DEPARTMENT OF HEALTH AND HOME OFFICE

GUIDANCE FOR PARTNERSHIPS AND PRIMARY CARE TRUSTS (PCTS)

COMMENCEMENT OF PCTS AS RESPONSIBLE AUTHORITIES FROM 30 APRIL 2004

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1. FOREWORD FROM HAZEL BLEARS MP AND MELANIE JOHNSON MP

Dear Colleague

COMMENCEMENT OF PRIMARY CARE TRUSTS AS RESPONSIBLE AUTHORITIES WITHIN PARTNERSHIPS

As you know, on the 30th April 2004 Primary Care Trusts (PCTs) in England became responsible authorities within crime and disorder partnerships under section 5(1) of the Crime and Disorder Act 1998, as amended by the Police Reform Act 2002. This is welcome news and we are pleased to be able to draw your attention to the joint Home Office and Department of Health guidance to support the new requirements.

The cost of crime has a huge impact on the NHS. Bed days related to crime and disorder cost the NHS between £1.1 and £2.3 billion per year. An estimated 116,000 NHS staff were the victims of violence and aggression in 2002 - 2003. Property damage, risk, liability or injury to staff costs between £300 million and £678 million per year. Effective crime and disorder strategies could impact on a range of national and local NHS priorities such as reducing health inequalities, improving the quality of life and independence of vulnerable older people and improving the life chances of children

The new status of PCTs as responsible authorities will formalise the role PCTs have in participating in Crime and Disorder Reduction Partnerships (CDRP), and give PCTs an equal voice. PCTs will now have more influence in shaping local action to tackle crime and the causes of crime. It will offer PCTs real opportunities to affect the quality of life for their resident population.

Crime and Disorder Reduction Partnerships (CDRPs) are currently in the process of auditing crime and disorder, anti-social behaviour and drug misuse in their area and PCTs should be participating in this. CDRPs will then be formulating their strategies which are due to be published by April 2005.

On drugs, there are already many successful examples of joint working. PCTs have a key role in increasing the numbers of problem drug users in treatment and act as a banker for pooled drugs treatment budget on behalf of local partnerships. PCTs local delivery plans address how the trusts are moving forward to achieve drugs treatment PSA. There are many successes and examples of best practice to be built upon.

Alcohol related harm also has a significant impact on the NHS, and up to £1.7 billion is spent by the NHS in England each year in dealing with the consequences of alcohol misuse. The impact is felt most keenly in A&E departments where at peak times up to 70% of attendance can be alcohol-related. The Alcohol Harm Reduction Strategy for England was published on 15 March 2004 and sets out the Government's plans for tackling alcohol-related harms. PCT's have a key role to play in delivering this strategy, both in terms of tackling the health harms that can arise from alcohol misuse and supporting a partnership response to incidents of alcohol related crime, particularly those targeted at NHS staff.

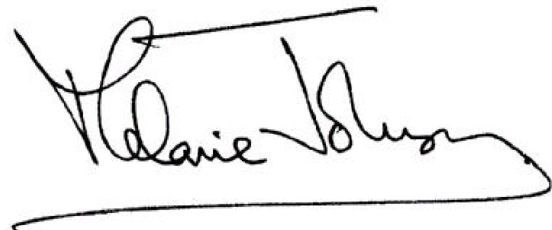
The joint Home Office and Department of Health guidance can be found on the following websites:

- http://www.crimereduction.gov.uk/aud02.htm
- http://www.drugs.gov.uk/WorkPages/CoreDocuments/PCTGuidance
- http://www.dh.gov.uk on the guidance pages
- http://www.nta@nhs.uk/programme/national/criminal_justice.htm#related

It has been developed to support PCTs in meeting their new statutory requirements. It explains how the new statutory duty should be applied, how this links to NHS priorities and plans and gives examples of joint work e.g. between PCTs and CDRPs from around the country.

We would encourage any PCTs that have not yet engaged in this process to do so as soon as possible and, just important, urge CDRPs to explore with their local PCTs how they can work together to deliver the real results – both in terms of crime reduction and improving the health of your population.

Best wishes.



HAZEL BLEARS **MELANIE JOHNSON**

2. SUMMARY OF REQUIREMENTS FOR PCTS FROM APRIL 2004

2.1 PCTs in England became "responsible authorities" under the Crime and Disorder Act 1998, amended by the Police Reform Act 2002, on 30th April 2004.

2.2 This means that now PCTs have a statutory responsibility to work in partnership with other responsible authorities, namely the police, fire and local authorities and co-operating bodies to tackle crime, disorder and the misuse of drugs[6]

2.3 The act places a duty on PCTs to:

- participate in an audit of crime and disorder, anti-social behaviour and drug misuse for the Crime and Disorder Partnership (CDRP) area or areas in which they fall; and

- contribute to the development of local strategies that effectively deal with the issues which are identified.

2.4 The first audit in which PCTs should participate needs to be completed by the end of September 2004 and after consultation with local communities the local CDRP must publish their strategy by April 2005. The strategy will last for three years.

2.5 The extent to which the PCT is involved in the delivery of the strategy is not specified. In practice this will be determined through local negotiation and it is likely to be greatest in areas where the delivery of action on drugs and crime and disorder makes a significant contribution to the PCTs own national or local priorities.

2.6 Action in support of the local Crime and Disorder Strategies may impact positively on a range of national NHS priorities including:

- Reducing health inequalities.
- Positive patient satisfaction surveys.
- Positive staff satisfaction surveys.
- Improvement in the life chances for children.
- Increasing the participation of problem drug users in treatment.
- Implementation of the National Service Framework for Mental Health.
- Reductions in waiting times.

2.7 Definitions of responsible authorities, co-operating bodies and invitees to participate provided at Appendix B.

2.8 Glossary of acronyms provided at Appendix C.

[6] See Appendix B for definitions for responsible authorities, co-operating bodies and invitees to participate.

3. MULTI-AGENCY WORKING

Links between the substance misuse, crime and health agendas

3.1 The cost of crime has a major impact on the NHS:

- 116,000 NHS staff were the victims of violence and aggression in 2002-03[2]
- Bed days related to crime and disorder costs the NHS between £1.1 and £2.3 billion per year[3]
- Property damage, risk, liability or injury to staff costs between £300 million and £678 million per annum[4]
- The cost of Domestic Violence to the NHS for physical injuries is around £1.2 billion a year.[5]

3.2 An Interim Analytical report on alcohol misuse published by the Prime Minister's Strategy Unit shows that:

- Alcohol-related accidents and illness lead to 150,000 hospital admissions per year in England.
- Around 40% of A&E admissions are alcohol-related.
- Dealing with alcohol-related illness and disease costs the health service in England up to £1.7 billion per year.
- Alcohol is associated with between 15,000 and 22,000 deaths each year in England.
- Between 780,000 and 1.3 million children live in families where one or more parents misuses alcohol.

