STRUCTURES AND ROLES: NHS and Community Safety in England

Structure of the NHS in England

The NHS is a large and complex organisation comprising many healthcare functions. It employs 5.9% of the UK workforce. One of the main features of the NHS is the divide between commissioners and providers of services. The structure of the NHS has evolved through legislative change; the latest of which being proposed within Health and Social Care Bill 2011.

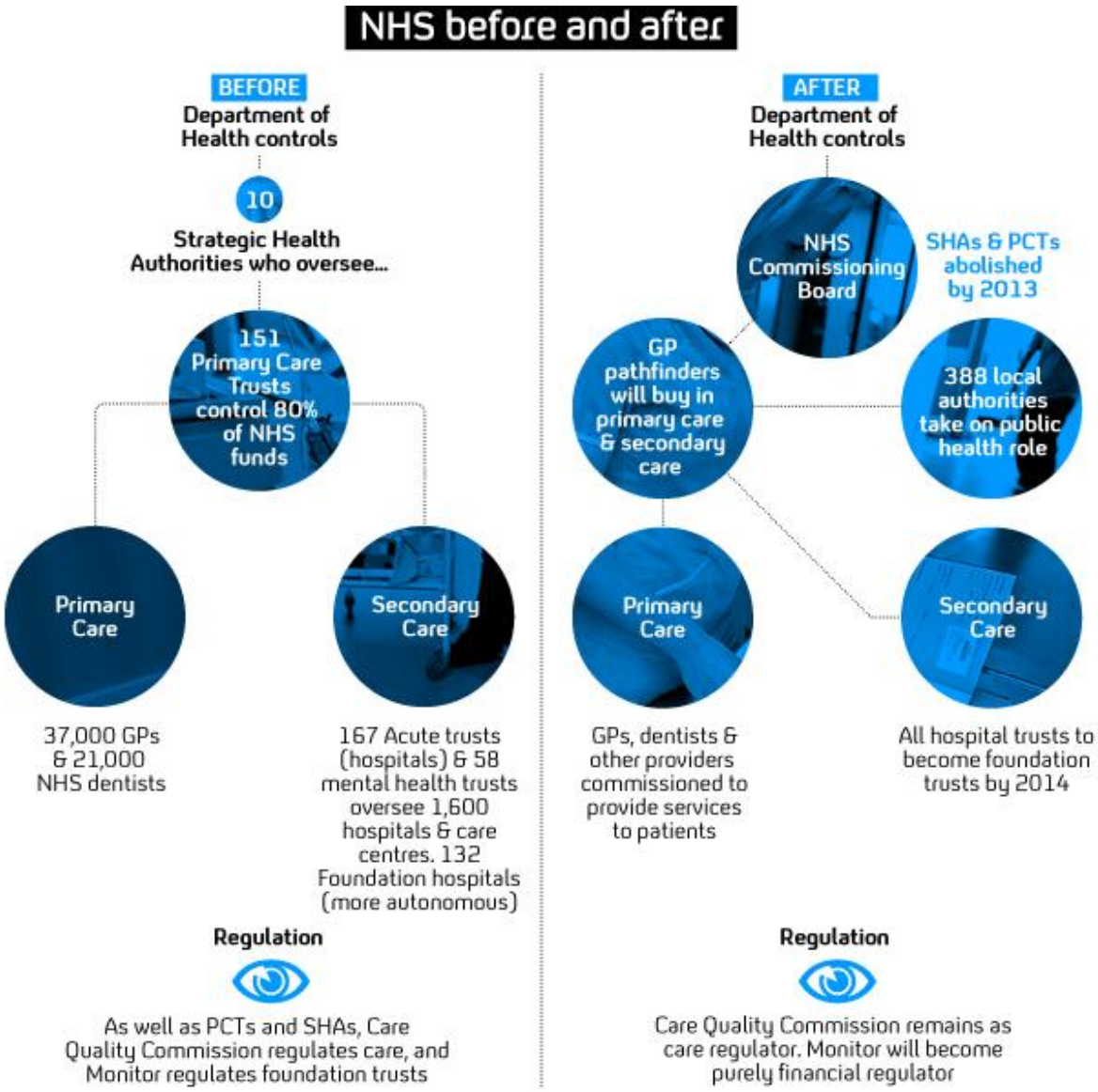


Diagram: NHS before and after 2013/14[1]

