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Home Office

Information Sharing to Tackle Violence, ISTV Standard Operating Procedure (SOP)

Excellence in Emergency Care

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Registered Charity Number: 1122689

VAT Reg. No. 173205823
Scottish Charity Number: SC044373

Information Sharing to Tackle Violence, ISTV: Standard Operating Procedure (SOP)

Reference/ Number	ISTV 2024	
Version:	V1.0	
Approved by:	RCEM ISTV Project Board	
Owned by [RCEM Committee]	RCEM Executive	
Date Approved:	March 2024	
Date issued:	March 2024	
Executive Owner:	Adrian Boyle PRCEM	
Name of Author(s) and Job Title(s):		
Target audience:	Clerical, Clinical and all ED Personnel	
Review date:	March 2027	
For action by	Home Office	
	NHS England	
	Acute Trusts	
	Directorate	
Key Words	Emergency Department, Violence, Injury Data sharing, Public Health	
Key Messages	To prevent future violence, anonymised Emergency Department data regarding patients who are injured in violent incidents should be routinely recorded and shared with local organisations within the legal framework to ensure privacy.	

Version Control and Amendment Log

Version No	Description of change	Author	Date
<i>Current version</i>	<i>Final draft v1</i>	TCH	19/02/24
<i>Previous versions</i>	<i>Summary of SOP content from contributors and reviewers</i>	EA	15/02/24
	<i>Skeleton document</i>	TCH	7/01/24

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ACKNOWLEDGEMENT

This project was completed by RCEM, in partnership with a team of medical professionals and subject matter experts.

The College would like to thank the Home Office who commissioned this project together with the many contributors and reviewers of this guidance.

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1 EXECUTIVE SUMMARY

Violent crime and particularly knife crime is a major public and political concern and causes significant harm to both individuals and communities.

The challenge is that approximately **three-quarters of violence-related injury is not reported to Police**, but these patients are often seen in Emergency Departments (EDs). In 2014 England implemented a system of capturing data regarding patients seen in EDs and anonymising the data and sharing with organisations to reduce violence related injuries - 'Injury Sharing to Tackle Violence (ISTV)', based on work done in Cardiff which had shown that up to **one third of violence-related injury may be prevented** by using ED data to inform prevention strategy.

The Serious Violence Duty is a statutory duty in the Police, Crime, Sentencing and Courts Act (2022). It requires Local Authorities to prevent and reduce serious violence, including identifying the kinds of serious violence that occur in the area, the causes of that violence (as far as it is possible to do so), and to prepare and implement a strategy for preventing, and reducing serious violence.

Under the Serious Violence Duty, the 42 Integrated Care Boards (ICB) have responsibility for both the collection of data (through the acute service providers) and violence prevention through the Community Safety Partnerships (CSPs) and Violence Reduction Units (VRUs).

In 2017 the Emergency Care Data Set (ECDS) was implemented in all English hospitals to collect better information about patients in EDs. Experience has shown that when patient data about injuries is collected as **routine data (in ECDS)**, it **doubled the number of patients identified** as having suffered violence related injury. This is because the previous ISTV strategy relied on a busy staff member remembering to collect the ISTV data fields.

The current (2024) programme has taken the core principles of ISTV and embedded these in routine (ECDS) data collection. The Home Office and Office for Health Improvement and Disparities have supported RCEM to relaunch the programme to improve uptake and ensure the benefits of the ISTV programme are available in all areas of the country.

The Royal College of Emergency Medicine (RCEM) has consulted widely to define the best practice of collecting the ISTV data, and this Standard Operating Procedure (SOP) should be used to inform and develop local policy that will:

- Provide consistent practice in collecting data
- Improve data processing and intelligence gathering based on the data
- Ensure that data quality is sufficient to support effective violence prevention
- Ensure that the data collection and sharing translates into effective prevention of violence through effective oversight



