HM Government

A whole-system multi-agency approach to serious violence prevention

A resource for local system leaders in England

Public Health England working with the Department of Health and Social Care and the Home Office.

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Contents

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Executive summary

In April 2018 the Government published its Serious Violence Strategy in response to increases in knife crime, gun crime and homicide across England. The strategy represents a step change in how to think and respond to serious violence, establishing a new balance between prevention and law enforcement (1). It declares a call to action to partners from across different sectors to come together and adopt a whole system multi-agency approach to tackling and preventing serious violence at a local level, often referred to as a 'public health approach'.

To support local areas in implementing a whole-system multi-agency approach, in accordance with World Health Organization (WHO) principles (2), the Government is introducing a range of initiatives including:

- a new statutory duty on public sector agencies and bodies to prevent and tackle serious violence, which will help create the conditions for collaboration and regular communication to share data and intelligence to understand and tackle the root causes of serious violence (3)
- investment in Violence Reduction Units (VRUs), in those areas of the country most affected by violent crime, to act as the focus and catalyst for transforming the local response (4, 5)
- making £200 million available over the next 10 years through the Youth Endowment Fund - a bold new attempt to put early intervention at the heart of efforts to tackle youth offending by supporting interventions and community partnerships working with children at risk of being drawn into crime and violence and increase our knowledge of what works to prevent this happening (6)

The aim of this resource is to propose a practical approach that will facilitate partners' understanding and response to serious violence as it is affecting their local communities. The approach advocates a whole system multi-agency approach that is place-based and incorporates public health principles (2).

This resource sets out some principles which local partners can adopt to work together to prevent violence. These principles are called the 5Cs because there are 5 component parts which are:

- collaboration
- co-production
- co-operation in data and intelligence sharing
- counter-narrative development
- community consensus, which is central to the approach

These can be used as a guide to address the specific needs of a local population reflecting local geographies, operating systems, existing partnerships and community assets, resources and most importantly need. Variation and innovation in the implementation of the approach in different localities therefore is expected but wherever the component parts of the approach are adopted it will apply the principles of public health to prevent and tackle serious violence.

The 5Cs approach supports a shared vision to create a safe and healthy community for all, free from violence and with meaningful opportunities for all.

1. Introduction

Violence affects the lives of millions, with long-lasting consequences (7). The global burden of violence and the requirement for a whole system approach to preventing violence is reflected in the Sustainable Development Goals (SDGs); 4 targets within the SDGs are specifically relevant to tackling violence and a further 7 have targets within them that address the risk factors for violence (8).

Violence is preventable, not inevitable (9, 10). Interventions, especially those in early childhood, not only prevent individuals developing a propensity for violence but also improve educational outcomes, employment prospects and long-term health outcomes (11). Tackling violence and its root causes can improve the health and wellbeing of individuals and communities and have wider positive implications for the economy and society.

Violence is an extremely diffuse and complex phenomenon (9). Defining violence is challenging and definitions are often based on judgements of the person defining it and their purpose (9). The WHO suggest an analytical framework which separates the different types of violence, the nature of the problem and the action required to deal with it but also identifies and emphasises the common features and linkages between the different types of violence which leads to a holistic approach to violence prevention (9). (See Section 3: What is meant by serious violence in this context?)

In its 2018 Serious Violence Strategy the government defines serious violence as “specific types of crime such as homicide, knife crime, and gun crime and areas of criminality where serious violence or its threat is inherent, such as in gangs and county lines drug dealing.” It also includes emerging crime threats faced in some areas of the country such as the use of corrosive substances as a weapon (1).

Since 2014 there has been a genuine increase in certain types of serious violence across England and Wales; specifically, homicide, knife crime and gun crime (1). However, it should also be noted that improvements in recording practices are also a factor.

These offences typically make up just 1% of all crime recorded by the police, however they cause some of the most serious harms to individuals, communities and societies (1). The Serious Violence Strategy is clear that there is a strong link between drugs and serious violence and the related harm and exploitation from county lines operations (1).

The Serious Violence Strategy acknowledges that serious violence is only perpetrated by a small minority, but those individuals can do considerable harm (1). Evidence indicates that males commit the majority of serious violence and that the peak age for carrying a weapon is 15 years old (1). There is currently insufficient evidence to conclude whether ethnicity is a predictor of offending or victimisation (1).

PHE recognises that serious violence extends to other forms of serious assault and that a significant proportion of violence is linked to either domestic abuse or alcohol. This resource concentrates on an approach to address serious violence set out in the Serious Violence Strategy (1).

Serious violence cannot be tackled in isolation. It must be addressed through prevention strategies that address the multiple risk factors that cause and perpetuate violence and promote the protective factors that mitigate against the perpetration and victimisation of violence. The Government recognises the need for a broader definition of violence to be adopted if a multi-agency or 'public health' approach to tackling and preventing serious violence is going to be implemented. It is encouraging local areas to understand the needs of their local population as part of its broader initiatives.

From a public health perspective preventing children and young people from becoming perpetrators or victims of violence is a key consideration to avoid escalating levels of harm to both children and wider society.

This resource presents a place-based multi-agency approach to tackling serious violence that can be applied to the complex police, health, local government and social care landscape in England.

Who the report is for

This resource is intended to stimulate local action through engagement with a wide range of partners and stakeholders in local health and justice systems including:

- police and crime commissioners
- senior police officers and police services
- local authorities: chief executives, director of public health, director of children's services, strategic lead for education, strategic lead for housing, health and wellbeing boards, community safety partnerships
- existing partnerships and collaborative bodies including community safety partnerships (CSPs) and youth offending teams (YOTs).
- local safeguarding children boards
- local academy head teachers and education networks

- other, non-mandated local multi-agency partnerships, such as community multi-agency risk assessment conference (MARAC)
- clinical commissioning groups.
- NHS England health and justice commissioners
- PHE centres
- third sector services, including service user and family representatives
- Jobcentre Plus
- Department for Work and Pensions employment support providers

The 5Cs approach calls for a whole system multi-agency approach to tackling and preventing serious violence.

2. What we mean by serious violence in this context

2.1 Violence definition and typology

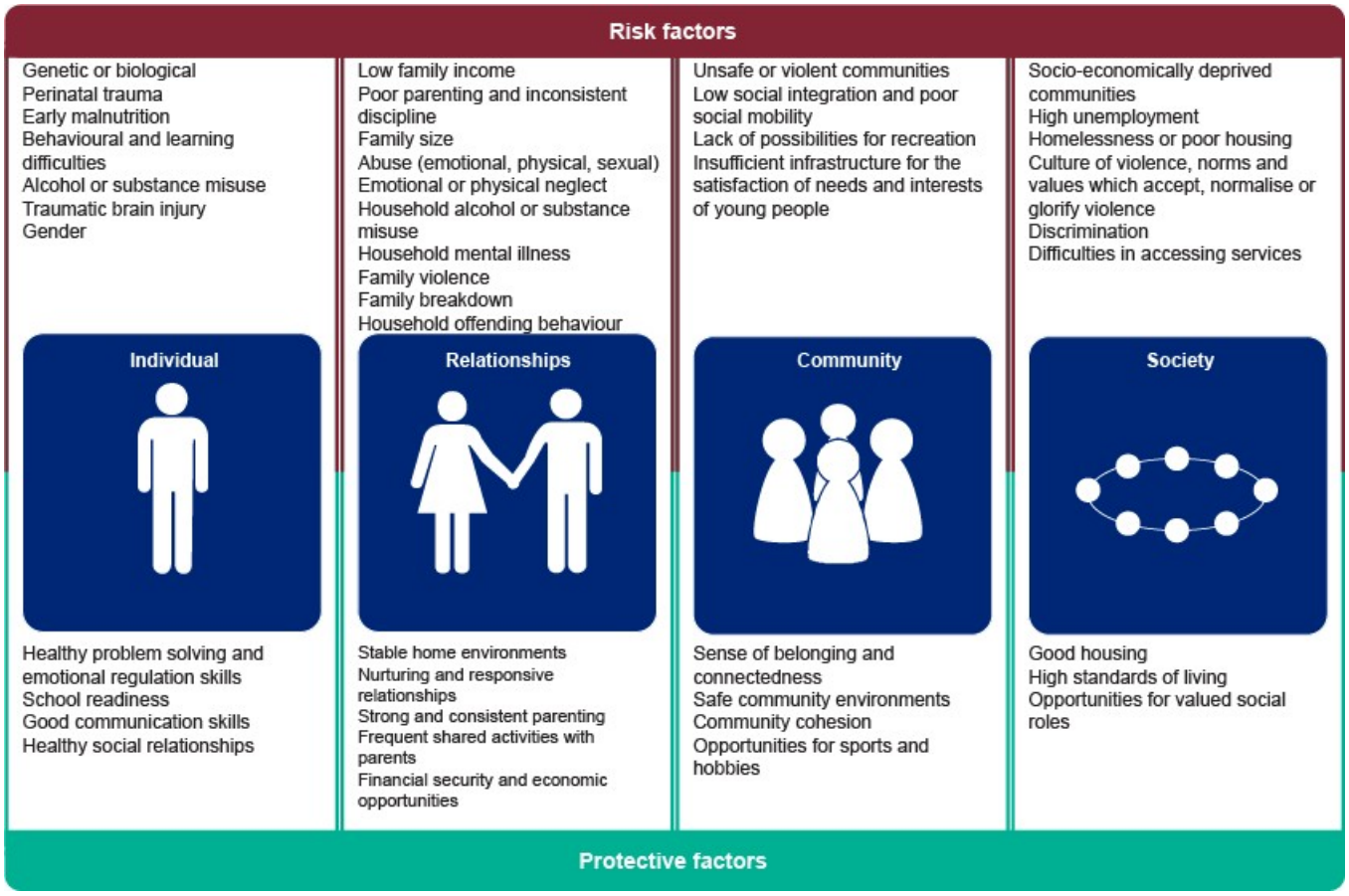
Violence is defined by the WHO as “the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a higher likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation” (11).

In their World Report on Violence and Health the WHO divides violence into 3 categories according to who has committed the violence: self-directed, interpersonal or collective; and into 4 further categories according to the nature of violence: physical, sexual, psychological or involving deprivation or neglect (11). The different forms of violence are not mutually exclusive and often occur simultaneously (11).

More than 1.3 million people worldwide die each year as a result of violence in all its forms (self-directed, interpersonal and collective), accounting for 2.5% of global mortality (11).

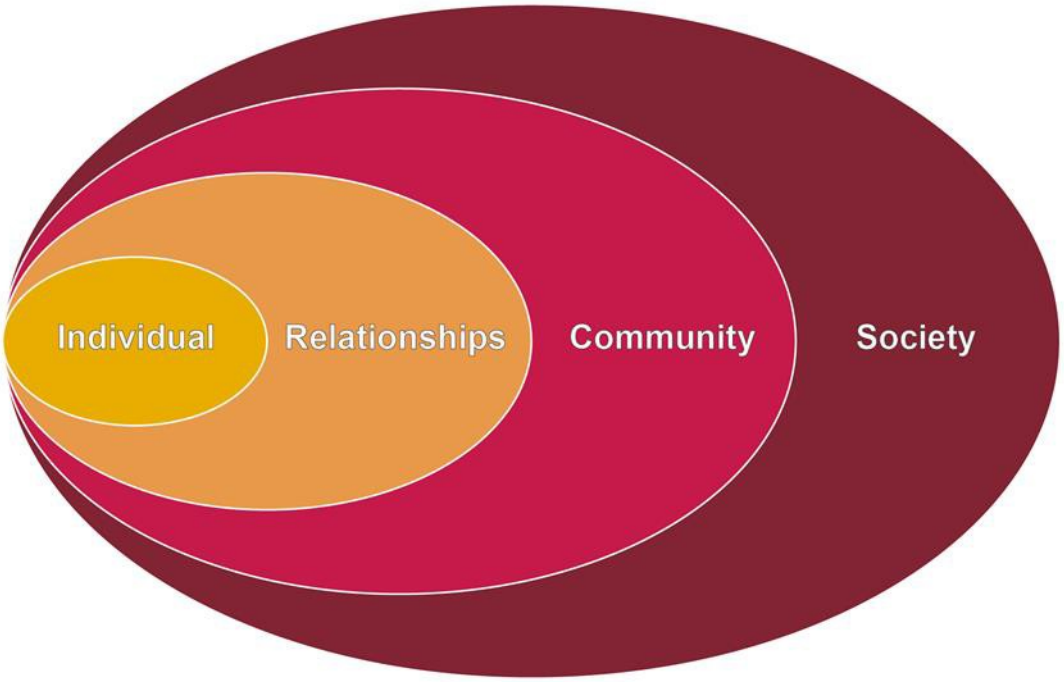
Despite these different forms and expressions of violence there are numerous and overlapping factors behind them that are either ‘risk factors’ for making violence more likely, or ‘protective factors’ which mitigate against victimisation or perpetration of violence (Figure 4) (11-16). Work to mitigate the risk factors, and to build the protective factors, can be preventative across multiple forms of violence. While we still need specialist services with in-depth understanding of the issues relating to the different expressions of violence, it can be helpful to work with wider partners to understand the overlaps and commonalities behind the different expressions of violence.

Figure 4: Risk factors which increase the likelihood of violence and protective factors which mitigate against perpetration or victimisation of violence (11-16)



The ecological framework of violence prevention (Figure 5) is based on the evidence that no single risk or protective factor can explain why someone, or groups of people, are at a higher risk of violence than others (11-13, 16). It considers violence as an outcome of interaction among many of the risk factors at the individual, relationship, community and the societal level and treats the interaction between factors at the different levels with equal importance (11-13, 16).

Figure 5: The ecological framework for violence (13)



2.2 Serious violence

In the 2018 Serious Violence Strategy, the government defines serious violence as “specific types of crime such as homicide, knife crime, and gun crime and areas of criminality where serious violence or its threat is inherent, such as in gangs and county lines drug dealing. It also includes emerging crime threats faced in some areas of the country such as the use of corrosive substances as a weapon” (1).

Since 2014 there has been an increase in certain types of serious violence across England and Wales; specifically, homicide, knife crime and gun crime (1). These offenses typically make up just 1% of all crime recorded by the police, however they cause some of the most serious harms to individuals, communities and societies (1). Current data suggests that the key drivers for the increases in serious violence are drugs and county lines activity (1).

The Serious Violence Strategy acknowledges that serious violence is only perpetrated by a small minority, but those individuals can do considerable harm (1). Evidence indicates that males commit the majority of serious violence and that the peak age for carrying a weapon is 15 years old (1). There is currently insufficient evidence to conclude whether ethnicity is a predictor of offending or victimisation (1).

Public Health England recognises that serious violence extends to other forms of serious assault and that a significant proportion of violence is linked to either domestic abuse or alcohol. This resource concentrates on an approach to address serious violence as defined by the Serious Violence Strategy (1).

Serious violence cannot be tackled in isolation and must be addressed through prevention strategies which address the multiple risk factors which cause and perpetuate violence and promote the protective factors which mitigate against the perpetration and victimisation of violence. The Government has recognised the need for a broader definition of violence to be adopted in its initiatives to promote a multi-agency or ‘public health’ approach to tackling and preventing serious violence. It is encouraging local areas to understand the needs of their local population as part of those initiatives.

3. Taking a public health approach

Public health has been defined as the science and art of (1) preventing disease, (2) prolonging life, and (3) promoting health and efficiency through organised community efforts (17).

The focus of public health is on the health, safety and wellbeing or entire populations; it aims to provide the maximum benefit for the largest number of people (11).

Public health relies on knowledge from a broad range of disciplines including medicine, epidemiology, sociology, psychology, criminology, education and economics as well as input from a range of public and private sectors working in health, social care, education, justice and policy. For these reasons public health is often referred to as a multi-agency approach; however, there are 6 guiding principles of public health which incorporate a broader set of skills than partnership working.

The underlying principles of a public health approach (2, 11) are that it is:

- focused on a defined population, often with a health risk in common
- with and for communities
- not constrained by organisational or professional boundaries
- focused on generating long term as well as short term solutions
- based on data and intelligence to identify the burden on the population, including any inequalities
- rooted in evidence of effectiveness to tackle the problem

4. A public health approach to violence

Public health principles provide a useful framework for investigating and understanding the causes and consequences of violence and can help to prevent violence from occurring in the first place through the implementation of primary prevention programmes, policy interventions and advocacy.

