GOVERNMENT OFFICE
FOR LONDON

Accident and Emergency Data Sharing in London: Early Lessons for Policy and Practice

---

A Report by Perpetuity Research - Commissioned and Funded by Government Office for London

Jessica Jacobson
Kate Broadhurst

July 2009

Perpetuity Research & Consultancy International (PRCI) Ltd
148 Upper New Walk · Leicester · LE1 7QA · United Kingdom
www.perpetuitygroup.com
prci@perpetuitygroup.com
Tel: +44 (0)116 222 5555
Fax: +44 (0)116 222 5557

Table of contents

Section 1. Introduction 2
- The development of A&E data-sharing in London 3
- The data-sharing review 4
- Overview of progress by local partnerships 5
  - Hospital A 5
  - Hospital B 6
  - Hospital C 6
  - Hospital D 6
  - Hospital E 7
  - Hospital F 7
  - Hospital G and Hospital H 7
  - Wider CDRP summary 7

Section 2. Issues Relating to Process 9
- Staff resources and data collection 9
- IT issues 10
- Other issues of process 11
  - Defining the data-set 11
  - Collation, anonymisation and transfer of data 12
  - Data analysis and feedback 13

Section 3. Issues Relating to Partnership 14
- Historical tensions and difficult beginnings 14
- 'What's in it for us?' 15
- Data-sharing as an element of broader partnership working 17

Section 4. The Policy Context 20
- The complexity of the policy context 20
- Need for improved co-ordination between areas 22

Section 5. Emerging Lessons 24
- Process 24
- Partnership 25
- Policy 25

Section 6. References 27

Appendix A: Cardiff minimum data-set 28

Appendix B: Revised minimum data-set, Addenbrookes Hospital 29

Section 1. Introduction

1.1 Accident and emergency departments (A&E) can contribute distinctively and effectively to violence prevention by working with Crime and Disorder Reduction Partnerships (CDRPs) and by sharing, electronically wherever possible, simple anonymised data about the precise location of violence, weapon use and day/time of incident. The provision of this data to CDRPs can be used to enhance the effectiveness of both targeted policing and enforcement activity, as well as contributing to the development of local CDRP violence reduction strategies. The ultimate objective in both cases is the reduction of all types of violent crime, which will also result in a reduction in A&E violence related attendances.

1.2 This report sets out the key findings of a London-wide review of early progress made towards the establishment of systems for the sharing of hospital accident and emergency (A&E) data. These systems are intended to entail the sharing of anonymised data on assaults that have given rise to A&E visits. Under the umbrella of the local Crime and Disorder Reduction Partnerships (CDRPs), the data are to be shared with the police and local authorities.

1.3 The main aim of A&E data-sharing, in London and elsewhere, is to enhance the capacity of CDRPs to tackle and reduce interpersonal violence. The potential for A&E data-sharing to contribute to violence reduction lies primarily in the fact that many assaults that lead to A&E treatment are not reported to the police, and A&E departments are thus a source of invaluable information about locations, dates and timings of assaults, and trends in weapon use.

1.4 This information can be used to assist the targeting of enforcement and preventive activities undertaken by the police, local authorities and other partners. Moreover, the development of systems of A&E data-sharing can be a catalyst for broader partnership working between A&E professionals and criminal justice agencies.

1.5 A review of the Crime and Disorder Act (1998) undertaken between November 2004 and January 2005 stressed the need for partnerships to be more intelligence-led in their approach. Under the new section 17A of the Crime and Disorder Act (introduced by the Police and Justice Act 2007) and SI 1831 (The Crime and Disorder (Prescribed Information) Regulations 2007) the primary care trust (PCT) is legally obliged to share information, and the required minimum datasets are specified. For the PCT this includes depersonalised records on hospital admissions relating to assaults and domestic abuse.

The development of A&E data-sharing in London

1.6 What is commonly known as the 'Cardiff model' of A&E data-sharing provides much of the impetus for the development of A&E data-sharing in London. In Cardiff, the collection and sharing of A&E assault data was initiated by the multi-agency Cardiff Violence Prevention Group in 1996. In 2000, A&E data-sharing was made an integral part of a large-scale, multi-agency programme aimed at tackling alcohol-related street crime in Cardiff (TASC). It is reported that, since then, the sharing of A&E data has substantially enhanced the effectiveness of efforts to police and manage alcohol-related violence and disorder, and hence made a significant contribution to the 40% drop in violence-related A&E attendances that was seen between 2002 and 2007 (Shepherd, 2007; see also Warburton and Shepherd, 2004). The A&E data-set that is collected and shared in Cardiff encompasses details on the assault time, location and type (including body part injured and weapon used, if any); the number and gender of assailants; and the victim's relationship to the perpetrator(s) (if any). (The Cardiff minimum data-set is provided in Appendix A of this report.)

1.7 The evident successes of the Cardiff model have led to efforts to replicate it elsewhere in England and Wales; and the importance of sharing information on assaults is highlighted by the Government's 'Action Plan on Tackling Violence, 2008-11' (HM Government, 2008). The Government Office for the South-East has recently promoted A&E data-sharing across south-east England (see Nurse et al, 2007, for a summary of this initiative). In mid-2008, the Community Safety Division of the Government Office for London successfully bid to the Home Office for funding to support the development of A&E data-sharing, along the lines of the Cardiff model, in a number of 'early adopter' boroughs and associated hospitals. The intention was that these early adopters would subsequently help to champion data-sharing in other sites.

1.8 The initial GOL efforts to support A&E data-sharing have been reinforced by the Home Office-sponsored Tackling Knives Action Programme (TKAP), which is currently operating in ten police force areas, including London. TKAP - which was originally scheduled to run from July 2008 to March 2009, but has since been extended for a further 12 months - promotes a range of activities aimed at reducing knife crime among young people. Under TKAP, the Home Office and the Department of Health strongly encouraged CDRPs to establish A&E data-sharing systems. Several London hospitals (including most of those that had been designated as early adopters by GOL) were identified as TKAP sites, in which data-sharing systems were expected to be set up by the end of March 2009.

The data-sharing review

1.9 Perpetuity was commissioned by GOL to undertake a review of A&E data-sharing across London. There were two main parts to the review. First, we conducted interviews with key partners in the early adopter and TKAP sites. In the interviews, we asked respondents to describe the progress made to date in establishing the data-sharing system, any obstacles that had been encountered, and how they were seeking to overcome these. In total, we spoke with a total of 18 individuals from the hospitals, local authority community safety teams, PCTs and the police. We also attended, as observers, one meeting of local partners at which the initiation of a data-sharing system was discussed.

1.10 The second part of the review involved a self-complete survey circulated to community safety managers across the remaining London CDRPs to explore the existence of other models of A&E /CDRP data sharing and to scope the range and effectiveness of these models. The information was extracted using a short electronic survey to gather basic information on the existence of data sharing models. Where an interesting response was received subsequent interviews with the nominated lead from within the CDRP (usually the CSP manager or police) and A&E department were undertaken to gather more detailed information.