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2 DEFINITIONS / GLOSSARY

Term	Acronym	Definition
Community Safety Partnership	CSP	Community Safety Partnership
Data Access Request Service	DARS	Data Access Request Service
Emergency Care Data Set	ECDS	Mandatory data set reportable by Type 1 and Type 3 Urgent and Emergency Care providers.
Emergency Department	ED	NHS department dealing with Type 1 Urgent and Emergency Care.
Emergency Medicine	EM	Emergency Medicine
Electronic Patient Record	EPR	Information technology used to collect patient data in health systems.
Integrated Care System / Integrated Care Board	ICB	Integrated Care Systems are NHS responsible regional authorities introduced in 2022. Integrated Care Boards are the responsible authority at health level for the Serious Violence Duty.
Information Governance	IG	Information Governance
Information Sharing to Tackle Violence	ISTV	Government initiative since 2009 to utilise anonymised health data to guide operational violence reduction strategies.
Serious Violence Duty	SVD	Police, Crime, Sentencing and Courts Act 2022, Part 2, Chapter 1, and associated guidance includes a 'Serious Violence Duty'
Urgent and Emergency Care	UEC	Unplanned / unscheduled healthcare provision
Urgent Treatment Centre / Minor Injuries Unit	UTC / MIU	NHS department dealing with Type 3 Urgent and Emergency Care.
Violent Injuries Subset	VIS	30-part subset of ECDS data items relating to violent injuries (including ISTV data items).
Violence Reduction Unit/Violence Reduction Partnership	VRU/VRP	Violence Reduction Unit/Violence Reduction Partnership
<p>UEC attendance types:</p> <p>Type 1 - Emergency Care patients seen in consultant-led 24/7 Emergency Department</p> <p>Type 2 - Emergency Care patients seen in Specialist ED (e.g. Eye Unit)</p> <p>Type 3 - Urgent Care patients seen in UTC or MIU.</p> <p>Type 5 - SDEC encounter (ambulatory / Same Day Emergency Care pathways).</p> <p>Type 7 (pilot) - Virtual consultations provided by EDs</p>		

3 INTRODUCTION

This SOP is for clerical and clinical staff and all ED personnel collecting ISTV data. It explains how ISTV information should be collected, and how it can be used to prevent future violence-related injuries.

The national ECDS and now Ambulance Data Set (ADS) data sets (from 2024) have been upgraded to fully integrate collection of the ISTV information and collecting injury data as a routine substantially improves data quality – doubling the number of patients identified as having suffered violence related injury when introduced in Barts / Royal London.

Interpersonal violence and the effects of this violence can have devastating effects on our communities. Staff working in EDs deal every day with the impact of violence but are also uniquely positioned to support a public health approach to violence reduction and prevention. Most ED team members live in the local areas and have a direct interest in keeping their families and communities safe.

Many people who are assaulted or injured due to violence will attend EDs but may choose not to report their injury or the events causing their injury to the Police. Police data about the number, location and types of violence are used to support both public health and policing plans to reduce violence.

The anonymised ISTV data does not duplicate Police data but rather is complementary – together they build a detailed and accurate picture of the local prevalence and types of violence. This then informs the local needs assessments and strategies to address these e.g. short-term shifts in Police focus, licensing changes, use of CCTV.

3.1.1 Development of ISTV from ‘Cardiff Model’

The ‘Cardiff Model’ of violence prevention evolved in the late 90s/ early 2000s, pioneered by Professor Jonathan Shepherd CBE, a maxillofacial surgeon. By using ED data to inform public health measures such as targeted policing and alcohol licensing, violence related injuries were substantially reduced.

The ‘Cardiff Model’ was adapted for England and an Information Standard Notice was published in 2014 (ISB1594: ‘Information Sharing to Tackle Violence Minimum Dataset’) which provided a legal and operational framework for collecting and sharing data regarding violence-related injuries with Community Safety Partnerships, CSPs (or equivalent).

3.1.2 Community Safety Partnerships (CSPs)

Community Safety Partnerships were introduced by Section 6 of the Crime and Disorder Act 1998 and bring together local partners to formulate and deliver strategies to tackle crime and disorder in their communities. Responsible authorities that make up a Community Safety Partnership are the Police, Fire and Rescue Authority, Local Authorities, Health Partners, and Probation Services and Violence Reduction Units

3.1.3 Violence Reduction Units (VRUs)

In March 2019, funding from the Serious Violence Fund was invested in Violence Reductions Units (VRUs) in 18 areas across England and Wales (and two more in 2022). These VRUs are a vital component of the local regions to tackle the root causes of serious violence. VRUs bring together police, local government, health and education professionals, community leaders and other key partners.

The purpose of VRUs is to identify local drivers of serious violence and support agreements to take necessary action to tackle these, including commissioning services aimed at prevention and early intervention instead of crisis response or secondary and tertiary prevention. VRUs drive local strategy and embed cultural change alongside their commissioning role. A fundamental principle of VRU function is for their strategy and proposed interventions to be data and intelligence-driven, which in turn is critically informed by data from ISTV.

3.1.4 Serious Violence Duty

The Serious Violence Duty is statutory guidance in Chapter 1 of Part 2 of the Police, Crime, Sentencing and Courts Act 2022. It requires specified authorities for a local government area to work together and plan to prevent and reduce serious violence, including identifying the kinds of serious violence that occur in the area, the causes of that violence (so far as it is possible to do so), and to prepare and implement a strategy for preventing, and reducing serious violence in the area.

From the perspective of an Emergency Department and the NHS, to discharge their responsibilities under the Serious Violence Duty requires them to support measures such as ISTV to inform strategic needs and understand local issues by identifying hotspots and individuals at risk.