Violence is a public health issue. Living without fear of violence is a fundamental requirement for health and wellbeing. Violence is a major cause of ill health and poor wellbeing and is strongly related to inequalities, with the poorest fifth of our society suffering rates of hospital admissions for violence 5 times higher than those of the most affluent fifth (11). It impacts on individuals and communities and is a drain on health services, the criminal justice system and the wider economy (18).

No country or community is untouched by violence (11). The global burden of violence and the requirement for a whole system approach to preventing violence is reflected in the Sustainable Development Goals (SDGs); 4 targets within the SDGs are specifically relevant to tackling violence and a further 7 have targets within them that address the risk factors for violence (19).

Violence is preventable, not inevitable and interventions, especially those in early childhood, not only prevent individuals developing a propensity for violence but also improve educational outcomes, employment prospects and long-term health outcomes (12). Tackling violence and its root causes can improve the health and wellbeing of individuals and communities and have wider positive implication for the economy and society.

Taking a public health approach to violence is not new. In 1996 the World Health Assembly declared violence a leading worldwide public health problem (20). The World Health Assembly called upon Member States to give urgent consideration to the problem of violence and requested the Director General of the World Health Organization (WHO) to develop a science-based approach to understanding and preventing violence (11, 20). This led to the development of the WHO 4-step process for implementing public health approach to violence (Figure 6) (2);

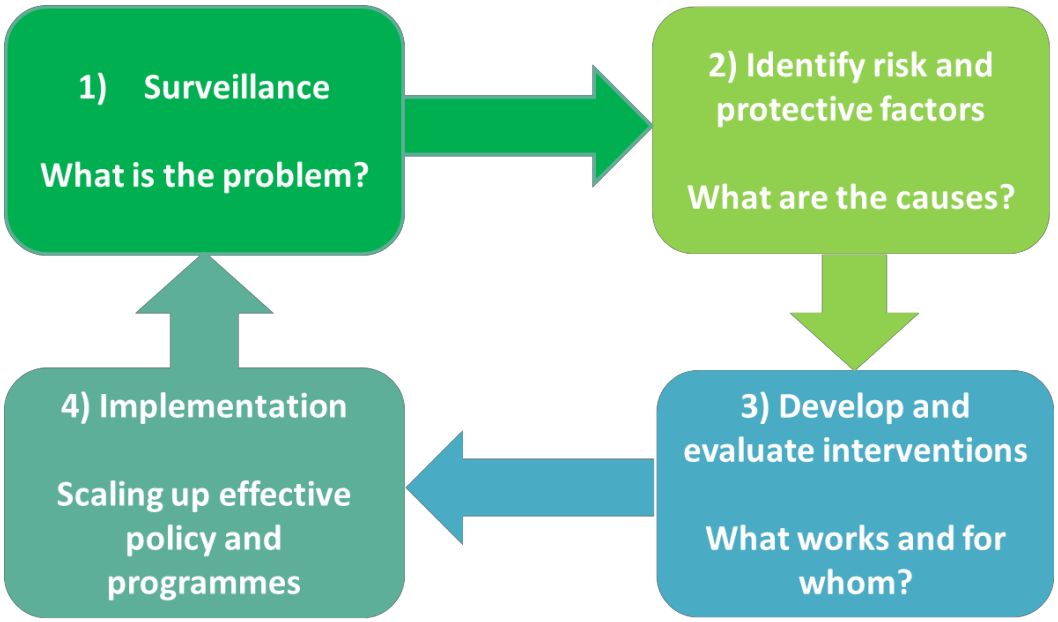
1. To define the problem through the systematic collection of information about the magnitude, scope, characteristics and consequences of violence.
2. To establish why violence occurs using research to determine the causes and correlates of violence, the factors that increase or decrease the risk for violence, and the factors that could be modified through interventions.

3. To find out what works to prevent violence by designing, implementing and evaluating interventions.
4. To implement effective and promising interventions in a wide range of settings. The effects of these interventions on risk factors and the target outcome should be monitored, and their impact and cost-effectiveness should be evaluated

The WHO 4-step approach seeks to improve health and safety for all individuals in a population by addressing underlying risk factors that increase the likelihood that an individual will become a victim or a perpetrator of violence (as detailed in the previous section).

Since 1996 public health approaches to violence have been implemented throughout the world, each with consideration of the WHO 4-step process but with variation, considering local systems, types of violence and factors driving increases in violence (16, 21-23).

Figure 6: The WHO 4-step process for implementing a public health approach



WHO's public health approach to violence seeks to identify the common risk factors driving violence, and the protective factors preventing violence. It encourages identification of these factors and implementation of interventions across all levels of the ecological framework; individual, relationship, community and societal, at the same time.

The WHO launched the first World report on violence and health on 3 October, 2002 (11). The World report on violence and health is the first comprehensive

review of the problem of violence on a global scale – what it is, whom it affects and what can be done about it.

The report clearly showed that investing in multi-sectoral strategies for the prevention of interpersonal violence is not only a moral imperative but also makes sound scientific, economic, political and social sense, and that health sector leadership is both appropriate and essential given the clear public health dimensions of the problem and its solutions (11).

The report also reviewed the increasing evidence that primary prevention efforts which target the root causes and situational determinants of interpersonal violence are both effective and cost-effective (11).

The WHO report recommended 6 country-level activities, which were (11):

- increasing the capacity for collecting data on violence
- researching violence – its causes, consequences and prevention
- promoting the primary prevention of violence
- promoting gender and social equality and equity to prevent violence
- strengthening care and support services for victims
- bringing it all together – developing a national action plan of action

5. A place-based multi-agency approach to serious violence prevention for England

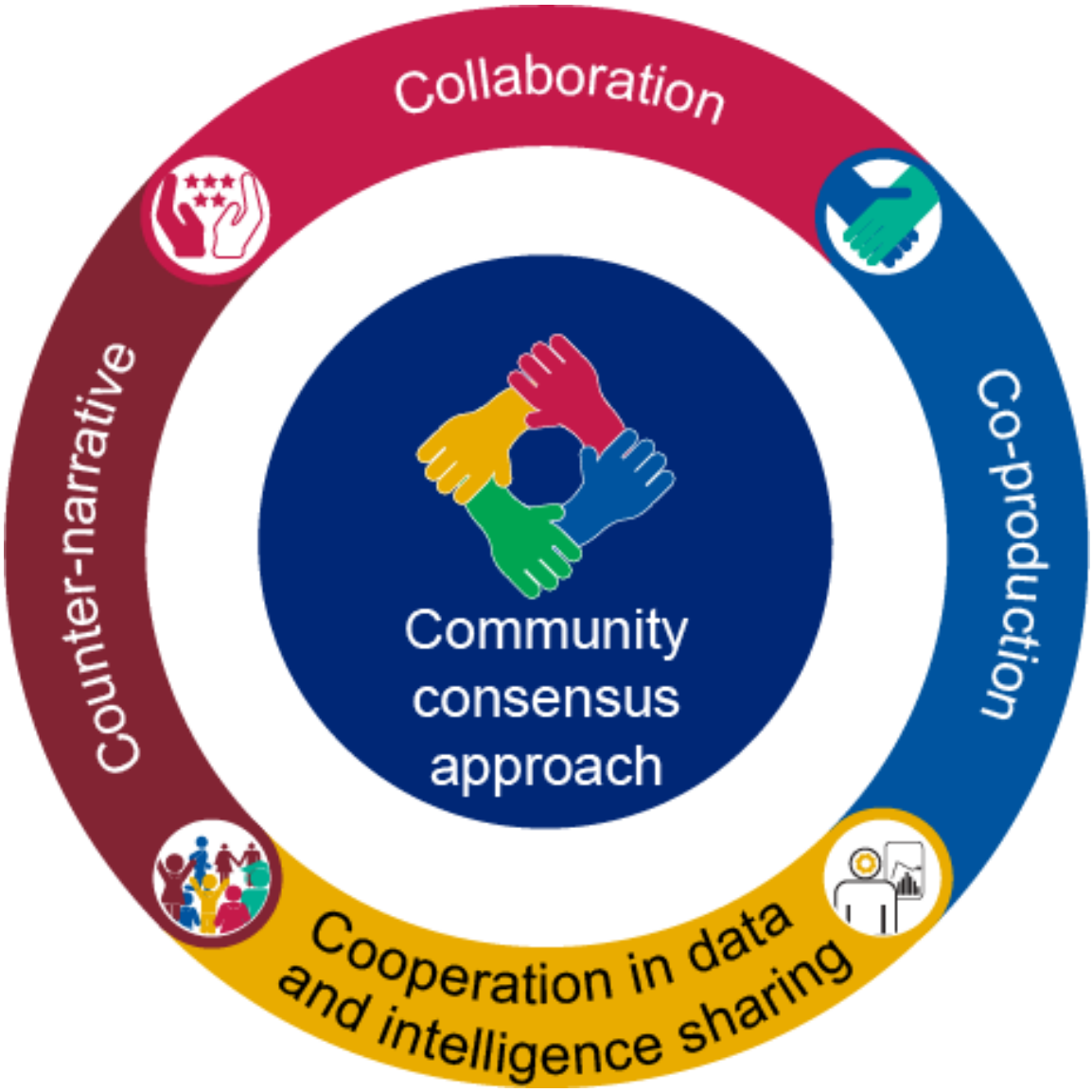
This chapter presents the 5Cs approach to serious violence prevention for England. It starts by explaining why a place-based approach to serious violence prevention is so important.

Then, an explanation and rationale for each C is provided; followed by a set of core actions that should be undertaken to achieve the component part of the approach. The core actions have been developed and refined through discussions with a range of stakeholders across police, health, national and local government and the third sector.

Case-studies demonstrating existing or emerging work are presented to provide practical examples of how the 5Cs approach can be implemented at a local level. The case-studies included, whilst extensive, do not provide a complete picture of all serious violence prevention work that is going on across England. The broad assortment of case-studies included however, demonstrate the current variation in the evolution of work, activities and stakeholder engagement between localities in serious violence prevention. Forthcoming government initiatives, particularly Violence Reduction Units, will provide opportunities for more streamlined presentation and consolidation of case studies in the future (5).

Some of the case-studies do not specifically relate to serious violence as defined in Chapter 3. The rationale for their inclusion is that in the Violence Reduction Unit guidance (5) (circulated to eligible areas) the Home Office stated that local areas should set their own reasonable definition of serious violence as long as it encompassed serious violence as defined in the Serious Violence Strategy (1).These case-studies have either been included because they provide examples of broader violence prevention work or to demonstrate what the stakeholders being tasked with addressing serious violence can achieve when they work collaboratively together.

Figure 1: The 5Cs: a place-based multi-agency to serious violence prevention



5.1 A place-based approach

Place is a physical setting and social context. It means different things to different people but always relates to somewhere meaningful to the individual. A place-based approach crosses organisational boundaries and is intended to reduce silo working by bringing partners together to focus on improving long term outcomes of the 'whole place' and not just individuals (7). To be effective the place must be meaningful to, and therefore defined by, local partners including members of the community.

Rationale

England covers a very large and diverse rural and urban geography with a large number of stakeholders involved in law enforcement, health, social care, education and local government.

In summary England has 343 Councils; 192 District Councils, 26 County Councils, 55 Unitary Authorities, 32 London Boroughs and 36 Metropolitan Districts. 9 PHE Centres, 7 NHS England Area Teams, 44 Sustainability and Transformation Partnerships (STPs) and 221 Clinical Commissioning Groups (CCGs). There are 43 police forces across England and Wales and 41 Offices of Police, Fire and Crime Commissioners (OPFCC); London and Manchester have separate arrangements where the Mayor's offices are responsible for overseeing efficient and effective policing in those areas. Violence Reduction Units are being established in 18 police force areas experiencing the highest rates of serious violence (4).

Each locality in England has a diverse population with different competing needs and priorities for public services. Local partners within each system will already have ways of working that they have adapted to suit the needs of their local populations. A one-size fits all approach to tackling serious violence is unlikely to be successful across England and there is a need for local areas to define their own "places" and boundaries to work within that is meaningful to them and works within existing local systems.

Core actions (7)

The core actions are:

- define the population group and the system's boundaries
- identify the right partners and services
- develop a shared vision and objectives
- develop an appropriate governance structure

- identify the right leaders and develop a new form of leadership
- agree how conflicts will be resolved
- develop a sustainable financing model
- create a dedicated team
- develop systems within systems
- develop a single set of measures

5.2 Collaboration

Rationale

Violence is preventable, not inevitable (9, 10). To tackle violence the root causes of violence must be addressed; only focussing on enforcement is not sufficient (1, 9, 13). Violence of all sorts is strongly associated with social determinants and is a result of the interaction of a number of risk factors which span the individual, family, community and society (9, 13). No issue relating to violence has a single cause or a single solution; to have an impact on the various context and underlying risk factors that contribute to violence, different partners from across the system must work collaboratively and adopt a whole systems approach (13, 14).

A collaborative whole-systems approach brings partners together from a broad range of functions who have the shared goal of tackling and preventing violence. It requires partners to form a collective understanding of a multi-agency approach; to collectively develop and own the scope of work and ways of working which reflect the needs of the local population and to jointly identify resources that will enable effective working.

Often partners do not consider violence prevention to be part of their remit but violence is a key inhibitor of many of the outcomes we want to see in our communities, whether that is: exposure to violence limiting a child meeting expected developmental targets including school readiness (for example due impact of trauma); or the fear of street based violence reducing people's use of outdoor spaces and therefore physical activity; or lost productivity for business due to the burden of victimisation (particularly impact of domestic violence which affects 1 in 4 women over their lifetime).

A collaborative approach requires those who understand the broader implications of violence to generate a collective understanding across all partners within the local system.

Core actions

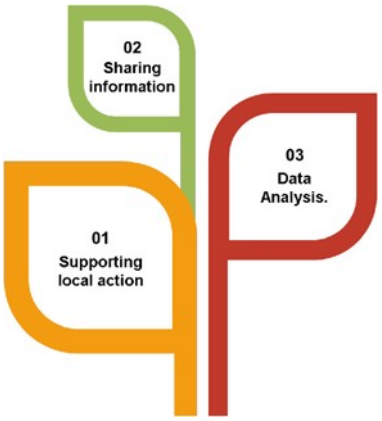
- Identify key local system leaders and bring them together
- Help partners to understand their role in violence prevention
- Define and create a common understanding of what a multi-agency approach is, what that means locally and what each organisations role within the collaboration is or can be
- Use data and intelligence to achieve a shared understanding of current local issues, opportunities to implement interventions and evaluate their impact
- Identify existing and required resources
- Collectively agree the governance arrangements for strategic and operational violence prevention work and link in with existing statutory boards where possible such as Health and Wellbeing Boards or Community Safety

Case studies

Case study: South West Violence Prevention Network

The South West Violence Prevention Network (SWVPN) was established in February 2017 by Public Health England South West Health & Wellbeing Team. The Network exists to advocate and create a collective understanding of a public health approach to violence prevention across all forms of interpersonal violence and seeks to prevent violence and abuse in the South West.

The network functions through the following 3 delivery areas:



Supporting local action – through the provision of bespoke technical support to local authority, emergency service and NHS partners; violence prevention webinars, the delivery of an annual multi-agency violence prevention conference.

Sharing information – through bi-monthly violence prevention e-bulletins sharing timely and relevant policy, research, and best practice information; network alignment with other relevant national and regional policy networks (such as the South West Emergency Services Collaboration); and sharing knowledge and information through the maintenance of the SW Violence Prevention Network mailing list.

Data analysis – supporting the development and implementation of evidence based practice for violence prevention, by: improving access to information and

services (such as the South West Survivor Pathway); supporting the development of the evidence base for bystander interventions (in partnership with the University of Exeter and Exeter City Football Club); supporting links between academia and practice; and advocating for data sharing for violence prevention.

The network is a thriving, multi-agency network currently comprising 340 professionals across the region working in the field of violence prevention and response. These include:

- emergency services
- public health
- NHS
- local authority
- education
- voluntary sector
- provider organisations
- academia

Case study: ONE Reading Prevention and Early Intervention Partnership

ONE Reading Prevention & Early Intervention Partnership is a strategic alliance between Public Sector partners and Reading's diverse voluntary sector and local community – with the shared aim of working together to improve outcomes for children, young people and families, to reduce demand on high costs services and to build resilient communities across our Town.