1.11 The original aim of the Perpetuity review was to produce a guidance document on A&E data-sharing, based primarily on our findings of what was working well and what was proving problematic in the early adopter/TKAP sites. However, at the outset of the research it rapidly became clear that all of the hospitals and CDRPs were still at very early stages of the process of establishing data-sharing systems; and, indeed, in some sites the process had barely begun. As such we were not able to draw general lessons for good practice from the partners' experiences, simply because not enough had yet been achieved. It became evident also that the agencies were encountering a range of difficulties that had not been widely foreseen within the government departments which – at both regional and national levels – had been promoting the establishment of A&E data-sharing.

1.12 Hence the focus of this review shifted: rather than aiming to produce a 'how to' guide on A&E data-sharing, we have sought to document the major challenges being encountered by local agencies as they start to work together on data-sharing, and to set out what can be done by (regional and national) governmental agencies to help agencies overcome or avoid potential pitfalls.

1.13 Over the course of this report, we discuss in turn three main areas of difficulty that emerged from our research interviews. Following this introduction, Section 2 sets out the key issues relating to the **processes** of data collection, transfer and use that the local agencies are grappling with. In Section 3, we address the topic of **partnership**,

and consider some of the problems that arise in this regard. Section 4 focuses on challenges associated with the **policy context** within which the data-sharing work is being carried out. Finally, Section 5 concludes the report with a discussion of potential governmental responses to the issues raised.

1.14 The research material presented in this report is drawn from the interviews conducted with representatives from the early adopter/TKAP sites, supplemented in places by findings from the wider survey of CDRPs.

1.15 It should be noted that while the research on which the report is based was conducted entirely in London, most of the issues that arose – in relation to process, partnership and policy alike - have broad applicability well beyond London.

Overview of progress by local partnerships

1.16 Before we move on to look at the main areas of difficulty encountered by the local partnerships, we will provide a brief overview how the early adopter/TKAP sites have been approaching the task of establishing A&E data-sharing systems. This is then followed by a short summary of the results of the wider CDRP survey. The names of the participating hospitals have been anonymised.

1.17 Since the situation in most of the sites was rapidly changing at the time of the research (February to March 2009), this overview is, even at the time of writing, bound to be somewhat out of date. Moreover, we sometimes received slightly conflicting reports of progress from different partners in the same site. Hence we cannot provide a definitive account of the work undertaken by the partnerships, but aim simply to give an indication of what had been achieved at the point at which we were in contact with the sites.

Hospital A

1.18 A data-set based on that used in Cardiff was developed for Hospital A. The hospital's electronic care records system (Symphony) was being reconfigured to permit receptionists to record some of the required data on assault victims, with additional data to be recorded by junior doctors. Electronic reports containing the collated data were then to be generated and emailed securely to police and community safety partners. The majority of incidents of violent crime in the borough are youth related and so in the first instance, the system was to incorporate assault victims aged less than 20 years old. Additional data on assault victims were to be collected by an outreach youth worker based in the hospital, and shared with partners. Prior to the reconfiguring of Symphony, some data were being collected manually and forwarded to partners.

Hospital B

1.19 Hospital B was amending its care records system (also Symphony) with a view to adopting the same data-collection and sharing system as was being developed at Hospital A, and the same data-set. Here, however, the system was to encompass all assault victims including adults, and there were no immediate plans to capture additional data on young people; nor was any manual data-collection being undertaken.

Hospital C

1.20 At Hospital C, a large proportion of violent incidents are alcohol-related. A four-week data collection pilot was undertaken in the hand trauma clinic. This entailed manual collection of data on assault victims, using a shortened version of the Cardiff data-set (for example, details on the perpetrator were not included) in the form of a questionnaire administered by nurses. The pilot was viewed as successful: patients did not object to answering the questions, and nurses found it quick and easy to administer. Following the pilot, the questionnaire was extended to include questions on perpetrator, and it was to be introduced into A&E. It was to remain a manual data-collection exercise to be undertaken by triage nurses. It was anticipated that a specialist alcohol nurse (shortly to be appointed) would assist with the questionnaires and with inputting the data on to a database. Data were to be extracted from the data-base and emailed to the joint police/local authority analyst on a regular basis.

1.21 There appeared to be limited scope for introducing electronic data collection at the Hospital C, because additional data fields could not be added to its care records system (Cerner Millennium) on a local basis.

Hospital D

1.22 Discussions were under way between A&E at Hospital D and the local Primary Care Trust, community safety department and police about the best way to proceed on A&E data-sharing. In 2004, a wide-ranging database on penetrating injuries (both assault and accidental) had been established at the hospital. The database comprised detailed clinical (and personalised) data, mainly drawn from patient records; but none of the data held had been shared with local partners, and it had not been maintained for much of the past year because the data analyst who was responsible for the database had retired and had not been replaced for several months. The A&E department and partners were exploring the possibility of adapting the database for the purpose of A&E data-sharing on assaults. Other options such as the

reconfiguring of the care records system, or the introduction of a manual data-collection system, were also being considered.

Hospital E

1.23 In 2006, the A&E department at Hospital E had undertaken some data-collection for the CDRP, but this work had stalled shortly thereafter: according to the police, this was because the data were not provided in a usable format; according to the hospital, this was because the police had not responded. The A&E department and local partners (primarily police and local authority community safety department) were now committed to developing a sustainable data-sharing system. The view of the hospital IT team was that the care records system (an older version of CERNER) could be amended so as to allow receptionists to record the data specified in the Cardiff minimum data-set. It was agreed that the IT team would take forward this work and that, in consultation with the police, they would explore methods of transferring the data, including the possibility of establishing a system of live feed.

Hospital F

1.24 Initial attempts to set up A&E data-sharing in Hospital F had faltered , partly because of a change in personnel within the A&E department, but also because the police had not been happy with the data they received for reasons that were unclear. However, renewed efforts at establishing an electronic data collection system were being made by the hospital's A&E department and the local police. This work was to be undertaken jointly with the Hospital E, as the two hospitals shared the same care records system.

Hospital G and Hospital H

1.25 The A&E departments at both hospitals, which are located in the same borough, had agreed in principle to undertake data-sharing with local partners, and the possible parameters and mechanisms were under discussion with the local authority community safety department. Within both hospitals, there was a strong preference for implementing electronic data collection that would be integrated within the respective care records systems, and the scope for doing so was being explored. A trial involving manual data collection was planned, in the meantime, in Hospital G.

Wider CDRP summary

1.26 Perpetuity received 17 responses to a short survey that was circulated via email to 26 CDRP representatives[1] that are neither a TKAP nor EA

[1] The none responses were chased on three occasions.

site and as such this represented a 65% response rate. Respondents were asked three key questions; the results follow.

1.27 Four CDRPs reported that a system of data exchange existed between the local hospital's A&E department and the CDRP in relation to crime. Seven reported that they had a lead contact or link person within the local hospital's A&E department. When asked how engaged the local hospital (particularly A&E) is in local partnership working to reduce violent crime five respondents reported the hospital was not at all engaged, six reported they were not very engaged. Four felt they were engaged and only one felt they were very engaged. [2]

1.28 Those who did report engagement were followed up via a telephone interview and the results are woven in throughout the body of this report.

[2] In addition through other sources Perpetuity are aware that two other CDRPs receive data electronically on a monthly basis and a further CDRP receives data on request.

