Department of Health

Information sharing to tackle violence

Audit of progress

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Prepared by

Social Care, Local Government and Care Partnerships Directorate Analytical Unit

Contents

Contents 4
1. Executive Summary 5
2. Introduction 7
   2.1 Background 7
3. Methodology 8
   3.1 Survey development 8
   3.2 Data sharing implementation score 9
   3.3 Survey distribution 9
   3.4 Survey response validation 9
4. Analysis 11
   4.1: Scoring 11
   4.2 A&E departments 12
   4.3 Community Safety Partnerships 15
5. Conclusion 19
Appendix 20
   Appendix A: Information Sharing Audit 2014 Scoring Methodology 20
   Appendix B: Information Sharing Advisory Group - Terms of Reference 22
   Appendix C: Implementation scores for A&E department respondents 23
   Appendix D: Implementation scores for Community Safety Partnership respondents 29
   Appendix E: Additional information collected from the A&E Survey 37
   Appendix F: Additional information collected from the Community Safety Partnership survey 38
   Appendix G: College of Emergency Medicine guideline 40

1. Executive Summary

In 2010, there was a commitment to deliver a reduction in violent assaults both locally and nationally by making hospitals share non-confidential information with the police so they know where gun and knife crime is happening and can target stop-and-search in gun and knife crime hot spots

On behalf of DH, the Social Care Directorate Analytical team has undertaken an independent national data collection to assess the extent of non-confidential information sharing between Type 1 Accident and Emergency (A&E) departments and Community Safety Partnerships (CSPs). The audit, carried out in summer 2014, is based on the College of Emergency Medicine (CEM) recommended guidelines as it predates the Information Standard published in September 2014. Organisations responding to the data request were allocated a score to measure the extent to which they are currently implementing information sharing protocols. A&Es and CSPs received similar questionnaires designed to enable comparison of results.

Key findings:

A&Es:

- 76 usable responses were received from the 143 NHS trusts with a Type 1 A&E department, equating to a 53% response rate.
- 61% of A&E respondents scored high on the implementation of the CEM guidelines. While the results from this audit are not entirely comparable to the audit carried out in 2012 due to differing methodologies, these figures would suggest that there has been an increase in the number of A&E departments sharing data to a high level (36% in 2012).
- 25% of A&E respondents scored low on the implementation of the CEM guidelines - either as a result of not yet collecting violent assault data, or the quality and completeness of the data is poor. This is similar to the proportion of A&Es not sharing data in the previous audit. Further investigation is needed to identify barriers to implementing information sharing successfully in these departments.
- Even taking the low response rate from Type 1 A&Es in London (only 8 usable returns were received out of 32 Type 1 A&Es), London had one of the lowest levels of information sharing, with 50% of A&E departments scoring high on implementation and 38% scoring low. Given the higher levels of violent assaults in London this is a cause for concern.
- 45% of A&E respondents share data at least once a month as recommended in the CEM guidelines whilst 22% share data on a less frequent basis. 33% report that they are not currently sharing data with CSPs.
- 41% of A&E respondents have a signed agreement about information sharing with one or more CSPs.
- For those scoring “high” on implementation, the most common obstacle to

implementing information sharing was difficulty in obtaining data from patients, who may be reluctant to provide information that may lead to legal consequences (58%). IT issues and resource issues such as lack of time or staff were the most common problems reported by A&E respondents with a low or medium score for implementation of information sharing.

- **CSPs:**
  - 148 usable responses were received from CSPs representing responses from around 60% of CSPs.
  - Over half of all CSPs who responded to the survey do not receive violence assault data from any A&E.
  - Of those that do receive violence assault data, over half is at a high level of implementation to CEM guidelines.
  - The highest numbers of CSP respondents receiving information from at least one Type 1A&E department were in the North West and the South East
  - Whilst a high response rate was attained in London, less than 25% of those respondents reported any information sharing occurring between themselves and a partner Type 1 A&E department.

2. Introduction

2.1 Background

In 2010 the Programme established a commitment to “make hospitals share non-confidential information with the police so they know where gun and knife crime is happening and can target stop-and-search in gun and knife crime hot spots”[1].

Due to their position in treating victims of violent assaults, hospitals are in an excellent position to promote community safety through the sharing of non-confidential information. The Cardiff Violence Prevention Programme[2] has shown that substantial reductions in violent injury can be achieved through consistent information sharing between health services, police, and local government.

The Department of Health (DH) established a programme to support A&Es to share information with Community Safety Partnerships (CSPs) at a local level. An initial audit of progress of the information sharing programme was carried out in 2012 by the Centre for Public Innovation and Gecko Social Health Outcomes[3].

The 2012 audit showed that much work remained to be done in order to meet the commitment, and that additional analysis was needed to identify why the commitment was not being met.

Thus this second audit was commissioned to examine in more detail how information sharing is being implemented and to look into motivational and technical issues that may affect the implementation of information sharing in Type 1 A&E departments.

The objectives of this audit were to:

- Measure the extent of information sharing at a local level to assess progress in meeting the commitment.
- Assess the progress that has been made in implementing information sharing since the last audit.
- Identify the factors that may affect or impede information sharing.
- Test the association between the extent of information sharing and the following factors: number of assault patients seeking A&E treatment; hospital admissions; local levels of violence[4].

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[1] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/78977/coalition_programme_for_government.pdf, page 13.

[2] http://orca.cf.ac.uk/15855/1/Effectiveness_of_anonymised_information.pdf

[3] http://www.publicinnovation.org.uk/wp-content/uploads/2013/01/AE-Data-Sharing-Audit-2012.pdf

[4] This analysis will follow in the second stage of the report due in mid 2015

3. Methodology

The aim of this audit is to assess the present level of implementing the commitment on information sharing between A&Es and CSPs and the progress that has been made since the previous audit in 2012. Additionally, it identifies the factors which may be influencing the rate of implementation in organisations. Two questionnaires were specifically designed to meet these objectives, one for A&Es and one for CSPs, and collection methods were established to ensure that the response rate would be sufficient.

3.1 Survey development

The questionnaires for this audit were developed using the SurveyMonkey web tool. This method was deemed the most suitable way to carry out the data collection due to the large number of potential respondents. An important consideration in survey design was the need to reduce the burden on the NHS, Local Authorities and the police arising from completing the questionnaire. Much use was made of the routing facility in SurveyMonkey which ensured that respondents only answered questions relevant to their situation as well as allowing additional probing of responses when necessary.

The questionnaires were developed with the purpose of providing data that could provide an objective measure of the current level of implementation of information sharing compared to CEM guidelines. Furthermore, questions were chosen to allow comparison to the previous audit where possible, as well as to determine the factors that can affect implementation. The A&E and CSP questionnaires used similar questions to allow comparison where possible. The key points to investigate were to measure the extent of information sharing at the local level compared to CEM guidelines. Questions were also developed to try and ascertain the extent to which implementation was affected by:

- Region size/variation
- Motivation/engagement
- Technical issues
- Partnership between A&E and CSP

An advisory panel of key stakeholders from all partnership organisations, listed in the Terms of Reference (see Appendix B), was established to give guidance and feedback at each stage of development. The initial draft questionnaires were tested by independent analysts and policy colleagues in Department of Health. After further refinement the questionnaires were piloted among a sample of around 15 A&Es and CSPs. In addition to providing feedback, A&E departments who took part in the pilot were also asked to record the length of time it took to complete the questionnaire. This was then fed into a Review of Central Returns (ROCR) form which was used to calculate and minimize the additional mandatory burden on the NHS. ROCR approval was obtained from HSCIC.