3.1.5 2024: Integration of ISTV data into ECDS

The 2014 initial roll-out of ISTV was successfully achieved, however over time it became clear that this model was very much dependent on ED clinical leadership to drive the process of data collection. By 2022 it became apparent that there was a high degree of unwarranted variation in the activity of ISTV programmes across the country.

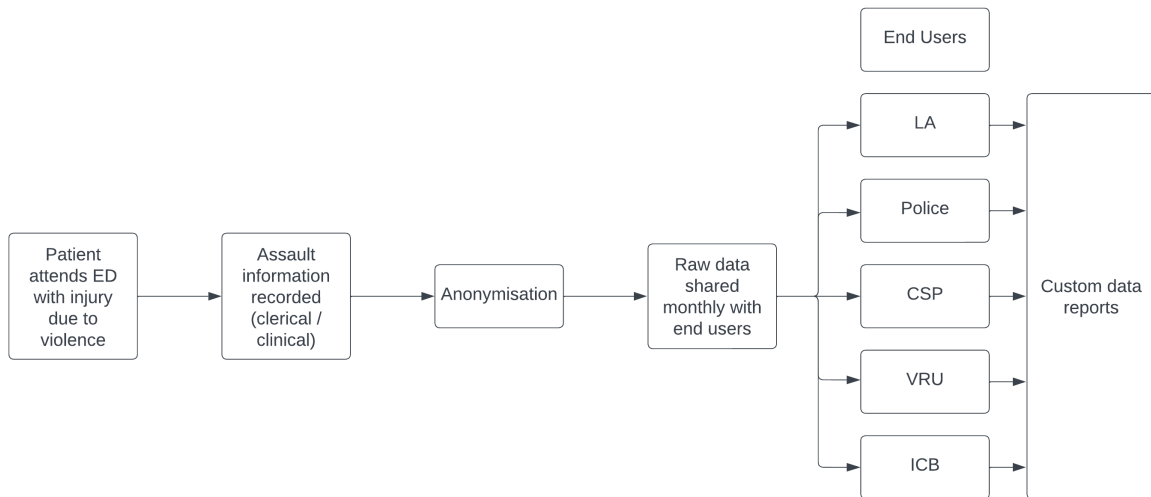


Figure 1: Current state of ISTV data sharing. Multiple varied ungoverned agreements between providers and end users (LA, Local Authority; CSP, Community Safety Partnership; VRU, Violence Reduction Unit; ICB, Integrated Care Board).

Version 4 of ECDS was released in January 2023, with a conformance date of July 2024, and includes all the data items in the dataset known as ‘Information Sharing to Tackle Violence’.

Over time, the local sharing of data with CSPs that was the mainstay of ISTV will be replaced with central processing and data flow to relevant authorities, including ICBs, CSPs and VRUs. There may be a need to review local data sharing agreements to support specific local requirements and during the transition phase.

4 PURPOSE

This ISTV Standard Operating Procedure describes the process for:

1. Recording (and sharing) information about violence by asking people injured in violence who attend any Urgent or Emergency Care (UEC) treatment unit. These include Emergency Departments (Type 1 [24-hour, consultant led, resuscitation-capable EDs], and Type 2 [mono-specialty EDs]), and Urgent Treatment Centres (UTCs, Type 3).
2. Anonymisation, data processing and data sharing to relevant organisations/agencies.
3. Using the anonymised data to inform violence prevention.
4. Describing an ideal future state for making useful data analyses available at ICB level across England (Figure 2)

The main purpose of this document is point 1 however the key activities of points 2 and 3 are described in the workflow section in appendix 11.2.

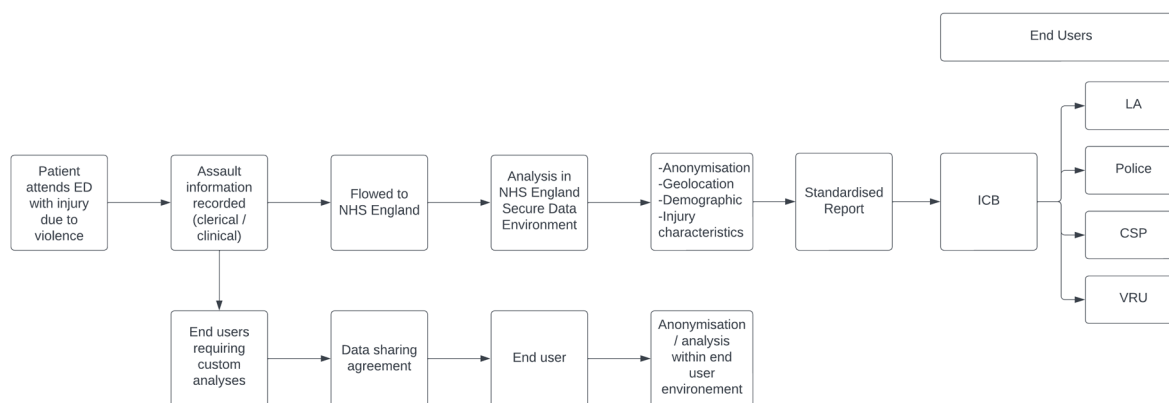


Figure 2: Future state for injuries data sharing (LA, Local Authority; CSP, Community Safety Partnership; VRU, Violence Reduction Unit; ICB, Integrated Care Board).