Section 2. Issues Relating to Process

2.1 A variety of practical issues relating to the processes of collecting, transferring and using A&E data pose the most immediate and obvious barrier to the establishment of effective systems of A&E data-sharing. In the early adopter/TKAP sites, the practicalities of data collection appeared to be the main focus of attention - possibly because this element of the data-sharing process is the most complex. (However, the focus on data collection may also reflect the fact that since the all the sites were at early stages of setting up A&E data-sharing, they were yet to address in detail issues relating to the transfer and use of data.) With respect to data collection, two key, interlinked problems were at the heart of partners' concerns: first, the problem of identifying A&E staff with the time and skills to collect the data; secondly, the problem of developing an adequate electronic system of data capture within the A&E department. This view was consistent amongst the wider CDRP respondents.

2.2 The two issues of staffing resources and IT are discussed, in turn, below; this is followed by a consideration of some additional issues relating to the processes of data collection, transfer and use.

Staff resources and data collection

2.3 If the data which comprise the minimum data-set are to be collected, staff within the A&E department have to identify patients that are assault victims, ask them about the details of the assaults, and record their answers - and any additional details relating to the injuries - accurately. The items in the minimum data-set relating to the victim's relationship to the perpetrator are potentially sensitive, and hence require that the related questions are asked with tact. This process of data collection is undertaken in a highly pressurised environment: A&E departments tend to be extremely busy places, especially on Friday and Saturday nights when the largest numbers of assault victims are admitted. A&E staff – especially clinical staff – work under the time pressures inherently associated with dealing with patients requiring urgent medical care, and those imposed by the national target of responding to patients within a four-hour wait time.

2.4 In this context, as hospital consultants told us in interview, a requirement for staff to spend even a few minutes recording additional details about individual patients can prove burdensome. The perceived risk of over-stretching A&E staff may lie behind much of the apparent reluctance of many A&E departments – in London and beyond – to engage in data-sharing in the past. According to several of our interviewees, this problem can best be overcome by ensuring that data collection on assaults is fully integrated within the existing A&E data

system, such that the time taken to request and record any additional details on assault patients is the minimum possible. However, as will be discussed under the heading 'IT systems', below, the development of an integrated data collection system is not always straightforward.

2.5 The burden on staff can also potentially be lessened by giving the bulk of the data collection work to administrative rather than clinical staff, since the former tend to be working under somewhat less intense time pressures. This is the approach favoured in Cardiff, where 'data entry was made a routine part of the patient admission procedure, and was incorporated into the receptionists' role' (Warburton and Shepherd, 2004: 473). Most of the London early adopter/TKAP A&Es have considered giving receptionists responsibility for data collection, but concerns have been raised about whether these staff have would have the requisite skills to record the information accurately; the typically high turn-over of reception staff is also seen as problematic. One interviewee also suggested that it would be difficult to ask patients relatively personal questions in the A&E reception area, which offers little privacy.

2.6 Hence in Hospital C, for example, the decision was taken to engage triage nurses in data collection – especially as it was felt that some of the questions about the assault would follow naturally from other questions they would routinely ask of all patients. Elsewhere, including Hospital E, A&Es were looking at a two-stage process whereby some of the data would be collected and input by receptionists, and the remaining data by clinicians (either doctors or nurses). At Hospital A, a three-stage process was under consideration, with data collected by receptionists and clinicians to be supplemented by information subsequently collected by an outreach youth worker based at the hospital. The youth worker follows up assault victims aged under 20 who are treated in A&E, and it was felt that, because he was not seen as an authority figure, he would be better able than the doctors to speak with young patients about the perpetrators of the violence they had suffered. A potential pitfall of a system in which data collection is carried out by different members of staff at different stages is that there is more scope for items to be missed or for errors to creep into the process. Whether this is the case, or whether robust training and management of all relevant staff can pre-empt such difficulties, remains to be seen.

IT issues

2.7 As noted above, the development of an electronic data collection process that is fully integrated within the wider care records system is seen by many as critical to the success of A&E data-sharing. At the time our research was carried out, the IT departments in some of the early adopter/TKAP hospitals were engaged in the task of reconfiguring their respective IT systems in order to add the data fields specified in

the minimum data-set. This appeared to be a time-consuming process in some cases, and certainly a more complex task than is suggested in guidance on A&E data-sharing which refers to the need to overcome logistical barriers to data collection by making 'simple adjustments to software' (Shepherd, 2007). However, there was reasonable optimism in those hospitals with the Symphony care records system and those with the original version of CERNER that the task of reconfiguring the software was achievable.

2.8 In contrast, there appeared to be no immediate scope for adding data fields to the CERNER Millennium care records system which had recently been installed at Hospital C, under the Connecting for Health programme.[3] It was reported by interviewees at Hospital C and in the local Borough Council that amendments to the system could be made only at a national level, and that this would take at least 18 months. This was also a cause of concern at Hospital G, which was anticipating the implementation of CERNER Millennium; here, frustration was voiced at the apparent lack of national-level commitment to addressing the shortcomings of CERNER with respect to data-sharing.

2.9 In the absence of a practicable option for electronic data capture, Hospital C was committed to undertaking manual data collection, through the use of paper questionnaires, in its A&E department. Hospital G was planning to introduce a similar manual system of data collection on a trial basis. Elsewhere, there was profound scepticism about the feasibility of such an approach: it was seen as simply too time-consuming for staff who would be required not only to record the relevant details of assaults by hand, but also then to input the information on a database (although in the case of Hospital C, funding had been made available for a specialist alcohol nurse who was expected to assist with data inputting). One hospital consultant, for example, commented that while this kind of manual data collection exercise could be undertaken for the purpose of a one-off survey of patients, it would inevitably 'fizzle out'. To achieve success the process of data exchange needs to be ongoing and as such barriers to its sustainability need to be addressed. If manual collection is not sustainable in the long term, electronic data capture has to be the preferred process.

Other issues of process

Defining the data-set

2.10 The issues discussed above are about *who* was to collect the data and *how* the data were to be collected. The question of *what* data were to be collected was also a concern for some local partners. For the most

[3] Connecting for Health is a national programme for upgrading IT systems across the NHS. It has encountered an array of technical problems since its launch in 2002.

part, agencies were making use of the Cardiff minimum data-set, or were amending this in minor ways. However, in some of the early adopter/TKAP sites and wider CDRP areas there seemed to be a degree of confusion over the exact composition of the data-set, since different versions had apparently been circulated among agencies. There was also some uncertainty over whether the benefits of collecting data on perpetrators (in addition to timings, locations and types of assault) would be worth the costs associated with the extra time this would take and/or the difficulty of asking victims to talk about perpetrators.[4]

2.11 More fundamentally, in some sites there was a lack of clarity over the basic parameters of the data-set that they were seeking to implement: that is, whether it encompassed victims of knife attacks only, victims of alcohol-related violence only, or all victims of violence. This reflected, in part, the complexity of the policy environment in which the data-sharing work had been initiated (see Section 4, below). It can be anticipated that the questions about the composition and parameters of the data-set will be resolved, in time, through clearer policy guidance at regional level, and negotiation between the partner agencies at local level.

Collation, anonymisation and transfer of data

2.12 Of course, the collection of data in A&E is only the very first stage of the data-sharing process. As noted above, if paper-based data collection is undertaken, the data must then be inputted on to some kind of data-base; but even where the data are captured electronically, the question then arises of how they will be collated and transferred to partners. Depending on the method and format of data entry, there may also be a requirement for the data to be anonymised by IT staff prior to transfer (as occurs, for example, in Cardiff).