Whilst the methodology used in this audit is based on that used previously in 2012, it has been refined to provide a more robust view of the extent to which information sharing has been implemented. It continues to be based on the achievement of CEM guidelines and takes all aspects of information sharing into account when allocating a score. However, as

a result, scores are not directly comparable between the two audits but allow the identification of general trends.

3.2 Data sharing implementation score

In order to be able to measure information sharing performance, a three point scale was used to categorise current levels of activity for both A&Es and CSPs:

- High: Good to full implementation of CEM guidelines.
- Medium: There is a data sharing system in place, but it is not fully compliant with CEM guidelines.
- Low: Poor implementation or not collecting and sharing data yet.

3.3 Survey distribution

The survey was first distributed at the beginning of July 2014 to all Type 1 A&E departments and CSPs in England. Distributing the questionnaire to Type 1 A&E departments was challenging, as there was no existing list of relevant contacts in A&E departments. The survey was therefore sent out using all available channels to increase awareness, as well as sending the survey to all individuals on the contact list from the previous audit. For A&Es the channels used were:

- A letter, directed to chief executives in NHS Acute Trusts, was circulated via Monitor to Foundation Trusts.
- Through the Standardisation Committee for Care Information (SCCI) to information departments.
- Through College of Emergency Medicines to clinical leads (consultants).
- The National Violence Surveillance Network
- NHS Trust Development Authority for non-Foundation trusts
- Directors of Public Health

For the CSPs the following were used:

- Local Government Association contact list
- College of Policing contact list
- Home Office published contact list

The number of responses was monitored while the survey was running. As a result of having to use a multitude of channels to reach A&E departments, a decision was made to significantly extend the period for response. In addition, 3 reminder letters were sent to increase the response rate. The survey finally closed at the end of September 2014, giving respondents a substantial three months response window.

3.4 Survey response validation

This audit received complete usable responses from 76 unique hospitals equating to a response rate of 53% out of the 143 NHS trusts with a Type 1 A&E department in England. However, CSPs were asked to name the organisation sharing information with them, and among the A&E departments actively information-sharing with CSPs were 35 that did not

independently respond to the questionnaire, suggesting that the survey results were not biased to A&Es that were already engaged in sharing information. A larger response was received from the separate questionnaire that was sent to CSPs, with 148 unique organisations responding.

In the case of an incomplete response in SurveyMonkey, e-mails were sent to the respondent asking them to finish the response to enable it to be used. When duplicate responses were received from an organisation, all respondents were contacted to establish which response should be used. If no response was received, then the most recent complete response was used.

4. Analysis

The analysis of the second audit on the implementation of information sharing between Accident and Emergency units (A&Es) and Community Safety Partnerships (CSPs) is split into two parts. The first focuses on the responses to the survey itself and a comparison of trends with the previous audit where applicable, given that both the methodology and the scoring mechanisms of the two audits are different. It also examines the hurdles in successfully implementing information sharing.

This analysis forms part one of the report. A second follow-up analysis is planned that will look into evaluating the impact of the information-sharing initiative in reducing violence in places that have been sharing violence data for over three years. It is proposed that the outcomes to be examined should include the correlation between the extent of information sharing and the following factors: numbers of assault patients seeking A&E treatment; hospital admissions, including the number of A&E attendances resulting from violence; and region size. Differences in scores between rural and urban areas will also be examined.

4.1 Scoring

The scoring methods for both the A&E and CSP scores are summarised below. Full details can be found in Appendix A. While some questions in this audit are directly comparable to the previous audit, since the aims of the two audits were different not all questions are similar. Overall, the results from the two audits should be treated with care, and changes in the assessment of information sharing for an individual organisation may be purely because of the change in scoring methodology used between audits.

4.1.1 A&Es

The overall implementation score for A&E departments is comprised of a collection score and a sharing score, and assesses the current level of information sharing according to College of Emergency Medicine (CEM) guidelines. The collection score is based on: whether the A&E is currently collecting data on violent incidents; for how long they have been collecting this data; and the quality and completeness of the data collected. The sharing score is determined by: whether the A&E is sharing this violence data with CSPs; for how long they have been sharing data; and the proportion of violent incidents for which data is shared.

4.1.2 CSPs

The score for CSPs is similarly comprised of two parts. The first part assesses the receipt of assault data, and whether the CSP is content with the frequency of the data received. The second part is based on whether the assault data is used in planning interventions, and if the CSP provides feedback on the quality and completeness of the data received.

4.2 A&E Results

4.2.1 Overall assessment of data sharing

Of those who responded, 61% have a high level of implementation of the CEM guidelines on information sharing (Table 1). 14% score medium meaning that they have started the process and put a data-sharing system in place but that improvements are still needed in making data-sharing more effective in order to achieve a reduction in violence assaults. 25% are classed as having a low level of implementation, meaning that they either have not yet implemented information sharing, or that the quality and completeness of the information they share is low.

Table 1: Distribution of the implementation scores for Accident and Emergency Departments

Implementation Score	Count	%
High	46	61%
Medium	11	14%
Low	19	25%
Total	76	

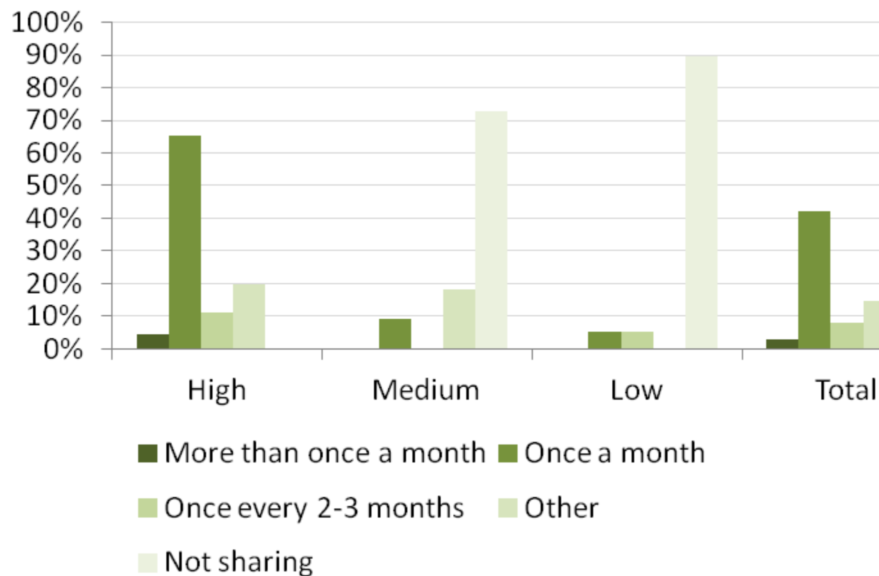
Table 2 shows the level of implementation of information sharing within each region. However, there is much geographic variation in survey responses with 21 A&E departments completing the survey in the North West and only 2 in each of the Eastern and East Midlands regions. In terms of implementation of information sharing there was less geographical variation. Overall at least 50% of the A&E departments have a high level of implementation within each region. Only Yorkshire & the Humber, London and the Eastern region have over 25% of respondents having a low level of implementation of information sharing, although the low level in London may be a cause for concern due to the elevated levels of violent incidents there.

Table 2: Assessment of implementation level of information sharing amongst A&E departments by region.

