# Information Sharing to Tackle Violence Guidance for Community Safety Partnerships on engaging with the NHS

*September 2012*

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| **Document Purpose** | For Information |
| **Gateway Reference** | 18092 |
| **Title** | Information Sharing to Tackle Violence – guidance for Community Safety Partnerships on engaging with the NHS |
| **Author** | Department of Health |
| **Publication Date** | **18 September 2012** |
| **Target Audience** | Police, Community Safety Partnerships |
| **Circulation List** | |
| **Description** | This is a guidance designed to support members of Community Safety Partnerships (CSPs), including the police, to deliver the Coalition Programme Commitment on information sharing to tackle violence. It should also support CSP partners to understand better ways of engaging with their health partners at a local level. |
| **Cross Ref** | N/A |
| **Superseded Docs** | N/A |
| **Action Required** | N/A |
| **Timing** | **N/A** |
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First published 18 September 2012
Published to DH website, in electronic PDF format only.
www.dh.gov.uk/publications

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## Information Sharing to Tackle Violence

1. This guidance is designed to support members of Community Safety Partnerships (CSPs), including the police, to deliver the Coalition Programme Commitment on sharing information to tackle violence. It should also support CSP partners to understand better ways of engaging with their health partners at a local level.

### Coalition Programme Commitment

2. The Coalition Programme states *"we will make hospitals share non-confidential information with the police so that they know where gun and knife crime is happening and can target stop and search in gun and knife crime hotspots."*[1]

### Why is it important?

3. Research indicates that only 23% of people injured and treated in hospital as a result of violent assaults are also recorded by police.[2] Hospitals are therefore well placed to promote community safety and wellbeing through sharing information appropriately. This does not need to compromise patient confidentiality; A&E departments (also known as Emergency Departments or EDs) are able to collect and share information on the type, location and time of assaults. This information can be anonymised and shared with CSPs to inform violence reduction measures, including licensing restrictions and targeted policing.

4. This approach to violence reduction was pioneered by Professor Jonathan Shepherd in Cardiff; it is sometimes referred to as the 'Cardiff Model.'[3]

### Government programme

5. The Department of Health has established a programme of work which focuses on supporting hospitals with an A&E department in England to collect and share information with Community Safety Partnerships at a local level. High quality information from hospitals can be used by CSPs to tackle all forms of violence through local interventions such as targeted policing or applying licensing restrictions to bars and clubs.

### Support and Tools for you

6. Key elements of the programme are designed to support local practitioners. They include:
   - An e-learning toolkit which is accessible to all frontline professionals and provides a clear outline of what is involved in successful information sharing;
   - Good practice case studies which show how six local areas across England and Wales have successfully implemented data sharing work to reduce violence;

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[1] http://www.cabinetoffice.gov.uk/sites/default/files/resources/coalition_programme_for_government.pdf, p.13

[2] Faergemann C, Lauritsen JM, Brink O, Stovring H. What is the lifetime risk of contact with an A&E department or an Institute of Forensic Medicine following violent victimization? Injury. 2008; 39:121-7. Epub 2006 Sep 1

[3] http://www.vrg.cf.ac.uk/Files/vrg_violence_prevention.pdf

- Distribution of funding to hospitals and CSPs to support delivery;
- A national audit on progress towards delivering the Coalition Commitment reported in September 2012. A further audit is due to report in 2013;
- The NHS Standard contract reporting requirement that enables local NHS commissioners to hold A&E providers to account for delivering information collection and sharing in line with the College of Emergency Medicine guideline (nationally mandated for local collection).[4] It should be noted that responsibility for the development of the NHS standard contracts transfers to the NHS Commissioning Board as part of the changes being made to the NHS. The obligations under 2013/14 contract will be subject to review.