2.13 In the early adopter/TKAP sites, there was a general sense that the issues of data collation, anonymisation and transfer could be relatively easily dealt with, once the more complex problem of developing a data collection system had been addressed. At Hospital A, the IT department was developing a largely automated system for downloading reports on the assault data, which could then be emailed to the police and local authority partners at regular intervals via a secure email link. At Hospital E, discussions were under way about the feasibility of connecting the police and local authority analysts directly to the assault data via a live feed. From police and local authority perspectives, timely access to the data is essential if the data are to be used operationally as well as strategically.

[4] In some sites within the South-East region, the decision has been taken to use a data-set that excludes the perpetrator items; such a data-set, which is used in Addenbrookes Hospital in Cambridge, is set out in Appendix B of this report. Under TKAP, a similar revised data-set was circulated to A&E departments and CDRPs in early 2009.

Data analysis and feedback

2.14 It is clear to all partners engaged in the development of A&E data-sharing that the whole exercise will be meaningless if the data are not used by the partners who receive them. Our interviewees in the police and local authority community safety departments were confident that the data could indeed be put to good use, but since they had not yet received data at the time of the research, they could not tell us in detail about what this would mean in practice. It was envisaged that the data would contribute to police and multi-agency tasking processes, particularly as they would be used in combination with police and other data to identify hot-spots of violent crime. In some areas it was hoped that the data could be used to advance understanding of offenders' journeys to crime as well as how victims travelled. There was also an expectation that, over the longer term, the data would feed into borough-wide strategic assessments.

2.15 There is perhaps a lesson here that relates to quality standards for analysts. It is advantageous for all analysts whose data feeds into a strategic assessment - not just those who directly work for the CDRP or police - to have an understanding of how their data relates to community safety and be able to understand and interpret their own information. This does not always appear to be the case and some analysts for example perform a purely performance management role. As such they have a limited understanding of working with the data they hold to interpret it for partners. Quality standards and analyst training may be needed to fill this gap.

2.16 The critical importance of feeding back to A&E departments how the data are used, and any emerging benefits of this use, was stressed by those we interviewed from the hospitals; one of the crime analysts we spoke to was also aware of the risk that the commitment of A&E staff to data-sharing could wane rapidly if the value of this work was not demonstrated to them. Again, however, it was too early for partners to have a clear idea of what specific mechanisms for feedback might be put into place.

Section 3. Issues Relating to Partnership

3.1 A&E data-sharing is, by definition, a partnership activity. Historically, as has been widely documented[5], CDRPs have struggled to engage health agencies fully in their work – notwithstanding the statutory inclusion of health within the partnerships.[6] Thus the success of local ventures to establish A&E data-sharing systems depends in part on the capacity of health, police and local authority partners to overcome any mutual mistrust or lingering tensions and to commit to working together. The evidence from the early adopter/TKAP sites is that this process of establishing constructive inter-agency relations is advancing, albeit sometimes slowly.

Historical tensions and difficult beginnings

3.2 Many of our interviewees from the police and local authority community safety departments spoke of having found it difficult, in the past, to engage with local health agencies. There would appear to be a variety of reasons for this – including the inevitable inter-agency differences in working culture and practices and, more broadly, differing perspectives on issues of crime and disorder.

3.3 For example, a senior police officer complained of the need for health practitioners and managers to overcome their perception that co-operating in community safety work is a matter of 'grassing to the police'. A local authority officer said that in her experience the agencies comprising the NHS make up a 'huge edifice … another world, almost', within which it is difficult to make contact with individuals and work out who is responsible for which areas of work. From the health perspective, a PCT representative commented that police dealings with hospital consultants can be problematic, thanks to the tendency of the police to 'see things in black and white'. One example of this, as described by another interviewee, was a meeting at which the police essentially told the consultants: 'You have to give us the data'; the response from the consultants was: 'We don't have to give you anything.'

3.4 In some of the sites, there had been initial attempts at data-sharing which had faltered and thereby served to reinforce rather than overcome the mutual mistrust or suspicion. A police interviewee in one borough told us that the CDRP had received one set of A&E data in late 2008, but none had been subsequently been forthcoming – partly

[5] Audit Commission (1999), HMIC (2000), Nacro (2001), Phillips, C. et al (2002), Home Office (2002), Crime Concern (2003)

[6] Under the Crime and Disorder Act 1998 (as amended by the Police Reform Act 2002) which established CDRPs, Primary Care Trusts are 'responsible authorities' and NHS trusts 'co-operating bodies'.

because of a change in personnel within the hospital A&E department. According to our respondent, the latest request to the hospital for data had been met with the response: 'When it's ready, it's ready.' In another borough, one month's A&E data had apparently been collected and passed to the police, but again there was no further data exchange for some months. The hospital perspective on this was that the police had simply not followed things up; the police account was that the original data had not been provided in a usable format, and they had requested that the format be altered but heard nothing thereafter from the hospital.

3.5 In the past, at least, health practitioners' concerns about patient confidentiality have been a barrier to A&E data-sharing. One hospital consultant told us that some of his colleagues tend to talk about patient confidentiality as a 'knee-jerk reaction' to any mention of data-sharing. However, the general feeling across the early adopter/TKAP sites was that confidentiality concerns were no longer key issue, because it had been made clear to all that the sharing of anonymised data only was what was being sought by the CDRPs. To ensure full anonymisation, it was agreed in most sites that the shared data would not include full addresses of patients (in cases where the assault location was the home), but only the first four postcode digits. The proposed data-sharing arrangements had, where necessary, been cleared by the hospitals' Caldicott Guardians[7], and, to varying extents, were being formalised in CDRP information-sharing protocols. In some of the sites, there was a clear interest within the police and local authority community safety departments in the possibility of sharing personalised A&E data in certain contexts – for example, for the purpose of referring repeat victims to appropriate services. This was not, however, a matter of immediate concern[8].

'What's in it for us?'

3.6 Partnership arrangements are likely to work most effectively where all the individual agencies perceive themselves to be benefiting directly from their involvement. A potential difficulty associated with A&E data-sharing is that it demands significant input and long-term commitment from the hospital A&E department, but it is the police and their community safety partners who most obviously and directly benefit from the activity. Hence across the early adopter/TKAP sites there was

[7] An NHS Caldicott Guardian is a senior person responsible for protecting the confidentiality of patient and service-user information and enabling appropriate information-sharing.

[8] Under new draft guidance from the General Medical Council, doctors are advised to contact the police if they believe a patient has been the victim of a knife attack, but not to disclose any identifying details about the patient, such as their name and address, without consent or unless disclosure is justified in the public interest. http://www.gmc-uk.org/publications/gmc_today/gmc_today_oct08/knife_crime.asp#gmc_launches_guidance_knife_crime. This expands on earlier GMC guidance on the reporting of gun-shot wounds: http://www.gmc-uk.org/guidance/current/library/reporting_gunshot_wounds.asp .

a recognition that the hospitals were entitled to ask: 'What's in it for us?' As an officer in one community safety department commented, 'It's a one-way track – we're just sitting there, reaping the rewards.'