Region	Assessment level						
	Percentage			Count			
	High	Medium	Low	High	Medium	Low	Total
East Midlands	100%	0%	0%	2	0	0	2
Eastern	50%	0%	50%	1	0	1	2
London	50%	13%	38%	4	1	3	8
North East	60%	20%	20%	3	1	1	5
North West	52%	24%	24%	11	5	5	21
South East	67%	11%	22%	6	1	2	9
South West	75%	8%	17%	9	1	2	12
West Midlands	50%	33%	17%	3	2	1	6
Yorkshire and the Humber	64%	0%	36%	7	0	4	11

Figure 3 shows the frequency with which data is shared by A&E departments with CSPs. Overall 45% of A&E departments share data at least once a month as recommended in the CEM guidelines. 22% share data on a less frequent basis, while 33% are not currently sharing data with CSPs. 69% of A&E departments implementing information sharing to a high level reported sharing data at least once a month. The majority of A&E departments with low and medium levels of implementation are not sharing data with any CSP.

Figure 3: Frequency with which information on violent assaults is shared by CSPs for A&E departments by level of implementation of information sharing.



Although the results from the two audits are not directly comparable, and thus trends should be treated with caution, there is an increase in the number of A&E departments with a high level of implementation of information sharing from 36% in the previous audit in 2012 to 61% at present. In 2012 18% of respondents had not yet implemented information sharing at all, while 73% had started the process of putting data-sharing systems in place but had yet to reach full implementation, suggesting that broadly the same percentage of A&Es had yet to implement useable information-sharing while many of those which had begun the process by the previous audit may have reached a high level of implementation at present.

4.2.2 Factors associated with level of implementation of information sharing in A&Es

Overall 41% of A&E departments have a signed agreement about information sharing with one or more CSP. Figure 4 shows the proportion of A&E departments that have a signed agreement, by level of implementation of information sharing. 60% of A&E departments with a high level of information sharing had a signed agreement with one or more CSP, while only 10% of A&E departments with either low or medium levels of information sharing had a signed agreement. While for many A&E departments not having a signed agreement has not been an impediment to achieving high levels of information sharing, among A&E departments with low or medium levels of information sharing the lack of a signed agreement with any CSP may indicate lower levels of activity in information sharing.

Figure 4: Proportion of A&E departments that have a signed agreement for information sharing with at least one CSP for each level of information sharing.

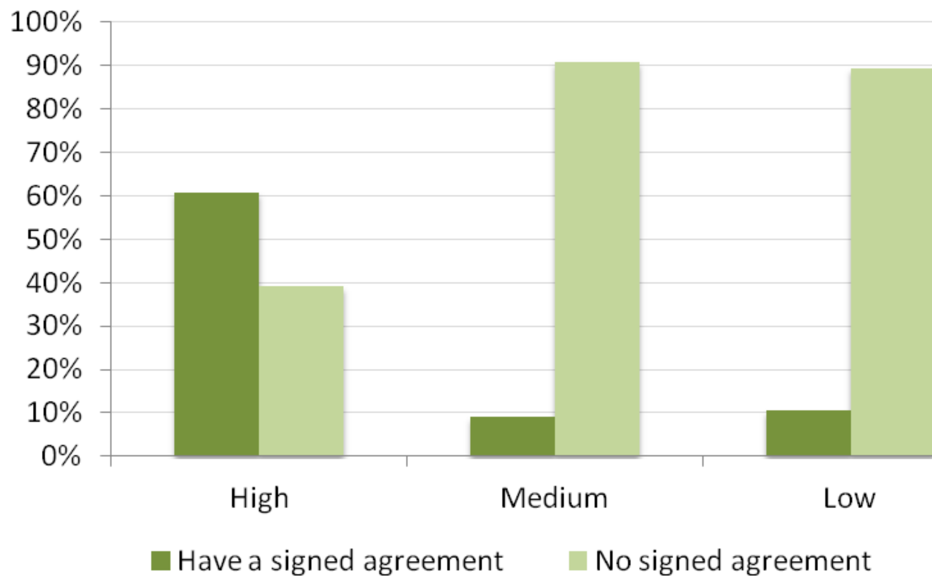
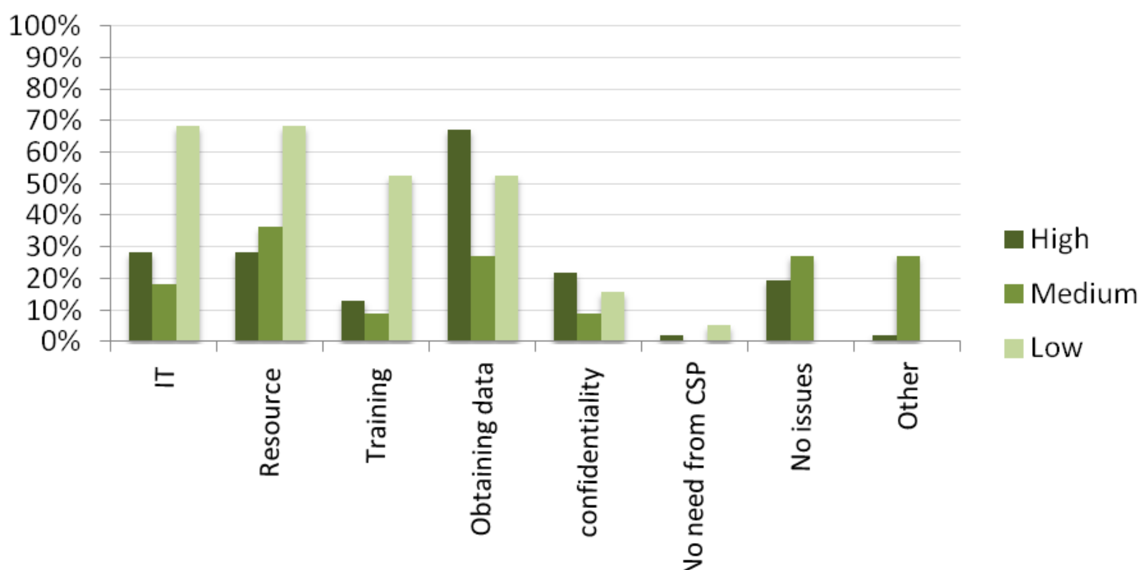


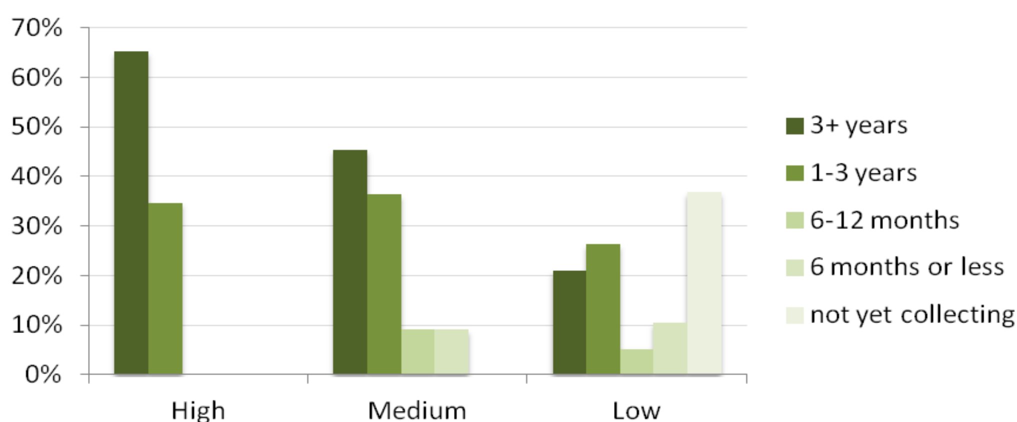
Figure 5 shows the proportion of A&E departments reporting different types of issues that they perceive prevent them from fully collecting data for information sharing, split by level of implementation of information sharing. 20% of A&E departments with a high level of implementation of information sharing, and 27% with a medium level of implementation reported no issues preventing information sharing. The most common problem for A&Es was difficulty obtaining data from patients, with 58% of A&E respondents overall reporting that this was an issue. Both IT issues and resource issues such as lack of time or staff were also common, and were reported by 37% and 39% of A&E respondents respectively. Both were particularly commonly reported by A&E respondents with a low level of implementation of information sharing, as was lack of training.

