Delivering safer communities

A guide to crime and disorder reduction partnerships

Key points

- PCTs have had legal responsibilities linked to reduction of crime and disorder since 2004, but some have failed to act effectively on them.

- By 2009, PCT performance indicators will be joined up with those of partners.

- Crime and criminal behaviour impacts on communities – and on healthcare service provision; it therefore also makes good sense for PCTs to work with partners to reduce it.

- PCTs should use the six ‘hallmarks of effective partnerships’ provided in the guidance to check the effectiveness of their crime and disorder reduction partnerships and identify areas for improvement.

Crime and criminal behaviour has direct and significant links to the health of local communities – dealing with crime is good health policy. Primary care trusts (PCTs) in England have had legal responsibilities related to the reduction of crime and disorder since 2004. There are some areas of excellent practice (see case studies), but in general only lip service has been paid to the new regulations. It is important that PCTs take their responsibilities seriously and this Briefing explains how the Home Office’s new document, Delivering safer communities: guidance for crime and disorder reduction partnerships and community safety partnerships, can help them do so. The legal responsibilities also apply to local health boards (LHBs) in Wales.

What the law says: ‘responsible authorities’

Under the Crime and Disorder Act 1998, PCTs are one of the five ‘responsible authorities’ which are under a duty to formulate and implement a strategy to tackle crime and disorder in their areas – the others are the police, police authorities, local authorities, and fire and rescue. There is no hierarchy; all are equally responsible.

The guidance: statutory requirements

Delivering safer communities provides guidance on community and disorder reduction partnerships (CDRPs) in the light of the Home Office’s crime strategy launched in July 2007 and the Police and Justice Act 2006 and subsequent regulations which came into force on 1 August 2007 in England and in Wales on 19 November. It covers new statutory
Domestic violence, too, puts huge pressures on health services, while people with mental health problems are all too often involved with the police and criminal justice services as victims and perpetrators of crime.

Fear of crime affects the health of the wider community – for example, by causing social isolation in older people. Children subject or witness to domestic violence are likely to have poorer social outcomes and, it follows, poorer health outcomes.

Crime also directly affects health services through violence against NHS staff, damage to property, and costs of replacement, repairs and security. Alcohol and drug dependency increase crime and impact on healthcare services – particularly, but by no means only, accident and emergency (A&E) departments.

PCTs: active partners

While PCTs need to be active partners in order to meet their duties under the law, by 2009 PCT performance indicators will be joined up with those of partners – for example, local authorities. Inactive partners may, therefore, be judged on the performance of others.

There is often a commonality of client group between partners which points to the logic of a joint

Case study 1. Haringey: domestic violence tackled

Domestic violence is often identified when patients arrive at hospital and frequently begins when women become pregnant. When women are at their most vulnerable, in hospital recovering from an attack or pregnant, they are more likely to return to the same domestic situation because they are frightened and can see no way out of their predicament.

Haringey PCT, Haringey Council and local hospitals are piloting a 24-hour domestic violence advice line. Information stands in the A&E and maternity departments of the Whittington and North Middlesex hospitals advertise the freephone number. Friday, Saturday and Sunday nights, 8pm–1am are the times when domestic violence is most frequently reported.
approach. For example, someone with an alcohol or drug problem is likely to have wider health problems and more likely than others in the population to be unemployed, to live in poor housing conditions, to come into contact with the police and criminal justice system and to be a client of local social services.

These are shared issues and not simply the responsibility of one local partner – or one partner at a time. The role of CDRPs is to provide a holistic approach to local crime and anti-social behaviour.

Partnership-working also helps to fund projects that may be too costly for one organisation – for example, shared funding of a post to enable all partners to share data.

Strategic leadership: the right people around the table

CDRPs must have the right people around the table if they are to be effective. The governing body for each partnership needs to be made up of strategic leaders who ‘can get things done’. In unitary or district areas, this is the director of public health and/or partnership-working, or possibly the director of commissioning; in a county area it should be a chief executive or director of public health.

Boards must recognise their organisations’ important statutory role in CDRPs and make sure that their board representative is of sufficient seniority to be able to make the decisions needed to deliver targets. Boards must, of course, satisfy themselves that they are carrying out their statutory duties.

Clear roles and responsibilities

Each partner will contribute to the CDRP in a range of ways, but particular roles and responsibilities of the partnership’s PCT representative could include:

- sharing information about the scale of substance misuse, violent crime or domestic violence
- suggesting how agencies can work together to combat these issues – for example, through reassessing the licensing of local premises or the provision of accommodation or jobs to substance misusers
- monitoring the effect of interventions on the uptake of health services; this is an indication of the effect of unreported community safety issues.

Information-sharing: cornerstone of CDRPs

Information-sharing is the cornerstone of effective CDRPs, but this has often been sporadic. In some instances, many partners have been reluctant to share both

Case study 2. Hull: city centre crime crackdown

In Hull, partners have been working together to combat violent crime in the city centre. Police and paramedics work together on Friday and Saturday nights – the police presence helps reduce violence while paramedics treat a variety of injuries and other problems on the street, reducing the number of people who present to A&E. Violent crime is reported to be down by 30 per cent in the last year and although A&E attendance figures are not yet available a significant reduction has been reported.