3.7 We interviewed one A&E consultant who made it clear that he would not want to help develop an A&E data-sharing system unless it had a clinical dimension: that is, that it was a system encompassing the recording of clinical data (for example on injury causation) which could then be drawn on by doctors and nurses for training and other purposes. He was unimpressed by the concept of an anonymised data-set comprising details of assault times, locations and so on: 'That would do nothing for us. ... If you're asking questions we're not interested in, you won't get the answers.' The response here would be to set out clearly the pay off for A&E staff in terms of reduced numbers of assault victims and related costs to the NHS more widely. The data sharing process does not purely facilitate a police response to a crime problem. It is about providing essential data to strategically drive the reduction of violent crime; and as such health have a clear role to play.

3.8 Another A&E consultant, in contrast, argued that clinicians were broadly supportive of data-sharing along the lines of the Cardiff model, because they were all too aware of the enormous costs of violent crime (most clearly displayed in the recent deaths in London of young knife crime victims) and were keen to contribute to any efforts that could potentially reduce levels of violence. Most of our hospital-based interviewees accepted the idea that A&E data-sharing should enhance the effectiveness of policing, and hence ultimately help to reduce the numbers of assault victims admitted to A&E departments. The difficulty, as one consultant expressed it, is that this is a long-term vision, and hospital priorities tend to be much more immediate: the very nature of the work and structure of hospitals is that the focus is constantly on 'hot issues' demanding urgent attention. Even at senior management level, he said, staff get caught up in crisis situations – such as an outbreak of infection or a shortage of beds – which inevitably take precedence over longer-term initiatives.

3.9 In this context, how can local partners help to persuade hospitals not only to get involved in A&E data-sharing in the first place, but also to maintain their engagement? Part of the answer, as recognised by many of those we spoke to across the various agencies, is to demonstrate the benefits of A&E data-sharing in terms of tackling violence – for example, by highlighting what has been achieved elsewhere (most notably, of course, in Cardiff) and, probably more importantly, by regularly informing the A&E departments of how the data are being used locally, and with what results. This is not just a matter of instituting formal feedback mechanisms, but also ensuring that more informal contacts between partners are maintained. There is a need, as we were told in one interview, for partners 'to grease the wheels by saying thank you'. A hospital consultant told us that much could be gained from local police officers visiting A&E to say that they had received the

data and what they were doing with it – especially if this was done as part of a broader effort to strengthen inter-agency relations and to demonstrate their commitment to supporting A&E in dealing with incidents of violence or disorder on the premises. Generally, there was view among those we spoke to that the more that A&E data-sharing is seen as an integral element of wider partnership working between the hospitals, PCTs, police and local authorities, the more likely it is to be sustained and effective.

Data-sharing as an element of broader partnership working

3.10 Notwithstanding the difficulties associated with engaging the hospitals in the data-sharing work, there is evidence that this process is well under way in London. At the time of our research, in all the early adopter/TKAP sites there was optimism that the key partners, including the hospitals, were committed to taking forward the task of establishing data-sharing – even if inter-agency relations were not always easy. A PCT representative in one of the sites commented that there was 'a real drive and interest and motivation to work together on this ... But it is quite laborious.'

3.11 As applies to almost all partnership work, it would appear that progress in A&E data-sharing is at least partly dependent on the presence of key individuals in relevant agencies with sufficient personal commitment to and interest in the initiative to take it forward and encourage the involvement of others. Active support for the work from both managers and clinicians at senior levels within the hospitals is another crucial element. Also critically important, in some areas, is the input of public health specialists who – thanks to the broad and cross-cutting remit of public health - have the expertise to bridge the gaps between clinical medicine and the criminal justice and community safety fields. Hence, for example, the establishment of the new post of Public Health Lead at Hospital C appears to have been a factor in the progress made by this hospital with respect to data-sharing.

3.12 As mentioned above, there was a general view among many of our interviewees that data-sharing was likely to work best where it was seen as an element of broader co-operation and partnership between the hospitals and the other local agencies. This is very much how A&E data-sharing has long been conceptualised in Cardiff. For example, in guidance on the Cardiff model, answers offered to the question 'How can Emergency Medicine contribute to community violence prevention?' include the following:

- By providing A&E representation at consultant level to local crime reduction/community safety partnerships.

- By providing local clinical experts for drinks license hearings in local courts, to make sure that licensing takes account of safety/injury risk.

- By being committed to decreasing community violence as well as treating the injured.

- By initiating and participating in local safety campaigns, working with local media (Shepherd, 2007: 4).

3.13 Formal involvement of A&E practitioners in CDRP structures, as is promoted by the Cardiff model, was not yet a common feature of the early adopter/TKAP data-sharing initiatives, although there were examples of closer, collaborative working:

  - An A&E Consultant from Hospital A had recently joined a violent crime sub-group of the local CDRP.
  - At Hospital A and to a lesser extent Hospital B, the data-sharing initiative was seen as part of a wider, multi-agency programme of work aiming to enhance the support offered to children and young people who were victims of assault – hence, for example, the involvement of the outreach youth worker based at Hospital A in the provision of data to the CDRP.
  - At Hospital C, the A&E data-sharing initiative was being developed in tandem with an alcohol programme, the main elements of which were to be a system of screening patients for alcohol problems and the provision of brief interventions. Under this programme, a specialist alcohol nurse was being recruited who, it was anticipated, would assist with the data-sharing process in addition to implementing the alcohol screening and brief interventions.
  - At Hospitals G and H, also, efforts were under way to develop data-sharing under the umbrella of an alcohol programme. An interviewee from the community safety department reported that by supporting the two A&Es in their dealings with alcohol-related problems, she hoped to be able to exercise some 'leverage' over them with respect to data-sharing.

3.14 A&E data-sharing can also reinforce, and be reinforced by, day-to-day co-operation between the police and A&Es. For examples, a consultant from Hospital A commented that the police are 'incredibly supportive to us' in dealing with problems of violence that flare up within the A&E department; as a consequence, A&E staff are happy to do anything they can to support the police – provided it does not breach patient confidentiality and it takes into account the busy clinical environment.

3.15 In contrast, a consultant from another hospital told us that there was general dissatisfaction among A&E staff with the local police who, for example, were often accused of simply 'dumping' drunk patients at the hospital. He hoped that the establishment of A&E data-sharing would

help to improve relations between the police and hospital – with the increased contact between the two agencies meaning that each would develop a greater understanding of the work of the other.

Section 4. The Policy Context

4.1 Thus far in this report, we have focussed on local developments and challenges. Clearly, however, the establishment of A&E data-sharing at a local level is not something that happens in isolation from the national and regional policy environment. Central government departments – primarily the Home Office and Department of Health – and their regional arms have an important role to play in promoting and facilitating data-sharing. Many of our respondents indicated that they welcomed and valued the available government support on data-sharing. However, some concerns were raised about aspects of the national and regional inputs. These concerns were in two main areas, which are discussed in turn below. First, the policy context was sometimes perceived as overly complex and, as a result, somewhat confusing. Secondly, there was some demand for greater co-ordination of local initiatives. .