This ONE Reading Strategic Framework demonstrates ONE Reading's commitment to Prevention and Early Intervention. It sets out a partnership response that will be at the heart of delivering ambitious outcomes for the children, young people and families of Reading.

In these challenging financial times, we need to break from traditional thinking and ambitiously take action. The Framework sets out a vision for a partnership of wraparound provision for families; where collaborative approaches define service agendas and address budgetary constraints.

The ONE Reading Strategic Framework has been developed through a Local Consensus, where we have agreed to work as equal partners to build on our agreed principles of communication, co-operation and equal respect to deliver our shared priority to deliver excellent services to children, young people and families across Reading. Additionally, partners have committed to a greater shared accountability for early help arrangements and to align resource (new/existing) into ONE Reading.

Case study: Essex Violence and Vulnerability Unit

Following the publication of the government's Serious Violence Strategy, the Office of the Police, Fire and Crime Commissioner for Essex created a framework that would collectively help to shape the strategic approach to serious violence and vulnerability across Essex.

The Framework was developed by a variety of members of the Safer Essex Partnership who established 4 task and finish groups looking at 4 key themes; data and understanding, awareness and education, prevention and interventions and leadership, partnership and co-ordination. The task and finish groups established a set of core principles that would underpin all the work undertaken in Essex to reduce violence and vulnerability. They identified key objectives within each of the 4 themes that would help to prioritise initial programmes of work.

The Framework identifies principles for violence and vulnerability work which are:

- improve visibility and awareness of partnership activity around violence and vulnerability
- increase the occurrence and effectiveness of prevention and intervention activities
- identify opportunities to add value to existing and planned activities
- identify gaps in current and planned activities
- highlight areas where cross-border and partnership working would be beneficial

A Violence and Vulnerability Unit has recently been established in Essex to support local stakeholders to deliver on these principles and work towards the objectives of each theme set out in the Framework.

Case study: Avon and Somerset Approach to Serious Violence

To inform the Avon and Somerset approach, the OPCC secured funding from the Home Office Early Intervention Youth Fund (underspend) to commission the Behavioural Insights Team (BIT) to better understand the nature and prevalence of Serious Violence across Avon and Somerset. This evidence base has included data analysis, literature reviews and stakeholder interviews. The final report will be available in July 2019 and will act as the framework for the development of local VRUs.

In May 2019 the OPCC jointly hosted a **Serious Violence Summit** with the Constabulary to discuss the national strategy, local good practice and interim findings from BIT. The aim of this event was to bring partners together to raise awareness of this issue and help spark local action. The morning saw presentations from a range of speakers including the Glasgow Violence Reduction Unit and a local ex-gang member. In the afternoon BIT presented their interim findings and then local stakeholders discussed a number of key questions in tables organised by local authority areas. Over 100 delegates attended from local authorities, police, health, education,

VCSE and other agencies. Table discussions covered both current serious violence issues and opportunities for prevention.

Case study: Nottinghamshire County Councils Director of Public Health Annual Report

Directors of Public Health in England have a statutory duty to write an Annual Public Health Report to demonstrate the state of health within their communities. It is a major opportunity for advocacy on behalf of the health of the population and as such can be extremely powerful both in talking to the community and to support fellow professionals in public health.

In 2018 Nottinghamshire County Councils Director of Public Health used public health approaches to violence prevention as the focus of their Annual Report.

Nottinghamshire enjoys lower rates of violence than many other places and most people enjoy lives that are relatively free from violence. However, the Director of Public Health used their Annual Report to highlight how violence disproportionately affects particular groups within the community. The Report makes clear that many of the services commissioned by Nottinghamshire County Council are fundamental to the violence prevention agenda and argues that funding in such services must be sustained.

The report took a deliberately broad view of violence, it identifies examples of good practice in Nottinghamshire, and makes recommendations for local authorities, local NHS organisations, and statutory members and partner organisations of the Health and Wellbeing Board and Safer Nottinghamshire Board. Using signposting to other local and national publications relating to community safety and violence prevention the Annual Report makes clear the requirement for partnership working and multi-agency approaches in violence prevention.

Case study: Fortify - a resilient, consistent collaborative approach to tackling serious violence in Sheffield

In Sheffield, we are determined to tackle serious violence and organised crime by working together to address the problem from multiple angles, underpinned by a resilient and consistent collaborative approach, which is delivered by Fortify, established in July 2018.

We adopt a ‘Four P’ approach (Prepare, Prevent, Pursue and Protect) and a fifth ‘P’, partnership, is embedded across everything we do. Partners involved in

Fortify include: Sheffield City Council: public health, social care, early years, MAST, CCE team, environmental health, trading standards, community safety; South Yorkshire Fire and Rescue; Sheffield Teaching Hospitals NHS Foundation Trust; Sheffield Children's Hospital; Sheffield CCG; Youth Justice Service; Probation; Pupil Referral Unit; Learn Sheffield. The involvement of partners in Fortify flexes depending on the issue being addressed and work is ongoing to further include education, primary care, the mental health trust, and the ambulance service. Fortify has 2 key bases –one for the disruption and enforcement arms (Shepcote Lane) and the other for the prevention arm (Star House). Co-location is available at Shepcote Lane which has been useful in developing relationships between police officers and partners.

We have excellent engagement across the city, with a sense of collective responsibility among partners and regular communication. All Fortify partners are engaged in sharing information, making disruptions and attempting interventions for those who are vulnerable, giving us a comprehensive understanding of serious and organised crime in Sheffield, which is expanding daily. Two dedicated team away days, one at tactical level and one at operational level, have facilitated increased connection between partners. Knowledge of different perspectives is key to collaboration. Understanding the capabilities and focus of our colleagues enables us to better work together.

A ‘Locality Review’, conducted by the Home Office in February 2019, highlighted the advanced status of partnership arrangements in Sheffield, citing the comprehensive knowledge built up by partners sharing data and intelligence, and showing us to be ahead of the game in comparison to most areas across the UK.

The Home Office also highlighted and welcomed the increased focus on criminal exploitation and the work we are doing to improve the way in which we not only respond to this issue, but also our move to prevent problems escalating by sharing information and responding positively to early signs.

Fortify also recognises the need to work with communities; they have coordinated a number of community meetings in key areas to establish a network of key contacts, increase the 2-way flow of information between communities and partners around serious organised crime and serious violence, support individuals to report issues and to provide opportunities for joint working.

Evaluation of Fortify is proposed in the form of action research. Action research is research in action, rather than research about action, in that it actively works at making change happen. It allows cycles of building a picture and gathering information, interpreting and explaining this information and then resolving any issues or problems (taking action). It allows development of a holistic

understanding while recognising the complexity of multi-agency initiatives like Fortify.

Additional resources

Public Health System Group: Quality in public health: a shared responsibility

Policing, Health and Social Care consensus: working together to protect and prevent harm to vulnerable people

College of Policing: Public health approaches in policing. A discussion paper

5.3 Co-production

Rationale

The approach and workstreams undertaken locally to prevent and tackle violence should be informed by the multi-agency perspectives of all partners. It should include a broad range of activities encompassing public protection, identifying & supporting vulnerable people, building personal and community resilience, and achieving joint aims of a healthy peaceful community.

Involving the community is an essential aspect of co-production. Establishing and maintaining community engagement can be challenging, it must be representative, equitable and be embedded in local governance arrangements. However, it can really leverage the energy and contribution of community organisations and faith groups which can bring significant reach and trust, as well as capacity to violence prevention work. Community asset-based approaches are detailed under Community Consensus.

Co-production and co-branding of all activities supports the idea of consensus and shared accountability.

Core Actions

- Co-produce an action plan/strategy that includes a broad range of activities encompassing public protection, identifying & supporting vulnerable people, building personal and community resilience, and achieving joint aims of a healthy peaceful community
- Explore opportunities for co-location of teams and secondments between organisations
- Incorporate core actions of collaborative working

Case studies

Case study: South West 16 Days of Action to end violence against women and girls

The 16 Days of Action to end violence against women and girls' is an international movement supported by the UN, WHO, and a large number of other international, national and local organisations fighting to end gender-based violence. The PHE South West (SW) Health and Wellbeing Team worked with the SW Domestic Abuse Network and the SW Office for Sexual Health to coordinate a regional campaign to improve the prevention and response to domestic and sexual violence and abuse (DSVA) in the South West.

Together with stakeholders, 2 shared objectives were chosen for the campaign which were identified as system-level actions that would benefit from a shared, regional approach to influence stakeholders to adopt improved responses to DSVA. These actions were promotion of:

- the Business in the Community (BiTC) and PHE toolkit on improving responses to domestic abuse in the workplace. - the toolkit is designed to help organisations make a commitment to respond to domestic abuse and build an approach that ensures all employees feel supported and empowered by their workplace to deal with domestic violence and abuse
- the South West Survivor Pathway website (see case study below)

To achieve the 2 shared objectives a comprehensive external communications strategy was put into motion which incorporated stakeholder engagement through workplace health networks, press releases, interviews with local journalists, digital communications of videos, graphics and case studies through Facebook and Twitter. Internally at PHE SW the White Ribbon Campaign was promoted to all staff via emails and a weekly article and free provision of white ribbons.

Results included:

- support from 82 stakeholders, many of whom ran their own campaigns but incorporated #SW16days into their digital communications
- 16 articles with a potential reach of 217,855
- 31 PHE tweets over the 16 days which generated 43,668 Twitter impressions, 502 engagements, 96 retweets and 110 likes
- 1,094 tweets by partners which had a potential reach of 9.7 million people and generated 1141 retweets
- 129 partner Facebook posts which generated 359 likes, 19 comments and 243 shares
- 1,631 visits to the download page for the BiTC toolkit, although it was not possible to confirm the number of downloads during the campaign
- 876 visits to the Survivor Pathway Website
- 312 visits to ManKind app download page
- 607 visits to the White Ribbon pledge page

Case study: West Midlands Co-Commissioned Identification and Referral to Improve Safety Scheme

IRIS is a well evidenced scheme which trains primary care colleagues in GP surgeries to identify early signs of domestic abuse (DA) and provides a direct referral into a domestic violence worker linked to the practice. In the West Midlands there were a couple of CCGs which had a small percentage of practices running the IRIS scheme, quite insecurely funded but operating thanks to the determination and passion of a few individuals convinced of the scheme's merits. Due to the benefits of earlier identification of domestic abuse, the Alliance sought to see far greater coverage of IRIS across the region. Upon preparing a business case and evidence brief for the police & crime commissioner, agreement was secured that part funding would be approved, upon the agreement of a co-commissioning approach to recognise the shared priority of tackling DA. A working group was set up which included a safeguarding lead from each CCG, with the group working to establish what a regional provision could look like.

Letters were sent to the Chief Officer of each CCG from the Alliance, outlining the benefits of IRIS and offering match funding. Upon the offer of funding, each CCG agreed to provide match funding and to continue providing a lead safeguarding team member to form a regional steering group. The steering group has proved

extremely useful, with the lead safeguarding nurses working hard with other CCG colleagues to ensure IRIS was promoted to GPs based on the evidence and patient benefits. The CCGs took on the commissioning, and domestic violence provider services were commissioned to deliver IRIS. For the second year of funding, it was agreed that CCGs would be planning to mainstream such provision, with the contribution of the Alliance reducing proportionally in subsequent years. A number of areas went from 0% to 50% coverage within their first year, receiving consistently positive feedback from GP staff and patients. An evaluation is currently ongoing, with a focus on investigating whether health improvements and reduced primary care costs (reduced prescription and appointment rates) can be seen as a result of IRIS.

Case study: Partnership Engagement and Enforcement Programme (PEEP) in Derby

This case study does not relate directly to work undertaken to address serious violence; however, it provides an excellent example of what can be achieved through collaboration, co-production and cooperation in data and intelligence sharing.

In the summer of 2017 drug-related ambulance call outs to Derby city centre – to deal with ‘Mamba attacks’ – peaked at 23 in a single day (corresponding to 52 client episodes). ‘Mamba attacks’ – aggressive begging and drug-related, distressing anti-social behaviour – had been increasing throughout the year due to an increase in the number of rough sleepers in the city centre and a rise in the use of synthetic cannabinoid receptor agonists (SCRA’s) by the homeless/rough sleeper population.

In response to the significant rise in ‘Mamba attacks’ the Partnership Engagement and Enforcement Programme (PEEP) was launched. The programme comprises a daily, virtual tasking group (with a dedicated co-ordinator) that directs partnership resources within the city centre to tackle visible, on-street problematic substance misuse and antisocial behaviour. The partnership resources currently deployed include: city centre police officers; treatment providers; homeless outreach workers; homeless charities; city centre rangers; Public Protection Officers; accommodation providers and the probation service.

A monthly steering group oversees the performance of PEEP and undertakes detailed case discussions of those identified as on - or relevant to - the programme. The programme has strategic buy-in from the Office of Police Crime Commissioner and the Health and Wellbeing Board

The premise of PEEP is simple. Clients can engage with the services available as part of the programme, if they chose not to engage and comply they face enforcement sanctions such as: arrests for breaching antisocial and exclusion prohibitive orders; issuance of criminal behaviour orders; and prosecutions for associated offences - that can result in short custodial sentences.

Alongside PEEP a huge Police Operation was undertaken that targeted drug dealers in and around the city centre resulting in over 80 arrests and a significant number of people (45) received sentences for drugs offences including supplying undercover officers. The Operation was a result of many items of intelligence being submitted by professionals and agencies working in the city - who worked in partnership with the Police to reduce the availability of SCRA's and reduce on-street drug-related violence and anti-social behaviour.

The partnership has acknowledged that cultural differences between agencies presented challenges to begin with. These have been overcome through robust leadership, development of an operating framework with clear criteria and an information sharing agreement.

PEEP has led to a significant reduction in the visibility of on-street drug taking, aggression and anti-social behaviour. Partnership working has developed in a business as usual model with routine daily information sharing and intelligence gathering. PEEP has been mainstreamed as part of the drug and alcohol service and is performance monitored as part of local management arrangements.

Case study: South West Survivor Pathway

The South West Survivor Pathway is an invaluable online resource designed to support professionals working with survivors of sexual violence and abuse - and their families, friends, colleagues and employers - to help them access services across the South West (SW). The website signposts to a huge range of specialist organisations accessible to anyone who has experienced sexual violence and abuse. The resource is broken down by local authority and was developed with people who work in the sexual violence sector. The aim of the website is to provide a trusted source of information that is regularly updated, is practical and easy to use for professionals working with survivors, and for survivors and their families who are looking to access support.

The website was initially developed in Bristol before being rolled out across the SW. The project was led by SARSAS (Somerset and Avon Rape and Sexual Abuse Support) with support of a multi-agency group - The Bristol Sexual Violence Reference Group, which is a forum of organisations that are seeking to tackle rape and sexual abuse. This includes preventing its occurrence and improving services for survivors. It comes under the umbrella of Bristol Domestic and Sexual Abuse Strategy Group. The funding was provided by Public Health Bristol.

Following the development and launch of the site in Bristol, the SW Office for Sexual Health (a multi-agency board which exists to improve the sexual health of those in the SW, led by the Directors of Public Health) recognised this as an example of good practice and sought to roll out the project across the SW. Funding was secured from NHS England and Health Education England. The roll out and mapping of services was done across the region by the Office in partnership with the local authority public health sexual health commissioners. The site was developed and is hosted by the company Rubicon. The site content is now managed by Public Health England South West and updated every 6 months, in partnership with commissioners and providers.

The South West Survivor Pathway was promoted during the South West 2018 16 Days of Action and has between 1,000 – 1,500 visits to the site per month.

Case study: North East Heroin and Crack Cocaine Action Area (HACCAA)

Heroin and Crack Cocaine Action Areas receive additional funding from the Home Office to help them to address how they locally respond to the increase in prevalence of heroin and crack cocaine and associated increases in violent and gang crime associated with these drugs through partnership working (1).

The North East HACCAA is one of 5 such areas in the country and is being led by Cleveland police, although covers 3 police force areas. The work is still in its infancy however the approach taken so far demonstrates the core actions required for a collaborative, co-produced approach.

To shape the action plan around this area of work the police convened a multi-agency seminar to understand different partners priorities in this area and to determine how they could be addressed through partnership working. The seminar had representatives from police, health, public health, criminal justice system and the local authority. As well as identifying priorities and opportunities the seminar was used as an opportunity to promote a co-ordinated approach to tackling the priorities collectively going forward. To enable wide engagement at the seminar the police lead relied on system leaders to promote and encourage attendance of relevant partners at the seminar.

