly relevant to a specific investigation;

iii) there are satisfactory undertakings that the information will not be passed on or used for any purpose other than the present investigation.'

Further, the guidance states (para 5.9): 'Requests for information relating to a number of patients in order to identify one or more is likely to be justified only if there is a very strong public interest.'

It is clear that the public interest argument must be taken seriously, and that it must be balanced by reasonable safeguards and boundaries. This does not provide *carte blanche* for unrestricted sharing of information but does require that it be properly considered. Kennedy & Grubb³⁹ state that even in cases where the offence or offender may not involve danger to the physical safety of others the public interest justification is applicable:

'It is suggested that it is – for two reasons. First, there is a general public interest in facilitating the due processes of the criminal justice system. In principle, any offence may justify disclosure. However, the less serious it is, the less likely the public interest in maintaining patient confidentiality will be outweighed. It is for this reason that the DoH, in its guidance, refers to 'serious crime' and by way of illustration in Annex D [1996 Guidance] lists 'serious arrestable offences' ... Secondly, in any event, to restrict the 'public interest' justification to dangers of the *physical* safety of others is too limiting. Other serious consequences to the public, such as fraud or dishonesty, should fall in principle within the justification (see eg *Price Waterhouse v BBC1 Holdings (Luxembourg) SA [1992] BCLC 583 (Millet J)*). Whether disclosure is, in fact, justified will depend on balancing the public interest in favour and against it.'

Risk and legal challenge

As mentioned earlier, the NHS Act 1977 and the Health Act 1999 establish a duty on health authorities to co-operate with local authorities, who are responsible authorities for the purpose of the Crime and Disorder Act 1998. It is possible that NHS agencies who refuse to co-operate in developing meaningful information protocols that consider properly this public interest case for disclosure may be open to judicial review.

37 GMC (2000)

38 DoH (1996). It is important to note this needs to be read in conjunction with guidance issued after the 1998 Data Protection Act.

39 Kennedy and Grubb (2000) pp. 1100–1111

Any NHS agency which does not develop a suitably comprehensive policy to deal with this issue leaves itself open to legal challenge. It is better to sort these things out before getting into court – especially if an NHS agency is defending itself against a challenge by an aggrieved patient. This must form part of the risk strategy for all NHS agencies.

Any policy should, in considering public interest, consider legal precedent and its implications for sharing information. The Crime and Disorder Act 1998 Protocols section of the *Manual for Caldicott Guardians*⁴⁰ is an important starting-place (although it should be noted that this manual is not comprehensive).

While NHS agencies are still acting with caution on the matter of information sharing, it is clear that they have:

- a common law duty of confidence with patient information
- a duty to participate in development of a protocol, stemming from their requirement to co-operate with crime reduction partnerships

There are also duties of confidence established by other legislation, as stated above. This is a legal issue that may need national guidance before it can be resolved. While the legal issues about information sharing are still difficult from an NHS perspective, this should not deter the development of protocols that:

- support and develop existing informal information-sharing
- provide clear justifications and a rationale for sharing of information that can identify individuals

Partnerships that have already done this kind of work include those in Surrey and Dudley in the West Midlands.

The development process for information-sharing protocols can be helped by sharing risk across all agencies in a partnership. Protocol development, legal advice and defence services should be handled in a way that meets everyone's needs and priorities. NHS risk advisers and lawyers should meet with their counterparts in other partner agencies at as early a stage as possible.

The White Paper *Reforming the Mental Health Act*⁴¹ includes proposed provisions that will introduce a new duty on health agencies and Social Services to share information with criminal justice agencies in certain circumstances.

Setting up an information-sharing protocol

It is also important to learn from the existing culture of 'informal' information-sharing between professionals at customer facing level. Every NHS agency has some form of unspoken arrangement for this with distinct, if perhaps unwritten, understandings between health staff and local police and the local authority. This culture, if unregulated, can compromise the interests and needs of patients. But any written protocol must learn from the actual situation on the ground, so that it suits the needs of the local agencies and individuals who need information.