Currently the NHS is divided into two sections. **Primary care** is the first point of contact for most people and is delivered by a wide range of independent contractors, including GPs, dentists, pharmacists and optometrists. **Secondary care** is known as acute healthcare and can be either elective care or emergency care. Elective care means planned specialist medical care or surgery, usually following referral from a primary or community health professional such as a GP.

[1] Channel 4 News

Structures and roles within Emergency Departments

Hospitals are *Providers* of services within secondary care. Hospitals are part of Acute Trusts or Foundation Trusts. http://www.nhs.uk/ServiceDirectories/Pages/AcuteTrustListing.aspx.

The Foundation Trust model will be streamlined and become the model for all NHS hospitals. This will also apply to all providers of commissioned care. By 2013 all NHS hospital trusts will have to become Foundation Trusts.

Local arrangements within Emergency Departments vary. There is not a specific person within health at a local level who will have lead responsibility for information sharing to tackle violence.

Key people in Emergency Departments include:

- Receptionists who "clerk", e.g. obtain personal details and basic assault information where relevant;
- Clinical staff, doctors, nurses and other specialists provide initial assessment, triage, manage access to treatment and initiate treatment;
- Managerial staff who coordinate and run service delivery;
- Information management and technical support staff who can support the technical means to make information sharing happen.

Getting the right engagement in ED's is vital. If you are looking to build engagement from outside the ED this may involve contacting several people and being pragmatic about the best approach to take.

Whether you are within the NHS or a partner organisation securing engagement from the following people at a senior and strategic level can be really helpful:

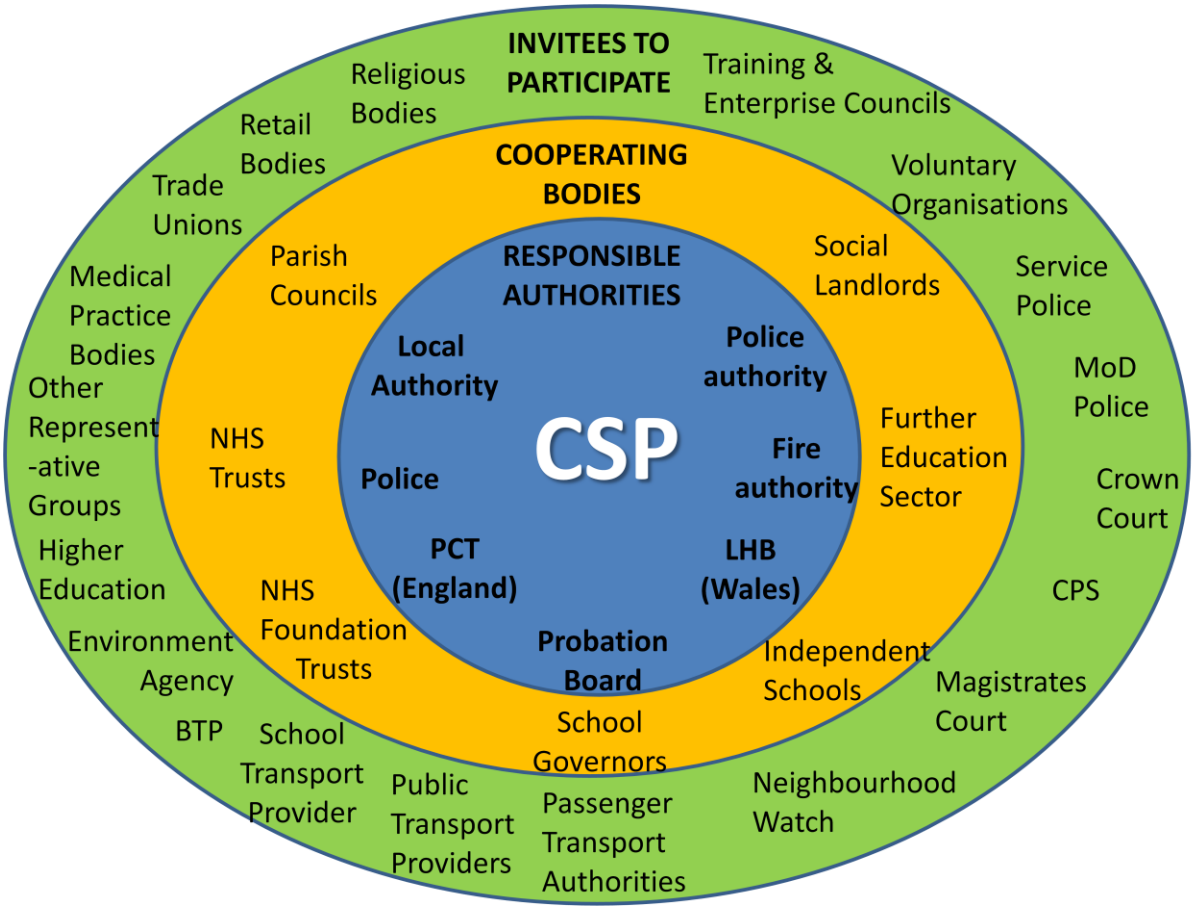
- Head of Emergency Medicine or Departmental Lead in your Emergency Department
- Chief Executive of the Acute hospital Trust;
- PCT Chief Executive (while PCTs are still relevant);
- Members of Health and Wellbeing Boards (especially Directors of Public Health);
- Caldicott Guardian (a named senior person responsible for protecting the confidentiality of patient and service-user information and enabling appropriate information-sharing)[2]