The information gathered at the seminar is now being developed into an action plan by the HACCAA lead. There will be a focus on data sharing and intelligence and establishing ways of joint working between police and frontline staff in the future.

As this is a regional programme of work, with the potential for a large number of stakeholders, a smaller partnership group has been established with the necessary system leaders required to set the strategic direction which meets on a bi-monthly basis. There is an expectation that members of the partnership engage with and feedback to members of their local Community Safety Partnerships. Additionally, part of the HACCAA role is to make sure a co-ordinated approach is adopted across the region and they therefore have a responsibility to engage with all relevant Networks in this space such as the regional Drug and Alcohol Commissioner Network, the regional Drug Related Death Network and the regional Service User Group.

5.4 Co-operation in data and intelligence sharing

Rationale

Data and information sharing is a key enabler for all multi-agency approaches (15), however organisations frequently report obstacles in sharing and access to all the relevant data sources, particularly since the introduction of the General Data Protection Regulation (GDPR) in 2018.

Through a collaborative approach, partners can overcome many of the barriers to effective data and information sharing and can create a Common Recognised Information Picture (CRIP) which can be used to mobilise effective preventative and operational interventions. To achieve this; the partnership must work together to understand what data is available and its utility; appropriate data-sharing protocols, which adequately protect personal information but enable population level and aggregate data to be gathered across agencies, must then be agreed.

Health data has an essential role to play in preventing violence. When combined with or used alongside data collected by other partners data it can:

- measure the levels and nature of violence in a local area
- identify the population groups and geographical areas most affected
- inform the development, targeting and evaluation of prevention activity

Fully anonymised health data are not regarded as personal data and therefore collection, use and storage of anonymised health data does not come under General Data Protection Regulation (16). The rules of the GDPR should be taken into consideration for all data that is collected, used and stored (17).

The establishment of successful, regular data sharing processes for anonymised health data between local health services and partners involved in addressing violence is crucial for supporting local prevention activity. The benefits of collecting and sharing anonymised health data for violence prevention have been demonstrated in Cardiff and London (15, 18).

There are a range of public sector data sources available that partnerships could agree to share including police, local housing association, Department of Work and Pensions, Troubled Families Programmes, Community Safety Teams. Service level data from provider organisations can also provide rich data in relation to the work they deliver.

Core actions

- Understand what data is routinely collected by different organisations and determine what role it could play in preventative and operational interventions
- Agree which agency has the expertise and resources to combine, analyse and interpret data into meaningful analytical products
- Draw up data sharing agreements which incorporate arrangements to protect identifiable individual level data
- Agree the different analytical products that will be produced and for what purposes i.e. needs assessment, licensing decisions, policing patrol routes, evaluation
- Use the data to understand where violence is most likely to occur, who the victims and perpetrators are and what the consequences and costs are.
- In the long-term data can be used to evaluate the impact of preventative and operational intervention

Case study: Yorkshire Ambulance Service data sharing to understand incidents relating to alcohol and violence

PHE and Yorkshire ambulance service (YAS) have worked collaboratively over the last year to share YAS data relating to incidents associated with alcohol or violence. Comparative analysis of YAS & hospital data has taken place to determine similarities & disparities across the datasets as well as themes & trends including analysis of age, gender, location and association of violence with alcohol.

A report will be produced which describes the data and small area data has been added to the SHAPE tool to allow visualisation of ‘hotspots’ of high incidence of alcohol or violence related ambulance call outs. This can be overlaid with other datasets included in the SHAPE tool to allow partners to understand more about areas with high numbers of violent call outs.

The sharing of pseudonymised data and comparative analysis has been enabled by a data sharing agreement (Appendix 2) that was co-produced by YAS and PHE Local Knowledge and Intelligence Service (LKIS). The clinical informatics and audit manager for YAS has also worked with PHE on the basis of an honorary contract to facilitate the project and improve PHE's knowledge and interpretation of YAS data.

The challenges that have been encountered during this work have been related to YAS data collection not being originally intended to inform projects such as this and therefore a definition of 'violence' had to be agreed from the fields available, which comes with caveats. Data quality issues are being addressed within YAS and the introduction of an electronic patient record which is being rolled out currently will improve data quality for subsequent analysis.

The joint alcohol & violence projects will be published, and data added to SHAPE at the end of June 2019. Following publication, we will obtain feedback from partners about the utility of the data.

Case study: The Essex Data Project

The Essex Data Project collates data from a number of partners (including Education, Children's Social Care (Assessment & missing), Adults Social Care, Youth Offending Service, Drugs & Alcohol, Community Rehabilitation Company, Police crimes, ASB and Missing persons data). The data is linked and reviewed to create dashboards which can guide targeted intervention.

The Essex Data Project has brought together partners to develop a platform that will be able to build an accurate picture of Essex. The data will not be 'live' but will be updated to ensure a realistic and relevant information source is available. The data will be mapped against other information (such as location of key services) and used to inform a strategic intelligence product. There will also be a predictive element to help inform planned activities and behaviours.

The Project is a good example of how joint-working is beneficial; partners have collectively scoped the requirements of the platform, shaped data sources that will add value, designed dashboards and signed up to an information-sharing protocol – as well as providing the data that will help to inform others.

Case study: London Violence Reduction Unit

In London colleagues at City Hall (covering Greater London Authority (GLA) and Mayors Office for Policing and Crime (MOPAC)) have pooled skills, resource and data with the aim of developing a flexible and innovative data tool that will enable

the evidence-based prioritisation of geographic areas that have greatest need in terms of crime, public perceptions and public health measures.

The tool should act as a decision-support system that will inform a range of VRU strategic and commissioning decisions going forward. The GLA's City Intelligence Unit (CIU) has gathered data from a range of sources for this tool. This includes a range of crime statistics from the MPS (Metropolitan Police Service) incident records; perceptions of crime, local areas and the police from the MOPAC Public Attitudes Survey; and public health data from the Office for National Statistics, Public Health England and a number of Central Government departments to include figures on deprivation, mental health, and issues for 15 children at home and at school. These data have been formatted to electoral ward where possible and London borough elsewhere.

The main output of this tool is a simple score that ranks areas on need in terms of crime, public perceptions and public health. This scoring system sets a threshold (for example the top 10%) for each measure and then assigns a score by counting the number of measures for which each ward is above that threshold. For example, if a given ward is in the top 10% in 7 of the 16 measures, that ward is assigned a need score of 7. Users can adjust the threshold and assign a weight for each variable. For example, if knife crime and deprivation are most important to a decision to target a programme, a higher weight can be given to those measures – which gives a more nuanced score and a ranking that is more relevant to the project they are working on. The scores for each ward can be viewed on a searchable table and on a zoomable map alongside other relevant data visualisations.

The aim of the tool is to bring different data sets together using a simple and flexible scoring system, specific to the needs of the user's project. It should not be thought of as an index or composite measure of a given concept that can or should be used more widely.

Additional resources

College of Policing: Injury surveillance: using A&E data for crime reduction. Guidance for police analysts and practitioners

RAND Europe: Using ambulance data to inform violence prevention. A guide for police, public health and violence prevention partnerships

Centre of Excellence for Information Sharing: Improving information sharing between Police and health services

5.5 Counter-narrative

Work with children and young people and community members to create opportunities for development and the option to pursue alternatives to criminal activities. Partnerships should help to support positive aspirations and promote positive role-models.

Rationale

Violence of all sorts is strongly associated with social determinants and is a result of the interaction of a number of risk factors which span the individual, family, community and society (9, 13). There is strong evidence that addressing the social determinants of health such as housing, education, and access to healthcare will result in better health outcomes, further enhanced by taking a life course approach by considering interventions from birth to old age (19).

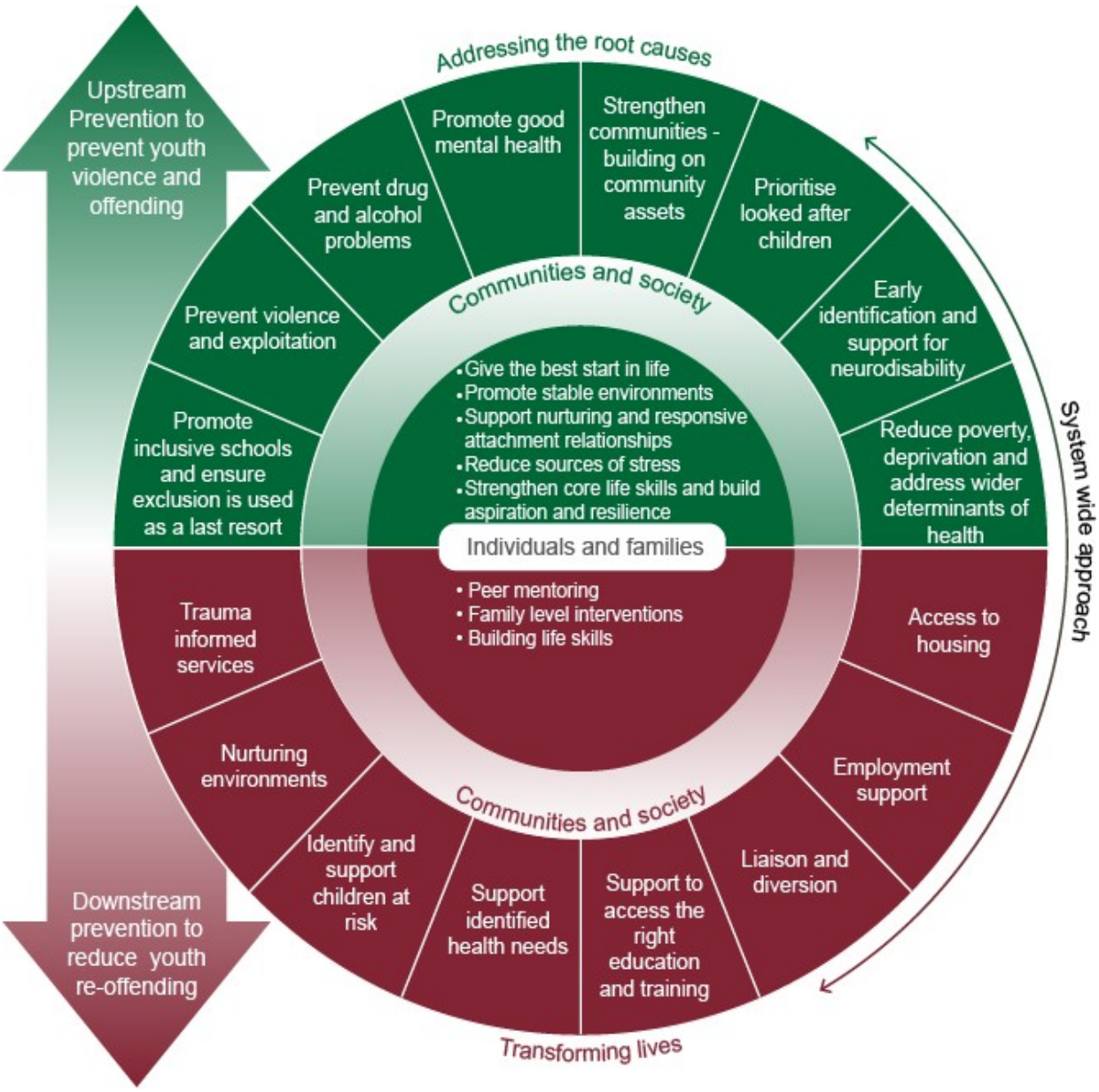
To tackle the root causes of violence and prevent it from happening in the future it is essential that the whole system makes a commitment to creating environments that nurture the protective factors that we know can help to mitigate against perpetration and victimisation of violence (Chapter 2 Figure 3).

PHE's CAPRICORN Framework (Figure 2) provides a comprehensive overview for upstream and downstream actions to prevent youth offending, reoffending and youth violence, using a public health approach, which integrates action at individual/family level and communities/societal level. Further details of the evidence base for each action area can be found in Collaborative approaches to preventing offending and re-offending by children (CAPRICORN).

Core actions

- Recognise and identify risk and protective factors acting at a local level
- Promote upstream universal approaches that aim to mitigate against perpetration and victimisation of violence through the partnership and its programme of work
- Work with the community to identify 'alternative' initiatives using its assets including long term opportunities for employment
- Communicate the available alternative initiatives to different agencies by embedding an understanding of the need for alternative narratives in all agencies working with or coming into contact with children and young people

Figure 2: The CAPRICORN Framework



Case studies: Upstream activities

Case study: West Midlands Mentors Against Violence Prevention (MVP)

The MVP programme has been used internationally, including in schools, universities, sports clubs and more. It utilises a bystander approach, using trained peer mentors to lead sessions with groups of other young people.

The programme aims to equip young people to be able to identify healthy and unhealthy attitudes and behaviours, and to develop young people as confident, positive leaders and shapers of their environments, modelling respect, concern for others and tolerance. Young people are identified not as potential victims or

perpetrators but as empowered shapers of their communities, able to support peers and challenge the inappropriate behaviour which they will encounter in life. To really prevent violence, we need to challenge the factors behind it: the bullying, the name calling, the sexist jokes, and importantly to challenge the silence when we do nothing and ignore negative behaviours. Silence conveys that those attitudes must be ok.

MVP works to give bystanders a range of safe intervention strategies – how you might help a friend or fellow student. The programme has the potential to reduce rates of exclusions and the occurrence of violent incidents; it can also bring about a change in culture within schools towards a more restorative approach to behaviour and create a safer and more settled environment.

The WMVPA employed 2 MVP coordinators to work across schools, and more recently youth groups, across the region, training and supporting schools to become MVP schools. Schools are not charged but need to identify some lead teachers and must work to consider how to embed MVP within their school environment. The Coordinators aim to make it as easy as possible for schools to adopt MVP, and the schools which have seen the greatest impact are those which have worked to embed MVP into their curriculum of timetables. Coordinators reach out to schools through existing local networks and connections, finding opportunities to talk about how MVP could support a school, particularly now in relation to statutory Relationships and Sex education requirements.

Evaluation is underway, but feedback from schools has been extremely positive. Mentors benefit from the leadership training and those on the programme enjoy peer led sessions about things that matter to them, resulting in feeling equipped to understand and interact with the issues they will encounter. Behaviours which had become normalised are now being seen as harmful.

Case study: St Johns Ambulance Health Cadets

St Johns Ambulance is developing a scheme working in partnership with local NHS trusts and NHS England to actively engage young people in social action in the health of their communities, and to provide vocational experiences and for young people to set them up for careers in the health sector. Whilst open to all young people, the programme will seek to work intensively with young people who are least likely to pursue a health career, offering them skills, confidence and direct experience of working in health. With 2 schemes aimed at 14-16 years old and 16-18-year olds nationally, young people are supported through educational attainment and mentorship, practical skills in healthcare for both physical and mental health issues, important training for applying for and sustaining a job in health and actual volunteering experience in and out of healthcare environments.

The aim is to bring 3,000 new young people nationally into the Health Cadet scheme, creating a new pathway into the health sector workforce, preserving the next generation of healthcare professionals and providing an opportunity for young people from all walks of life to build a rewarding career. The scheme is being rolled out nationally in the coming years.

Case study: No Knives Better Lives (NKBL)

NKBL is a Scottish national programme delivered at a local level that aims to deter young people from carrying knives. It is a collaboration between Scottish Government and YouthLink Scotland (the national agency for youth work in Scotland).

NKBL is a primary prevention initiative that specifically addresses the issue of knife carrying but is informed by and complimentary to wider policy priorities and interventions that aim to prevent offending and anti-social behaviour.

There are 2 strands to the delivery of the NKBL engagement programme.

Strand 1 – Using social marketing and youth work methods to communicate information about the risks and consequences of knife carrying, positive decision-making and the importance of reporting knife carrying.

Strand 2 – Capacity-building work to support the delivery of local prevention work with young people.

The 4 R's of Prevention
We believe that effective knife carrying education and prevention should be informed by the 4R's of prevention and a youth work approach.

Reassurance
Young people are aware that knife carrying is not common (this is important as protection is a common reason given for knife carrying).

Risks and consequences
Young people are aware of the very serious legal and personal risks and consequences of carrying a knife or any offensive weapon.

Resilience
Young people are more aware of the influences, fears and pressures that can lead to the decision to carry a knife and how these can be managed or avoided.