3.3 In 2001-02 in Britain, there were 1.2m incidents of alcohol-related violence. Almost half the victims of violent crime say their attacker was under the influence of drink. Similarly nearly half of victims of domestic violence said their attacker had been drinking. And in all, alcohol-related crime in England is estimated to cost up to £7.3 billion per year.

3.4 Domestic violence accounts for almost a quarter (23%) of all violent crime. (British Crime Survey, 2000) and the cost of Domestic Violence to the NHS for physical injuries is around £1.2 billion a year. Victims subject to domestic violence often suffer a series of injuries, both physical and mental and not all these currently seek medical help for these.

3.5 Domestic violence can also have a damaging effect on a child's health, educational attainment and emotional well-being and development. The potential scale of this impact on children is vast - in up to 90% of incidents involving domestic violence where children reside in the home, the children are in the same or the next room (Hughes, 1992). Nearly three quarters of the children on the 'At Risk' registers of local

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[2] Department of Health figures

[3] Based on *Hospital Episode Statistics* figures for bed days caused by crime related illness and injury and UK studies reporting that in-patient costs £5200 to care for an average length of hospital stay of 12 days.

[4] Based on a telephone survey of NHS agencies

[5] The Cost of Domestic Violence, Sylvia Walby (University of Leeds) Summer 2004

authority social services departments are experiencing or witnessing domestic violence which means at least 750,000 children a year. Growing up in a violent household is also a major factor in predicting delinquency.

The benefits of partnership working to meet the substance misuse, crime and health agendas

3.6 Offending and problematic drug and alcohol use are strongly associated with poor educational achievement, low literacy levels, mental health problems, dual diagnosis, poverty, deprivation, discrimination and unemployment. Tackling these factors can lead to improved health outcomes.

3.7 Working together to tackle crime and disorder and the misuse of drugs and alcohol can make significant contributions to health priorities to reduce inequalities, improve health and access to services by:

- improving the working lives of conditions for NHS staff by reducing the risks of violent attacks and abuse;
- reducing pressures on emergency services as a result of violence related injury;
- reducing waiting times by reducing the demands on services from crime-related ill health;
- improving the health and life chances of children and young people;
- developing integrated services to support victims of crime, particularly victims of domestic violence, young offenders or offenders with mental health problems and those experiencing drug and alcohol dependence or dual diagnosis, and at risk of repeat victimisation;
- developing more effective prison health care and links with community provision for primary care and the treatment of mental health problems, drug and alcohol dependence, and other chronic ill health problems which are prevalent among prisoners;
- better engaging ordinary community members and citizens in decisions and policy making.

Existing joint working arrangements

Local Probation Areas

3.8 The Reducing Re-offending Action Plan sets out a number of important actions for the Home Office in partnership with other Departments. Together the actions aim to reduce re-offending through improving offenders' access to mainstream services essential for rehabilitation. There are a number of actions for the Probation Service, linked in the case of ex-prisoners to Prison Service action. Actions to address accommodation, mental and physical health, and drugs and alcohol mis-use are particularly relevant and will require co-ordinated work between PCTs, Strategic Health Authorities, the Probation Service and others at regional and local level. Examples include joint work to ensure that mental health intervention in prison is effectively followed up in the community and that requirements for mental health or drug treatment are taken into account in planning crime reduction and housing strategies, including access to appropriate housing through Supporting People.

3.9 In addition to providing clinical treatment for drug users, health are key players on the DAT/JCG who are represented on the Supporting People working groups. It is important that all partners use their influence to ensure that there is appropriate accommodation to support drug users in treatment and who have completed treatment. PCTs will also need to be familiar with the CJIP initiative and how health services will be accessed by local CJIT teams.

3.10 The Dangerous and Severe Personality Disorder Programme is piloting new services specifically for people who present a high risk of committing serious violent or sexual offences as a result of a severe personality disorder. The pilot units are at Rampton and Broadmoor hospitals and Whitemoor and Frankland prisons.

3.11 Services for people with severe personality disorder are also being piloted in medium secure and specialist hostel settings providing 75 new places. These are available in specified trust areas in London and Newcastle. Specialist community teams will support these.

3.12 On occasion, for example, where there is a determinate sentence, high-risk offenders with a severe personality disorder will be released into the community. Whether or not they have passed through the different levels of care mentioned above, the successful assessment and management of their offending and mental health needs depends on co-operation between local health services, the prison service, the national probation service and the police. This would be facilitated via the Multi-Agency Public Protection Arrangements.

Multi-Agency Protection Panels

3.13 In a number of areas across England and Wales, PCTs and other health agencies are making significant contributions to the assessment and management of sexual and violent offenders in the community who pose a risk of serious harm to others. These arrangements are known as Multi-Agency Public Protection Arrangements (MAPPA) and are led by a Responsible Authority, as set out under section 325 of the Criminal Justice Act 2003, comprising the police, probation and prison service. The statutory duty for police, probation and the prison services to develop Multi-Agency Public Protection Arrangements recognised the value of wider engagement with social care agencies. Early indications are that MAPPA is making significant contributions to public safety and reducing the level of serious re-offending.

Prison Service

3.14 From 2006 responsibility for commissioning prison health services will devolve to PCTs, which, working with the prisons in their areas will aim to ensure that appropriate and effective health services are in place to meet the needs of those held in custody and following their release back to the community. It is well established that the prison population has exceptionally high levels of mental ill health and substance misuse problems. Improving access to services for this group has an important contribution both in terms of meeting their health needs and so help meet NHS objectives and targets, and helping to reduce reoffending by increasing the prospects of successful resettlement. The mental health in-reach programme to prisons along side the developments in improving mental health services in the community e.g. assertive outreach, crisis resolution, personality disorder services, and primary mental health care all relevant in the context of meeting the needs of this group.

Neighbourhood Renewal and Local Strategic Partnerships (LSP)

3.15 Most areas have an overarching LSP responsible for the local Community Plan. All LSPs have been asked to prioritise development of a 'green, clean and safe' environment to underpin success in other issues. The integrated partnerships including PCTs have further opportunities to ensure their analysis, objectives and actions on health, well being, and community safety are fed into the LSP and reflected in the community plan. Integrated partnerships should therefore ensure robust links with their LSPs are in place or developed.

Prolific Offenders Strategy

3.16 Out of a million active offenders, 100,000 offenders have 3 or more convictions and are responsible for half of all crime. 20,000 individuals leave this pool every year and are replaced by another 20,000 offenders. The most active 5,000 of this group are responsible for one in ten offences. We have, therefore, developed a prolific and priority offenders strategy to address this group of offenders. This is an end to end strategy, in three complementary parts:

- Prevent and Deter – to stop people (overwhelmingly young people) engaging in offending behaviours and graduating into prolific offenders;
- Catch and Convict - actively tackling those who are already prolific offenders; and
- Rehabilitate Rehabilitate and Resettle – working with identified prolific offenders to stop their offending by offering a range of supportive interventions. Offenders will be offered the opportunity for rehabilitation or face a very swift return to the courts.