Figure 5: Issues reported by A&E departments as preventing them from collecting all the minimum required violent assault data items, by level of implementation of information sharing.



There would appear to be a link between implementation level and the duration of data collection, as can be seen in Figure 6. All A&E departments with a high level of implementation have been collecting data for at least one year. Of those departments 72% are achieving a high level of implementation, while 60% of those that have started collecting data but have implemented for less than one year currently have a low level of implementation.

Figure 6: Percentage of A&E departments with high, medium or low levels of implementation of information sharing by duration of data collection.



Just under half of survey respondents said that they had received training for implementing information sharing such as attending a presentation on the subject, or an e-learning toolkit (Table 7). Unsurprisingly training levels were higher amongst A&E departments with high levels of implementation of information sharing, while just over a quarter of respondents in departments with low or medium implementation had received training.

Table 7: Percentage of survey respondents who reported receiving training on implementing information sharing.

	High	**Medium**	**Low**	**Overall**
Training	63%	27%	26%	49%
No training	37%	73%	74%	51%

4.3 Community Safety Partnerships

4.3.1 Overall assessment of data receipt and use

Community safety partnerships (CSPs) were sent a similar survey [5] which asked them about their methods and protocols for receiving the information from their associated

[5] The questionnaire for Community safety partnerships can be found in the accompanying document.

Accident and Emergency departments (A&E's). When a CSP has responded to the survey and reported that they do not receive any information from A&Es, they have been assigned "No Score" as the overall score consists of both scores relating to receipt of data and subsequent use of data[6].

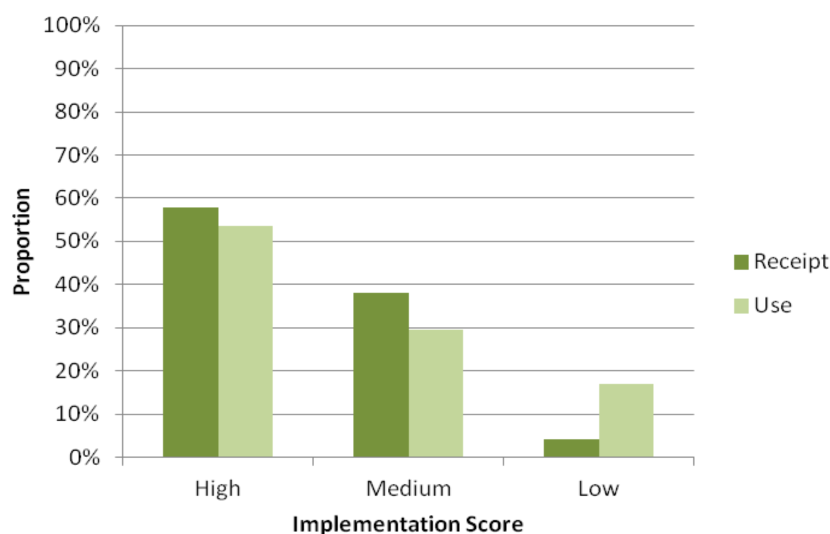
Table 8 shows that over half of the CSPs surveyed were not receiving any form of information from any A&E department, and of those that were receiving information, over half of them were achieving a high score, around a quarter medium and the remainder low.

Table 8: Distribution of the scores for all respondents to the CSP questionnaire.

Status	Score	Count	%
Receiving Information	**High**	38	25.6%
	Medium	20	13.5%
	Low	13	8.8%
Not receiving Information	**No Score**	77	52.0%
	Total	**148**	

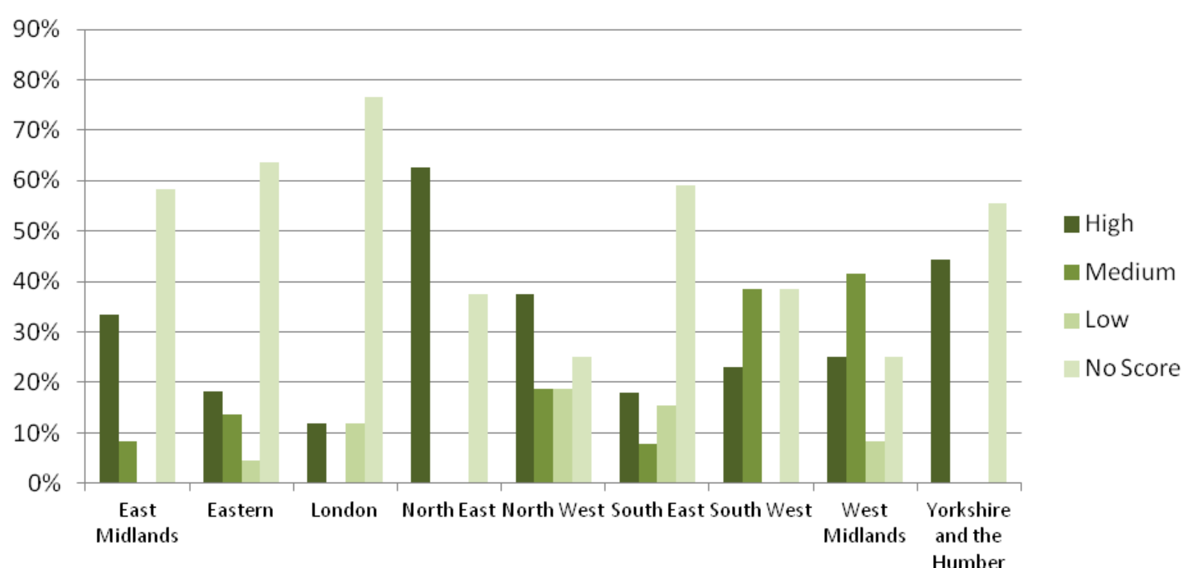
Figure 9 shows that for those CSPs scoring high or medium, the proportion reporting receiving data was slightly greater than the proportion using data. However, the pattern is reversed for those with a low implementation score. Figure 10 below shows the geographical distribution of CSP respondents

Figure 9: Proportion of the scores for receipt and use for the 71 CSPs who say they receive information.



[6] Further data including breakdowns by different criteria can be found in Appendix E

Figure 10: Implementation score of CSPs who submitted a response to the survey, by region.



4.3.2 Factors associated with level of implementation of information sharing in CSPs

Survey responses show that those CSPs who have partnerships with the A&Es they receive information from have higher scores than those who don't. Around 2/3 of those who do have partnerships score high on the implementation scale (Table 11).

Table 11: Proportion of implementation scores of CSPs who receive information from at least one A&E department, by Partnership status

Partnership status	High	Medium	Low	Total
Partnerships with **all** A&E's	63%	22%	14%	**49**
Partnerships with **most** A&E's	100%	0%	0%	**1**
Partnerships with **half** of A&E's	100%	0%	0%	**1**
No partnerships with **most** A&E's	0%	0%	100%	**1**
No partnerships with **all** A&E's	26%	47%	26%	**19**
Total	**38**	**20**	**13**	**71**

Provision of feedback is reported as being an important part of the protocol. Table 12 shows that all CSPs who receive a low implementation score provide less, if any, feedback to their associated A&Es.