All NHS agencies in an area that wishes to introduce an information-sharing protocol should go through the following process, at first internally and then with partner agencies. The first action point is to appoint a person with responsibility for information-sharing. In the first instance, the Caldicott guardian may be the most obvious person for the job. Whoever is appointed will have responsibility for implementing a strategy as follows:

- 1 Work internally to assess types of information to be shared and which legislative principles cover them, and produce draft guidance on this. Remember the principle outlined above that anonymised data – even data about genito-urinary medicine services covered by the Venereal Diseases Regulations 1972 – may, and in fact should, be shared with the partnership. Identified information needs clear protocols.
- 2 Involve the risk manager and legal advisers to the Trust/Authority at every stage. Consult the relevant legal adviser to the local authority to ensure that lawyers take a view. In some areas Trusts may wish to take recourse to counsel's opinion about the public interest defence for sharing information.
- 3 Work with the partnership to produce a protocol that harmonises the NHS legislative framework with that of the partnership. The questions in the box below should help facilitate this process.
- 4 When the protocol details have been developed and clarified, work should begin on a clinical governance framework for information-sharing that covers:
 - using anonymised data for a crime audit, with similar arrangements to those adopted for Warner or other statistical returns
 - identifying data

40 NHS Executive (1999b)

41 DoH (2000b)

Information to be shared

- 1 *Which information?* In relation to which victims, offences, offenders and situations.
- 2 *Anonymised or not?*
- 3 *Why?* Reasons for sharing. Reasons for not sharing.
- 4 *Who?* Shares or receives the information.
- 5 *How?* Informal arrangements / protocol / joint training / ownership
- 6 *Compare.* 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. The Cardiff Violence Prevention Group has designed a consent form for local Accident & Emergency departments to use with patients, so that they can collect data that will be used in crime audits.

CI(2000)8 from the Chief Inspector of the Social Services Inspectorate, *Casework Information Needs in the Criminal Justice System*, set out a report of the Joint Inspectorates requiring greater compatibility and co-operation between agencies. This provides a useful source of information about some of the problems in sharing identifiable information.

Key learning about information sharing

- Learn from Child Protection and Vulnerable Adults protocols.
- Conduct rigorous internal and joint preparatory work.
- Learn from work already done on community care.
- Involve Risk Managers.

Suggested strategies

- We provide plans for different health agencies to work on crime reduction.

The following strategies provide some basic mechanisms for different parts of the NHS within their key roles to address crime and disorder issues. These, together with the matrix in **Getting started**, can provide an initial plan.

A suggested strategy for the NHS Executive nationally

Element	Action
Commitment	<ul style="list-style-type: none"> • Issue guidance on requirements, outcomes and expectations of NHS roles in crime and disorder process. • Create register of lead and accountable NHS agencies.
Reviews and dissemination	<ul style="list-style-type: none"> • Commission systematic reviews and dissemination of work on Health & Crime.
Evidence-based planning	<ul style="list-style-type: none"> • Support development of a Cochrane Health and Crime Collaborating Group.
Support for other agencies, authorities and partners	<ul style="list-style-type: none"> • Issue guidance in the form of an HSC. • Require inclusion of crime and disorder partnerships into existing strategic process in health. • Work Jointly with Home Office and Partnership Support Programme.
Violence against staff	<ul style="list-style-type: none"> • Continue current work on violence against staff.
Research & development	<ul style="list-style-type: none"> • Develop a research needs plan on health and crime.
Information-sharing	<ul style="list-style-type: none"> • Support introduction of guidance to ensure local protocols on information sharing are fully effective.

A suggested strategy for an NHS regional office

Element	Early stages
Commitment	<ul style="list-style-type: none"> • Create regional lead accountable person and register with Government Office/Regional Crime Director. • Support regional crime and disorder forum, especially development of a health approach to crime and disorder. • Ensure inclusion of crime and health into regional strategies.
Regional performance management function	<ul style="list-style-type: none"> • Performance monitor NHS work on crime and disorder. • Support and advise on inclusion of crime and disorder work into HImPs, SsaFs, JCIPs and appropriate strategies.
Regional R & D function	<ul style="list-style-type: none"> • Support research and development on crime and disorder issues within regional strategy, in consultation with Regional Crime Directors.
Public health	<ul style="list-style-type: none"> • Inclusion of crime and disorder, and monitoring of health and social exclusion, within Regional Public Health Observatory functions. • Provide guidance to districts on use of health data for crime and disorder audits and trend analysis.