3.17 The strategy commences from September 04 and the delivery of all three strands of the strategy will be the responsibility of CDRPs and their partners. In practice, the strategy will be identifying individuals for intensive monitoring and management who are likely to have multiple health and social care needs. Under the rehabilitate and resettle strand, these individuals should be provided with support to assist them out of offending lifestyles. These types of individuals often do not have access to mainstream health services and this an opportunity for the PCT to prioritise development of health and support services for a highly impactful group of offenders whose cycle of offending needs to be ended.

3.18 Additionally the PCT should contribute to the 'prevent and deter' strand of the strategy to ensure the right range of programmes and interventions are in place on the ground to identify and work with those young people, from a very early age, who will go on to cause the most harm to communities unless there is an appropriate continuum of interventions to address their needs.

4. STATUTORY REQUIREMENTS

Functions of Responsible Authorities

4.1 The CDA 98 as amended by the PRA 02 places a new statutory duty on "responsible authorities" to work together and with other agencies within the community, to tackle crime and disorder and misuse of drugs (substance misuse in Wales).

4.2 Working in partnership, responsible authorities are required to carry out an audit to identify the extent of crime and disorder, anti-social behaviour and misuse of drugs problems in their area, and develop strategies that deal effectively with them. These statutory requirements are contained in sections 5 and 6 of the CDA 98 (as amended by the PRA 02).

4.3 Section 97(2) of the PRA 02 amended section 5(1) of the CDA 98 to extend the range of bodies who are "responsible authorities". From September 1998 these have consisted of local authorities and chief officers of police. From 1st April 2003, responsible authority status was extended to police authorities, fire authorities, and health authorities in Wales.

4.4 PCTs in England became "responsible authorities" on 30th April 2004.

Audit requirements: responsible authorities must in partnership:

- carry out a review of the levels and patterns of crime and disorder (including anti-social behaviour) and the misuse of drugs in the area, taking due account of the knowledge and experience of persons in that area, including ordinary community members;
- act in association with co-operating bodies[6] specified in the Orders made under section 5(2) of the CDA;
- invite the participation of 'invitees' to participate[6] from local communities and others specified in the Orders made under section 5(3) of the CDA;
- prepare an analysis of the results of the review;
- publish locally a report of that analysis;
- obtain the views of the public on that report.

Strategy requirements: responsible authorities must in partnership:

- formulate strategies taking account of the analysis and the responses to the audit setting out:

– agreed objectives of the responsible authorities, co-operating bodies and invitees to participate;
– short and long term performance targets[7].

- publish a document which must include:

– details of the co-operating bodies;
– details of the review;
– the analysis of the results of the review.
– the strategies, including in particular.

- the objectives and who is responsible for achieving them **and** the performance targets[7].

4.5 Further guidance on completing an audit and formulating a strategy, co-operating bodies and invitees to participate is available at www.crimereduction.gov.uk/aud00.htm **and** www.drugs.gov.uk/WorkPages/CoreDocuments/AuditandStrategyToolkit

Why have an audit and strategy?

4.6 The requirement to undertake an audit and formulate and implement a strategy is to ensure that all responsible authorities:

- are jointly aware of the nature and extent of crime and disorder, anti-social behaviour and the misuse of drugs in their area;

- are able to identify the methods of developing and implementing effective action to reduce these problems and deploy resources accordingly;

- are able to formulate and publish a strategy that responds to the expressed needs of local communities, includes the key findings from the audit, and sets out actions to be taken to tackle the problems identified through the audit and consultation process;

- are able to address local priority areas and identify crime reduction and misuse of drugs targets; and

[7] where this relates to PCTs as responsible authorities, targets should be read as goals/aims all NHS targets are contained in the Planning and Priorities Framework (PPF)

- undertake annual planning activity informed by a clear picture of where funds need to be allocated.

What is now expected of PCTs?

4.7 PCTs have a statutory responsibility to work in partnership with other responsible (set out above) authorities and co-operating bodies[6] to tackle crime and disorder and misuse of drugs issues locally. This means that they must participate in the crime and disorder and misuse of drugs audit, and the formulation and delivery of the strategy within their local authority area.

4.8 It is essential that PCT representatives on partnerships are sufficiently senior to command the respect of other partners and to be able to take decisions and commit resources. Where one PCT represents others, the same will apply. However, arrangement will need to be in place to ensure that partnership business is expedited through prompt communication with all of the PCTs which are being represented.

4.9 The audit and strategy process should form part of the planning already taking place in Drug Action Teams (DATs). Information on drug misuse and drug related crime would have also been included in crime and disorder audits since their inception.

4.10 Through this process local partnerships will need to ensure that there is a thorough understanding of the problems and needs in their area in order to formulate joint crime and disorder and misuse of drugs audit and develop strategies. This should include consultation directly with ordinary citizens about types of services that should be available and the nature of problems in their areas

4.11 DATs have previously undertaken drugs audits and needs analysis in their normal business planning and review processes. The information collected by partnerships to gather the information pertaining to drugs misuse for the audit should therefore be the formalisation of the planning already undertaken by DATs in the commissioning of its drugs services and in its delivery of the National Drugs Strategy.

4.12 For DATs, there should be no need to re-invent the wheel in order to comply with the new statutory requirement to complete joint crime and disorder and misuse of drugs audits. DATs have collected a range of data – through task groups, through annual returns and through commissioning services – that should be analysed and built upon as part of the audit and form part of the joint strategy.

When should this happen?

4.13 The statutory duty for PCTs to contribute to delivery of local crime and disorder and misuse of drugs issues and the formulation of the audit and strategy commenced on 30 April 2004. The first audit in which PCTs should participate needs to be completed by the end of September and the strategy published by April 2005, after consultation with local communities.

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[6] See Appendix B for definitions for responsible authorities, co-operating bodies and invitees to participate.

How should this be applied?

4.14 Under the CDA, PCTs are made responsible authorities in respect of each partnership within which they are based . The Act does not prescribe how this should happen locally, so it is for local PCTs and partnerships to determine the best way to arrange this. This is important given that boundaries are not co-terminous, particularly in two-tier local authority areas, and PCTs may need to be actively involved in the development of local crime and disorder strategies across a number of partnerships.

4.15 Local arrangements will therefore be needed to agree whether all of the PCTs within a particular local authority should participate in the local partnership or if one PCT should play a lead role, as is currently the case in relation to PCT involvement in Drug Action and Alcohol Teams. The Crime and Disorder Act does not place a statutory duty on other NHS trusts to be involved in developing an audit or strategy. PCTs may however discharge their obligations by commissioning other NHS trust to deliver services.

What happens if the PCT does not comply?