Case study 3. Hull: domestic violence victim support

Hull PCT is working closely with the police and probation service on the partnership’s parenting support programme. This recognises that children are often the victims of domestic violence and abuse, not just in the short term but in relation to future problems.

A child who is subject – or witness – to domestic violence is more likely to suffer from a range of disadvantages which often lead to poor health and increasing pressures on local health services.
personal and depersonalised information, despite their power to do so under section 115 of the Crime and Disorder Act 1998.

Chief executives should be aware that their organisations have legal responsibilities to share data – and they stand to gain from doing so. There is now a wide variety of data that must be provided by PCTs and LHBs, if held:

- records of various categories of hospital admissions relating to assault, mental and behavioural disorders due to psychoactive substance use, toxic effect of alcohol, and certain other admissions related to alcohol
- records of admissions to hospital in respect of domestic abuse
- numbers of mental illness outpatient first attendances and people receiving drug treatment
- records of ambulance call-outs to crime and disorder incidents

In addition, other useful information includes data collected on patients receiving treatment in A&E departments, walk-in centres or other treatment centres for assault, suspected abuse, gun or knife wounds and other crime and disorder-related incidents.

Why accountability to the community is crucial

An effective CDRP should be visible and accountable to its community for the decisions and actions it takes on their behalf. All partners need to be aware of their responsibilities within the partnership and have the right systems in place to provide information to the community.

Plan for action: achieving delivery

The partnership plan is the basis for the CDRP and is designed to ensure that it delivers services that meet the needs of its communities.

The plan should also enable individual CDRP members to understand their respective roles in supporting delivery.

In developing the plan, partners are expected to identify cross-cutting issues where they can work with other partnerships or agencies. Examples include linking with the drug action team’s annual treatment plan.

Working with their partner local authorities, PCTs could use their new responsibilities to develop a joint strategic needs assessment to

Case study 4. Preston: preventing alcohol-related crime

In a bid to combat alcohol-related crime, as well as address public health objectives, Preston Community Safety Partnership appointed a secondee from Lancashire Police as alcohol project manager who worked alongside public health officials to engage local businesses and reduced opportunities for alcohol-related crime.

Recognising the cross-cutting impacts of alcohol misuse on crime and disorder and public health, the project manager produced an alcohol-related crime prevention strategy. Building on the positive relationship established with pub and club operators, the partnership sought to work with local alcohol retailers to cut alcohol-related crime while complementing public health objectives and statutory obligations under the Licensing Act.

The prevention strategy involved a number of initiatives, including Pubnet, which engaged all the city’s major alcohol retailers by sharing information on performance and risks.

The partnership used existing services and structures of the relevant responsible authorities. Outcomes included improved performance in reducing alcohol-related crime.

Additional benefits included improved partnership-working between police and health services and improved information-sharing, and data from A&E departments on assaults in licensed premises is now used to complement information gathered by the police.
Case study 5. Milton Keynes: cutting drunken behaviour

Volunteers from Buckinghamshire Fire Service supported by local police and part of Milton Keynes CDRP targeted drunk and disorderly behaviour. Volunteer firefighters handed out free bottles of water to people entering and leaving a popular Milton Keynes club.

The water helped to cut drunkenness, which in turn resulted in fewer incidents for the police and health service to deal with. The scheme was popular with club goers and it has now been extended to weekends and key events.

Case study 6. Southwark: street-drinking initiative

This two-year project used a multi-agency approach to address a long-standing issue in this south London community. The team used a problem-solving approach to engage wider partners and develop a sustainable solution.

There was a long history of problematic street drinking, but it had dramatically worsened in recent years, with large groups of drinkers now congregating in busy areas throughout the day, seven days a week. Their presence reduced the quality of life for people living or working in, or travelling through, the area.

It took six months to set up the project. This entailed:

- intelligence-gathering and monitoring of perpetrators
- community consultation
- setting up local partnership framework agreements
- research into best practice
- identifying funding.

The initiative resulted in tangible performance improvements, in particular an 89 per cent reduction in the numbers of street drinkers, the dispersal of street-drinking groups in target areas and a reduction in complaints from the community and local business.
PCTs have a clear role to play in the reduction of crime and disorder. This is not only a legal obligation, but part of their responsibility to the patients and public they serve.

Only through effective partnership-working can we continue to build safer and healthier communities.

The NHS Confederation knows that there is excellent work already happening in this area; however, it is crucial that best practice is spread further. We need to see partnership strategies supported by the hallmarks provided in this guidance become an integral part of trusts’ work programmes in this area.

There are many benefits to be reaped by the health service’s investment in delivering safer communities, including reducing the impact of crime and disorder on NHS services, staff and facilities. Success will be built on information-sharing, accountability and a clearly defined multi-agency approach. Of course, this poses challenges for managers, but is an important part of reinforcing the wider role of NHS organisations as responsible agents for change in their local communities.

For more information on the issues covered in this Briefing, contact elaine.cohen@nhsconfed.org

The Primary Care Trust Network

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