The complexity of the policy context

4.2 As stated in the introduction to this report, A&E data-sharing across London has been promoted by the Community Safety Division of GOL, which in 2008 identified a number of 'early adopter' sites and made a small amount of funding available for them. In some areas, work was already under way prior to the GOL initiative: for example, in Lambeth and Southwark the two PCTs had already met with their local A&E departments to discuss data-sharing in the context of widespread concerns about knife crime among young people. After the initial push from GOL, the issue of A&E data-sharing was moved higher up the political agenda with the Home Office's establishment of TKAP in ten police force areas, including London. The development of effective systems of A&E data-sharing was highlighted as a key objective of TKAP, and hence became a priority for the Metropolitan Police Service, both centrally and thereafter at local (borough) levels. At the same time, pressure was also brought to bear on London's health agencies, at regional and local levels, once the Department of Health was brought into TKAP's ambit with a view to promoting data-sharing.[9]

4.3 The high political profile and cross-departmental reach of TKAP have thus helped to ensure that A&E data-sharing has been a focus of sustained attention in some local areas in London. However, several of our interviewees indicated that they found the political and policy context of the data-sharing work to be confusing and overly complex. This may have been partly a consequence of the sheer number of bodies that have sought to impact directly on developments. At national

[9] The Department of Health is also promoting A&E data-sharing through its 'Framework for Violence and Abuse Prevention, which is currently under development (DH, 2008).

level, both the Home Office and Department of Health, largely through their TKAP remits, are engaged in the work; additionally, the Centre for Public Innovation has been commissioned by the Department of Health to provide practical support and guidance to local partnerships across all the TKAP areas, including London. At a pan-London level, the GOL Community Safety Division and Regional Public Health-London, along with NHS London (London's Strategic Health Authority) have all engaged directly with the early adopter/TKAP sites. The Metropolitan Police Service has also exerted a pan-London influence, through its Territorial Policing department (within which TKAP is located). And GOL's commissioning of Perpetuity to carry out this review brought one more organisation into the mix.

4.4 The involvement in the data-sharing initiative of such an array of different bodies should in theory have brought an added impetus to local developments. In practice, some of our interviewees reported that they or colleagues had been confused at receiving multiple queries and requests about data-sharing from different sources. There is a danger here that without co-ordination the effect of the different policy inputs will be diluted. In at least one of the hospitals, some initial reluctance to engage in the data-sharing work was apparently further entrenched as staff perceived that they were subjected to an excessive amount of pressure from assorted outside bodies. At the other end of the spectrum, there was a lack of awareness of the broader policy context: one community safety officer said she had thought that the A&E data-sharing initiative in which she was involved was 'one hundred per cent local', and that the first she knew of any pan-London dimension was when she was told about the Perpetuity review. Given that the success of the data sharing process lies in part on encouraging two key partners – health and community safety to work collaboratively, it is essential that their regional and national organisations similarly adopt a joined up approach to co-ordination.

4.5 An allied problem was the perceived lack of clarity of the policy focus. One hospital interviewee spoke of having become 'completely confused' when she first heard about TKAP, because up to that point she had understood that the data-sharing initiative was targeting alcohol-related violence, rather than knife crime. Others also reported that they were unclear as to whether alcohol-related, knife-related or all assaults were the intended focus of the data-sharing work; and this uncertainty was apparent in how some described the details of the systems that they were developing. The Cardiff Model has application across all types of violent assault and partners should be encouraged to realise the benefit of collecting and sharing data that will contribute to a range of community safety strategies and operations that are locally determined.

4.6 GOL's distribution of funding to support the development of data-sharing systems was another source of confusion in some areas. GOL had initially made £5,000 available to each early adopter hospital, but

not all had taken the funding at first; and those sites which were designated as TKAP rather than early adopter sites, originally did not receive any funding, although they were subsequently offered the same £5,000 as the early adopters. The net result of this was that some partners were aware that funding was available, but did not understand the criteria and methods by which it was being allocated. Availability of funding should not be a barrier to progress. Lessons drawn from this review indicate that external funding is not a prerequisite to success, in fact in some places progress is being made without the additional £5,000 funding. It is true that there may be some relatively low cost implications in relation to modifications to IT systems to facilitate data collection but once these hurdles are cleared a successful system of depersonalised data exchange does not require ongoing financial investment.

Need for improved co-ordination between areas

4.7 The pan-London promotion of A&E data-sharing provides an opportunity for co-ordination and co-operation between local areas in their development of data-sharing systems. For example, whilst every area is being encouraged to develop locally applicable solutions, the early adopter/TKAP sites can learn from each other about the feasibility of alternative approaches to data collection and data transfer to ensure they do not spend time reinventing the wheel or repeating each other's mistakes. The dissemination of the available evidence on 'what works' in A&E data-sharing, drawn from Cardiff and elsewhere is also, of course, an important part of this process.

4.8 There have been some events that have brought representatives from the early adopter/TKAP sites together to discuss the aims and methods of data-sharing, and to feed back on progress; but despite this, communication between the areas appears to have been limited. At the time of our research, it seemed that the partnerships were largely working in isolation from each other, devising piecemeal approaches and solutions to their local problems. Whilst some issues will be unique to a local context or at least have unique characteristics to a common issue, some issues will be common and as such opportunities for effective co-ordination are crucial. Clearly, the local partnerships themselves have to take some responsibility for supporting each other and co-ordinating their activities, where appropriate, but the regional bodies have a clear role to play in facilitating communication between the sites and disseminating guidance and other relevant information across all areas. One illustration of the lack of regional co-ordination was the fact that, as we have noted above, different versions of the minimum data-set had apparently been circulated among partnerships at different times, causing a degree of confusion.

4.9 The Summit event held in April 2009 provided an excellent opportunity for a wide range of local stakeholders from police, CDRPs and health

to meet, hear from the experience of both the London pilots and Professor Shepherd (Cardiff Model) and explore the process of data exchange through workshops and discussion. Events of this nature demonstrate how regional bodies can steer local partnership in the right direction whilst allowing them to develop bespoke data exchange solutions to fit locally relevant problems.

4.10 Part of the very rationale of having 'early adopter' sites was that learning from these partnerships would help to inform developments in other London boroughs. The results of this review are intended to feed into this process. So it is perhaps too much to expect that there would be effective co-operation and co-ordination between the early adopter (and TKAP) sites themselves at this early stage. Nevertheless, some of the issues that emerged from our interviews highlight the critical importance of regional and indeed national support, guidance and direction from the outset.

4.11 One such issue is cross-border working: in some of the sites, there was an interest in devising a data-sharing system whereby, ultimately, all CDRPs would have full access to A&E data from all London hospitals; by definition, the development and implementation of such a system would require a pan-London approach. Cross-border data-sharing is bound to be a more complex and pertinent issue in London than it is in Cardiff, since many A&E presentations in London are likely to cross borough boundaries due to the:

- nature and density of London's population
- geographical proximity of the various A&E departments
- presence of trauma centres and specialist injury units.

4.12 Data-sharing between some neighbouring boroughs is already under discussion – for example, it was intended that two of the early adopter/TKAP boroughs, which are located close to the boundary between two boroughs, would both provide their full data-sets to the CDRPs in both boroughs. Nevertheless, there remains value in collecting and sharing at the local level given that the development of a pan London mechanism will take time.