5 SCOPE

The Standard Operating Procedure covers the collection and sharing of anonymised information from patients who present with injuries potentially caused by violence to Types 1, 2 and 3 Urgent and Emergency Care treatment units, i.e. 24-hour, consultant led, resuscitation-capable EDs, mono-specialty EDs, and UTCs (Types 1, 2 and 3) in England.

6 Duties, Roles and Responsibilities

6.1.1 Integrated Care Board

The Serious Violence Duty in the Police, Crime, Sentencing and Courts Act (2022) requires specified authorities to work together and plan to prevent and reduce serious violence.

The Integrated Care Board (ICB) Commissions acute services including Urgent and Emergency Care which is responsible for collecting data regarding violence.

The ICB is also the body responsible for receiving data regarding violence related injuries from NHSE, processing that data and then distributing the data to bodies responsible for violence prevention.

6.1.2 Acute Trust – Organisational Responsibility and Governance

The Responsible Officer (usually the Medical Director) of the NHS Acute Trust has overall responsibility for ensuring professional compliance with GMC standards laid out in 'Good Medical Practice.'

Under the GMC Good Medical Practice 2024 there is a specific duty to:

Protect and promote the health of patients and the public.

[\[https://www.gmc-uk.org/professional-standards/professional-standards-for-doctors/good-medical-practice/the-duties-of-medical-professionals-registered-with-the-gmc\]](https://www.gmc-uk.org/professional-standards/professional-standards-for-doctors/good-medical-practice/the-duties-of-medical-professionals-registered-with-the-gmc)

6.1.3 Acute Trust – Emergency Department

The Responsible Officer will normally delegate responsibility for injury data collection to the Director of the Emergency Department who is responsible for ensuring that:

- electronic patient records systems are appropriate for capturing high-quality data
- nominated staff groups are responsible for collecting injury data
- staff groups receive appropriate training and support to collect data
- the physical environment supports the collection of injury data while maintaining an appropriate degree of privacy and dignity
- data quality regarding violence related injury is sufficient to support good quality violence prevention work
- There are processes for receiving feedback on data use e.g. from VRUs / CSPs to share with the ED team, including local analysis and resulting actions

Successful data collection requires collaboration between clinical, clerical and operational staff. E.g.

- A senior clinician with specific responsibility for Public Health issues in the ED
- The clerical staff lead
- Informatics/ Business Intelligence/ Data Science expert.

6.2 Operational responsibilities

The process is operationally under the responsibility of the emergency department senior management team; they may delegate this to the emergency department reception team.

As described in the following section the default choice is that ISTV data should be collected by clerical staff. This is because clerical staff turnover is usually minimal, which enables quick and accurate coding. Furthermore, clerical staff often live close to the hospital in which they work and are part of the local community and will know the described sites of injury.

Clinical staff, however, will have the opportunity to speak with patients in a more confidential environment and in more detail, in which patients may feel more comfortable to disclose information. As such it is desirable that the electronic patient record systems should enable ISTV data to be recorded by clerical staff and clinical staff.

6.3 Information governance responsibilities

In any case where patient information is being shared, even between NHS organisations, it is critical that public trust is maintained.

Information governance responsibility ultimately sits with the Caldicott Guardian and Responsible Officer (as Data Controller) of the Acute Care Trust that is collecting the data.

They then transfer the responsibility to the Data Controller of the Integrated Care Board when the data is received there, and the Data Controller has responsibility for validation / data cleaning / data distribution.

For example, see the Sample Information Sharing Agreement in Appendix 1.

Even anonymised data cannot be shared without the risk of de-identification, and therefore the scrutiny and approval of the Caldicott guardians of all organisations handling the data is critical.

<https://www.nature.com/articles/s41467-019-10933-3>

7 PROCEDURE SPECIFIC DETAIL

7.1 Guidance for collecting injury data

[This section should be read in conjunction with the ECDS User Guide, available on the NHS website, as this is regularly updated]

In ECDS version 4 which has a conformance data of July 2024, the freetext place of assault data has been incorporated into ED injury data collection.

This section describes injury data collection, with a focus on how it relates to ISTV:

- injury date and time
- injury intent
- injury mechanism
- location (type and freetext description)
- involvement of drugs or alcohol
- activity status / type

In addition to the routine demographic data collected, the additional items outlined in this section should be asked from a person injured in violence and entered into the EPR system.