4.16 The Act does not specify what should happen in the event that a PCT or other responsible authority fails to meet requirements of legislation. The SHAs have a role in ensuring that PCTs are engaged particularly where service delivery was threatened e.g. through failure to participate in the joint commissioning of services or to deliver a national or locally agreed NHS target.

4.17 In certain cases the statutory duty may be enforced through the courts by way of judicial review). Application for judicial review can be made by those with "an interest", ie other responsible authorities, local residents etc. In addition, if a local authority or PCT failed in it's duty, then a partner or member of the public could address this through the Local Government Ombudsman and the Health Services Ombudsman. The SHA also have a role in ensuring PCTs are engaged (see section 7).

5. WAYS IN WHICH THE STATUTORY DUTY MIGHT BE APPLIED TO IMPROVE PARTNERSHIP WORKING

Role of PCTs

5.1 The statutory duty requires PCTs to contribute to the development of a local strategy to combat crime and disorder and misuse of drugs in their local area. The extent to which the PCT is involved in the delivery of the strategy will be determined through local negotiation and it is likely to be greatest in areas where the delivery of action on drugs and crime and disorder will contribute to the PCTs own national or local targets.

5.2 In particular PCTs might consider the extent to which involvement in the strategy will impact on targets to reduce health inequalities, improve the working lives of staff, improve life chances of young people, increase the numbers accessing drug treatment and reduce waiting times, particularly within A & E.

5.3 A number of PCTs have a history of successful involvement in partnerships. This will provide a sound basis for closer engagement in line with their enhanced role of responsible authorities.

5.4 Below are some practical ways in which PCTs can contribute to their local crime and misuse of drugs agenda:

- Actively engage in partnership activities/meetings/events.
- Act as conduits for information held within NHS trusts which would be helpful in supporting the 2004 audit.
- Influence the type of information collected that will support future audits and allow meaningful review of the success of local strategies.
- Evaluate the extent to which action on drugs and crime and disorder would improve health outcomes, reduce health inequalities or NHS costs.
- Participate in commissioning or performance management activities.
- Explore how Patient and Public Involvement (PPI) activities can be enhanced to support the crime and disorder and misuse of drugs strategy.
- Contribute to efforts to promote healthy attitudes to drugs and alcohol in workplace settings, perhaps alongside action to reduce smoking.
- Explore how local crime and disorder and drugs strategies and PCTs' Local Delivery Plans and Prison Health Delivery Plans can be more closely aligned and whether crime reduction could be prioritised as part of PCT action to address inequalities and improve public health.
- Provide information and multi agency training to staff on community safety issues particularly as they affect NHS staff and patients.
- Participate in communications campaigns.
- Consult actively with local community groups and use innovative methods to engage ordinary community members in helping inform policy and practice
- Consider staff placements and secondments with the partnership and/or partner agencies.
- Give appropriate priority to the rehabilitation of offenders, especially prolific ones, commensurate with their responsibilities to reducing crime and improving the environment of the communities that they serve.

- Adopt a multi-agency response to tackling domestic violence and child protection.
- Contribute to a holistic package of support for victims of crime, by ensuring liaison includes contact with voluntary support organisations such as Victim Support.
- Identify and seek to overcome barriers to the rehabilitation of offenders with health problems such as drug dependence.
- Identify and disseminate good practice, working alongside other partner agencies.
- Develop protocols with local probation areas to ensure that offenders with mental health problems leaving prison have access to appropriate treatment as part of their continuing programme of care.
- Disseminate relevant national and local NHS research to partner agencies.

5.5 PCTs and Strategic Health Authorities can also help by enabling all NHS staff, particularly frontline staff, to recognise their potential to encourage the victims of crime to report offences and in doing so prevent/reduce crime and its effects. Frontline NHS staff are in frequent contact with older people, victims of domestic violence, sexual offences, race/hate crimes and the most vulnerable families and younger people (including those with mental health problems) who are most likely to be the victims of crime. Partners should assist by ensuring that incidents involving NHS staff are dealt with promptly and efficiently.

PCT role in relation to Alcohol and Alcohol Strategy

5.6 The Alcohol Harm Reduction Strategy for England, published on 15th March 2004 highlights that in reducing the alcohol harms to health of alcohol misuse each year it would be good practice for each Primary Care Trust (PCT), or by arrangements a lead PCT or partnership which acts on behalf of other PCTs and agencies within a local authority area, to publish:

- Details of the partnership responsible for commissioning alcohol prevention and treatment services including its membership and a single point of contact for enquiries.
- Planned and actual increases in the numbers accessing treatment for alcohol-related problems.
- A statement outlining the arrangements for alcohol treatment and points of contact for those requiring help.
- A statement outlining the arrangements for the promotion of sensible drinking.
- A statement outlining the contribution alcohol prevention and treatment will make to the Crime and Disorder Strategy.

5.7 Many Drug Action Teams have already extended their remit and are now Drug and Alcohol Action Teams, The Government's Alcohol Harm Reduction Strategy for England encourages the remaining Drug Action Teams to similarly extend their remit. Within the Drug and Alcohol Action Team structure the strategy envisaged that PCTs would remain responsible for commissioning treatment for alcohol-related conditions, whilst all DAAT partners would share a responsibility for the identification and referral of individuals with alcohol-related problems, as well as for wider prevention and enforcement activity.

Section 17 of the Crime and Disorder Act 1998

5.8 Section 17 places a duty on certain partner agencies to exercise their various functions with due regard to the need to do all that they reasonably can to prevent crime and disorder in their local areas. The reach and impact of section 17 will be reviewed later in 2004. Whilst s17 does not presently apply to PCTs, PCTs are encouraged to consider how they can adopt the principles of section 17. This would mean building crime reduction considerations wherever appropriate in to the fabric of policy, decision making, resource allocation and the routine delivery of services.

5.9 Other responsible authorities provide a range of services in their community including policing, fire protection, planning, consumer and environmental protection, transport and highways, housing, education and social services. They each have a key statutory role in providing these services, and in carrying out their core activities, can significantly contribute to reducing crime and improving the quality of life in their area.

5.10 PCTs might choose to respond to this by building domestic violence awareness training in to training programmes for key front line staff or by routinely monitoring the levels of crime related calls to Ambulance Services and admissions to Accident and Emergency Departments into the contracts they place with NHS Trusts.

6. INFORMATION SHARING

Existing HO Guidance

6.1 Tackling crime, anti-social behaviour and misuse of drugs depends upon robust information exchange between all the agencies involved, and this is an important benefit of partnership working. The Home Office crime reduction information website (www.crimereduction.gov.uk/infosharing) provides lots of good guidance to partnerships about data sharing and how to do this, it also includes a protocol wizard to enable partnerships to develop their own data sharing protocols. The Department for Constitutional Affairs has produced guidance "Public Sector Data Sharing (www.dca.gov.uk/foi/sharing).