4.13 An issue demanding urgent attention at a national level is that of IT and, more specifically, the scope for amending the CERNER Millennium care records system to permit electronic collection of the minimum data-set. A question that is likely to come to the fore once anonymised data-sharing is established is the extent to which personalised hospital data can be routinely shared with CDRPs – but personalised data-sharing is unlikely to be undertaken by health agencies in the absence of clear and definitive guidance from the Department of Health and General Medical Council.

Section 5. Emerging Lessons

Process

5.1 Lessons drawn from this review indicate that external funding is not a prerequisite to success. Whilst it is true that there may be some relatively low cost implications in relation to modifications to IT systems to facilitate data collection, once these hurdles are cleared a successful system of depersonalised data exchange does not require ongoing financial investment.

5.2 Local partners need to set out clearly the potential pay-off that data-sharing offers to A&E staff, in terms of reduced numbers of A&E admissions related to assaults. The data sharing process does not purely facilitate a police response to a crime problem. It is about providing essential data that can support strategic work on violent crime; and it is clear that health professionals have a role to play in this. This message will be reinforced where both managers and clinicians at senior levels within the hospitals give their active support to data-sharing.

5.3 Equally important is the provision of regular feedback to A&E departments of how the data are being used locally, and with what results. This is not just about formal feedback mechanisms, but also informal contact between partners. Additionally, the more that A&E data-sharing is seen as an integral element of wider partnership working between the hospitals, PCTs, police and local authorities, the more likely it is to be sustained and effective.

5.4 The main practical difficulties which were being faced by the early adopter/TKAP sites related to the process of data collection. Two key, interlinked problems were apparent: first, the problem of identifying A&E staff with the time and skills to collect the data; secondly, the problem of developing an adequate electronic system of data capture within the A&E department.

5.5 The burden on staff can be lessened by giving the bulk of the data collection work to administrative rather than clinical staff, since the former tend to be working under somewhat less intense time pressures. Electronic data capture is likely to be more sustainable than manual recording, but the scope for reconfiguring the CERNER Millennium care records system is currently limited. For those A&E departments with older care records systems, the task of reconfiguring these systems to include the additional data fields appears more straightforward.

5.6 In short, data collection on assaults is most feasible and sustainable where it is fully integrated within the existing A&E data system and wider care records system. An integrated data collection system is one in which staff ask for and recorded any additional data on assault victims as part of the process by which they request and record data on all patients admitted to A&E.

5.7 From police and local authority perspectives, timely access to the data is essential if the data are to be used operationally as well as strategically. It is clear to all partners engaged in the development of A&E data-sharing that the whole exercise will be meaningless if the data are not used by the partners who receive them.

Partnership

5.8 London has chosen to adopt the Cardiff Model minimum data set that has application across all types of violent assault so that partners can realise the benefit of collecting and sharing data that will contribute to a range of community safety strategies and operations that are locally determined.

5.9 The success of local ventures to establish A&E data-sharing systems in part depends on the capacity of health, police and local authority partners to commit to work together and overcome any lingering mutual mistrust. The evidence from the early adopter/TKAP sites is that this process of establishing constructive inter-agency relations is advancing.

5.10 Partnership arrangements of any kind are likely to work most effectively where all the individual agencies perceive themselves to be benefiting directly from their involvement. A&E data-sharing demands input and long-term commitment from the hospital and yet on the surface it is the police and their community safety partners who most obviously and directly benefit. Moreover, within hospitals a variety of crisis situations - such as outbreaks of infection or shortages of beds – are liable to take precedence over longer-term initiatives such as data-sharing projects.

Policy

5.11 Given that the effective data-sharing process demands collaboration between key local partners (health, police and local authority), it is essential that their regional and national organisations adopt a similar joined up approach to advising and supporting local development of data exchange.

5.12 The Summit event held in April 2009 provided an excellent opportunity for a wide range of local stakeholders from police, CDRPs and health

to meet, hear from the experience of both the London pilots and the Cardiff Model and explore the process of data exchange through workshops and discussion. Events of this demonstrate how regional bodies can steer local partnerships in the right direction whilst allowing them to develop bespoke data exchange solutions to fit locally relevant problems.

5.13 The size and density of London's population, and the complexity of its health structures, make the establishment of effective data-sharing across London a more challenging task than it is in Cardiff. In particular, the fact that A&E presentations often cross borough boundaries means that there are obvious benefits to be gained from the development of a data-sharing system that offers all London CDRPs full access to A&E data from all London hospitals.

5.14 By definition, the development and implementation of such a system requires a pan-London approach. This will take time to realise and in the meantime there remains value in the collection and sharing of A&E data at the local level.

Section 6. References

Audit Commission (1999) *Safety in numbers: promoting community safety*, London: Audit Commission

Crime Concern (2003) *Working with Health Services to Reduce Crime and Disorder*; Swindon: Crime Concern

Department of Health (2008) *Healthier, fairer, safer Communities - connecting people to prevent violence: towards a framework for violence and abuse prevention* (draft), London: DH

HM Government (2002) *Improving Partnership Working: PCTs and Tackling Crime and Disorder and the Misuse of Drug,* London: Home Office

HM Government (2008) *Saving lives. Reducing harm. Protecting the public. An action plan for tackling violence 2008-11*, London: Home Office

HMIC (2000) *Calling time on crime: A thematic inspection on crime and disorder*, London: Home Office

Nacro (2001) *Better Health, Lower Crime*: *briefing for NHS and partner agencies*, London: Nacro

Nurse, J., Sheehan, D., Stewart, J. (2007) Summary of Cardiff/SE regional violence – emergency department information sharing project: consideration for national roll-out,
http://www.gos.gov.uk/497648/docs/300069/EDDataSharing