A suggested strategy for a health authority, Primary Care Group or Primary Care Trust

Element	Early stages	Mature stages	Continuous improvement
Commitment	<ul style="list-style-type: none"> Attend crime and disorder reduction partnership. Inclusion of crime and disorder issues in, HImP, SSAF and JCIP. 	<ul style="list-style-type: none"> Ensure co-ordination of NHS response across all NHS agencies. 	<ul style="list-style-type: none"> Develop lead trusts and officers able to work across HA, Trust, PCG, PCT and provider barriers.
Partnership	<ul style="list-style-type: none"> Key regular person to attend Partnership from Public Health Function or Commissioning function. Educate other partners in the contribution, needs and priorities of NHS. 	<ul style="list-style-type: none"> Place public health and needs assessment functions of HA at disposal of the crime and disorder partnership. Develop an NHS Health & Crime task group comprising PCGs/PCTs/providers and aspects of the HA/FHSA function. Use this group to develop NHS providers' responses. 	<ul style="list-style-type: none"> Develop lead trusts and officers able to work across HA, Trust, PCG, PCT and provider barriers.
Audit	<ul style="list-style-type: none"> Rapid review of research and evidence to assess what can be done. Rapid review of what is being done/purchased. 	<ul style="list-style-type: none"> Epidemiological studies, health needs analysis. Effectiveness audits and realignment of purchasing plans. Link with GIS systems for health planning. 	<ul style="list-style-type: none"> Detailed epidemiological research aligned to health aspects of crime & disorder strategy for locality.
Commissioning and alignment	<ul style="list-style-type: none"> Include what is being done in JimP, HImP, SSAF and JIP and in local crime and disorder reduction partnership's strategy. 	<ul style="list-style-type: none"> On basis of audit evidence and effectiveness reviews, realign services commissioned to meet needs identified. 	<ul style="list-style-type: none"> Development of health inequalities approach to crime and disorder work. Support development of Local Strategic Partnerships and be actively involved.
Target setting & strategic planning	<ul style="list-style-type: none"> Include what is being done in JimP, HImP, SSAF and JIP. Commit to Best Value/Business Excellence as a framework. 	<ul style="list-style-type: none"> Include health aspects of crime and disorder strategy included in local crime reduction strategy. Use the NHS Health & Crime task group referred to help develop crime reduction targets. 	<ul style="list-style-type: none"> Focus on themes for specific action and purchasing each year. Review progress jointly with partners and realign purchasing plans.
Culture & delivery	<ul style="list-style-type: none"> Ensure the inclusion of what is to be done on crime in Working Together in Partnership. 	<ul style="list-style-type: none"> Ensure the diversity of professions represented in PCGs, PCTs, NHS Trusts and other providers work to produce holistic response to health and crime. 	<ul style="list-style-type: none"> Develop joint information, training and audit/needs assessment functions.
Risk	<ul style="list-style-type: none"> Develop a risk minimisation plan for: staff at risk; violent patients; and crime against NHS. Include risk to staff and patients from crime in IIP and existing plans. 	<ul style="list-style-type: none"> Divert monies otherwise spent on risk into evidence-based purchasing of services. Develop risk strategies for managing crime by staff and patients. 	<ul style="list-style-type: none"> Review and realign services based on evaluation.

A suggested strategy for an NHS Trust

Element	Early stages	Mature stages	Continuous improvement
Commitment	<ul style="list-style-type: none"> Attend crime reduction partnership. Include statement about development of plan in Jimp, HImP, SSAF and JIP. Assess core functions (depending on kind of trust eg PCT/Acute/Community) for links with crime and crime reduction. 	<ul style="list-style-type: none"> Ensure co-ordination of NHS response across all NHS agencies. 	<ul style="list-style-type: none"> Develop lead trusts and officers able to work across HA, Trust, PCG, PCT and provider barriers.
Partnership and excellence	<ul style="list-style-type: none"> Support development of joint plan and conduct Best Value-style review or clinical audit of relevance to crime and disorder of all clinical work. Seek cross-cutting approach to improving health of victims of crime and offenders. Develop clinical guidelines for prevention, management and aftercare of crime in all settings (for staff and patients). 	<ul style="list-style-type: none"> Assist in patient and community involvement work. 	<ul style="list-style-type: none"> Revisit and improve clinical audit / Best Value-style review programme, align with health inequality and crime and disorder action plans.
Risk	<ul style="list-style-type: none"> Conduct risk and costs of crime audit (eg violence against staff, property, etc). Develop a safe care policy for staff and volunteers of the Trust, to protect them from crime and disorder and deal with offenders (security, aftermath of attack and assault, etc). 	<ul style="list-style-type: none"> Conduct a Best Value-style review of this. 	<ul style="list-style-type: none"> Develop and implement a strategy for reducing the costs of crime.