6.2 The Home Office has also recently published a concise guide "*Safety and Justice: sharing personal information in the context of domestic violence - an overview" (*www.homeoffice.gov.uk/rds/dprpubs1.html*)*. The guide provides a brief overview of why responsible information sharing is so important in the context of domestic violence, and how and when personal and sensitive information should be shared. The guide is aimed at practitioners who directly provide advice, support or protection to victims of domestic violence or may have a role in risk assessment. This will include a range of practitioners from the health, education, criminal justice and social welfare fields.

6.3 In addition, Home Office "Guidance for Local Partnerships on Alcohol-Related Crime and Disorder Data" published in February 2003 highlights some valuable data sources for auditing and profiling local alcohol-related crime and disorder and alcohol misuse. Sharing of such data will help partnerships to measure and understand the nature and extent of alcohol-related crime and disorder, to identify hotspots and to develop strategies to tackle problems. It would also enable the police and the PCT to using the relevant data to join forces to give clear messages about the dangers of under-age drinking.

Existing NHS Guidance

6.4 A summary of the principles and associated good practice that should be incorporated in Crime and Disorder Protocols can be found in **"Protecting and Using Patient Information: A Manual for Caldicott Guardians (Crime and Disorder Act 1998: Protocols)".**

6.5 Updated guidance on the common law and disclosures in the public interest can be found in the NHS Code of Practice on confidentiality (Annex B) which includes a disclosure model to help decide when it is appropriate to disclose confidential health information-
http://www.dh.gov.uk/PolicyAndGuidance/InformationTechnology/PatientConfidentialityAndCaldicottGuardians/AccessHealthRecordsArticle/fs/en?CONTENT_ID=4084181&chk=SylKTl

6.6 The NHS Information governance toolkit also which includes includes examples of protocols - http://nww.nhsia.nhs.uk/infogov/igt/KnowledgeBase.

What sort of information should and can be shared between PCTs and partnerships for the audit?

Information that follows(paras 6.7 –6.11) has been extracted from the NHS Code of Practice on Confidentiality and the Manual for Caldicott Guardians

6.7 Section 115 of the Crime and Disorder Act 1998 provides that any person has the power to lawfully disclose information, for the purposed of the Act, and in pursuance of measures to reduce crime and disorder, to the police, local authorities, probation service or health authorities, where they do not otherwise have this power. However whilst section 115 ensures that all agencies have a power to disclose, it does not impose a requirement on them to exchange information and responsibility for disclosure remains with the agency that holds the data.

6.8 In the absence of a statutory requirement to disclose the disclosing agency must be confident that, on balance (assuming no statutory restrictions on disclosure), there is an overriding public interest in the disclosure. Under common law staff are permitted to disclose personal information in order to support prevention, detection, investigation and punishment of serious crime and/or to prevent abuse or serious harm to others. A judgement is required that the public good that would be achieved by the disclosure outweighs both the obligation of confidentiality to the individual patient concerned and the broader public interest in the provision of a confidential service.

6.9 The NHS clearly has an important role to play and should contribute as fully as they are able whilst operating within the constraints provided by common and statute law. Each case must be considered on its merits. Decisions will sometimes be finely balanced and staff may find it difficult to make a judgement. It may be necessary to seek legal or other specialist advice (e.g. from professional, regulatory or indemnifying bodies).

6.10 Having said that, the Courts have ruled that the common law duty of confidence does not apply to information that has been effectively anonymised so that individuals cannot be identified. **There is thus no barrier to the sharing of effectively anonymised data.**

6.11 The Department of Health support the nomination of designated officers to regulate, monitor and act as the channel through which requests for information are made and handled and recommend that the Caldicott Guardian should be the designated individual for NHS organizations.

Protocols and Good Practice

6.12 The best way of ensuring that disclosure is properly handled is to operate within a carefully worked out information sharing protocol. Protocols should be supported by all the agencies involved and should be made available to the public. NHS organizations need to ensure that the particular sensitivities that apply to health information are appropriately reflected.

7. LINKS TO EXISTING NHS PRIORITIES AND PLANS AND RESOURCES

Existing NHS Priorities And Plans - Strategic Fit: the NHS Plan and Performance Planning Framework

7.1 The NHS Improvement Plan: Putting People at the Heart of Public Services sets out the priorities for the NHS between now and 2008. It supports the continuing commitment to a 10-year process of reform first set out in the NHS Plan, in July 2000.

7.2 A key tenant of the Improvement Plan is to place a far greater emphasis on local responsibility with fewer national targets being set. Local services will set their own targets reflecting the local circumstances, ethnicity and inequalities of the communities that they service and the local priorities of the people who use them. There is to be a far greater emphasis on prevention and into tackling inequalities in health. SHAs will oversee the delivery of these targets and ensure they are sufficiently stretching.

7.3 Some national targets will however remain to support the primary aim of producing a faster, fairer service that delivers better health and tackles inequalities. These targets are grouped around four broad themes and form the Public Sector Agreement with the NHS.

- The Health of the population.
- Improving Patient/User and carer experience of the NHS and Social Services.
- Chronic care management.
- Fair Access to services.

7.4 Within these themes, there are a number of specific targets that may be positively impacted on by partnership working on the substance misuse/crime agenda. These include:

- Increase the proportion of drug users in treatment programmes by 100% by 2008 and increase year on year the proportion of users successfully sustaining or completing treatment programmes.
- Reduction in health inequalities.
- Secure sustained improvements in NHS patient experience as measured by independently validated surveys.
- Improving the quality of life and independence of vulnerable older people by supporting them to live in their own homes.

7.5 The primary responsibility for the monitoring and review of Trusts against the priorities, targets and standards set for the NHS takes place within the NHS performance assessment framework and is conducted by Strategic Heath Authorities. Independent monitoring and inspection falls to the Healthcare Commission.

Resources

7.6. PCTs already contribute significant resources to the delivery of the treatment and act as the banker for adult pooled treatment budget for drug treatment as well as in relation to other areas of health provision which might impact or are affected by crime.

7.7 Crime reduction funding to partnerships is largely by way of the Building Safer Communities fund (BSC). The fund is designed to enable CDRP/DAT partnerships, or CDRPs working closely with DATs, to take a more holistic and structured approach to using their funds to reduce crime and combat drugs misuse. This incorporates the former Communities against Drugs funding.

7.8 Participating as responsible authorities is likely to result in PCTs also making mainstream resources available for partnership activities where these contribute to the achievement of goals shared between partner agencies. The extent to which this happens will reflect local negotiation and the PCTs own priorities. In line with the move towards greater local responsibility DH will not be placing requirements on how the additional funding which will be made available for PCTs to support the NHS plan should be spent.

7.9 The PCTs new status as responsible authority will enhance the PCTs opportunities to influence the spend of other partners, identify opportunities for joint funding and achieving mutual economies. PCTs should work with partners to identify the budgetary implications of their responsible authority status and agree their contribution (cash and in kind) to the work of the partnership.