Responsibility
Young people are aware of the importance of telling someone if they know that someone else is carrying a knife.

Although a Scottish programme all the resources used by the organisation are freely available to download from their website. These include online practitioner training packages, peer education training, educational toolkits for schools and youth work settings and a range of supporting resources from high-quality videos and animations to posters, leaflets, reports and evaluations.

Case study: Building the evidence based for bystander interventions – collaborative working in the South West

Bystander programmes focus on equipping people with the skills to recognise and safely respond to problematic attitudes and behaviours that contribute to a culture where violence occurs.

As a primary prevention intervention, bystander approaches aim to modify the risk factors associated with violent behaviour (including attitudes, beliefs and social norms which promote violence) and empower people with the knowledge, confidence and skills to safely intervene.

The initiatives in this case study are designed to address DSVA. These are key public health issues which place significant burdens on the health and wellbeing of individuals, families, communities and services.

The Intervention Initiative
The Intervention Initiative is a free, evidence-based education programme (8), developed by the University of the West of England and funded by Public Health England. It is designed to prevent sexual coercion and domestic abuse in university settings, through empowering students to act as prosocial citizens. The evidence review which was used to develop the programme is published by Public Health England (9) .

The Intervention Initiative is widely-implemented in universities across the UK and is recommended as an evidence-based bystander intervention programme by the Universities UK Taskforce examining violence against women, harassment and hate crime affecting university students (10).

Following the successful launch and implementation of the Intervention Initiative, 2 pilot projects have been developed and implemented by a collaboration of academic, public health, and voluntary sector partners in the South West of

England. to test the bystander approach in different settings; Football Onside and Active Bystander Communities. These are described in brief below:

Football Onside

Tackling violence and abuse through bystander intervention

Football Onside is a pioneering bystander intervention programme which trains participants to notice and intervene to prevent violence against women and girls (VAWG) in football and sport. The programme has been delivered to staff at Exeter City Football Club Community Trust and has been evaluated by researchers at the University of Exeter.

Active Bystander Communities (ABC)

ABC is a domestic abuse primary prevention programme, co-produced by academics and public health and domestic abuse practitioners, which builds upon the approach taken in the Intervention Initiative. The evaluation sought to assess the interventions feasibility, acceptability and potential for effectiveness as a community-level intervention.
Both ABC and Football Onside Interventions have been evaluated and are showing positive results. Results will be published in forthcoming peer-reviewed publications.

Case study: SportInspired Play.Believe.Achieve programmes

SportInspired exists to provide early, game-changing opportunities for children growing up in poverty to live healthy, happy childhoods, and follow their dreams, despite their circumstances. Since 2008, we have used sport to help transform the lives of over 85,000 children and young people across the UK. Based on our learning, combined with other best practice out there, we co-design and deliver programmes that encourage children to believe in themselves and bring fractured communities together.

Our model

Step 1 – Co-Create

We work in partnership with young people from local schools and sports clubs to shape the programme content to make sure it responds to their needs. We tailor our delivery to the learning styles and specific needs of the Young Leaders, jointly creating their goals and action plans and agreeing incentives for their completion of the programmes.

Step 2 – Festival – The hook for long term participation

This is a high-octane sports festival run by the Young Leaders with support from volunteer Mentors and SportInspired team.

Young Leaders co-design the festival; for example, choosing the sports clubs, venue's and creating sample team spirit names for the participants, curating dances and chants (all used to heighten excitement at the festival).

During the event children sample exciting, locally available sports, focusing on local clubs that are likely to be new for participants. These might include street dance, martial arts, parkour (free running) boxercise, volleyball and fencing. The festival builds new and powerful connections between children and young people from neighbouring schools as well as local volunteers typically form local businesses.

Step 3 – 20 weeks of Legacy clubs

The festival is essential to inspire long term participation in local sports clubs. After the festival children are set up to take part in an activity of their choice for a period of 20 weeks (the accepted duration to drive behavioural change).

The first cohort of Young Leaders are trained to achieve a Sports Leader Level 1 Qualification. In the second year, this group will support the second cohort and be trained to achieve their Sports Leader Level 2 qualification, and this will continue as each group graduates.

SportInspired additionally incorporates the Five Ways to Mental Wellbeing and nutrition sessions into the programme, equipping children to develop positive emotional wellbeing.

Case studies: Downstream activities

Case study: Nottinghamshire County Councils targeted youth worker service

Based on the findings presented in Nottinghamshire's Annual Public Health Report (case study within Collaboration) the Public health team is partnering with the County Council Youth team in order to fund and deliver a tertiary prevention intervention with young people who are high-risk for being either victims or perpetrators of knife crime.

The plan is to set up a targeted youth worker service in addition to the universal youth service offer in the county. This team will do outreach to young people who are referred by the police or YOT and work with them on diversionary activities (outdoor activities, music etc), education and employment aspirations and resilience building.

While the public health team does a lot of work which falls under the heading of knife-crime prevention, much of it is early years intervention and does not show rapid results.

We are planning a comprehensive evaluation strategy for this work to hopefully support its extension at the end of the planned 2-year pilot but also to contribute to the (currently minimal) evidence base for this kind of project.

Case study: St John Ambulance First Responders

The effects of serious violence mean young people need the skills to save a life if their friend is stabbed and bleeding to death or experiencing PTSD after a being attacked as a coercion tactic. St John Ambulance know that young people that come across these symptoms of serious violence and lack the skills or confidence to deal with them. We know that not all young people can identify with wearing a uniform and are unlikely to join their cadet scheme to get those skills. Young Responders is built from the success of their previous programmes working with young people at risk of knife crime, to work through partners to give 10,000 young people the skills and confidence to respond to the health needs of their communities. A light touch, easily accessed training package is delivered either directly or through train-the-trainer. The scheme will aim to target those most vulnerable to issues like serious violence, social isolation, extreme poverty and mental health problems. The value of human life, and the biological effects of violence are part of the packages they offer meaning that Young Responders learn and absorb alternative narratives about their safety and the wellbeing of their peers. The scheme will be designed and trialled with multiple youth audiences.

Case study: Young Londoners Fund

The Mayor's £45 million Young Londoners Fund helps children and young people to fulfil their potential, particularly those at risk of getting caught up in crime. The Fund supports a range of education, sport, cultural and other activities for young Londoners.

So far 179 projects have been awarded funding, these include activities ranging from theatre groups and employability training to football clubs and art sessions. For more information on the range of projects available and the impact they are having click here.

Additional Resources

Public Health England: Prevention – A life course approach

Public Health England: Collaborative approaches to preventing offending and re-offending in children (CAPRICORN)

5.6 Community consensus approach

Rationale

Community consensus lies at the heart of a place-based multi-agency approach to serious violence prevention. The approach must be with and for local communities, it should empower them to actively participate and get involved in tackling issues that affect them collectively. This is essential for legitimacy and for any ‘new’ work being carried out by partners (particularly statutory work) to be seen as valid by communities. Most communities will already have a number of small local organisations working to address the challenges affecting them. Partners must seek to bring them in and use their intelligence and experience, which can enable links into communities otherwise not receptive to the usual channels.

In the context of serious violence universal approaches to engaging the community need to be balanced with targeted interventions and support which address the needs of specific groups (23). Community engagement strategies should include members of the community who are most at risk of violence both as victims and perpetrators, and those members of the community who have already been affected by violence (23).

There are a range of community engagement techniques and methodologies that can be used. The choice locally will depend on the objective trying to be achieved

through the community engagement. Most effective community engagement processes usually involve having a clear scope, being connected to a local governance and decision-making structure, inclusive, focus on building relationships and trust and regular feedback to demonstrate how involvement has been influential in affecting change (23).

Feedback from a peer review process of community engagement in relation to gang and youth violence undertaken by the Home Office in 2011 highlighted that there is no “one size fits all” solution but suggested some general principles that seemed to work in relation to gangs and youth violence (23) which are:

- strong leadership
- making use of existing resources and avoid duplication
- make use of statutory partners existing resources
- be vigilant of a perception that violence is normal or that it cannot be tackled
- involve the community in decisions that affect them
- engage a wide range of communities and individuals
- make use of expertise, programmes and service providers already available to your organisation
- involve businesses, faith groups, civil society organisations and private citizens
- engage young people
- create multiple opportunities for community members to get involved
- commitment and patience, recognising that prevention interventions can have short and long-term outcomes

Other methods include: approaching voluntary sector partners to aid the process as many will have ‘user groups’ to tap into; running a range of consultation events, some in partnership with local organisations to draw in people connected to them; and linking in with existing youth engagement and youth voice arrangements such as Youth Police & Crime commissioners, Children in Care Councils, or youth parliaments.

Core actions

- Map out community assets and consider how you can build on these
- Use participatory approaches, actively involve community members actively in design, delivery and evaluation
- Reduce barriers to engagement
- Collaborate with those most at risk of being victims or perpetrators of violence
- Address community-level factors such as social networks, social capital and empowerment as well as the environment

Case studies

Case study: West Midlands Gangs Commission

The Commission on Gangs and Violence established in 2016 is a community-informed community-led response to an increase in gang-related crime within Birmingham during 2015 and early 2016.

Led by senior community members, faith leaders and youth providers this group has conducted research into the causes of violent crime which culminated with recommendations. At the core of these recommendations we are advocating a Public Health Approach, engaging with young people and providing early intervention to vulnerable people. This group has key youth representation, and this will be used to engage and promote key messaging and the principles of the VRU.

It has delivered a significant body of evidence and the Gangs and Violence report, published in 2017 includes detailed references to the main issues affecting the community. During the period of the research, Birmingham received much media coverage concerning stabbings, shootings, violent attacks and the ‘new generation of young people’ allegedly carrying them out. It was important therefore for the Commission to acknowledge this and to delve into the communities most affected, to gain an insight into the way in which violence presents, and potential solutions.

The Commission is responding to serious violence using a Public Health approach and therefore recognises that there are no quick fixes. An extensive consultation exercise informed the commission that violence was the result of a number of interrelated risk factors including a lack of employment opportunities and/or low aspirations increase the risk of young people being exploited by organised criminal gangs and, in particular, being drawn into drug-related activity. While only a minority of children and young people are involved with gangs, gang members account for disproportionate levels of crime in affected communities and are at risk of involvement in violence as both perpetrators and victims.

Many of the young people associated with issues relating to gangs and violence have experience ACEs, come from deprived backgrounds and are cautious of engaging with authority figures; in effect ruling out effective engagement by the statutory services which comprise the public sector.

How then was the Commission able to acquire the information required to formulate a community response?
Firstly, the Commission recognised that local ‘communities’ in the West Midlands are diverse and multi-faceted, and are comprised of businesses, universities,

colleges, schools, parents, the voluntary and faith-based sectors, migrant communities, people who live and work in the West Midlands and those who are most vulnerable within our society (this is not an exhaustive list). The Gangs and Violence Commission works to identify, listen and collaborate with our communities in different ways –through existing forums and new voices of legitimacy and experience. It has enabled local communities to identify community ambassadors and mentors to mobilise responses which address their own local community issues or needs. Trusted advocates possessing legitimacy and cultural competence have been funded locally to help with this agenda.

The Gangs and Violence Commission described above shows our commitment to community leadership, co-production, co-implementation and joint accountability. Our approach to commissioning services encourages collaboration between local providers and involves facilitation and support of networking events for local providers, thus making them aware of the service delivery opportunities that exist.

Secondly, the Commission worked across a broad spectrum of policy areas, from youth unemployment, and supporting ex-offenders, to educational practices and attitudinal change. In doing so, the Commission ensures that consultation with members of the community is genuine, consistent and broad ranging, and not simply ‘lip-service’. On-going consultation with the community, ensures that this process is cyclical and information flows between the community (potential service users) and providers. (The Commission).

Finally, the Commission has ensured that the diverse and sometimes opposing views of those within the community are respected and taken into consideration. Discussions are open, frank and the Commission recognises that the sensitivities around issues relating to gangs and violence require a different approach, and thus one that in some ways will necessitate broaching difficult topics and testing new and innovative approaches.

Case study: London Violence Reduction Unit

Putting community and young people at the heart of our work to have a sustainable long-term approach towards reducing violence is one of 3 strategic aims of London’s VRU.

The VRU Partnership Reference Group has been set up to provide strategic direction, support and challenge the work of the Unit. The group is chaired by the Mayor is made up of representatives from community groups and specialists in health, education, police, probation and local government.

One of the first actions of the London VRU is establishing a young people’s action group which will be resourced and empowered to lead on parts of the VRU’s work

programme. Young people will have a stake in all of the Unit's work but particularly on changing the message around violence, ensuring the youth voice is properly representative and by supporting peer-to-peer engagement.

The Unit has also brought together a group of 30 community stakeholders to form a Community Involvement Planning group which has supported the Unit in planning engagement and shaping priorities. In January 2019 approximately 150 community organisations came together to discuss the establishment of the VRU and were able to input ideas.

Through a series of formal and informal meetings, workshops and discussions with various community partners the Community Involvement Planning Group has worked with the VRU to develop a set of commitments for the VRU in its operations across London, with Londoners:

Work with a wide range of community voices
We will work to ensure we are reaching out beyond the most established voices by working with partners to draw on their expertise and access their networks.

Be as accessible as possible and create meaningful opportunities for involvement
We recognise that institutions like the VRU can be hard to reach and can feel inaccessible for many groups. We will work to reduce feeling as many of those barriers as possible by getting out of City Hall and creating clear and varied avenues to engage with this work, so that no one is excluded. We will always consider the scheduling of meetings etc to best enable a range of partners as well as young people to participate. We will ensure there is the necessary time and space to work together.

Recognise where communities are coming from
The community is not one homogenous block. Different sets of issues and inequalities create different challenges. We know that there is no one-size-fits-all approach and we must recognise different groups' needs and perspectives.
Be transparent about the decisions we are making and the impact of community involvement: we will be open and transparent about decisions that are being made and how community input has shaped them. We will always be clear why we are asking for your input and what we have done as a result. Where appropriate, we will publish as much of your input as possible, so you can hold us to account.

Amplify community voice
The VRU's purpose is to change the story in London, for Londoners, but we will take part in the national debate too and when we do, it will be informed by the unique expertise and experiences of London's communities.

Ensure community involvement is sustained over the long term
We commit to creating regular opportunities for structured community involvement, alongside ongoing dialogue. This will take various forms including but not limited to meetings and events.

Involve young people
We commit to putting youth voice and representation at every level of the VRU working including its decision-making and we will pay young people for their time. Enable opportunities: we will play our part in enhancing opportunities for the communities we work with, including looking for routes to employment and skills development and utilising opportunities that may arise within the GLA family.

Tackle stereotypes
We will seek not to perpetuate damaging stereotypes of the communities we work with; we will work to consider how we are using our channels to share positive stories of the communities we work with, alongside more challenging ones.

Additional resources

Public Health England: A guide to community-centred approaches for health and wellbeing

The King's Fund: A citizen-led approach to health and care: Lessons from the Wigan Deal

Figure 3: Summary of 5Cs and core actions

Component	Core Actions Required
Place-based	• Define the population group and the system's boundaries • Identify the right partners and services • Develop a shared vision and objectives • Develop an appropriate governance structure • Identify the right leaders and develop a new form of leadership • Agree how conflicts will be resolved • Develop a sustainable financing model • Create a dedicated team • Develop systems within systems • Develop a single set of measures
Collaboration	• Identify key local system leaders and bring them together • Help partners to understand their role in violence prevention • Define and create a common understanding of what a multi-agency approach is, what that means locally and what each organisations role within the collaboration is or can be • Use data and intelligence to achieve a shared understanding of current local issues, opportunities to implement interventions and evaluate their impact • Identify existing and required resources • Collectively agree the governance arrangements for strategic and operational violence prevention work and link in with existing statutory boards where possible such as Health and Wellbeing Boards or Community Safety Partnerships
Co-production	• Co-produce an action plan/strategy that includes a broad range of activities encompassing public protection, identifying & supporting vulnerable people, building personal and community resilience, and achieving joint aims of a healthy peaceful community • Explore opportunities for co-location of teams and secondments between organisations • Incorporate core actions of collaborative working
Co-operation in data and	• Understand what data is routinely collected by different organisations and determine what role it could play in preventative and operational interventions

intelligence sharing	• Agree which agency has the expertise and resources to combine, analyse and interpret data into meaningful analytical products • Draw up data sharing agreements which incorporate arrangements to protect identifiable individual level data • Agree the different analytical products that will be produced and for what purposes i.e. needs assessment, licensing decisions, policing patrol routes, evaluation • Use the data to understand where violence is most likely to occur, who the victims and perpetrators are and what the consequences and costs are • In the long-term data can be used to evaluate the impact of preventative and operational intervention
Counter-narrative	• Recognise and identify risk and protective factors acting at a local level • Promote upstream universal approaches that aim to mitigate against perpetration and victimisation of violence through the partnership and its programme of work • Work with the community to identify 'alternative' initiatives using its assets including long term opportunities for employment • Communicate the available alternative initiatives to different agencies by embedding an understanding of the need for alternative narratives in all agencies working with or coming into contact with children and young people
Community-consensus	• Map out community assets and consider how you can build on these • Use participatory approaches, actively involve community members actively in design, delivery and evaluation • Reduce barriers to engagement • Collaborate with those most at risk of being victims or perpetrators of violence • Address community-level factors such as social networks, social capital and empowerment as well as the environment

6. International and national public health approaches to serious violence

In 2004, the WHO initiated the Violence Prevention Alliance (VPA) (24); a network of WHO Member States, international agencies and civil society organisations working to prevent violence. VPA participants share an evidence-based public health approach that targets the risk factors leading to violence and promotes multi-sectoral co-operation. Participants are committed to implement the recommendations of the World report on violence and health (11).