Case Study: Smoking

At first sight the relationships between smoking and crime are minimal. We have, however, already established that those who suffer most from crime and those who commit most crime are in that proportion of the population already most disadvantaged in health and social terms. In addition to this, tobacco is related to several forms of crime:

- It can be an impetus to acquisitive crime, so that people can buy tobacco.
- Illegal tobacco smuggling costs an estimated £1 billion in lost taxes annually. It involves intimidation and violence.
- Some shopkeepers and many illicit traders illegally supply tobacco to under-age smokers.

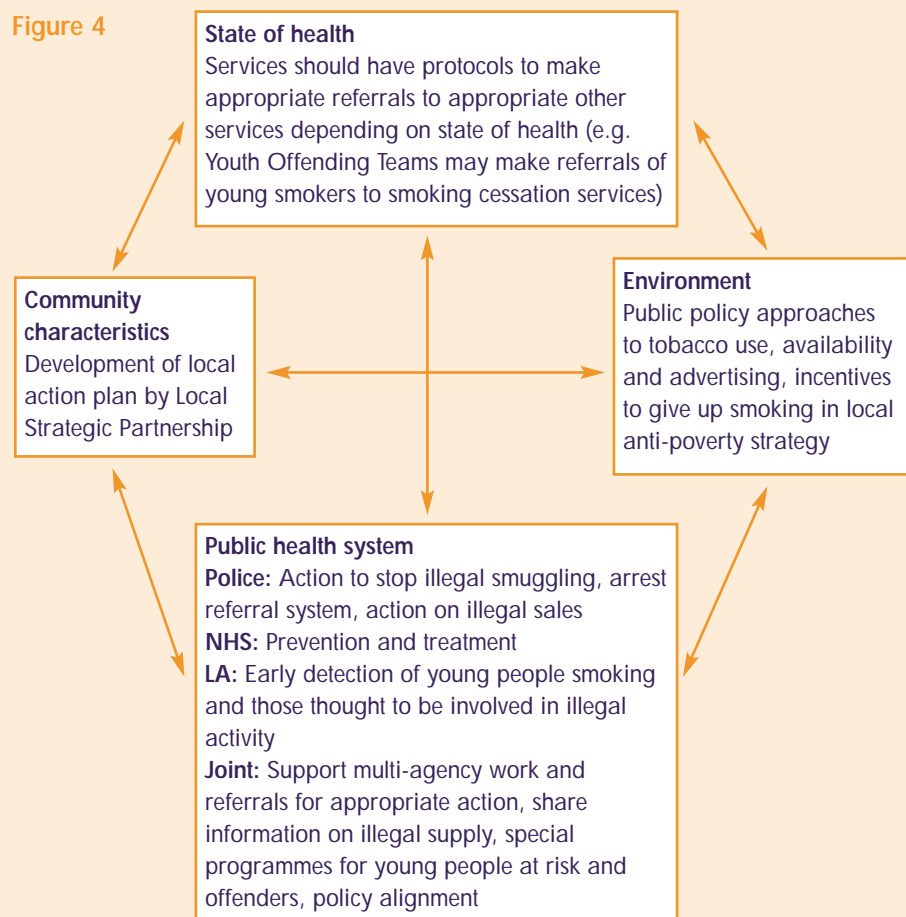
Nicotine addiction is a major public health problem; the most effective form of nicotine delivery is tobacco smoking. Addiction is quick to establish and difficult to give up. Acquisitive crime is sometimes a resort for smokers. The White Paper *Smoking Kills* established a framework for dealing with the 120,000 people per annum who die from smoking in the UK and the £1.7 billion annual cost to the NHS. The government set the following targets:

- to reduce smoking among children from 13 per cent to 9 per cent or less by the year 2010; with a fall to 11 per cent by the year 2005
- to reduce adult smoking in all social classes so that the overall rate falls from 28 per cent to 24 per cent or less by the year 2010; with a fall to 26 per cent by the year 2005
- to reduce the percentage of women who smoke during pregnancy from 23 per cent to 15 per cent by the year 2010; with a fall to 18 per cent by the year 2005

The NHS Smoking Cessation Allocations for 2000/2001 allocate more money to areas with higher smoking-related problems and prevalence. These are also areas with higher than average rates of crime and disorder. LAC (99) 4 issued guidelines to local authorities on smoking in residential care establishments, especially those for young people. Anti-smoking activities aimed at young people present opportunities to put across wider messages about drugs and alcohol and prevent offending at a later age.