7.10 The Spending Review 2004 will set the NHS Priorities and Planning Framework (PPF), for 2005-2008. Revenue resource limits for 2005/6 were set in 2002 and remain unaltered. The PPF will coincide with the requirement to develop and publish a Crime and Disorder strategy. As with other partners, PCTs should ensure that any budgetary implications are taken into account in their own budget planning cycle and are incorporated as far as is possible to the Local Delivery Plan for 2005/6.

8. CO-TERMINOSITY AND TWO-TIER AREAS

8.1 Guidance issued on 21 November 2003 http://www.crimereduction.gov.uk/integration.htm confirmed the criteria for the integration of Drug Action Teams (DATs) and Crime and Disorder Reduction Partnerships (CDRPs) in unitary authorities and closer working with CDRPs in two-tier authority areas. These arrangements should be finalised by 1 April 2004, although in some areas the new arrangements are still being developed.

8.2 The structure of partnerships, and the boundaries within which they are operating, will affect the division of responsibility for crime and disorder and drugs audits, strategies and annual reports at a local level. For example, in some two tier local authority areas, audits and strategies will be completed at county level with CDRPs contributing, although audits and strategies will be published at district (CDRP) level In other areas, partners may choose to produce an audit and strategy for each CDRP.

8.3 As CDRPs operate at the level of the district council administrative area in two tier authority areas in many areas they will not be co-terminous with PCTs. Despite the progress that many partnerships have made towards adopting closing work, arrangements in two-tier local authority areas remain complex and it may be particularly challenging for PCTs to engage where there is a lack of coterminosity with local authorities. For example, in Cheshire there is one DAAT, six CDRPs and four PCTs.

8.4 All partners will therefore need to discuss and agree local arrangements to determine how PCTs can best contribute to the development of the audits and strategies in the local authority areas that they cover. This is not something for which there is a 'one size fits all' solution. For example, PCTs will need to agree whether all of the PCTs within a particular local authority should participate in the local partnership or if one PCT should play a lead role as is currently the case in relation to PCT involvement in Drug and Alcohol Action Teams. Where there is ambiguity or difficulty in determining suitable arrangements, GOs should assist in formulating the decision. Where it is agreed that one PCT should take the lead on behalf of others in a particular area, all PCTs remain responsible for ensuring that relationship is sustained and take remedial action if this is not the case.

8.5 While this is a matter for local decision making, in some two-tier local authority area, the development of Crime and Disorder Reduction Groups at county level (particular for smaller counties) may be appropriate, in the same way that some counties have overarching local strategic partnerships. This would also fit with the existing arrangements for Drug Action Teams and other local public health networks which host other cross-cutting activities such as those around teenage pregnancy, transport accidents, sexual health, tobacco etc. It would also align with the county-based Children and Young People’s Strategic Partnerships and Youth Offending Team Steering Groups.

8.6 The key to successful engagement will be ensuring that PCT representatives on partnerships are:

- sufficiently senior to command the respect of other partners;
- able to take decisions on behalf of their organisation;
- able to commit resources.

8.7 Where one PCT represents others, as is likely to be the case in some areas, the same will apply. However, robust arrangements will need to be in place to ensure that partnership business is expedited through high level contact and prompt communication with all PCTs being represented.

9. ROLE OF STRATEGIC HEALTH AUTHORITIES AND GOVERNMENT OFFICES

How can Government Offices and Strategy Health Authorities support new requirements?

9.1 GOs/SHAs will be expected to support the commencement of PCTs as responsible authorities. The National Treatment Agency (NTA) also play an important role in supporting PCTs and SHAs in the achievement of the national treatment agenda/targets. In particular GOs/SHAs can offer support through:

- considering existing partnership structures and working groups to ensure overlaps are kept to a minimum and that work done in one forum is built on by another (where agendas overlap, added value could be achieved by giving consideration to merging or linking working groups);
- helping partner agencies' understand each other's organisations, including awareness of targets, focus, drivers etc;
- providing a link between networks already developed within the region which bring together community safety and health individuals and disseminating information which is of common interest;
- providing a link for post-release health care planning between those PCTs with a prison and those without
- undertaking research to link crime and health information on a regional basis and providing information on other available data sources;
- providing guidance and assistance on information sharing;
- evaluating projects and disseminating good practice;
- considering the training needs of PCT members joining partnerships and how these could be met.
- advising PCTs on how they can engage with communities and groups in line with forthcoming 'How to' Guide on engagement for integrated partnerships in respect of crime, alcohol and drugs.

How will SHAs and GOs monitor and ensure compliance with statutory duty?

9.2 Strategic Health Authorities will continue to be responsible for performance managing PCTs. They will seek to ensure the delivery of the NHS element of partnerships' crime and disorder and drugs strategies including the drug treatment target. In particular they will monitor the impact of involvement, or lack of it, on national and local targets as outlined in PCT Local Delivery Plans and may intervene where necessary. SHAs will be supported in this by the National Treatment Agency in relation to drugs.

9.3 The level of PCT engagement will also be reviewed by GO appraisal of partnerships' self-assessments and improvement plans and assessment of partnerships' crime and disorder and drugs audits and strategies. For example, one partnership in the West Midlands identified the need to build better links with the PCT as an action within their self-improvement plan; this will now be monitored by Government Office for the West Midlands. The NTA will also support GO in undertaking this process in relation to drug treatment.

10. APPENDIX A – PRACTICE EXAMPLES

The following practice examples are a snapshot of those received during the last consultation and are not a reflection of the full range of good practice in partnerships and government offices. They have not been centrally evaluated.