Since the World Health Assembly declared violence a leading worldwide public health problem in 1996 (20) a number of population level public health approaches to violence have been implemented throughout the world. The 3 approaches detailed below have received a lot of attention in the British media.

All 3 of the approaches have been recognised by the WHO Violence Prevention Alliance as meeting the components of a public health approach (24). However, the evidence supporting their effectiveness is mixed and the locations and circumstances in which they were implemented were very different to England. This chapter describes each approach, the evidence base and considered the approaches applicability to England.

6.1 Cure Violence

Cure Violence was founded in 1995 at the University of Illinois at Chicago School of Public Health. Originally launched under the names ‘The Chicago Project for Violence Prevention’ and ‘CeaseFire’ the population level approach aims to stop lethal violence before it occurs and stops its spread by interrupting ongoing conflicts, working with the highest risk to change behaviour related to violence, and changing community norms (25, 26).

The approach

The Cure Violence approach is based on the theory that violence is like a contagious disease which has the ability to spread throughout populations but will also respond and can be contained by the implementation of targeted interventions which focus on those most susceptible to contracting violence (25). Professor Gary Slutkin, the founder of the Cure Violence model, described that individuals living in an environment where violence is a well-established norm are more likely to be susceptible to violence and their exposure to violence increases the likelihood that they will become violent themselves (21). The Cure Violence

approach therefore, in addition to highly targeted interventions with individuals, includes interventions aimed at changing community norms and acceptance that violence is inevitable.

The Cure Violence health model uses 3 components that are used to reverse epidemic disease outbreaks (Figure 7); 1) interrupting transmission of the disease 2) reducing the risk of the highest risk 3) changing community norms (21).

Figure 7: The Cure Violence Health Model

The model uses violence interrupters and outreach workers to implement specific activities aligned to each of the 3 components to reduce violence in specific communities (Table 1) (21, 27).

Table 1: Components of the Cure Violence Model and associated interventions (21)

Interrupt transmission	**Reduce highest risk**	**Change community norms**
Trained violence interrupters and outreach workers prevent shootings by identifying and mediating potentially lethal conflicts in the community and following up to ensure that the conflict does not reignite. **Prevent Retaliations** – Whenever a shooting happens, trained workers immediately work in the community and at the hospital to cool down emotions and prevent retaliations – working with the victims, friends and family of the victim, and anyone else connected with the event. **Mediate Ongoing Conflicts** – Workers identify ongoing conflicts by talking to key	Trained, culturally-appropriate outreach workers work with the highest risk to make them less likely to commit violence by meeting them where they are at, talking to them about the costs of using violence, and helping them to obtain the social services they need – such as job training and drug treatment. **Access Highest Risk –** Workers utilize their trust with high-risk individuals to establish contact, develop relationships, begin to work with the people most likely to be involved in violence. **Change Behaviours –** Workers engage with high-risk individuals to	Workers engage leaders in the community as well as community residents, local business owners, faith leaders, service providers, and the high risk, conveying the message that the residents, groups, and the community do not support the use of violence. **Respond to Every Shooting –** Whenever a shooting occurs, workers organize a response where dozens of community members voice their objection to the shooting **Organize Community –** Workers coordinate with existing and

people in the community about ongoing disputes, recent arrests, recent prison releases, and other situations and use mediation techniques to resolve them peacefully. **Keep Conflicts 'Cool'** – Workers follow up with conflicts for as long as needed, sometimes for months, to ensure that the conflict does not become violent.	convince them to reject the use of violence by discussing the cost and consequences of violence and teaching alternative responses to situations. **Provide Treatment –** Workers develop a caseload of clients who they work with intensively – seeing several times a week and assisting with their needs such as drug treatment, employment, leaving gangs.	establish new block clubs, tenant councils, and neighbourhood associations to assist **Spread Positive Norms –** Program distributes materials and hosts events to convey the message that violence is not acceptable.

Cure Violence is a non-profit organisation (NGO) which must be employed to implement a certified version of the Cure Violence model that adequately adopts all the component parts of the model for a reduction in violence to occur (21).

The Cure Violence organisation supports localities to recruit and train violence interrupters and culturally-appropriate outreach workers they also provide the Cure Violence electronic database. This specific database allows the violence interrupters and outreach workers to track the levels of violence that are happening and carry out a root-cause analysis when violence does occur to understand what could have been done to prevent the violence from occurring in the first place (21).

The Cure Violence model requires health and law enforcement to work together. The exact nature of the relationship depends on the environment where the Cure Violence model is being implemented but the Cure Violence technical assistants

try to support the partnership working in localities and advocate 4 guiding principles which demonstrate that both law enforcement and health partners:

- are working on the same issue in the same area
- have the primary interest of reducing violence and making communities safer
- are focused on working with communities
- rely on data to guide implementation

The evidence

The Cure Violence organisation was ranked 10th in NGO Advisor's 2018 report of the Top 500 NGOs in the world; the approach is currently being implemented in 10 countries across more than 25 cities and 60 communities (24). The evidence from evaluations about the effectiveness and impact of the Cure Violence model however, is mixed (28).

In urban areas where there are high crime rates and the Cure Violence model is implemented with high fidelity there is some evidence that the model reduces gun violence in communities (29-31).

The Cure Violence model was initially delivered in 7 neighbourhoods in Chicago under the name CeaseFire Chicago. Process and impact evaluations were conducted which included qualitative and quantitative data collection and analysis. The process evaluation highlighted problems with implementation of the model because it was trying to establish new programmes in neighbourhoods with high crime rates and distrust in authorities, difficulties in recruiting and retaining high-risk individuals as staff and lack of consistent funding (29). Nonetheless the model was successful in reaching high-risk individuals involved in violent behaviour (29). The community and participants thought that the program was 'very important' in conveying anti-violence messages (29). The Violence Interrupters were also found to be critical in preventing violent confrontations which could have led to retaliatory shootings (29).

A sixteen-year time series analysis which aimed to assess neighbourhood level change in gun violence found that the introduction of the program had significantly reduced shootings in 5 of the 7 neighbourhoods; after taking account of other factors the reduction in shootings by 16%-34% could be attributed to the CeaseFire program in 4 of the 7 sites (29). The impact evaluation also found that there were reductions in gang involvement and retaliatory shootings in some of the neighbourhoods (29).

The evaluation of Baltimore Safer Streets in 2012 which examined the effect of implementing the Cure Violence model in 4 neighbourhoods with the highest rates of homicide and gun violence demonstrated how challenging fidelity is to

achieve even within one city and the impact this has on the effectiveness of the intervention. Across the 4 neighbourhoods the reduction in homicides ranged from 56% to no significant difference and in one neighbourhood the number of homicides increased by 2.7 times what it had been prior to the Cure Violence intervention. All 4 neighbourhoods saw a reduction in not fatal shootings of between 22%-53% (28, 31).

Programs that have included only partial components of the Cure Violence model, such as efforts in Newark (32), Pittsburgh (33), and New Orleans (34), appear not to reduce gun violence or affect other crime-related outcomes.

The evaluation of the Phoenix, Arizona replication of CeaseFire Chicago; the Phoenix TRUCE project highlighted challenges with the model despite high fidelity (35). The researchers found significant issues with the partnership working between Violence Interrupters, outreach workers and police and concluded that the model led to an increase in mistrust in police within communities and the legitimacy of the role of the police was diminished (35). This was because of the model's emphasis on the need for Violence Interrupters and outreach workers to distance themselves and work independently from the police. However, in Phoenix it led to a breakdown in communication and challenges to timely, appropriate and meaningful data sharing (35).

TRUCE implementation was not overseen by a strategic advisory board. The researchers commented on the impact of this stating that there was a lack of clarity of roles and responsibilities and that stakeholders were left to create their own idea of the strategic direction of the project – ideas that were often not compatible with each other (35).

The evaluation also raised questions about the generalisability of the Cure Violence model to cities and localities that are different to Chicago in terms of concentration of violence within small confined areas. The model is required to be targeted to an area that is geographically small enough to walk but has a high concentration of gun violence. The current available evidence suggests that high fidelity is required for a reduction in gun violence to take place, as acknowledged by the researchers in Phoenix this reduces the generalisability of the Cure Violence model to different forms of violence and locations where the violence is spread over a much broader area (35).

In terms of reducing violence, the results in Phoenix were mixed, in accordance with the findings of other evaluations. The evaluation found that on average there were 16 fewer violent events occurring every month in the area where Cure Violence had been implemented. However, this overall decline was driven by an overall decline in assaults. The implementation of TRUCE was associated with an increase in shootings in the target area (28, 35).

The independent evaluations undertaken on the Cure Violence model provide mixed evidence in support of the violence prevention model. Evaluations of multi-component interventions targeted at neighbourhoods or populations are challenging as they are unable to take into consideration numerous other contributing factors that might be influencing the outcome of interest, in this case a reduction in gun violence. Random control trials however are impractical, infeasible and are associated with high costs. Nonetheless, Butt et al consider the following questions remain unanswered about the Cure Violence model despite the evaluations that have been carried out (28):

1. Do program effects accrue to the community only after a large number of individuals are directly influenced by the program to stop shooting, or are community residents in general affected by hearing or seeing the program's message?
2. How many conflict mediations are sufficient to effect change? Does the composition of those involved in mediations matter?
3. Does the expected change in social norms related to violence spread from high-risk participants directly to the rest of the community, or is the primary causal pathway to the larger community from individual participants through social networks of other high-risk individuals?
4. What is the timeframe for the transmission of new social norms, and how pervasive do antiviolence norms have to be before they can be reliably measured at the community level?
5. How important are the collateral services and supports often provided by CV staff (occupational, legal, educational, etc.)? Can the strategy operate successfully without offering social services or other supports to individual participants?
6. Can the model achieve results without the involvement of all the collaborative partners specified by the model, particularly law enforcement and the faith-based community?

In September 2016 Cure Violence published its analysis looking at the relationship between the Cure Violence Model and Citywide Increases and Decreases in Killings in Chicago (27). The analysis suggests that there is an inverse relationship between the level of implementation of the Cure Violence model and the level of shootings and killings in Chicago. The authors argue that Cure Violence should be rolled out across all areas with high rates of lethal violence in Chicago (27). Alternatively, it could be interpreted that the results show that the focus on tertiary prevention found in the Cure Violence model has not led to a sustained change in violence within the community. Inclusion of primary and secondary prevention within the model could have helped to reduce the risk of individuals becoming victims or perpetrators of violence or led to changes in social norms of violence within the community (36). But, the Cure Violence model does provide evidence that violence reduction can benefit from

the mobilisation and participation of community members in pursuit of positive goals (36).

The approach's applicability to England

The published evaluations of the Cure Violence Model provide varying conclusions of its impact and effectiveness, however one common theme argued in all of them is that fidelity to the original model is essential to reduce gun violence (28-34). As highlighted by Fox et al (35) this means that to introduce the cure Violence model in England geographical areas would need to have a high enough concentration of violence and be small enough for violence interrupters to be able to walk around on foot.

There are few areas in England that would meet these initial criteria for implementation because gun violence in the UK represents only a small proportion of serious violence. The increase in serious violence since 2014 has been experienced across all almost all police forces in England and Wales. One explanation for this is the phenomenon of county lines in which drug-selling gangs from the major urban areas, like London, Birmingham and Liverpool – possibly driven by excess supply – have sought to exploit markets in other towns and areas (1).

Academic evidence shows that county lines drug-selling gangs are generally much more violent than the local dealers who had controlled the market previously (1). A public health approach to serious violence in England, while 'place-based', must also be able to link in to work going on in other 'places' and be undertaken across a large enough 'place' to address the fact that one of the drivers for the increase in serious violence is nationwide and not happening at a neighbourhood level. Also, gun violence in the United States is not directly comparable to the broader violence, including knife crime, that the UK is currently experiencing.

In addition to the lack of generalisability of the Cure Violence Model to England the Model is particularly resource intensive. It requires a number of violence interrupters to be recruited and work within local areas alongside implementation of a new electronic database. Across England there are already a number of third sector organisations who provide mentoring and support to victims and perpetrators of violence who are known and recognised within the communities they work. Most of these organisations also provide some primary and secondary prevention as well as tertiary prevention, the focus of the Violence Interrupters in the Cure Violence Model, which aims to tackle the root causes of violence. Rather than trying to reinvent or replicate fantastic work that is already going on in local communities we need to consider how public and private sector

organisations can work better with third sector organisations to ensure they are supported by the rest of the system.

The same applies to the Cure Violence electronic database, in England public sector organisations already collect a large amount of data, rather than looking to implement another new database organisations must be supported to share and analyse relevant data so that it can be utilised in a meaningful way.

6.2 Scotland's Violence Reduction Unit

The Scottish Violence Reduction Unit is a national centre of expertise on violence and sits within Police Scotland. The unit was originally founded in 2005 by Strathclyde Police; after Scotland was branded the most violent country in the developed world, they wanted to try a different approach to tackling violence (23).

In 2006 the unit expanded from its Glasgow focus to become a national Scottish Violence Reduction Unit directly funded by the Scottish Government with an annual budget of around one million pounds (37).

The approach

Scotland's Violence Reduction Unit (VRU), like the Cure Violence model, considers violence as an infection which can be cured and focuses on preventing the spread of violence and changing the norms with in the community (23).

The public health approach has 3 broad strands incorporating enforcement, attitudinal change and prevention and include multi-agency working to deliver collaborative projects and programmes (38).

The enforcement strand of Scotland's approach is important to consider as it is not a traditional feature of the WHO's public health approach to violence prevention.

Strathclyde Police's initial approach to tackling serious violence combined deterrence approaches from Boston CeaseFire and Cincinnati Police Department and prevention and community norm change activities of the Cure Violence Model (29, 39, 40). The focus was split equally between stricter policing and prevention work.

The initial flagship programme of the VRU, implemented in 2008, was Glasgow's Community Initiative to Reduce Violence (CIRV) which was adapted from Cincinnati's CIRV programme to reflect local needs and conditions (41). The programme invited gang members to voluntarily attend engagement sessions where a clear message was communicated to them – 'stop the violence' (42).

They were also told that if any individual committed an act of violence then enforcement would be focused on the gang as a whole (42). In addition, gang members were also offered a case manager who identified their individual health and social needs and helped them to access services which could offer them a constructive alternative to gang life (41). Following the introduction of the CIRV programme reductions in weapons carrying were recorded in target populations but there were no significant reductions in rates of physical violence. The CIRV programme was discontinued in 2011 due to several factors including lack of; political will, strong leadership, engagement from health and social care partners and ongoing evaluation to demonstrate any impact the CIRV was having. Around the same time CIRV was being implemented there was an increase in the maximum sentence for knife carrying from 2 to 5 years, and a dramatic increase in the use of stop and search with rates in 2010 recorded as being around 4 times higher than England and Wales (43). Injury surveillance units were established within A&E departments to collect data on timing and location of incidents. The data was used to help the police target hotspots of violent activity.