By working together creatively, local crime and disorder reduction partnerships, Health Action Zones (where they exist) and the NHS can include appropriate crime and disorder messages and activities within actions that are primarily aimed at improving health by preventing smoking. The possibilities of work on this are outlined in Figure 4, which uses the health assessment model.⁴² In this model different agencies within the public health system (police, local authority, NHS, etc) work together to create a unified approach to all the problems caused by tobacco.

Figure 4



42 King's Fund (1994) Section 4, p. 10

ICD–10 codes and crime and disorder reduction partnerships

- **The International Classification of Diseases contains codes that can usefully be used to record social and health exclusion, as well as crime-related injuries and health problems. These codes can be used to compile data on the health/crime problems in an area.**

The International Classification of Diseases (ICD) Edition 10 contains over 12,400 codes that can be used to record diagnoses for hospital admissions. ICD-10 has been used in England since 1994. The codes provide a range

of medical and non-medical reasons for diseases.

There are major issues about consistency of recording and quality of recording data about social and health exclusion; the ICD-10 codes reproduced in Table 11 can usefully be used for recording social and health exclusion. They provide a starting-point for compiling consistent and reliable data, for use by the whole crime and disorder reduction partnership, on the risk factors associated with crime, social exclusion and poor health. In addition, some codes may be used to classify violence and injury of undetermined intent.⁴³

⁴³ For a discussion of the use of these codes to compile data in a specifically medical context, see Appleby and Perkins (2000).

Table 11 ICD–10 Codes: social and health exclusion

Z550	Illiteracy/low-level literacy
Z551	Schooling unavailable/unattainable
Z552	Failed examinations
Z553	Underachievement in school
Z554	Educational maladjustment and discord with teachers
Z558	Other problems related to education
Z559	Problem related to education, unspecified
Z560	Unemployment, unspecified
Z567	Physical/mental strain re unemployment
Z586	Inadequate drinking water supply
Z588	Other problems related to physical environment
Z590	Homelessness
Z591	Inadequate housing
Z592	Discord with neighbours, landlord and lodgers
Z593	Problems related to living in residential institution
Z594	Lack of adequate food
Z595	Extreme poverty
Z596	Low income
Z597	Insufficient social insurance/welfare support
Z598	Other problems: housing/economic circumstances
Z601	Atypical parenting situation
Z604	Social exclusion and rejection
Z608	Other problems related to social environment

Conclusions

- **Reducing crime brings enormous benefits to the NHS.**
- **Health agencies can play a vital role in crime and disorder reduction partnerships.**

The links between crime and public health are clear. Action on improving public health can help to reduce crime, and vice versa. Reducing crime brings benefits to the health system and frees up resources that can be used for other NHS work.

The NHS is a key partner in action on crime and health. The health care system has an important role to play in bringing about crime reduction. Health agencies need to be active

partners in local crime and disorder reduction partnerships.

The focus should not remain narrowly on crime reduction. Health action on crime and disorder will contribute to success in other areas of public life that are closely bound up with crime: poverty, and social and health exclusion.

This document is very much an initial guide. There is legislation pending that may necessitate changes in the future. We would welcome your comments and views, especially examples of good practice being developed by local partnerships. Please send any feedback to me, Jim McManus, at the address on the inside front cover of this briefing.

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About Nacro

Nacro is the principal independent organisation in England and Wales working to reduce crime. We employ over 1,000 staff who, together with volunteers, run a wide range of practical projects. At a strategic level, Nacro works with partners at national, regional and local levels to develop and implement effective strategies for tackling crime.

In the field of 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

We use our strong track record in research to produce publications and briefings on all aspects of community safety. Many of the briefings are contained in our free quarterly mailing, which is sent to community safety practitioners throughout England and Wales.

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