7.1.1 Who should collect the injury data?

The staff group responsible for collecting injury data will depend on local practice. In practice the poor usability of many ED IT systems means that

- speed and accuracy in data collection
- low staff turnover (expertise in using the IT system)
- collecting data at the start of the patient pathway

are critical components of good injury data collection and the clerical (reception) staff are entirely capable of performing this. Collection of injury data does not require a medical or nursing degree, and to have clinical staff collect this data diverts resources from patient care.

The gold standard IT system would have clerical staff collect the information from patients and then ensure that clinical staff treating the patient can submit, add to, review and validate the information recorded by clerical staff. This is important because patients may be uncomfortable or unwilling to disclose information about their injury in a waiting room where there is little privacy. Clerical (or clinical) staff should therefore be able to collect this information later in the patient journey in a more private environment.

7.1.2 Injury date and time

Suggested question: "When did the injury happen?"

This should represent the approximate date and time that the injury occurred. If the date or time is not known it should be estimated.

7.1.3 Injury intent

In assault cases, it is important to distinguish between assault by a single assailant or multiple as this may indicate gang activity.

Suggested question: "Was this intentional?"

Where the injury was the result of an intent, the options are:

- Self-inflicted injury
- Apparent assault (single assailant)
- Apparent assault (multiple assailants)

If it is not clear whether there was one or multiple assailants, best judgement should be used.

Other options for unintentional injuries include:

- Non-intentional injury
- Complication of medical care
- Injury caused by animal
- Injury due to legal intervention

Select the option that best describes the **human** intent to produce the injury/poisoning, not the intent to undertake an activity that may have resulted in injury.

- For example, a dog used intentionally as a weapon should be coded according to the human intent, i.e. 'apparent assault'. The involvement of the dog is captured as the injury mechanism, 'injury from dog'
- A stray dog that bites a postal worker should be coded as 'injury caused by animal'. The involvement of the dog is captured as the injury mechanism, 'injury from dog'
- If more than one selection is equally appropriate, select the first option in the list. This applies especially to any doubt over whether one or multiple assailants were involved, if in doubt it should be record as an assault as by a single assailant.

7.1.4 Injury mechanism

Patients may volunteer this but if in doubt and/or to clarify, check by summarising back to the patient with the mechanism it appears to meet:

Suggested question: "How did this happen?"

Clarification question "So you were punched in the face?"

Types of mechanism:

These are grouped into logical areas e.g. falls / blunt injury / sharp injury and the most common groups involved in violence related injury are shown:

Blunt injury

- Blunt force / pushed
- Punch with fist
- Kick with foot
- Hit with head (head butt)
- Human bite
- Blow from blunt object [specify]
- Crushing injury

Sharp injury

- Stabbed / cut with knife
- Stabbed / cut with glass / bottle
- Penetrating wound

Firearm / Explosion

- Gunshot wound
- Injury due to projectile
- Injury due to firework
- Injury due to explosion

Threat to breathing

- Respiratory obstruction due to inhaled foreign body
- Patient found hanging
- Asphyxia by obstruction of mouth and nose
- Asphyxiation : other

Staff should identify which type of injury mechanism occurred and then select the specific injury mechanism e.g.

- Stabbed with knife = Sharp injury, Stabbed/cut with knife
- Shot with gun = Firearm/explosion, Gunshot wound
- Run over by car = Blunt injury, Blow from blunt object

- Hit with hammer = Blunt injury, Blow from blunt object
- Punched = Blunt injury, Punch with fist

7.1.5 (Geographical) assault location description - Free text

The purpose of this field is to capture the geographical location of an assault (not the location of the injury on the patient's body).

Suggested question: “Where were you when this happened?”

The aim is to be as specific as possible without identifying any patient or relatives

DO include data that is as specific as possible without identifying patient

- Assault happened at patient's home -
- (records location of assault without entering identifiable data)
- Red Lion Pub – too many potential matches
- Red Lion Pub, Anytown – more specific and potentially geolocatable
- Red Lion Pub, Station Road, Anytown – geolocatable

Try to avoid terms that could apply to multiple locations e.g. London Bridge alone would mean the bridge, but London Bridge Underground Station, London Bridge Railway Station, London Bridge Hospital, London Bridge Hotel are all different locations.

As the freetext data will be used locally, use can be made of data referring to a venue, street, or feature that can be recognised. For example:

- Fenham, Newcastle – too broad an area
- Lanecrost drive, Fenham, Newcastle – good resolution
- War memorial, Stamford, Lincolnshire

Location data should enable a subsequent reviewer to identify the location and assign it to a unique point on a map (geolocatable).

DO NOT include patient identifiable data in this field e.g.

- Assault by *brother* in street.
- Assault happened at patient's home, 13 Gren Street, Anytown – (contains patient's address)

DO NOT include whole or partial postcodes.