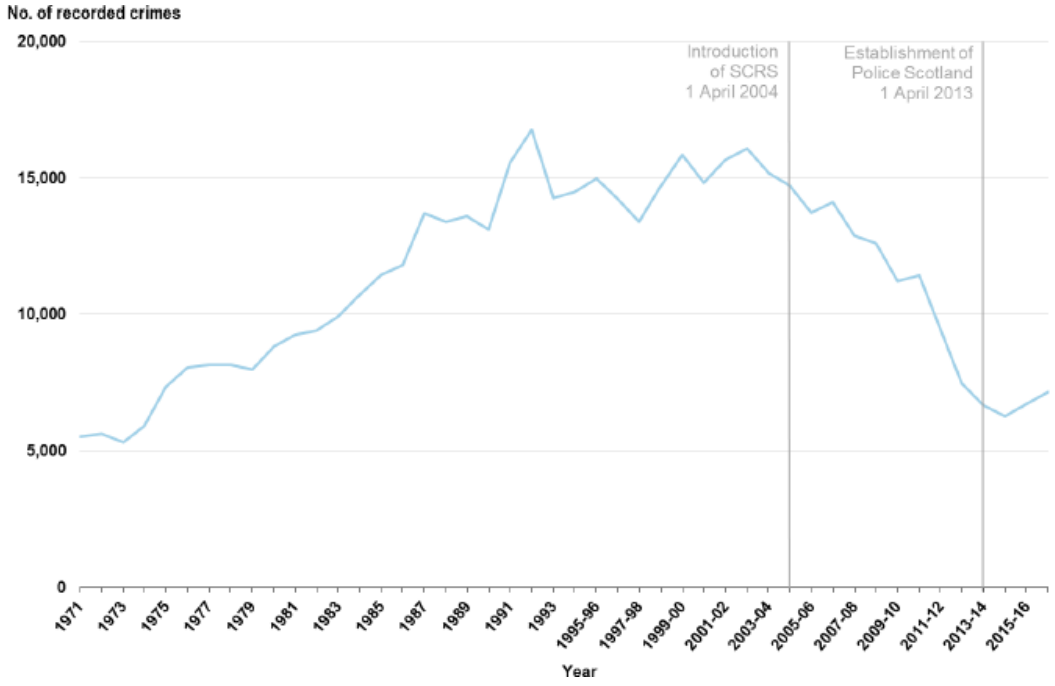
Since the introduction of the VRU in 2005 the murder rate in Glasgow has fallen by 60% and the number of people attending hospital with facial trauma has significantly reduced. The reduction in the violence that is occurring has meant that, more recently, the VRU has been able to focus around 90% of their work on primary, secondary and tertiary prevention of violence, as outlined in their 10-year strategic plan (44).

A wide variety of violence prevention initiatives have been pursued through different organisations and partnerships in different localities across Scotland. There is no central database of all the programmes but in 2014 a call for best practice examples of violence prevention or reduction programmes received 190 responses. While not an exhaustive list this provides an indication of the amount of work agencies are undertaking individually or collaboratively (38). A brief description of the projects that are currently implemented under the banner of the Violence Reduction Unit can be found at http://actiononviolence.org/vru-projects.

The evidence

Since the establishment of Scotland's VRU in 2005 police recorded non-sexual violence, which includes attempted murder and serious assault, homicide, robbery and other violence, fell by 54% until 2014-15 (45). The latest published data show an increase of 6% of police recorded non-sexual violence between 2014-15 to 2016-17 (a change in the reporting of serious assault in 2015 could have led to crimes not previously classified as serious assault now being included within this category and could explain some of the increase) (Figure 8) (43, 45).

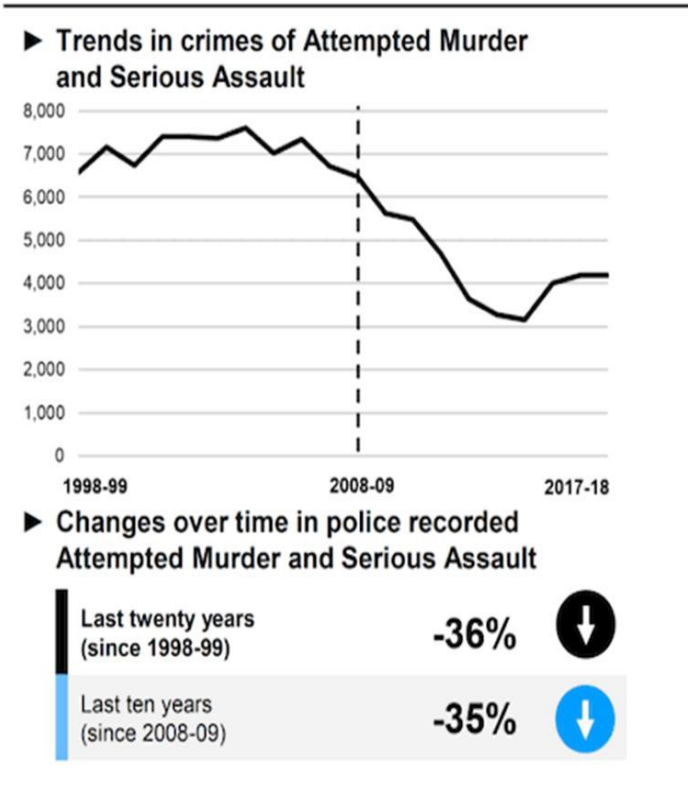
Figure 8: Non-sexual crimes of violence recorded by the police, 1971 to 1994 then 1995-96 to 2016-17 (45)



The number of crimes recorded by the police as attempted murder and serious assault has decreased by 34% between 2008-09 to 2017-18 (46). A study of a sample of these records has found that the overall decrease is because of fewer cases in the West of Scotland (46). Comparative analysis of the characteristics of serious assault between 2008-09 with 2017-18 found that perpetrators were less likely to use a weapon in 2017-18, however the use of a knife or other bladed weapon was still much more common in the West of Scotland (Figure 9) (46).

Nationally Scottish hospital data indicate that emergency admissions due to assault have fallen consistently since 2008; in 2016-17 emergency admissions for all assaults had fallen by 56% and emergency admissions due to assaults by a sharp object had fallen by 59% (47).

Figure 9: Recorded Crime in Scotland. Attempted Murder and Serious Assault 2008-09 and 2017-18



Although the decreasing trends in violent crime and hospital admissions due to assault throughout Scotland are compelling it is not possible to link these reductions directly with any of the work of Scotland's VRU.

Recently it has been argued that any potential impact of the VRU is confounded by general similarities in falling violence seen in both Glasgow and London up until 2012-13, when Greater London saw an increase in rates of violence but rates in Strathclyde continued to fall (48). In the absence of a specific evaluation of the role the VRU had in reducing crime and violence in Greater Glasgow it is impossible to attribute this continued and sustained decline to the VRU (48).

The lack of systematic robust evaluations of any work undertaken by the VRU to demonstrate its impact on violence has been a problem since the initiation of the Community Initiative to Reduce Violence and has been given as one of the reasons the CIRV was discontinued after 3 years in 2011 (41).

A limited post project evaluation of the CIRV showed that compared to a neighbouring area (with a similar socioeconomic profile and problems with youth gangs) that did not have the CIRV programme in place, the CIRV intervention area saw a greater reduction in weapons carrying of 84% compared to 40% (49). Both areas saw a reduction in violent offending with the intervention group seeing an increased rate reduction (49). This overall reduction was attributed to the Gangs Taskforce enforcement approach that was also rolled out across Glasgow at the same time (49). No significant difference in the reduction of violent crime reported to the police was found between the 2 areas. The authors of the study highlighted that it was not possible to replicate the Cincinnati CIRV exactly, there had been a requirement for the intervention to be tailored to the nature of the specific problem Glasgow was experiencing and the resources that were available (49). The authors advocate that thoughtful interpretation, development, and customization of the model is required rather than replication.

To date there is no conclusive evidence that the increase in stop and search experienced in Glasgow until 2012 has been effective in terms of longer-term crime prevention (43). There is some evidence that suggests that short-term, targeted initiatives may be effective. When then societal costs and impact are considered however, the argument for sustaining high levels of stop and search is weakened (43).

The current universal schools-based programmes that are delivered as part of Scotland's VRU are based on a strong evidence base that developing young people's emotional, social and problem-solving skills can prevent gang involvement, youth violence and crime (50). Robust evidence from the UK about the effectiveness of secondary and tertiary interventions in violence prevention is currently lacking. Available reports and evaluations of Scotland's VRU current

projects predominantly focus on descriptive data about the number and characteristics of the individuals the projects have been delivered to (51, 52). Qualitative data about the impact of the projects is positive but evaluations are not currently carried out in a robust way that allows the overall effectiveness of the projects to be understood (51, 52).

The approach's applicability to England

When considering the applicability of Scotland's VRU approach to England it is important to consider the context that the VRU was established.

The new approach of tackling violence was initially established in Glasgow, which geographically is the size of 2 London Boroughs and was the responsibility of one police force. Glasgow had a long history of territorial gangs and associated violence, with drugs and alcohol fuelling most of the violence in the late 1990's and early 2000's. At the time the police knew who a lot of the gang members were and most of the violence was contained within Glasgow. This allowed Strathclyde Police to adopt a stronger enforcement approach initially through increased stop and search and increasing the minimum sentence for carrying a knife and working with gang members to implement the CIRV initiative. As previously noted, England's geography and therefore the organisational structures that operate within it and much larger and complex than Scotland and new drivers for the increase in serious violence such as County Lines and social media are presenting new challenges to an already complex problem that didn't exist when Scotland's VRU was first established.

Following the initial enforcement and tertiary prevention activities the VRU received long-term funding and the commitment from Scottish government to support a new partnership approach that didn't just focus on enforcement. Whilst the latter has been realised in England a commitment for long-term funding to support this approach is still awaited.

The reduction in Scotland's violent crime and hospital admissions due to assault are to be commended however the lack of systematic evaluations and the different context that Scotland's VRU was established should make give grounds for caution in simply replicating the model like for like in parts of England. Instead, aspects of Scotland's approach which are supported by evidence should be incorporated into the approach for England and evaluation must be a key aspect of implementation.

From a primary prevention perspective, the EIF has reviewed the evidence into what works to prevent gang involvement, youth violence and crime. Interventions with strong evidence behind them include skills based and family focussed programmes. The key features of successful interventions are programmes that:

- seek to create positive changes in the lives of youth and or their families, as well as prevent negative outcomes
- use a trained facilitator, experienced in working with children and families
- work with youth in their natural environments and include skills practice, parent training and or therapy depending on the level of risk

From Scotland's VRU interventions would include the Mentors in Violence Prevention, Medics Against Violence, Resilient Scotland.

6.3 The Cardiff Model

The Cardiff Model is a multi-agency approach to violence prevention that relies on the strategic use of information from health and law enforcement services to improve policing and community violence prevention initiatives. Information sharing, and collaboration are key to the approach.

The approach

The Model was initiated by Professor Johnathan Shepherd, a surgeon and professor at Cardiff University, in 1997; full data sharing and use were implemented in 2003 (22). The theoretical basis of the Model is that by enhancing information available from the police with relevant data from emergency departments and by using health professionals to advocate in favour of violence prevention, more violence can be prevented than that from police effort alone (22). The theory is informed by evidence from the UK and Scandinavia that only a quarter to one third of violent incidents that result in attendance at an emergency department appear in police records (53-55), therefore by combining health and police data multi-agency partnerships would have a greater understanding of the totality of violence occurring in a community.

Violence-related injury data was collected in the emergency department, including location, date, time and mechanism of injury (56). These data were combined with police recorded assault data and then mapped to provide a visual representation of where violence was frequently occurring within Cardiff (22, 56, 57). The combined police and health data assisted in identifying public spaces such as bars and streets where violence was frequently occurring and facilitated the introduction of evidence-based violence prevention interventions such as changes in the environment (increased street lighting and pedestrianisation of sections of a city centre street with a high concentration of bars and night clubs), policy change (plastic glasses used instead of glass) and promotion of stronger community partnerships (57, 58). It was also used to inform public space deployment of closed circuit television (CCTV) and licensing decisions and appeals (57, 58).

The evidence

Implementation of the Cardiff Model was associated with a substantial and significant reduction in hospital admissions related to violence when rates were compared to 14 similar comparison cities in England and Wales during the same time period and after adjustment for potential confounders (57). The unique characteristics of the Violence Prevention Group, that had been formed in Cardiff, that were not present in any other partnership work across the comparable cities during the period of evaluation were the systematic collection, summary and use of emergency department data for violence prevention and the participation of emergency department and maxillofacial clinicians in statutory partnership meetings (57). An economic evaluation showed that the implementation of the Cardiff Model led to substantial cost savings for the health service and the criminal justice system compared to the 14 similar cities (59).

In 2002, the Trauma and Injury Intelligence Group (TIIG), a multi-agency Injury Surveillance System (ISS) was established in the North West of England. The TIIG had a focus on improving the data collected via emergency departments, the contribution alcohol made to intentional and unintentional injuries and understanding the contribution sharing ED data made to local violence and alcohol-related harm prevention (60). Arrowe Park Hospital in Wirral was one of the first emergency departments to join the TIIG IIS and consistently provide data. A 6-year analysis of the injury-related data collected in the Arrowe Park emergency department concluded that collection of additional emergency department data on assault details and alcohol use prior to injury, and its integration into multi-agency policy and practice, was associated with a decrease in attendances because of intentional injury by 35.6% and alcohol-related assault attendances by 30.3% (60).

The Cardiff Model and the North West TIIG IIS were supported in part by an academic structure and were established as part of ongoing research programmes (57, 60). However, the model of information sharing was validated outside of an academic setting in Cambridge where they implemented effective information sharing with minimal extra funding or infrastructure development (61). Implementation of the model led to a 20% reduction in the number of emergency department attendances due to assault, and a 35% reduction in violent crimes with injury reported to the police (61). There was no reduction in the number of hospital admissions following assault. Information collected from the emergency department provided added support in influencing licensing decisions and instituting control measures in violence hotspots (61).

There has been wide support nationally and internationally for the approach taken in the Cardiff Model (62). The UK government has been promoting it since 2007 in their Safe Sensible Social alcohol strategy (63). In 2012 the Department of

Health and Social Care published guidance for Community Safety Partnerships on engaging with the NHS (64) and in 2014 introduced a Standard on Information Sharing to Tackle Violence as part of their commitment to reduce knife and gun crime (65). Information sharing was also promoted in the 2016 Modern Crime Prevention Strategy (66). Most recently the Cardiff Model dataset has been incorporated into the new Emergency Care Data Set which software suppliers are required to include in their products, so all emergency departments have the tools to collect and process anonymised assault data.

In 2016 Jacoby et al undertook a scoping review looking at literature published from 1990 to 2016 focused on local and regional health service and law enforcement collaborations in injury surveillance, control and prevention from around the world (62). 128 articles were included in the final review which yielded 2 major findings: overall, the combination of health service and law enforcement injury data adds value to surveillance systems and lots of partnerships have been developed to improve injury control and prevention but there are few studies that have evaluated the impact and sustainability of these partnerships (62).

Despite the evidence that supports the strategic use of information from health and law enforcement services to improve policing and community violence prevention initiatives; the implementation of national guidance and standards; and the availability of the assault proforma in emergency departments; data collection, sharing and interpretation of assault data is variable across the county.

Conclusion

The formal evaluations available for the 3-population based public health approaches to violence demonstrate how challenging it is to effectively evaluate public health, or system wide interventions. Nonetheless the World report on violence and health clearly showed that investing in multi-sectoral strategies for the prevention of interpersonal violence is not only a moral imperative but also makes sound scientific, economic, political and social sense. It is important that the lessons learnt from the 3 approaches are used to inform the approach for England based on the evidence that is available.

All 3 approaches have been identified by the WHO Violence Prevention Alliance as public health approaches despite having different component parts. This reflects the first common theme that all the approaches promote; the need for local interpretation. All 3 approaches advocate that local areas understand the needs of their local population and the resources available to tackle the issue so that approaches can be proportionate and tailored appropriately. This will be particularly important across England as different ‘places’ are experiencing different levels and drivers of serious violence and violence, and the funding available for public health approaches to violence prevention will vary.

The second common theme is the requirement for strong strategic leadership and multi-agency buy in with the involvement of the community. These components will make sure the approach is able to address the root causes of violence as well as support those who are already victims or perpetrators of violence in a sustainable way.