[2] http://www.dh.gov.uk/en/Managingyourorganisation/Informationpolicy/Patientconfidentialityandcaldicottguardians/DH_4100563

Structure and role of Community Safety Partnerships in England

Every local authority has a Community Safety Partnership (CSP) that is responsible for formulating and implementing a strategy to address the crime, disorder and substance misuse problems in their local area. They work out local approaches to deal with issues including antisocial behaviour, drug & alcohol misuse, and re-offending.

CSPs are made up of representatives from the police and police authority, the local council(s), and the fire, health[3] and probation services. These are known as the CSP Responsible Authorities. Each of these representatives contributes their own particular local knowledge, professional expertise and resources to ensure that the issues of most concern to local people are prioritised and addressed. The Responsible Authorities work with others, known as the Cooperating Bodies, who have a key role to play in community safety, including community groups, parish councils, registered local landlords, NHS Trusts and the further education sector. Further the CSP has a duty to engage with a much wider set of representative groups, as well as consulting their communities directly.



[3] Local health boards (LHBs) in Wales and primary care trusts (PCTs) in England.

CSP partners are required by statute[4] to work together to:

- Assess the local problems with crime, disorder, anti-social behaviour, substance misuse and behaviour that adversely affects the environment
- Develop and implement a strategy to tackle the priority problems identified through the above assessment
- To share depersonalised data, already held in a depersonalised format, for the purposes of reducing crime and disorder[5]

Violent crime clearly falls within the remit of CSPs and all partners are required to share & analyse relevant data, and to work together to formulate & implement a strategy to tackle local violent crime problems as set out above. CSPs also have a specific responsibility with regards to reviewing domestic homicides[6]

There are currently 310 CSPs in England, and 22 in Wales. Details of your local CSP can be found at http://www.homeoffice.gov.uk/crime/partnerships/contacts/

[4] CSPs were set up under Sections 5-7 of the Crime and Disorder Act 1998. The act has been amended several times since, with major changes introduced through the Police and Justice Act 2006.

[5] http://www.homeoffice.gov.uk/publications/crime/info-sharing-community-safety/

[6] http://www.homeoffice.gov.uk/publications/crime/DHR-guidance?view=Binary