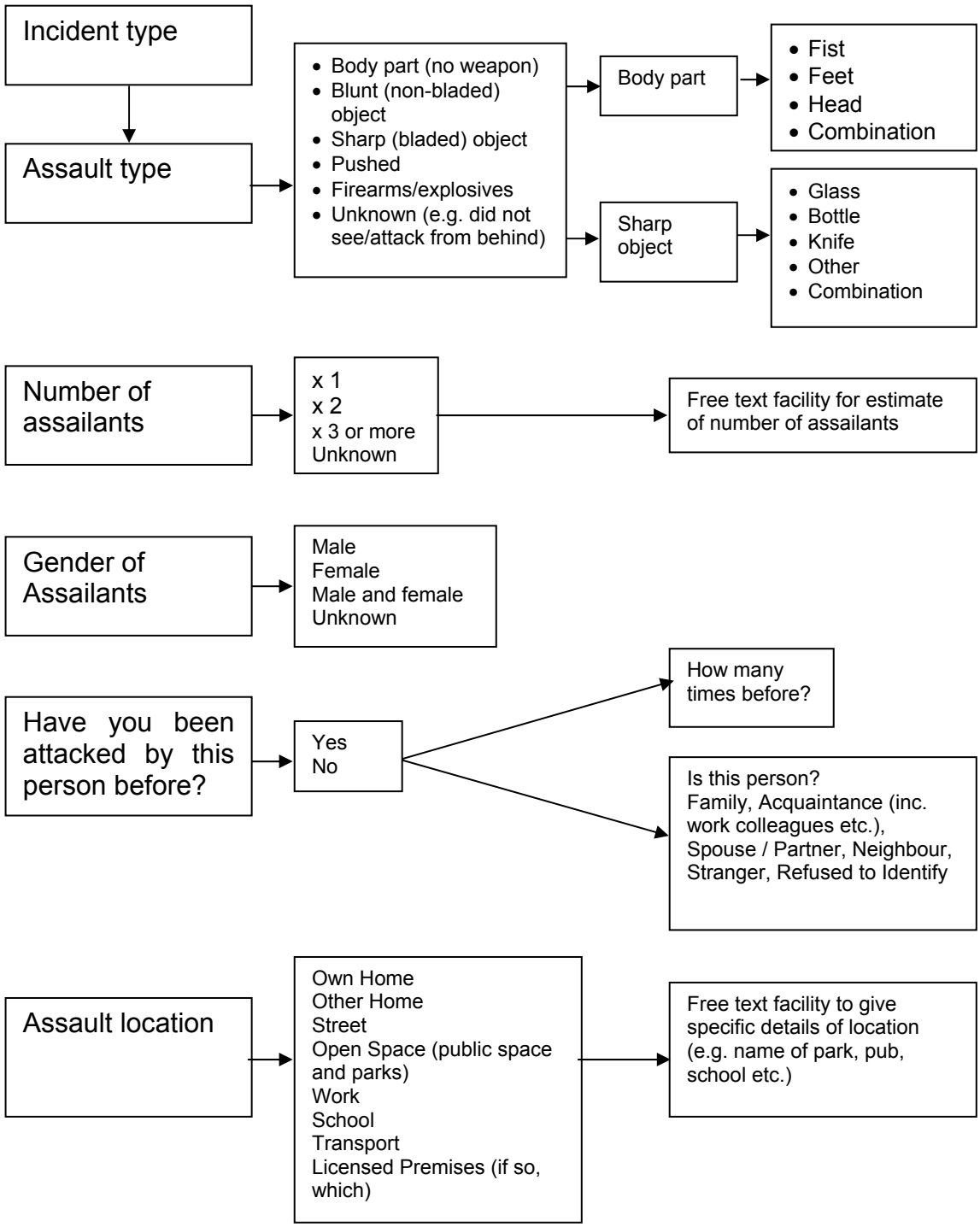
Phillips, C. Jacobson, J. Prime, R., Carter, M. and Considine, M. (2002) *Crime and Disorder Reduction Partnerships: Round one progress*, Police Research Series Paper 151, London: Home Office

Shepherd, J.P. (2007) 'Effective NHS contributions to violence prevention: the Cardiff model', prepared for Rt Hon Alan Johnson MP, Cardiff University.

Warburton, A.L. and Shepherd, J.P. (2004) 'Development, utilization and importance of accident and emergency department derived assault data in violence management', *Emergency Medicine Journal*, 21, 473-7

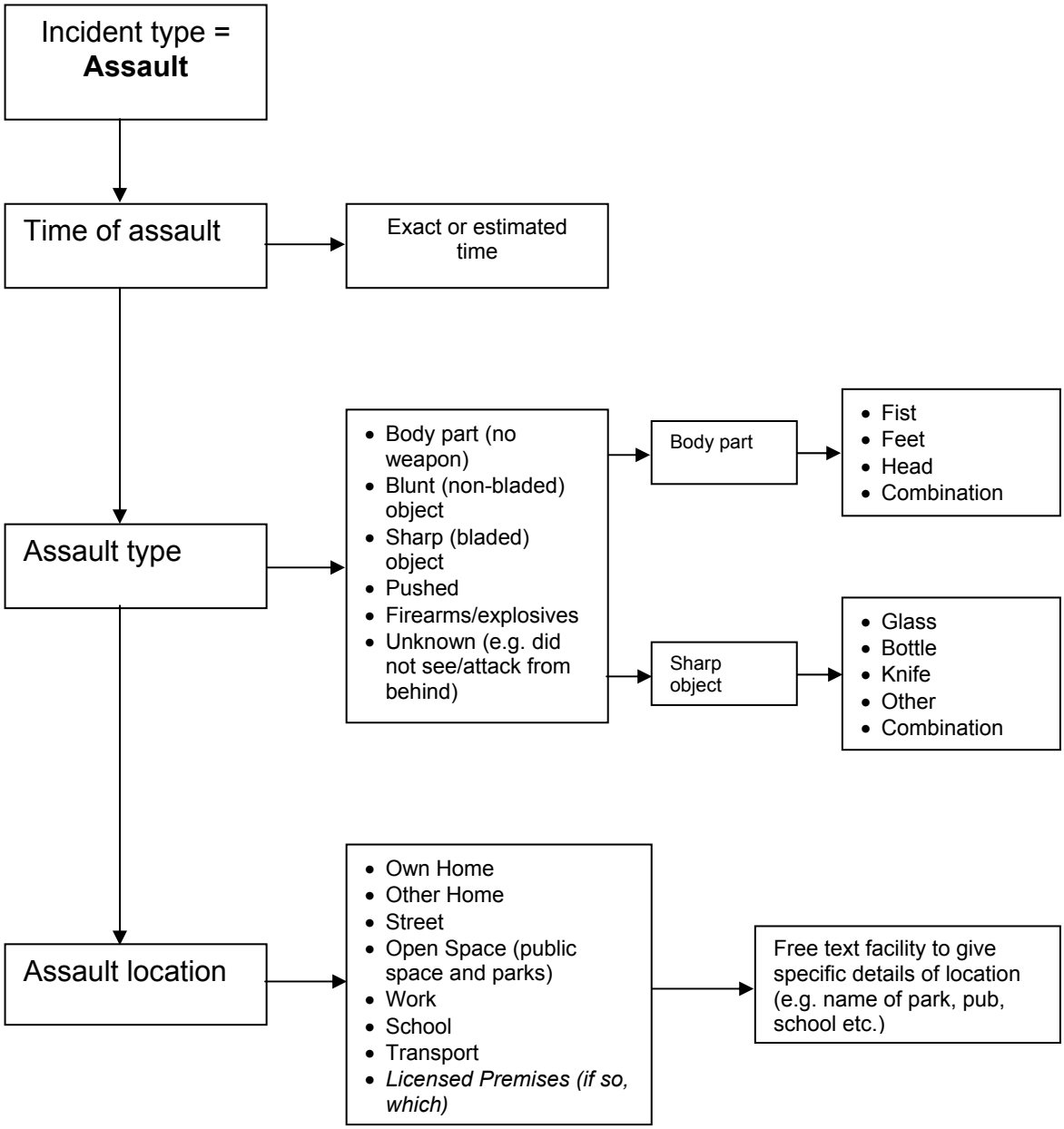
Appendix A: Cardiff minimum data-set

Based on the data collected by receptionists in the Emergency Department of the University of Wales Hospital Trust:
(Date, time, demographics)



Appendix B: Revised minimum data-set, Addenbrookes Hospital

Revised minimum data-set used in Emergency Department of Addenbrookes Hospital, Cambridge



Perpetuity Research & Consultancy International Ltd
148 Upper New Walk
Leicester
LE1 7QA
United Kingdom
Tel: +44 (0)116 222 5555
Fax: +44 (0)116 222 5557
www.perpetuitygroup.com
prci@perpetuitygroup.com