Avoid abbreviations and nicknames, as these may not be easily locatable which reduces the likelihood of hotspots being identified. For example:

- Ward 9 @ WXH – unlikely to be consistently locatable without local knowledge.
- Ward 9, Whipps Cross Hospital – easy to understand and match.

Avoid unnecessary detail: e.g. anything other than location in this field, for example:

- Assault by partner at Red Lion Pub, Anytown – identity of alleged perpetrator not needed
- Red Lion Pub, Anytown – is sufficient

If the assault happened at a house not belonging to the patient then make it clear it is not the patient's home address. For example:

- Sky-high Flats, Anytown – record simple location (of house party) without further detail
- **NOT** 'Assaulted at house party' as this is unclear whether the patient's own house or not

[It is likely that a future version of ECDS will differentiate between patient's home and another home]

Capture the location to the best resolution the patient is able to provide. In some cases this will be broad, e.g. Stratford Town Centre, but this should be entered in preference to recording unknown location.

Please be specific to a location rather than a journey, for example:

- Blue street, Anytown - geolocatable
- **NOT** On way to school – not geolocatable

If the patient is unwilling or unable to disclose a location note that the location is unknown. It is not necessary to record any further detail.

7.1.6 (Geographical) place of injury - Categorical

This is the general category of the place of injury and is helpful for categorising the types of place where injury of all types is occurring.

Suggested question: “*Where were you when this happened?*”

The selection should reflect the organisational area of responsibility:

- A sports area in school grounds would be ‘school’
- A garden at a historic National Trust estate would be ‘recreational area’

Where differences in the list occur, select the ‘primary’ location:

- For an injury which occurred on a farm (grouped as ‘outside’), the injury may have occurred inside a building, however this should be selected as ‘farm’
- A sports facility, licenced premises or school (grouped as ‘inside’) may have outdoor areas, but the primary location (‘sports facility,’ ‘licensed premises’ or ‘educational establishment’ respectively) should be selected. If more than one selection is equally appropriate, select the first option in the list.

NB while this document is focused on the violent injury data, the collection and use of the non-violence related injury data has a much wider public health benefit e.g. the information about where in the home injury occurs is particularly valuable for older patients who might have falls on stairs at home, or children having injuries e.g. from blind cords or from falling down stairs when there is no stair guard. This can then inform preventative measures e.g. short blind cords to minimise the risk of strangulation, better floor coverings and stair guard programmes.

7.1.7 Injury alcohol or drug involvement

Suggested question (may not be necessary) : “Would I be correct in thinking you or your assailant had taken alcohol ?”

This is a judgement call of the person collecting the data as to whether the injury is likely to have occurred as a result of alcohol and/ or drug involvement.

NB it does not have to be the patient who has been affected by drugs / alcohol – it can be the assailant.

One does not need proof that alcohol or drugs were involved – only that the person completing the data entry judges it more likely than not that the patient or an assailant had consumed alcohol or drugs prior to the incident resulting in the injury.

[NB this field applies only to patients with injuries - a patient who has consumed so much alcohol that the alcohol intoxication is the sole/ primary reason for their attendance (and they have not injured themselves) should have a diagnosis of ‘alcohol intoxication’ which is not an ECDS injury code and therefore should not trigger injury data collection.]

7.1.8 Injury activity status, Injury activity type

Suggested question: “*What were you doing at the time you were injured?*”

Staff are advised to use Injury Activity Status to identify the whether the injured person was working, being educated or at leisure. Options for Injury Activity Type Status are:

- Leisure
- Activity of daily living
- Paid work
- Unpaid work
- Being educated

Staff should use the one most appropriate to what the patient was doing at the time of the injury.

Staff are advised to use Injury Activity Type to identify the specific activity the injured patient was performing at the time of the injury.

There are several high-level categories with multiple detailed options in Injury Activity Type. These include:

- Essential activities (e.g. bathing, showering, preparing food)
- Leisure at home (e.g. DIY, hobbies, gardening)
- Leisure outside home (e.g. shopping, restaurant, bar, club)
- Transport (e.g. walking, driving, motorcycle rider/passenger, cyclist, electric scooter)
- Work
- Sports

E.g:

- Assaulted outside nightclub = Leisure outside home, Social: restaurant / cafe / pub / club
- Assaulted at home = Leisure at home, Indoor recreation
- Assaulted on train = Transport, Passenger (public transport)
- Run over by car = Transport, Walking outdoors

When an activity or sport is not listed, select the nearest appropriate option.

This data is particularly important to identify people who are injured by violence in the course of their work e.g. Emergency Care workers, NHS staff, Police, Prison Officers but also Social Workers, Teachers.

Many of the activities listed in 'injury activity type' can be undertaken in a variety of roles e.g. ambulance staff can be working in variety of roles:

- Paramedic (paid work)
- Ambulance staff St John's ambulance (unpaid work)
- Ambulance staff – paramedic trainee (being educated)

This data item helps understand which groups of people are vulnerable to injury and how injury prevention can best be targeted at those most at risk.