Table 12: Proportion of implementation scores of CSPs who receive information from at least one A&E department, by feedback status

Feedback status	**High**	**Medium**	**Low**	**Total**
Feedback given to **all** A&E's	80%	20%	0%	**46**
Feedback given to **most** A&E's	0%	0%	0%	**0**
Feedback given to **half** of A&E's	100%	0%	0%	**1**
Feedback not given to **most** A&E's	0%	0%	100%	**1**
Feedback not given to **all** A&E's	0%	48%	52%	**23**
Total	**38**	**20**	**13**	**71**

Table 13 shows a clear division in respondents in the use of data from A&Es. With the exception of only one CSP all respondents said they either used the data from all of their A&E's or none at all, suggesting that data must reach a level of usability in order for the CSP to be able to use it in any way.

Table 13: Implementation score of CSPs who receive information from at least one A&E department, by use status

Use status	**High**	**Medium**	**Low**	**Total**
Data from **all** A&Es is used	73%	21%	6%	**52**
Data from **most** A&Es is used	0%	0%	0%	**0**
Data from **half** of A&Es is used	0%	0%	100%	**1**
Data from **most** A&Es is not used	0%	0%	0%	**0**
Data from **all** A&Es is not used	0%	50%	50%	**18**
Total	**38**	**20**	**13**	**71**

5. Conclusion

The audit results suggest that there has continued to be good progress amongst A&E departments already implementing information sharing with CSPs, with an increase in the number of A&E departments that comply with the CEM guidelines since the previous audit in 2012. However, the proportion of A&Es that are not collecting and sharing data with CSPs has remained the same. It is therefore important to come up with new strategies to engage A&Es who have not yet begun sharing information. IT and personnel resource issues were highlighted as a particular barrier to information sharing by these A&Es, and further work needs to be done to identify how to optimally address these issues. Amongst A&E departments already sharing information the main hurdle was obtaining information from patients, which is understandable because they may be reluctant to share such information, and training programmes may help to help staff deal with such difficult situations.

Further investigation is needed for the London area. There are 32 A&E departments in London, but only 8 responded to the survey and of those only 4 are currently implementing information sharing according to CEM guidelines, while 3 are not yet sharing information. Given the elevated levels of violent assault in the area, fully implementing information sharing in that area should be a priority.

There were a number of limitations in this audit. The response rate was below our target, and any future audit should develop a central distribution list, since this was a major hold-up for this audit. There was also variation in who responded within each organisation, with receptionists, nurses, consultants and managers answering in different places, and these individuals would have different perspectives and knowledge of the implementation of information sharing. In some regions there were few A&E departments that responded, making a regional analysis more difficult. Finally we were unable to link responses between A&E departments and CSPs, meaning that we were unable to get a complete picture of the process of information sharing between partner organisations.

Plans for a secondary analysis are underway, which will look in more detail at factors which affect the extent of information sharing, and will evaluate the impact of information sharing in reducing violence in areas that have implemented data sharing for several years.

Appendices

Appendix A: Information Sharing Audit 2014 Scoring Methodology

Data source:

- Data collected through questionnaires answered by A&E departments and Community Safety Partnerships in England. There are 143 NHS Trusts with Type 1 A&Es and approximately 250 CSPs.

Analysis objectives: This analysis is designed to:

- Provide an objective score to each A&E and CSP that represents the extent of the implementation of information sharing by that organization.
- Consider which factors have an effect on information sharing.

Overall implementation level - A&E questionnaire

The overall implementation level score for A&E departments is comprised of scores for data collection and for data sharing. The questions used for each score are:

Collection:

a. Is the A&E department collecting violent assault data? Is there a routine arrangement in place?
b. How long has the department been collecting violent assault data?
c. For what proportion of violent incidents is the department collecting data?
d. For what proportion of violent incidents are each of the following collected: date and time; primary method of assault; specific location?

Sharing:

a. Is the A&E department sharing violent assault data with CSPs? Is this sharing routine?
b. For how long has the department been sharing violent assault data?
c. For what proportion of violent incidents is the department sharing data?

The overall score was assigned by combining the collection and sharing scores as follows:

Collection Score	Sharing Score	Overall Implementation Level
Low	Low	Low
High	Low	Medium
Low	High	Medium
High	High	High

Overall implementation level - CSP questionnaire

The CSP overall implementation level score is comprised of two components: a score for receipt of data and whether the CSP is content with the frequency of the data received, and a score for the CSPs use of the data and whether they provide feedback to their A&E partners. The questions used for each score are:

Receipt of data:

a. Is the CSP receiving violent assault data from one or more A&E department? Is there a routine arrangement in place?
b. Is the CSP content with the frequency of the data received?
c. Does the CSP provide feedback to A&E regarding the quality, completeness or frequency of the data received?

Use of data and providing feedback:

a. Does the CSP use the data received to support community safety and violence reduction activities?
b. How does the CSP rate the quality and completeness of the data received?
c. Does the CSP provide feedback to the relevant A&E regarding the quality, completeness and frequency of the data they receive?

Overall Score

CSPs are awarded a score for receipt and use for each hospital they receive information from. These scores are averaged to give a single overall implementation score. The overall score is assigned by combining the receipt and the use scores as follows:

Receipt Score	Use and feedback Score	Overall Implementation Level
High	High	High
Medium	High	High
High	Low	Medium
High	Medium	Medium
Low	Medium	Medium
Medium	Medium	Medium
Low	High	Medium
Medium	Low	Low
Low	Low	Low

Appendix B: Information Sharing Advisory Group - Terms of Reference

<table>
<tr><td>Objectives:</td><td>In order to meet the commitment, DH has undertaken:

The assessment of the current extent of the implementation of information sharing between CSPs and A&Es

Our objectives are to:
Measure the extent of information sharing at local level to inform the commitment.
Understand the factors affecting information sharing. These may potentially include region size, motivation and engagement of staff, technical issues, and the strength of the partnership between A&E and CSP.
Test the correlation between extent of information sharing and the following factors: numbers of assault patients seeking A&E treatment; hospital admissions; local levels of violence.</td></tr>
<tr><td>Aims:</td><td>The advisory group will:
Advise on writing the survey questions to meet the objectives of the assessment.
Advise on the analysis plan and metric used to determine the current state of information sharing.
Suggest questions that are complementary to other information sharing work strands.
Help with developing contacts and chasing survey responses.
Be aware of current audit progress to avoid duplication of work.</td></tr>
<tr><td>Communication</td><td>Via emails followed up with teleconferences to discuss questionnaire and analysis.