[4] 2012/13 NHS standard contract for acute, ambulance, community and mental health and learning disability services, Section B The Services, p.41

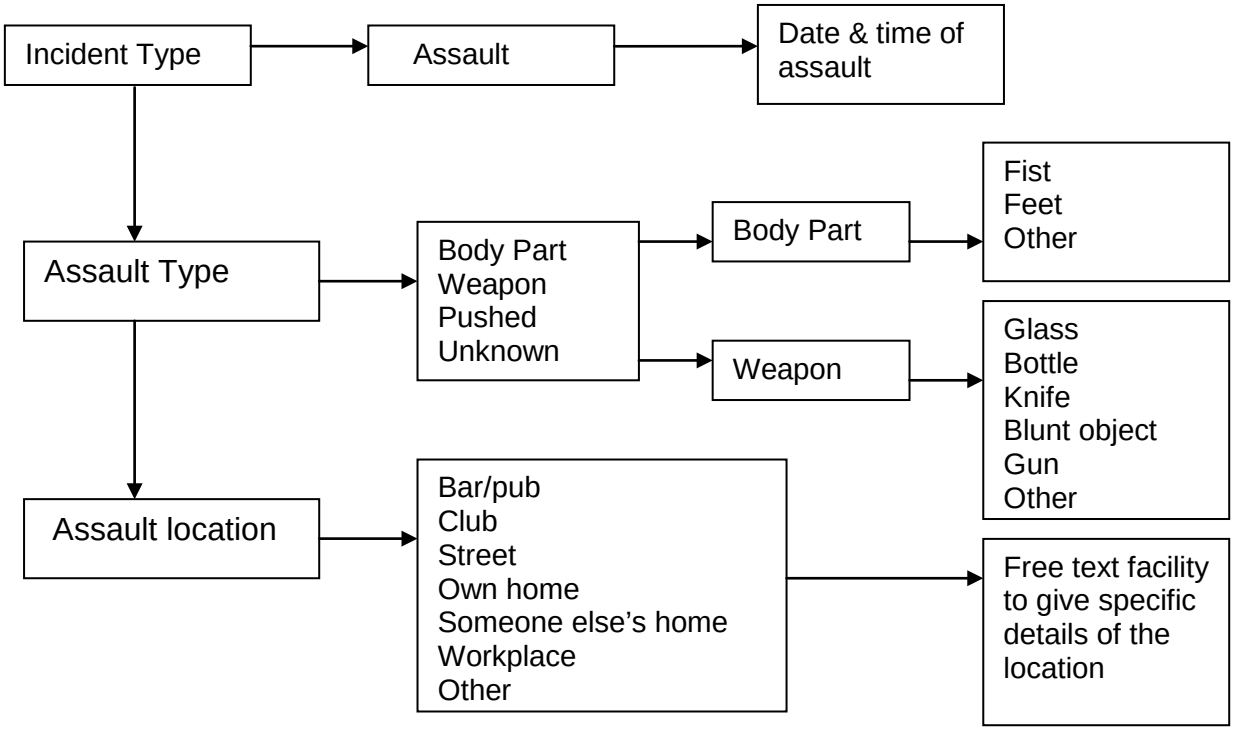
## Data Collection

7. Key data items, as specified in the College of Emergency Medicine guideline, are:

    - *date and time of assault;*
    - the *type of assault;*
    - *location of assault* – this is essential to provide a focus for violence reduction. Information such as the name of a pub, street, park, school or other institution can be very helpful for implementing practical interventions.

### The College of Emergency Medicine recommended dataset

8. The data items are represented below:




### Data use and feedback

9. In order for data sharing to work effectively it is important to try to secure the following activities:

    - Engagement of key partners at a strategic and tactical level, including the A&E, local authority, police and community safety partnership.
    - Data is recorded and distributed electronically
    - Data is shared and analysed by Community Safety Partnerships
    - Data is used to inform operational policing and other violence prevention initiatives.