NB: While this document is focused on the violent injury data, the collection and use of the non-violence related injury data has a much wider public health benefit e.g. the information about what sports result in injury and particularly those resulting in the most severe head injury which may predispose to early onset dementia. Occupational injury risks are also important to highlight e.g. from farms as this can inform prevention measures.

7.1.9 Optional data items

In addition to national injury data items recorded above, additional data that may be collected at a site level may include detail about the involvement of a weapon or the relationship of an assailant to the patient.

Unlike the items above, these are not flowed centrally to NHSE for processing and distribution but are held locally and may be shared depending on the local data sharing agreements endorsed by the Caldicott guardian.

NB If the Caldicott guardian has not explicitly approved additional data items they must not be collected.

7.2 Summary Examples

The ECDS Injury information items therefore build a picture of what happened to a patient. For example:

27-year-old man presents with a broken nose, facial and rib fractures after having been punched by several assailants outside the Bright Lights nightclub in Wolverhampton, after drinking heavily and taking cocaine:

- Injury Intent: Apparent assault (multiple assailants)
- Injury Mechanism: [Blunt injury] Punch with fist
- Place of Injury: [Entertainment] Outside licensed premises: pub club bar
- Assault Location Description: “on pavement outside Bright Lights nightclub, Wolverhampton town centre”
- Injury Drug Alcohol: [Alcohol and cannabis] Alcohol: retail beer / wine / spirits | [CNS Stimulant] Cocaine
- Injury Activity Status: Leisure
- Injury Activity Type: [Leisure outside home] Social: restaurant / cafe / pub / club

A 19-year-old fast food delivery worker presents with a broken ankle after having been intentionally rammed off his scooter outside Burger World in Sheffield City Centre.

- Injury Intent: Apparent assault (single assailant)
- Injury Mechanism: [Blunt injury] Blow from blunt object [specify]
- Place of Injury: [Outdoor] Road / pavement
- Assault Location Description: Burger World, Sheffield
- Injury Activity Status: Paid work
- Injury Activity Type: [Transport] Electric bicycle
- Injury Drug Alcohol: [NULL]

A 24-year-old took overdose of paracetamol at home in bedroom, after drinking vodka, with intent to die (this example is not an example of an assault but is a common clinical scenario that requires injury data)

- Injury Intent: Self-inflicted injury
- Injury Mechanism: [Environment] Poisoning / overdose
- Place of Injury: [Home] Bedroom
- Injury Activity Status: Leisure
- Injury Activity Type: [Leisure at home] Indoor recreation
- Injury Drug Alcohol: [Alcohol and cannabis] Alcohol: retail beer / wine / spirits

7.3 Information sharing

7.3.1 Information items shared

The data must NOT contain any person identifiable items.

Secure data processing of the free text data must ensure that e.g. names, house names or numbers, hospital ID numbers and telephone numbers must be deleted before sharing.

The following is an example of items that may be shared

- a. Age [by 10-year age band]
- b. Gender
- c. First four characters of home postcode (if occurred in patient's home)*
- d. Date and time of injury
- e. Injury Intent
- f. Mechanism of Injury
- g. Type of location of assault
- h. Assault Location Description (Free Text)

Optional data items that may be shared locally include [examples]

- i. Type of injury e.g. first diagnosis coded (e.g. facial fracture)
- j. Accommodation status (identifies homeless patients)
- k. Safeguarding (identifies patients at risk of further harm)
- l. Weapon used

[* Data processing should map the four-character postcode to the Lower Super Output Area, the geographical unit of area that broadly maps to four-character postcode for social and demographic modelling.]

All information must be shared in a safe format and by a safe method according to NHSE protocols for sharing patient level data AND must be specifically approved by the Caldicott Guardian of both the organisation collecting and receiving the data.

7.3.2 Data processing / cleaning / grading

NHSE is currently working to develop a method of centrally processing the data collected by ECDS, including the freetext Assault Location Description. The result of the processing is a clean version of the Assault Location Description, free of any Patient Identifiable Data and which has also been graded to ensure that the highest value descriptions visible.

7.3.3 Recipients of information

The information is shared from a named individual at the collecting organisation e.g. an Acute Provider Trust to a named individual at the Integrated Care Board who is the designated data controller for the purposes of Information Governance.

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The Integrated Care Board must ensure that the data does not contain any data that could potentially identify a patient before distributing it to the VRU / CSPs or other organisations working on behalf of the Local Authority in violence prevention.

7.3.4 Frequency of information sharing

ECDS data flows daily to NHSE and therefore daily updates to the ICBs will be possible once data flows from NHSE have been agreed.

Daily data will enable rapid evidence-based response to health scares e.g. spiking.