Individual contact will be established with particular members where they have specific expertise to help.</td></tr>
<tr><td>Frequency</td><td>As needed</td></tr>
<tr><td>Membership and timetable:</td><td>Membership will include, but is not limited to, representatives from:
Public Health England researchers
Liverpool John Moore's University researchers
TIIG
College of Emergency Medicine
A&E representation (York)
CSP representation
Department of Health Policy
Home Office
Health and Social Care Information Centre- Information Standard
NHS England
Public Health England policy</td></tr>
</table>

Appendix C: Implementation scores for A&E department respondents

Region	NHS Trust	Hospital	Score		
			Collecting	Sharing	Implementation
South East	Brighton and Sussex University Hospitals NHS Trust	Royal Sussex County Hospital	High	High	High
Yorkshire and the Humber	Leeds Teaching Hospitals NHS Trust	St James's University Hospital, General Infirmary	High	High	High
South East	Portsmouth Hospitals NHS Trust	Queen Alexandra Hospital Portsmouth	High	High	High
South West	Taunton & Somerset NHS Trust	Musgrove Park Hospital	Low	Low	Low
North West	Aintree University Hospital NHS Foundation Trust	Aintree University Hospital	High	High	High
Yorkshire and the Humber	Airedale NHS Foundation Trust	Airedale General Hospital	Low	Low	Low
South East	Ashford and St Peter's NHS Foundation Trust.	St Peter's Hospital	High	High	High
London	Barts Health NHS Trust	The Royal London Hospital	High	High	High
West Midlands	Birmingham Children's Hospital Foundation Trust	Birmingham Children's Hospital	High	Low	Medium
North West	Blackpool Teaching Hospitals NHS Foundation Trust	Blackpool Victoria Hospital	High	Low	Medium
North West	Bolton NHS Foundation Trust	Royal Bolton Hospital	Low	Low	Low
Yorkshire and the Humber	Bradford Teaching Hospitals NHS Foundation Trust	Bradford Royal Infirmary	Low	Low	Low

Region	NHS Trust	Hospital	Score		
			Collecting	**Sharing**	**Implementation**
East of England	Cambridge University Hospitals NHS Foundation Trust	Addenbrooke's Hospital	High	High	High
North West	Central Manchester University Hospitals NHS Foundation Trust	Manchester Royal Infirmary	High	High	High
North East	City Hospitals Sunderland NHS Foundation Trust	Sunderland Royal Hospital	High	High	High
North West	Countess of Chester NHS Foundation Trust	Countess of Chester Hospital	High	High	High
North East	County Durham and Darlington NHS Foundation Trust	University Hospital of North Durham	Low	Low	Low
Yorkshire and the Humber	Doncaster and Bassetlaw Hospitals NHS Foundation Trust	Doncaster Royal Infirmary and Bassetlaw Hospital	High	High	High
South West	Dorset County Hospital NHS Foundation Trust	Dorset County Hospital	High	High	High
London	Ealing Hospital NHS Trust	Ealing Hospital	High	Low	Medium
North West	East Cheshire NHS trust	Macclesfield District General Hospital	Low	Low	Low
North West	East Lancashire Hospitals NHS Trust	Royal Blackburn Hospital	High	Low	Medium
South East	Epsom and St Helier University Hospitals NHS Trust	Epsom General Hospital	High	High	High
South East	Frimley Park Hospital NHS Foundation Trust	Frimley Park Hospital	High	High	High
North East	Gateshead Health NHS Foundation Trust	Queen Elizabeth Hospital Gateshead	High	Low	Medium
South West	Gloucestershire Hospitals NHS Foundation Trust	Gloucestershire Royal and Cheltenham General Hospitals	High	High	High

Region	NHS Trust	Hospital	Score		
			Collecting	**Sharing**	**Implementation**
South West	Great Western NHS Foundation Trust	Great Western Hospital	High	High	High
Yorkshire and the Humber	Harrogate and District NHS Foundation trust	Harrogate District Hospital	High	High	High
London	Homerton University Hospital NHS Foundation Trust	Homerton Accident & Emergency Department	High	High	High
London	Imperial College Healthcare NHS Trust	St Mary's Hospital	Low	Low	Low
London	Imperial College Healthcare NHS Trust	Charing Cross Hospital	Low	Low	Low
London	King's College Hospital NHS Foundation Trust	Kings College Hospital	High	High	High
North West	Lancashire Teaching Hospitals NHS Foundation Trust	Royal Preston Hospital and Chorley and South Ribble Hospital	High	High	High
South East	Maidstone and Tunbridge Wells NHS Trust	Maidstone and Tunbridge Wells Hospital at Pembury	Low	Low	Low
North West	Mid Cheshire Hospitals NHS Foundation Trust	Leighton Hospital	High	High	High
South West	North Bristol NHS Trust	Southmead Hospital	Low	Low	Low
North west	North Cumbria University Hospitals NHS Trust	West Cumberland Hospital	Low	Low	Low
North East	North Tees and Hartlepool Hospitals Foundation Trust	University Hospital of North Tees	High	High	High
South West	Northern Devon Healthcare NHS Trust	North Devon District Hospital	High	High	High
Yorkshire and the Humber	Northern Lincolnshire and Goole NHS Foundation Trust	Emergency Care Centre, Scunthorpe General Hospital	Low	Low	Low

| Region | NHS Trust | Hospital | Score |

			Collecting	Sharing	Implementation
North East	Northumbria Healthcare NHS Foundation Trust	Hexham General Hospital, North Tyneside General Hospital and Wansbeck General Hospital	High	High	High
East Midlands	Nottingham University Hospitals NHS Trust	Queens Medical Centre	High	High	High
North West	Pennine Acute Hospitals NHS Trust	Fairfield General Hospital	High	High	High
South West	Plymouth Hospitals NHS Trust	Derriford Hospital	High	High	High
Yorkshire and the Humber	Rotherham NHS Foundation Trust	Rotherham Hospital	High	High	High
South West	Royal Cornwall Hospitals NHS Trust	Royal Cornwall Hospital (Treliske)	High	High	High
South West	Royal Devon and Exeter NHS Foundation Trust	Royal Devon and Exeter Hospital (Wonford)	High	High	High
London	Royal Free London NHS Foundation Trust	Royal Free Hospital	Low	Low	Low
North West	Royal Liverpool and Broadgreen University Hospitals	Royal Liverpool University Hospital	High	High	High
South East	Royal Surrey County Hospital NHS Foundation Trust	Royal Surrey County Hospital	High	Low	Medium
South West	Royal United Hospital NHS Trust	Royal United Hospital	High	Low	Medium
North West	Salford Royal NHS Foundation Trust	Salford Royal Hospital	High	High	High
South East	Salisbury NHS Foundation Trust	Salisbury District Hospital	Low	Low	Low
Region	NHS Trust	Hospital		Score	

			Collecting	Sharing	Implementation
West Midlands	Sandwell & West Birmingham NHS Trust	City Hospital/ Sandwell District General Hospital	High	Low	Medium
Yorkshire and the Humber	Sheffield Children's NHS Foundation Trust	Sheffield Children's Hospital	Low	Low	Low
Yorkshire and the Humber	Sheffield Teaching Hospitals NHS Trust	The Northern General Hospital Accident and Emergency Department	High	High	High
East Midlands	Sherwood Forest Hospitals	King’s Mill and Newark Hospitals	High	High	High
South West	South Devon NHS Trust	Torbay General Hospital	High	High	High
West Midlands	South Warwickshire NHS Foundation Trust	Warwick Hospital	High	High	High
North West	Southport and Ormskirk Hospital NHS Trust	Southport and Formby District General Hospital	High	High	High
London	St George's Healthcare NHS Trust	St George’s Hospital London	High	High	High
North West	St Helens and Knowsley Hospitals NHS Trust	Whiston Hospital	High	Low	Medium
North West	Stockport NHS Foundation Trust	Stepping Hill Hospital	High	High	High
South East	Surrey and Sussex Healthcare NHS Trust	East Surrey Hospital	High	High	High
West Midlands	The Dudley Group NHS Foundation Trust	Russells Hall Hospital	High	High	High
North West	University Hospital of South Manchester NHS Foundation Trust	Wythenshawe Hospital	High	Low	Medium
West Midlands	University Hospitals Coventry and Warwickshire NHS Trust	University Hospital Coventry and Warwickshire	High	High	High