- Good communication takes place – all parties should be informed about the difference information sharing is making

10. Feedback from the CSP to A&E is essential, in order to demonstrate that information is being used. The motivation and commitment of NHS staff to support data sharing is dependent on feedback about the use and impact of the information. There are some really powerful stories about how A&E data has been used to reduce violence and it is really important to share those with all partners.[5]

11. Sometimes it is also helpful to feedback constructive criticism – for example, where data is flowing but the quality may be low. It can be challenging to collect good quality location data. Where problems like this exist then feedback is a key way of addressing them.

## Using data to tackle alcohol licensing

12. Assault data may also be of use to licensing authorities (district level or unitary authorities in England and Wales) and the local police to inform decisions under the Licensing Act 2003. Where assault data shows that incidents took place at or outside a particular bar, it can be used to impose conditions on a licence to prevent violence and disorder, or promote community safety.

13. The Government has introduced a number of measures to give local areas greater powers to tackle irresponsible premises and the harms associated with alcohol (see Chapter 3 of the Government's Alcohol Strategy[6]). Since 25 April 2012, health bodies have been 'responsible authorities' under the Licensing Act, giving them a greater say in local decisions about licensing. This function will transfer to the local authority as part of its public health responsibilities and is expected to form part of the Director of Public Health role. Health bodies can present health-related evidence (where relevant to the licensing objectives), such as data on violence-related A&E attendances and ambulance callouts, to licensing authorities. They must also be notified about new licence applications, variations and reviews.

14. Statutory and supporting guidance on alcohol licensing is available on the Home Office website. This includes:
    - Amended guidance under Section 182 of the Act[7]
    - Guidance on health bodies as responsible authorities[8]

15. Case studies involving alcohol-related data sharing are available at the Alcohol Learning Centre: www.alcohollearningcentre.org.uk

[5] http://www.nursingtimes.net/nursing-practice/clinical-specialisms/accident-and-emergency/using-ae-data-to-prevent-violence-in-communities/5028058.article - see case studies in particular

[6] http://www.homeoffice.gov.uk/publications/alcohol-drugs/alcohol/alcohol-strategy

[7] http://www.homeoffice.gov.uk/publications/alcohol-drugs/alcohol/guidance-section-182-licensing

[8] http://www.homeoffice.gov.uk/publications/alcohol-drugs/alcohol/alcohol-supporting-guidance/health-responsible-authority

## How can you engage more effectively with NHS partners?

16. The NHS reforms which come into effect fully as of April 2013 will enable change to be driven through the clinicians who know the health needs of their patients. They are underpinned by proper local engagement, partnership working and effective local scrutiny.

17. Some services that previously could only be provided in an acute hospital can now be safely be provided in a local health centre, GP surgery or even the patient's own home. At the same time, other services requiring highly specialist care are being centralised at larger, regional centres of excellence, where there is clear evidence this improves health outcomes. More information on the NHS structure reforms is available at: http://healthandcare.dh.gov.uk/context/

18. There is not a specific person within health at a local level who will have lead responsibility for information sharing to tackle violence. Getting the right engagement may involve contacting several people and being pragmatic about the best approach to take.

19. Securing support from the following people/groups can be really helpful:

- Head of Emergency Medicine or Departmental Lead in your A&E Department and Chief Executive of the Acute hospital provider;
- Primary Care Trust Chief Executive (until PCTs are abolished on 1 April 2013); and Clinical Commissioning Groups (CCGs) thereafter;
- Health and Wellbeing Boards (especially Directors of Public Health);
- Caldicott Guardians.[9]

### Role of the NHS Commissioning Board

20. The NHS Commissioning Board (The Board) is nationally accountable for the outcomes achieved by the NHS, and will provide leadership for the new commissioning system to improve quality and patient outcomes and safeguard the core values of the NHS. The Board has overall responsibility for a budget of £80bn, of which it will allocate £60bn directly to Clinical Commissioning Groups. It will directly commission a range of services including primary care and specialised services and have a key role in improving broader public health outcomes.