These key themes, highlighted as being important in the 3 international and national examples of public health approaches to serious violence prevention, along with information and evidence obtained through various stakeholder engagement activities (Appendix 1) have been used to inform PHE's 5Cs place-based multi-agency approach to serious violence prevention for England.

7. Steps for starting

To assist local areas in implementing the 5Cs: a place-based multi-agency approach to serious violence initial steps for starting have been identified.

Community consensus lies at the heart of the 5Cs approach therefore the steps for starting have been aligned to PHE's forthcoming steps for starting a whole systems approach to community centred public health (67, 68).

A place-based multi-agency approach to serious violence prevention requires a shift from traditional ways of working to a whole systems approach. It is important to recognise and accept that change is complex, messy at the beginning, takes time and requires flexible approaches. Small steps and small amounts of funding can start the journey to building trusting relationships with communities.

Steps for starting a place-based multi-agency approach to serious violence prevention

1) Strengthen partnerships at a strategic level, including members of the community, by holding a Serious Violence Summit to build a clear vision and align agendas.
2) Use the Summit to gain senior buy-in and commitment and identify champions to drive change.
3) Recognise and build on what is already going on. Map local community assets and understand what data is routinely collected by different organisations.
4) Use the data to understand where violence is most likely to occur, who the victims and perpetrators are and what the consequences and costs are.
5) Co-produce an action plan/strategy that clearly articulates a broad range of core activities and desired outcomes for the community in relation to violence prevention.

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Appendix 1. Development of the 5Cs place-based multi-agency approach to serious violence prevention for England

PHE has been working across Government on the design and delivery of a multi-agency approach to serious violence prevention reflecting the commitments in the Serious Violence Strategy (1).

At the Home Office-led International Violent Crime Symposium in November 2018, a number of UK and international best practice examples of public health approaches to serious violence prevention were identified (69). PHE have looked further at these models to understand the generalisability of approaches to England specifically to inform what a place-based multi-agency approach to serious violence prevention for England should look like and the component parts that would be required for implementation.

To develop a place-based multi-agency approach to serious violence prevention for England, PHE's National Health and Justice Team, has used a mixed methodology. Combining critical appraisal of the 3 public health approaches identified by the Home Office (Cure Violence, Scotland's Violence Reduction Unit and the Cardiff Model), and extensive stakeholder engagement to make sure that the proposed approach is feasible and acceptable to the different organisations expected to implement a multi-agency approach at a local level.

During the development of the 5Cs model, PHE's National Health and Justice Team established PHE's Serious Violence Prevention Network. A network of public health professionals from relevant PHE National Teams (Health and Justice, Drug, Alcohol and Tobacco, Children and Young People, Public Mental Health and, National Engagement Lead for Police and Fire Services Healthy People) and representation from the 9 PHE Regional Centres. The relationships held by the Network members at a national and local level across police, health, national and local government and the third sector, have been instrumental in developing and informing the contents of the resource.

Aim

Understand, refine and communicate what a multi-agency or public health approach to serious violence prevention would look like for England

Objectives

Use WHO definitions to provide a clear explanation of what a public health approach means in the context of violence and serious violence.

Critically appraise 3 multi-component population level international and national public health approaches to violence identified by the Home Office to understand their strengths and limitations and applicability to England.

Use the findings of the critique to inform a multi-agency approach to serious violence prevention for England.

Seek feedback about the feasibility and acceptability of the proposed approach, and refine it accordingly, from a range of stakeholders involved in serious violence prevention.

Use stakeholders' expertise and experience to co-develop core actions to support the component parts of the place-based multi-agency approach for England.

Methods

WHO publications and reports were used to set the context of violence as a public health issue and to provide definitions of violence (and how this is associated with the definition of serious violence in the Serious Violence Strategy), a public health approach and a public health approach to violence prevention.

Evaluations of the 3 multi-component public health approaches identified by the Home Office (Cure violence, Scotland's Violence Reduction Unit and the Cardiff Model) were critically appraised to identify and understand the strengths and limitations of the approaches and their applicability to England. Our goal was to capture and provide a balanced overview of the existing evidence of the impact and effectiveness of the 3 approaches to violence prevention and use this to inform and develop an approach for England. A further model, developed by West Midlands PHE Centre using the WHO Violence Prevention Alliance methodology, was also reviewed as it was identified during the process led by PHE as an exemplar of good practice. Due to the challenges of evaluating such approaches, we felt it was appropriate to consider a wider range of evidence identified through a variety of sources, including:

- peer-reviewed journals identified through the internationally recognised database PubMed and further articles identified through snowball methods
- authoritative organisations and 'what works' clearinghouses, such as the World Health Organisation (WHO), College of Policing What Works Centre for

Crime Reduction, the Early Intervention Foundation, Cure Violence, Scotland's Violence Reduction Unit, Center for Disease Control National Center for Injury Prevention and Control
- academics and experts working in the field
- attendance at relevant conferences at events: Sharing Emergency Data to Tackle Violence (July 2018), Home Office International Violent Crime Symposium (November 2018), Home Office Serious Violence Strategy Launch (November 2018 and January 2019), Tackling Gang and Youth Crime (January 2019), Multi-Agency Approaches to Tackling Knife Crime Conference (July 2019)

After the collection and review of the evidence from the sources detailed above PHE's Health and Justice Team working with other key informants developed a new model of a multi-agency approach to serious violence prevention for England: the 5Cs. This approach was presented to and discussed with a range of stakeholders across police, health, national and local government and the third sector including:

- Public Health England
- West Midlands Violence Prevention Alliance
- London's Violence Reduction Unit
- Ministry of Justice
- Home Office
- Youth Justice Board
- Department of Health and Social Care
- NHS England and NHS Improvement
- Association of Police and Crime Commissioners Office
- Association of Directors of Public Health
- Thames Valley Police
- Clinical Director of Major Trauma and Acute Surgery Kings College Hospital
- Local Offices of Police, Fire and Crime Commissioners
- St Johns Ambulance
- Public Health Wales

Feedback from these engagements was used to refine the approach into the one presented in this document.

Case studies to demonstrate the existing work already going on around the country using public health principles and the 5Cs approach were collected through members of PHE's Serious Violence Prevention Network.

Appendix 2. Data sharing agreement between Yorkshire Ambulance Service and PHE

Data Sharing Agreement

Ref:

1.0 Organisations

This data sharing agreement (the "**Agreement**") is drawn up between:

Public Health England, an Executive agency of the Department of Health ("PHE"), of Wellington House, 133-155 Waterloo Road, London SE1 8UG, United Kingdom; and and:

Yorkshire Ambulance Service NHS Trust (YAS)

In this Agreement YAS and PHE are individually referred to as a "party" and collectively as the "parties".

2.0 Period of Agreement and Termination

This Agreement commences on 01/07/2016 and will terminate on 01/07/2020 unless extended by the mutual agreement of both parties in writing, in which case an Amendment will be issued by PHE to replace this document. Either party shall be entitled to terminate this Agreement upon giving a written notice of three (3) months to the other party.

3.0 Data Retention and Disposal

The data provided under this Agreement will be retained for the period of the Agreement, after which they will be destroyed in an auditable and verifiable manner as required by the data controller, as outlined in clause 11 of this Agreement.

4.0 Data Required

YAS will supply **non-patient identifiable** data items as listed in Schedule 1 to PHE.

Definitions from the 1998 Data Protection Act ("DPA"):

Data means information that:

a) is being processed by means of equipment operating automatically in response to instructions given for that purpose

b) is recorded with the intention that it should be processed by means of such equipment
c) is recorded as part of a relevant filing system or with the intention that it should form part of a relevant filing system, or
d) does not fall within paragraph (a), (b) or (c) but forms part of an accessible record as defined by section 68 of the DPA.

Data controller means a person who (either alone or jointly or in common with other persons) determines the purposes for which and the manner in which any personal data are, or are to be, processed.

Data processor, in relation to personal data, means any person (other than an employee of the data controller) who processes the data on behalf of the data controller.

5.0 Purpose for the Use of Data

Questions:

1. Can we use ambulance data to understand and map the geographical locations where alcohol-related ambulance call outs occur within Yorkshire?
2. Can we use ambulance data to give us more information about falls; geographical locations where there are high rates of all falls specifically falls at home. To further look at whether we can ascertain whether there are particular housing types or demographic groups which are having higher rates of falls at home.
3. Can we use ambulance data to look at the 'unmet need' of ambulance call outs for self-harm which are not being picked up in the HES data? Are there particular demographic groups or geographical areas in which there are higher rates of ambulance call outs for self-harm?

6.0 Specific Conditions

Use of the data supplied is for the purposes set out above. The data will not be shared with any other organisation or named individual not explicitly referred to within this Agreement. If the information referred to herein is subject to a freedom of information or other request to share the data, then PHE will obtain agreement in writing from the data provider before undertaking this.

Information tools derived from this dataset will be provided to other organisations without the specific consent of the data provider but will always be in an anonymised format.

PHE will be permitted to use the data for the purpose of carrying out analysis using appropriate statistical methods and the output of such analysis may be published by PHE on its website and in peer-reviewed journals or made available directly to health professionals or members of the public, YAS will be acknowledge in any such publication.

Nothing in this Agreement shall affect the ownership of any intellectual property rights or know-how exclusively owned by a party or existing prior to this Agreement. No right or

license under any intellectual property owned by PHE or the data provider is granted or implied under this Agreement.

7.0 Permitted Users

No individuals other than those named in this clause 7 can access the data under this Agreement ("Permitted Users") and the data must only be used for the explicit purpose set out in clause 6 above. **PHE** will inform the data provider of staff changes prior to new staff members gaining access to the data listed in this Agreement.

Full Name and Job Title	**Name and Address of Organisation where this individual will access the data supplied**
Barbara Coyle, Associate Director, LKIS Northern and Yorkshire	Public Health England West Offices, Station Rise, York, YO1 6GA
Verity Bellamy, Principal Health Intelligence Analyst (LKIS Northern and Yorkshire)	Public Health England West Offices, Station Rise, York, YO1 6GA
Charlotte Wood, Health Intelligence Specialist and Knowledge Transfer Facilitator	Public Health England West Offices, Station Rise, York, YO1 6GA
James Nelson-Smith, IG Lead, HES Lead	Public Health England West Offices, Station Rise, York, YO1 6GA

8.0 User Obligations

PHE formally acknowledges its explicit commitment to maintaining the confidentiality, safety, security and integrity of any data provided under this Agreement and which may be held under its guardianship.

Users of the data supplied are obliged to comply with all applicable data protection laws.

9.0 Audit

During the period of this Agreement PHE acknowledges the right of the data provider to undertake an audit of PHE with respect to the use and storage of the data detailed in this Agreement to ensure that all terms of this Agreement are being abided by. PHE agrees not to withhold reasonable requests to undertake audits for the purposes set out in this Clause 9.

10.0 Transfer of Data between PHE and the Data Provider

The data will be handled as patient identifiable and will be treated by PHE and the data provider in accordance with NHS best practice and Information governance (IG) Toolkit procedures for the transfer and use of patient identifiable data.

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11.0 Storage of Data and Data Destruction

Data will be stored in a PHE Data Centre, in the UK.

The data can only be accessed from computers physically within the organisation and can only be used by authorised members of the organisation.

Network policies enforce complex passwords, history, password expiry and logon attempts. Password management systems are used to establish rules concerning the use of passwords in systems. Session timeouts exist which activate automatic screen locking after a period of inactivity.

Each information asset has an accompanying System Level Security Policy, and it is the responsibility of the Information Asset Owner to only grant authorisation for access as detailed in the organisation's Access Control policy. Access authorisation to information systems is audited on an annual basis.

Data will be securely wiped and destroyed according to PHE corporate policy.

12.0 Data Retention

The data will be retained by the PHE until the end date of the Agreement. Extension of the retention period is subject to a formal review by both parties.

13.0 Confidentiality

The parties each undertake to keep confidential and not to disclose to any third party, or to use themselves other than for the purposes of this Agreement: any confidential or secret information in any form directly or indirectly belonging or relating to the other, its affiliates, or their business or affairs, disclosed by the one and received by the other pursuant to or in the course of this Agreement, the existence and terms of this Agreement (**Confidential Information**).

Each party undertakes only to disclose the Confidential Information of the other to those of its officers, employees, agents and contractors to whom, and to the extent to which, such disclosure is necessary for the purposes contemplated under this Agreement. In the event of any incident relating to a breach of confidentiality, each party shall notify the other and initiate their reporting procedures without delay.

The obligations contained in this clause shall survive the expiry or termination of this Agreement for any reason, but shall not apply to any Confidential Information which:

- is publicly known at the time of disclosure to the receiving party, or
- becomes publicly known otherwise than through a breach of this Agreement by the receiving party, its officers, employees, agents or contractors, or
- can be proved by the receiving party to have reached it otherwise than by being communicated by the other party including being known to it prior to disclosure; or having been developed by or for it wholly independently of the

other party; or having been obtained from a third party without any restriction on disclosure on such third party of which the recipient is aware, having made due enquiry; or is required by law, regulation or order of a competent authority (including any regulatory or governmental body) to be disclosed by the receiving party, provided that, where practicable, the disclosing party is given reasonable advance notice of the intended disclosure

14.0 Breach of Conditions

Notification of breach PHE agrees to report immediately to the data provider instances of breach of any of the terms of this Agreement.

Right to terminate access The breach of any of the terms of this Agreement shall result in the immediate termination of access to the data and the return of any data to the data provider.

15.0 Changes to Terms of Agreement

No change, modification, extension, termination, or waiver of this Agreement, or any of the provisions herein contained, shall be valid unless made in writing and signed by duly authorised representatives of the parties hereto.

If the person signing for PHE should leave their post or the responsibility for this Agreement changes from them, then it is incumbent on that person to arrange a new signatory to this Agreement and the data provider must be informed of this requirement immediately.

16.0 Indemnity and Limitation of Liability

Nothing in this Agreement limits or excludes either party's liability for:

- death or personal injury resulting from negligence, or
- any fraud or any sort of other liability which, by law, cannot be limited or excluded.

The liability of either party for any breach of this Agreement or arising in any other way out of the subject matter of this Agreement, will not extend to any loss of business or profit, or to any indirect or consequential losses.

17.0 No partnership or agency

Nothing in this Agreement is intended to, or shall be deemed to, establish any partnership or joint venture between any of the parties, constitute any party the agent of another party, nor authorise any party to make or enter into any commitments for or on behalf of any other party.

18.0 Governing Law and Jurisdiction

This Agreement and any dispute or claim arising out of or in connection with it or its subject matter or formation (including non-contractual disputes or claims) shall be governed by and construed in accordance with the laws of England.

The parties to this Agreement irrevocably agree that the courts of England shall have exclusive jurisdiction to settle any dispute or claim that arises out of or in connection with this Agreement or its subject matter or formation.

19.0 Agreement Signatures

For and on behalf of:	For and on behalf of:
YAS	**PHE**
Signed:	Signed:
Print Name:	Print Name: Barbara Coyle
Post/Title:	Post/Title: Associate Director Local Knowledge and Intelligence Service (LKIS) Yorkshire and the Humber
Date:	Date: 09/07/2018

Schedule 1: Data to be provided under this Agreement

Field name	Patient identifiable?	Purpose	Notes
Date of incident	No	To enable analysis of whether time of year or day of the week has implications on call outs for specific incidents (e.g. falls in winter, or alcohol call-outs at weekends)	
Time of incident	No	To enable analysis by time of day (e.g. are alcohol call-outs mainly at night)	
Lower Super Output Area (LSOA) of incident	No	To enable analysis of where incidents took place and identify areas of greatest need	To be derived from postcode prior to data being shared
Home address (Y/N)	No	To identify falls at home as opposed to falls outside the home as these are thought to be different cohorts	Derived from: does incident postcode = home postcode. Actual address will not be provided
Sex	No	To assess whether there are differences in gender for particular incidents	
Five-year age band	No	To assess whether incidents are associated with particular age groups e.g. older people and falls	To be derived from patient age or patient DOB
Destination	No	To understand whether the patient was then transferred to hospital or not	Actual code not required only whether the patient has been conveyed
Call out code (AMPDS code)	No	To enable us to identify in more detail the reasons for call out particularly for self-harm to understand which incidents get classified as ‘self-harm’	
Working impression	No	To give us the classification of ‘self-harm’ not given elsewhere	
Code after exam	No	To identify cohorts of interest e.g. alcohol related call outs	