Region	NHS Trust	Hospital	Score		
			Collecting	**Sharing**	**Implementation**
North West	University Hospitals of Morecambe Bay NHS Foundation Trust	Royal Lancaster Infirmary	Low	Low	Low
North West	Warrington and Halton NHS Foundation Trust	Warrington Hospital	Low	Low	Low
East of England	West Hertfordshire Hospitals Trust	Watford General Hospital	Low	Low	Low
South West	Weston Area Health NHS Trust	Weston General Hospital	High	High	High
North West	Wirral University Teaching Hospitals	Arrowe Park Hospital	High	Low	Medium
West Midlands	Worcestershire Acute Hospitals NHS Trust	Alexandra Hospital	Low	Low	Low
North West	Wrightington, Wigan and Leigh NHS Foundation Trust	Royal Albert Edward Infirmary	High	High	High
Yorkshire and the Humber	York Teaching Hospital NHS Foundation Trust	Scarborough Hospital	High	High	High
Yorkshire and the Humber	York Teaching Hospital NHS Foundation Trust	York Emergency Department	High	High	High

Appendix D: Implementation scores for Community Safety Partnership respondents

Region	Organisation	Information sharing score[7]		
		Receipt	Usage	Implementation
East Midlands	Ashfield & Mansfield Community Safety Partnership	High	High	High
East Midlands	Bassetlaw, Newark & Sherwood Community Safety Partnership	High	Medium	Medium
East Midlands	Bolsover District Council		No Score	
East Midlands	Boston Borough Council		No Score	
East Midlands	Broxtowe Borough Council		No Score	
East Midlands	Corby Borough Council	High	High	High
East Midlands	East Lincolnshire Community Safety Partnership		No Score	
East Midlands	Kettering Borough Council	High	High	High
East Midlands	North Kesteven District Council		No Score	
East Midlands	North Lincolnshire Safer Neighbourhoods Partnership		No Score	
East Midlands	Nottingham Crime & Drugs Partnership	High	High	High
East Midlands	Safer South Derbyshire Partnership		No Score	
Eastern	Basildon Borough Council		No Score	
Eastern	Braintree District Council		No Score	
Eastern	Brentwood Borough Council		No Score	
Eastern	Cambridge City Community Safety Partnership	Medium	Medium	Medium
Eastern	Castle Point Borough Council		No Score	

[7] CSP respondents who report not receiving data from A&Es are assigned “No Score”

Region	Organisation	Information sharing score[8]		
		Receipt	**Usage**	**Implementation**
Eastern	Central Bedfordshire Council		No Score	
Eastern	Chelmsford City Council	High	High	High
Eastern	Colchester Borough Council	Medium	Medium	Medium
Eastern	Epping Forest District Council		No Score	
Eastern	Fenland Community Safety Partnership	Medium	Low	Low
Eastern	Hertsmere Borough Council		No Score	
Eastern	Norfolk Constabulary	High	High	High
Eastern	Rochford District Council		No Score	
Eastern	Safer Harlow Partnership		No Score	
Eastern	Safer Peterborough Partnership	High	High	High
Eastern	St Edmundsbury Borough Council		No Score	
Eastern	Stevenage Borough Council	High	Medium	Medium
Eastern	Suffolk County Council	High	High	High
Eastern	Tendring District Council		No Score	
Eastern	Three Rivers District Council		No Score	
Eastern	Thurrock council		No Score	
Eastern	Uttlesford District Council		No Score	
London	City of Westminster Council		No Score	
London	Ealing Council		No Score	
London	London Borough Islington		No Score	
London	London Borough of Barking and Dagenham		No Score	

[8] CSP respondents who report not receiving data from A&Es are assigned “No Score”

Region	Organisation	Information sharing score[9]		
		Receipt	**Usage**	**Implementation**
London	London Borough of Bexley		No Score	
London	London Borough of Brent		No Score	
London	London Borough of Enfield	Low	Low	Low
London	London Borough of Hackney Council	High	High	High
London	London Borough of Hammersmith and Fulham		No Score	
London	London Borough of Havering		No Score	
London	London Borough of Hillingdon	Medium	Low	Low
London	London Borough of Merton		No Score	
London	London Borough of Richmond upon Thames		No Score	
London	Royal Borough of Greenwich		No Score	
London	Royal Borough of Kensington and Chelsea		No Score	
London	Safer Croydon Partnership London Borough of Croydon		No Score	
London	Southwark Council	High	High	High
North East	Durham County Council		No Score	
North East	Gateshead Council	High	High	High
North East	Hartlepool Borough Council	High	High	High
North East	Redcar & Cleveland Borough Council		No Score	
North East	Safe Newcastle	High	High	High
North East	South Tyneside Council		No Score	

[9] CSP respondents who report not receiving data from A&Es are assigned "No Score"

Region	Organisation	Information sharing score[10]		
		Receipt	**Usage**	**Implementation**
North East	Stockton Borough Council	High	High	High
North East	Sunderland City Council	High	High	High
North West	Blackburn with Darwen Borough Council	High	High	High
North West	BSafe Blackpool	High	High	High
North West	Cheshire West & Chester Council	High	High	High
North West	City of Manchester Partnership	Medium	Low	Low
North West	Fylde Council	High	High	High
North West	Halton Borough Council	Medium	Medium	Medium
North West	Knowsley Council	No Score		
North West	Lancashire Constabulary	High	High	High
North West	Lewes District Council	No Score		
North West	Liverpool City Council	No Score		
North West	Salford City Council	Medium	Low	Low
North West	St Helens Metropolitan Borough Council	No Score		
North West	Stockport Council - Community Safety Unit	Medium	Medium	Medium
North West	Tameside Council	Medium	High	High
North West	Wirral Community Safety Partnership	Medium	Low	Low
North West	Wyre Council	Medium	Medium	Medium
South East	Bracknell Forest Council	No Score		
South East	Canterbury City Council	No Score		

[10] CSP respondents who report not receiving data from A&Es are assigned “No Score”

Region	Organisation	Information sharing score[11]		
		Receipt	**Usage**	**Implementation**
South East	Cherwell District Council	High	High	High
South East	Chichester District Council	Medium	High	High
South East	Chiltern and South Bucks District Council		No Score	
South East	Dartford Borough Council	Low	Low	Low
South East	Dover District Community Safety Partnership		No Score	
South East	East Hampshire District Council		No Score	
South East	East Sussex County Council	Medium	Low	Low
South East	Fareham Community Safety Partnership		No Score	
South East	Gosport Borough Council		No Score	
South East	Hampshire Police		No Score	
South East	Maidstone Borough Council		No Score	
South East	Medway Council		No Score	
South East	Mid Sussex District Council		No Score	
South East	Milton Keynes Council	Medium	Medium	Medium
South East	Mole Valley District Council		No Score	
South East	New Forest District Council/Safer New Forest	Medium	Low	Low
South East	Oxford Safer Community Partnership	High	Medium	Medium
South East	Portsmouth City Council		No Score	
South East	Royal Borough of Windsor and Maidenhead		No Score	

[11] CSP respondents who report not receiving data from A&Es are assigned “No Score”

Region	Organisation	Information sharing score[12]		
		Receipt	**Usage**	**Implementation**
South East	Safer Hastings Partnership		No Score	
South East	Safer North Hampshire	High	High	High
South East	Sevenoaks District Council		No Score	
South East	Shepway District Council	Medium	Low	Low
South East	South Oxfordshire/Vale of White Horse District Councils	High	High	High
South East	Southampton City Council	High	High	High
South East	Surrey Heath Borough Council	High	High	High
South East	Swale Borough Council		No Score	
South East	Tandridge District Council	Medium	Low	Low
South East	Thanet District Council	Medium	High	High
South East	Tonbridge & Malling Borough Council		No Score	
South East	Waverley Borough Council	Low	Medium	Medium
South East	Wealden District Council		No Score	
South East	West Berkshire Council - Community Safety Partnership		No Score	
South East	West Sussex County Council	Medium	Low	Low
South East	Winchester City Council		No Score	
South East	Wokingham Borough Council		No Score	
South East	Wycombe District Council		No Score	
South West	Bath and North East Somerset Council		No Score	
South West	Bristol City Council	High	High	High