EXAMPLES OF JOINT PROJECTS	
Bridgenorth	PCT has worked on a number of projects with the CDRP, such as 'Safer Clubbing for Young People', 'Crucial Crew' and 'Senior Safety'.
Cambridgeshire	Several PCTs actively involved in CDRPs. In South Cambridgeshire, PCT contributed to the crime and disorder strategy. Work is ongoing to align partnership objectives and action plans with the PCT's local delivery plan.
Cannock Chase	PCT has been a member of the Community Safety Partnership since 2001, has a local shared care prescribing scheme specialising in substance misuse and is actively involved in a multi-agency domestic violence support project.
Canterbury and Coastal PCT	Involved with the audit and formulation of CDRP strategies since PCT was formed. Endeavoured to ensure that performance indicators associated within these strategies reflect those contained within the local delivery plan as well as other associated community based strategies/actions plans. The partnership team reports to the PCTs Professional Executive team and local joint initiatives have included distraction burglary, new initiatives on drugs and alcohol, PCT involved in local licensing forum.
Derbyshire	PCT work with community safety partnership on neighbourhood management project – with workers for elderly and below school age that link with community houses and neighbourhood workers. Funding been provided for neighbourhood management to patrol community hospital who have also linked with local GPs to enable rangers to patrol.
Greater Manchester	St. Mary's Sexual Assault Referral Centre – collaboration between Central Manchester Healthcare NHS Trust, Greater Manchester Police, and Greater Manchester Police Authority. It operates a open referral system on a 24-hour basis whereby clients can access the full range of services without reporting to the police, ie forensic medical examination, emotional and practical support, one to one counselling, post-coital contraception and pregnancy testing, screening for sexually transmitted infections, and 24 hour telephone support and information line, support through criminal proceedings.
South Tyneside	PCT has worked closely with the DAT in designing and running a number of innovative consultation and community engagement projects to determine local people's awareness of drug issues and their views about services
Hillingdon PCT	Sits on the Community Safety and Drugs Partnership, which produces 3 yearly local Community Safety Strategy and leads the work of the Drug and Alcohol team. In 2003, set up health and crime project to raise awareness of how much health services contribute to crime and disorder reduction across a wider front. Aim was also to find out whether staff recognise potential to prevent crime and reduces its effect and act on it. On young people, PCT has developed partnerships and joint working with Local Education Authority, Police and local voluntary organisations, assisting on housing, education, YP counselling, sexual health, drug treatment and community outreach.
Kent	East Kent Coastal Teaching Primary Care Trust (and previously as the Thanet PCG and Channel Primary Care Group) has been an active member of the Dover and Thanet CDRP for several years. A Senior PCT representative chairs

	the Drug and Alcohol Sub Groups of both CDRPs. PCT actively involved in the setting up of the Racial Incident Reporting Line in East Kent (producing much of the publicity material). The PCT is involved in various other projects including Domestic Violence.
Leeds	Set up a Rough Sleepers Support Team to respond to drugs misuse and crime among rough sleepers and beggars in city centre, with representatives from the police, housing, drug treatment providers and the PCT. More people are entering treatment, more people are supported in accommodation and more people are accessing benefits. The number of rough sleepers in the city has halved and the robbery rates in the city centre have gone down.
London	The London Agenda for Action on Alcohol published in January sets out the nature and extent of alcohol use in London and future priorities for the NHS, local authorities and the criminal justice agencies. Key priorities include reducing alcohol related crime, disorder and nuisance on streets, reduce harmless effects of alcohol on children and families, and increase knowledge of alcohol use and alcohol related harm prioritising information on alcohol and its impact in London.
London	Stella project in London provides links between the domestic violence and substance misuse agendas. It also seeks to encourage screening for domestic violence problems as part of treatment agency assessments and access to information for NHS primary care workers on substance misuse services available.
Liverpool	Citysafe in Liverpool has established three joint action groups, through which a number of programmes have been developed to improve the safety of NHS staff and reduce crime. These include: • target hardening of community clinics; • targeting of offenders involved in vehicle crime in and around hospitals or clinics; • improved lighting and CCTV coverage to reduce fear of crime experienced by staff and patients; • the development of programmes to reduce anti-social behaviour in A&E departments.
Mansfield	Mansfield District and Ashfield PCT - Consultant Nurse in Domestic Violence chairs the local domestic violence forum, sits on 2 local CDRPS. Domestic violence is recognised as one of the 6 Crime targets within the Crime Reduction Strategy. This has resulted in the PCT receiving additional funding via the partnership for practical safety measures, and training resources, delivering a well developed strategic response to domestic abuse for service users and improving the multi agency response for victims with additional benefits to service planning.
Shrewsbury and Atcham	CDRP and PCT co-funded and worked in partnership on the Alcohol Awareness Roadshows project, run by IMPACT. The project ran at number of venues (including workplace settings, GP waiting rooms, schools, community centres, youth centres, canteens, libraries and supermarkets) with the aim of informing and educating the general public on alcohol-related issues.
South Staffordshire	PCT has part funded a Peer Education Project based on young volunteers training their peers on issues such as drugs, alcohol, teenage pregnancy, and health matters. Through the PCT, Health Promotion in Schools has been encouraged and a large number of schools within the district are now Health Promoting Schools.
Wakefield	Successful joint working around domestic abuse in Wakefield where GPs

	question patients to establish whether domestic abuse is the cause of depression etc.
West Midlands	Provided late night buses to get people out of the area swiftly had an early impact in reducing the numbers who presented at the nearby A&E.
Wychavon	CDRP has funded a project to develop a CD-ROM "Young People, Healthy Living" on lifestyle education, which has had considerable input from the PCT.

EXAMPLES OF INFORMATION SHARING PROJECTS	
Blackpool, Fylde and Wyre NHS Trust	Established an information exchange system with Lancashire constabulary, the aim of which is to see an overall reduction in violent crime in Blackpool. The A&E department at Blackpool Victoria hospital will enquire of those assaulted whether they would be prepared for incident to be reported to the police. If consent is granted, then name address and contact details are provided to the police who follow up action. Police and hospital regularly analyse information for trends and hotspots in consultation with other local agencies.
Bristol	Bristol CSP and Bristol A&E departments have developed information sharing processes, including software. Contact John Richards, BCSP Milton Keynes General Hospital Trust (as was) – A&E and health visitors were lead partners in developing a local info sharing protocol on domestic violence.
Cardiff	The Cardiff Targeting Alcohol-related Street Crime (TASC) project targets crime and improve health by reducing levels of binge drinking. In particular data gathered and collated by an A & E nurse dedicated to the project underpinned the design of successful interventions.
East Kent	A&E data (for example number of assaults, those that present with drug problems) is now being made available for mapping of criminal activity.
Kent	Kent DAAT established a joint commissioning team with 3 PCTs with lead role representing 9 in area. Also established quarterly meetings with CDRP Officers and Chairs of the Drug and Alcohol CDRP sub groups to ensure that joint planning is established and information is exchanged. The DAAT produces a quarterly statistical bulletin which contains information on numbers accessing treatment, numbers, types and location of arrests, hospital admissions data and A&E data (East Kent only) as well as other sources of data. This is an extremely useful planning tool.
Merseyside	The Worst Kept Secret project in Merseyside provides a helpline service and gathers anonymised data from GP practices in the area.
Tees Valley	Have developed a Multi-Agency Drugs Database on behalf of 5 DATs and partners in Tees Valley area. It has proved a powerful information tool to inform local DAT plans and services. It combines information kept by separate agencies on drugs misuse by individuals which enables the elimination of multiple counting and identifies proportion of drugs users known to more than one agency, providing aggregate information to DATs and partner agencies.

11. APPENDIX B - DEFINITIONS

Responsible authorities

What is a responsible authority?

Section 5 (1) Act defines responsible authorities for each local government area as:

- the council for that area and, where the area is a district and the council is not a unitary authority, the council for the county, which includes the district (eg in two-tier authorities) both district and county councils are responsible;
- every chief officer of police where any part of their police area lies within the local government area;
- every police authority where any part of their police area lies within the local government area;
- every fire authority where any part of their area lies within the local government area;
- in Wales, every health authority where the whole or any part of their area lies within the local government area;
- in England, every Primary Care Trust where the whole or any part of their area lies within the local government area (subject to commencement order).