21. The Board's central role is to drive improvement in outcomes for patients, ensuring a fair and comprehensive service across the country. It will also promote the NHS Constitution and

[9] A Caldicott Guardians are senior people within each NHS organisation who act as "guardians" to oversee all procedures affecting access to person-identifiable health data. They will usually have an interest in information sharing more broadly.

champion the interests of patients, using choice and information to empower people to improve services. The Board is accountable to the Secretary of State via an annual mandate. It will be an independent, statutory body, free to determine its own organisational shape, structure and ways of working.

## Clinical Commissioning Groups

22. Under reforms outlined in the Health and Social Care Act, CCGs will take over responsibility for commissioning the majority of NHS services in England. From 2013-14, CCGs will have access to public health advice, information and expertise in relation to the healthcare services that they commission, provided by local public health teams based in local authorities. CCGs will be commissioning-only organisations and will not be providers of health services. CCGs will take on the statutory duties in the Crime and Disorder Act, which were previously duties of PCTs and SHAs. They will be statutory bodies, so will become the statutory partners on Community Safety Partnerships. They will also have commissioning responsibility for A&E Departments / local acute hospitals in their area.

## Health and Wellbeing Boards

23. Health and wellbeing boards (HWBs) now exist in 134 out of 153 local authority areas. This means that a future part of the new health landscape is in place now. These boards will have representation from Directors of Public Health and a range of relevant partners from each local authority area. Therefore, engaging with these boards could be a good gateway into health in local areas. HWBs may be able to advise on ways to contact relevant A&E Departments. They can also advise on the partnership/engagement agenda more broadly.

## Accident and Emergency Departments

24. The A&E Department is the most important place for collecting information in a hospital. Since A&E Departments each have their own organisational arrangements, there is no specific person who will lead on this work. If you are experiencing difficulty in engaging with a relevant A&E on this agenda, you should make contact with the Chief Executive of the Acute Trust and request their advice on who is most appropriate to engage with on this issue.

25. Some of the most important people to engage in A&E Departments, when trying to establish or improve information sharing arrangements include:

- Receptionists who are the first point of contact with the public. They obtain personal details and basic assault information where relevant;
- Clinical staff, doctors, nurses and other specialists provide initial assessment, triage, manage access to treatment and initiate treatment;
- Managerial staff who coordinate and run service delivery;
- Information management and technical support staff who can provide the technical means to make information sharing happen;

- The provider's Caldicott Guardian and Senior Information Responsible Officer.

For information on Caldicott Guardians see the following hyperlink:
http://www.dh.gov.uk/en/Managingyourorganisation/Informationpolicy/Patientconfidentialityandcaldicottguardians/DH_4100563

## Additional Resources

The College of Emergency Medicine Guideline on Information Sharing to Reduce Community Violence - http://www.collemergencymed.ac.uk/Shop-Floor/Clinical%20Guidelines/default.asp

For Case Studies and support tools – http://www.publicinnovation.org.uk/Data_Sharing.html

Data Sharing in the North West – http://www.nwpho.org.uk/ait/

For work on Ending Gang and Serious Youth Violence - http://www.homeoffice.gov.uk/publications/crime/ending-gang-violence/gang-violence-detailreport

For work on Tackling Violence Against Women and Girls - http://www.homeoffice.gov.uk/publications/crime/call-end-violence-women-girls/action-plan-new-chapter

Cardiff Violence & Society Research Group – http://www.cardiff.ac.uk/dentl/research/themes/appliedclinicalresearch/violenceandsociety/index.html

General Medical Council Confidentiality Guidance: http://www.gmc-uk.org/guidance/ethical_guidance/confidentiality_36_39_the_public_interest.asp

The 2012-13 NHS Standard Contract for acute, ambulance, community and mental health and learning disability services, Section B, The Services, p.41 -

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_131988