[12] CSP respondents who report not receiving data from A&Es are assigned “No Score”

Region	Organisation	Information sharing score[13]		
		Receipt	**Usage**	**Implementation**
South West	Cheltenham Borough Council	Medium	Medium	Medium
South West	Cornwall Council	High	Medium	Medium
South West	Cotswold District Council	Medium	Medium	Medium
South West	Devon County Council	Medium	Medium	Medium
South West	Exeter City Council		No Score	
South West	Forest of Dean District Council		No Score	
South West	North Somerset Council	High	High	High
South West	Plymouth City Council	High	Medium	Medium
South West	Somerset County Council		No Score	
South West	South Gloucestershire Council		No Score	
South West	Wiltshire Council	High	High	High
West Midlands	Herefordshire Council	Medium	Medium	Medium
West Midlands	Nuneaton and Bedworth Borough Council		No Score	
West Midlands	Safer Solihull Partnership	High	High	High
West Midlands	Shropshire Council	High	Medium	Medium
West Midlands	Stoke-on-Trent Safer City Partnership		No Score	
West Midlands	Tamworth Borough Council		No Score	
West Midlands	Walsall Council	High	High	High
West Midlands	Warwickshire County Council	Medium	Medium	Medium
West Midlands	Coventry City Council	High	High	High
West Midlands	Sandwell Council	Medium	Medium	Medium

[13] CSP respondents who report not receiving data from A&Es are assigned “No Score”

Region				
West Midlands	Worcestershire County Council	Medium	Low	Low
Yorkshire and The Humber	City of York Council	High	High	High
Yorkshire and The Humber	Doncaster Metropolitan Borough Council	High	High	High
Yorkshire and The Humber	Hull Community Safety Partnership (Citysafe)		No Score	
Yorkshire and The Humber	Ryedale District Council		No Score	

[14] CSP respondents who report not receiving data from A&Es are assigned “No Score”

Appendix E: Additional information collected from the A&E Survey

Table E-1: Collecting and sharing scores for all respondents used in the A&E survey

	Collecting Score		**Sharing Score**	
Score	**Number**	**%**	**Number**	**%**
High	57	*75%*	46	*61%*
Low	19	*25%*	30	*39%*
Total	**76**			

Table E-2: Proportion of violent assaults for which information intended for sharing is collected, by information type (76 respondents)

Information Type	**Proportion collected**					
	70% or greater	**50%-70%**	**25%-50%**	**25% or less**	**Never**	**Not collecting**
Date and time	61%	22%	4%	3%	1%	9%
Method of assault	34%	26%	9%	17%	4%	9%
Specific Location	37%	22%	12%	18%	1%	9%

Table E-3: Implementation score of A&E respondents, by the number of CSPs that they share with (76 respondents)

Number of CSPs information is shared with	Number	*High*	*Medium*	*Low*
More than 3	5	*7%*	*0%*	*0%*
3	4	*4%*	*1%*	*0%*
2	8	*11%*	*0%*	*0%*
1	34	*39%*	*3%*	*3%*
0	25	*0%*	*11%*	*22%*

Table E-4: Implementation score of A&E respondents by collecting status (76 respondents)

Collecting Status	**Number**	**High**	**Medium**	**Low**
Collecting routinely	60	61%	14%	4%
Collecting non-routinely	9	0%	0%	12%
Not collecting	7	0%	0%	9%

Appendix F: Additional information collected from the CSP Survey

Table F-1: Proportion of implementation scores of CSPs who receive information from at least one A&E, by signed agreement status (71 respondents)

Signed agreement status	**High**	**Medium**	**Low**	**Total**
Signed agreement with **all** A&E's	66%	24%	11%	**38**
Signed agreement with **most** A&E's	0%	0%	0%	**0**
Signed agreement with **half** of A&E's	80%	0%	20%	**5**
No signed agreement with **most** A&E's	67%	0%	33%	**3**
No signed agreement with **all** A&E's	28%	44%	28%	**25**
Total	**38**	**20**	**13**	**71**

Table F-2: Proportion of implementation scores of CSPs who receive information from at least one A&E, by arrangement status (71 respondents)

Arrangement status	**High**	**Medium**	**Low**	**Total**
Routine arrangement with **all** A&E's	59%	29%	12%	**51**
Routine arrangement with **most** A&E's	50%	0%	50%	**2**
Routine arrangement with **half** of A&E's	50%	0%	50%	**4**
Non-routine arrangement with **most** A&E's	0%	0%	0%	**0**
Non-routine arrangement with **all** A&E's	36%	36%	11%	**14**
Total	**38**	**20**	**13**	**71**

Table F-3: Proportion of implementation scores of CSPs who receive information from at least one A&E, by length of time information has been received from at least one A&E (71 respondents)

Time receiving information from at least one A&E	**High**	**Medium**	**Low**	**Total**
Less than 6 months	29%	43%	29%	**7**
6 months to 1 year	60%	20%	20%	**5**
1 year to 3 years	53%	29%	18%	**38**
Longer than 3 years	62%	24%	29%	**21**
Total	**38**	**20**	**13**	**71**

Table F-4: Proportion of implementation scores of CSPs who receive information from at least one A&E, by frequency that data is received (71 respondents)

Frequency that data is received	**High**	**Medium**	**Low**	**Total**
More than once a month	50%	25%	25%	**8**
Once a month	65%	23%	13%	**31**
Once every 2-3 months	44%	33%	22%	**18**
Other	43%	36%	21%	**14**
Total	**38**	**20**	**13**	**71**

Table F-5: Proportion of implementation scores of CSPs who receive information from at least one A&E, by the satisfaction with the frequency with which data is received (71 respondents)

Satisfaction with the frequency with which data is received	**High**	**Medium**	**Low**	**Total**
Happy with the frequency of receipt for **all** A&E's	56%	26%	19%	**54**
Happy with the frequency of receipt for **most** A&E's	33%	33%	33%	**3**
Happy with the frequency of receipt for **half** of A&E's	100%	0%	0%	**1**
Not happy with the frequency of receipt for **most** A&E's	0%	0%	0%	**0**
Not happy with the frequency of receipt for **all** A&E's	46%	38%	15%	**13**
Total	**38**	**20**	**13**	**71**

Table F-6: Proportion of implementation scores of CSPs who receive information from at least one A&E, by Receipt of additional information status (71 respondents)

Receipt of additional information status	**High**	**Medium**	**Low**	**Total**
Additional Information received from **all** A&E's	62%	24%	14%	**42**
Additional Information received from **most** A&E's	0%	0%	0%	**0**
Additional Information received from **half** of A&E's	100%	0%	0%	**1**
Additional Information not received from **most** A&E's	0%	0%	0%	**0**
Additional Information not received from **all** A&E's	39%	36%	25%	**28**
Total	**38**	**20**	**13**	**71**

Appendix G: College of Emergency Medicine guideline

"Emergency departments should routinely collect, electronically wherever possible, data about assault victims at registration. Receptionists should collect the **date and time** of the assault, the **location** (name of pub, club, school, street etc) of the assault in free text and which **weapon** (fist, foot and so on was used)."