Section 5 (4) of the Act defines local government area as:

- in England - each district or London borough, the City of London, the Isle of Wight and the Isles of Scilly;
- in Wales - each county or county borough.

The role of responsible authorities

For audits, the role of responsible authorities is to:

- review levels and patterns of crime and disorder (including anti-social behaviour) and misuse of drugs (substance abuse in Wales), taking into account the knowledge and experience of persons in the area;
- act in association with co-operating bodies;
- invite the participation of invitees to participate;
- prepare an analysis of the results of the review;
- publish a report of the analysis locally;
- obtain the views of the public on the report;

For strategies, the role of responsible authorities is to:

- develop a strategy taking into account the analysis and responses to it, setting out agreed objectives of responsible authorities, co-operating bodies and invitees to participate and short and long term performance targets;
- publish a document that must include details of the co-operating bodies, details of the review, analysis of the results of the review, the strategy (including the objectives) and who is responsible for achieving the objectives and the performance targets;
- submit copies of their strategies and published documents and an annual report on the implementation of their published strategies during the preceding 12 months to the Secretary of State. This is required under Section 6A of the Crime and Disorder Act 1998. Further guidance on the content and timing of the annual report will be published soon.

Co-operating bodies

What is a co-operating body?

Section 5 (2) of the Crime and Disorder Act 1998 states that responsible authorities must act in co-operation with **every probation board**, any part of whose area lies within the area. The Secretary of State also requires responsible authorities to work in co-operation with the following in each local government area:

- Parish Councils (England).
- Community Councils (Wales).
- NHS Trusts.
- Schools' governing bodies.
- Independent schools' proprietors.
- Further education governing bodies.

The role of co-operating bodies

Co-operating bodies represent local groups or agencies who can provide a significant contribution to tackling crime and disorder and drugs misuse in the local area. The Crime and Disorder Act 1998 requires objectives to be set for the co-operating bodies and other contracted agencies when strategies are developed. Therefore, co-operating bodies must:

- play a key part in both the audit and strategy development process;
- be important partners in the implementation and on going development of the strategy.

The Act also places a legal obligation on co-operating bodies to:

- co-operate fully in the work of the auditing and strategy setting process;
- help deliver the objectives set out in the crime and disorder and drugs strategy.

Co-operating bodies should be able to provide data or information to improve the understanding of local crime and disorder and misuse of drugs problems and contribute to the benefit of the local community as well as benefiting the core functions of their respective agencies. These bodies should be able to bring the benefit of their knowledge and expertise and details of their ability to help support partnerships' initiatives through early interventions either as part of their core work or by working together with other constituent partnership agencies.

Partnerships must understand the role and requirements of these other agencies and identify what they can contribute in terms of information, resources and ideas. You should also help them to understand what benefits they can reap from partnership working in terms of their own work and core functions.

Invitees to participate

Who are invitees to participate?
Invitees to participate represent a range of local groups and organisations that are involved and engaged in their local community.

Section 5 (3) of the Crime and Disorder Act 1998 includes a list of invitees to participate. This list is not exhaustive and you must make every effort to encourage local groups and communities to be actively involved in the audit and strategy process. The list includes:

- Social landlords.
- Drug Action Teams / Drugs and Alcohol Teams.
- Training and Enterprise Councils.
- Youth Voluntary Organisations.
- Crown Prosecution Service.
- Crown Court Managers.
- Magistrates Court Committees.
- Neighbourhood Watch committees.
- Victim Support Service members.
- Service Police.
- Ministry of Defence Police.
- Public transport/School transport providers and operators.
- Passenger Transport Executives and Passenger Transport Authorities are subject to commencement order that came into force on 23 February 2004
- Bodies providing services to women, young, elderly, physically and mentally disabled.
- Bodies providing services to minority ethnic groups, gay and lesbian groups.
- Bodies providing services to residents.
- Religious bodies.
- Companies.
- Retail bodies.
- Trade unions.
- Medical practitioners.
- Bodies representing medical practitioners.
- Higher education governing bodies.

Many of these groups gather large amounts of information in their day-to-day activities and can help to provide a fuller understanding of the causes of crime and/or misuse of drugs in the local community. They can be particularly helpful in areas where there is a lack of information on the extent of drug related harms in the area. RAs should also consider working with agencies that can give a fuller picture of particular geographic areas or specific minority groups.

Involving invitees must be a core aspect of the audit and strategy process. Their local knowledge of dealing with victims and perpetrators is invaluable in understanding the problem, considering how to find solutions and implementing and monitoring initiatives.

You may also want to involve in other agencies in your audit including:

- Treatment agencies.
- Accident and emergency departments.
- Voluntary agencies.

Partnerships should also:

- consider how to involve victims and witnesses in the audit and strategy process.
- be aware of, and make the appropriate links to, the work of Local Criminal Justice Boards.

The Victims and Witnesses National Strategy (July 2003) sets out how the Government plans to make sure that victims and witnesses get a better deal from the Criminal Justice System. Recommendations in the strategy were taken forward in the Domestic Violence, Crime and Victims Bill 2003**.** Partnerships should also be aware of the National Strategy for Restorative Justice (July 2003), which highlights the role that restorative justice can have in increasing the satisfaction and confidence of victims.

12. APPENDIX C: GLOSSARY

GLOSSARY	
A&E	Accident and Emergency
ASB	Anti-Social Behaviour
BSC	Building Safer Communities fund
CDA 98	Crime and Disorder Act 1998
CDRP	Crime and Disorder Reduction Partnership
Co-operating Bodies	*From the Crime Reduction website*
CSP	Community Safety Partnership
DAT / DAAT	Drug Action Team / Drug and Alcohol Action Team
GO	Government Office (fopr the Region)
GPs	General Practitioners
HORDs	Home Office Regional Directors
Invitees to participate	*From the Crime Reduction website*
LAs	Local Authorities
LHBs	Local Health Boards
LNRS	Local Neighbourhood Renewal Strategy
LSPs	Local Strategic Partnerships
NAW	National Assembly for Wales
NDS	National Drug Strategy
NHS	National Health Service
NRF	Neighbourhood Renewal Fund
NTA	National Treatment Agency
PCTs	Primary Care Trusts
PPI	Patient and Public Involvement
PRA 02	Police Reform Act 2002
PSA target	Public Service Agreement target
Responsible Authorities	*From the Crime Reduction website*
Section 17 (of the Crime and Disorder Act 1998)	Mainstreaming the vital work of crime and disorder reduction across the wide range of local services and putting it at the heart of local decision-making. (Section 17 has not yet been extended to PCTs but will be considered under a broader review of the CDA later this year)
SHA	Strategic Health Authorities
YOT	Youth Offending Team