8 REFERENCES

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Violence Reduction Units

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8.2 Reports

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https://rcem.ac.uk/wp-content/uploads/2021/10/QEC_Guideline_Information_Sharing_to_Reduce_Community_Violence_Sept2017.pdf

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[What is the Cardiff Violence Prevention Model? |Violence Prevention|Injury Center|CDC](#)

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<https://www.publicsafety.gc.ca/lbrr/archives/cnmcs-plcng/cn34563-eng.pdf>

8.3 Published research

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The Cardiff Model for Violence Prevention

[2022-Report Cardiff-Model-for-Violence-Prevention.pdf](#)

9 ASSOCIATED DOCUMENTS

Title	
ISTV SOP FAQs	
ISTV SOP Factsheet	
ISTV SOP Checklist	
ECDS data set	https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/emergency-care-data-set-ecds/ecds-guidance
ECDS data dictionary	https://www.datadictionary.nhs.uk/data_sets/clinical_data_sets/ecds_v4.html

10 APPENDICES

10.1 APPENDIX 1: Sample Data Sharing Agreement

This agreement facilitated the exchange of information between [Hospital] and [ICB]

The information supplied will only be processed for the purposes specified within this document. Any proposals to further process the information or for other uses must be approved by the Caldicott Guardian of [Hospital]

The information supplied must be kept securely in both electronic and printed form. It should be accessible only to those that have a need and are authorised to have access. Hard copy should be protected by at least one physical security barrier e.g. a locked container within a secured building. Information should be disposed of securely and safely when no longer required for the purpose for which it was originally provided.

Name and address of organisation requesting information:

Name and address of organisation supplying the information:

Details of information requested:

Data recorded from assault victims on entry to the Emergency Department at Addenbrooke's Hospital as mandated by the ISTV legislation and Information Standards Notice.

Reasons for information exchange:

Following the Crime & Disorder Act (1998) and the formation of Crime and Disorder Reduction Partnerships (CDRPs) there has been a requirement for partnerships to regularly monitor the level of crime and disorder in their area.

It is seen as vital that the [ICB] supports the information and research requirements of the partnerships in the county have access to a wide a range of data as possible.

The specific sharing of data relating to assault victims is intended to:

- Provide a better understanding of violent crime in the area as a large proportion of assaults go un-reported to the police. - To help other local agencies understand the seriousness of violence from a health standpoint, particularly the number and seriousness of injuries sustained. - To help the police and CDRPs target crime prevention measures more effectively
- To reduce the burden placed on the Emergency Department by decreasing the number of assault victims.

Information Governance Questions:

1. *Who / what post will receive the data?*

2. *Where on your computer systems will the data be held? (e.g. a secure drive)*
3. *How will this data be protected (e.g. password, encryption)*
4. *How will you secure and protect hard copies of the data?*
5. *How will you securely dispose of electronic / hard copy data?*

Standard Operating Procedure

1. Research Manager will receive the data.
2. The data will be held on a secure network drive that only the following named individuals have access to: (Senior Research Officer - Community Safety) (Senior Research Officer - Data Management and Mapping) (Research Manager - Information Systems & Crime);
3. No unauthorised persons will be able to access the data and each of the named officers above have been subject to Criminal Record Bureau checking and data protection training.
4. Hard copies of the data will be stored in a locked filing cabinet that only the named individuals above have access to.
5. A procedure is in place at [ICB] for the disposal of both sensitive and confidential paper and electronic documents.

Signatories

On behalf of [ICB]

I agree to manage the data in accordance with the terms listed.

Name: Date.....

Position: Caldicott Guardian

On behalf of [Hospital]

I agree to the information detailed in this agreement being shared for the specific purposes listed, provided all conditions are adhered to.

Name:.....Signature..... Date.....

Position: Caldicott Guardian

10.2 APPENDIX 2: ISTV WORKFLOW

The ISTV workflow covers collection of data in the ED, described in detail below, and is the focus of this document. However, to understand the whole process, it is essential to document the end-to-end ISTV workflow that also includes:

- i. Data flow from provider organisations to NHS England
- ii. Data flow to cleaning centre
- iii. Data processing - removal of potentially identifying data
- iv. Data assurance and measurement of data quality
- v. Data flow to correct organisation with statutory responsibility for preventing violence (the Integrated Care Boards)
- vi. Using the data to inform violence prevention
- vii. Governance and Assurance of the process.

As there have been many changes in both the data flows and organisational responsibilities since ISTV was launched in 2014, the core points of these activities are described here, *specifically identifying the organisation responsible for delivering this service*:

10.2.1 Previous ISTV data flow

When the ISTV process was initiated in 2014, there were several likely reasons it failed to embed consistently within NHSE. The original template for ISTV - the Cardiff Model of violence prevention - relied on data collection being promoted in one centre by an individual clinician, and several other sites had achieved good results, but again relied on one passionate clinician to drive the collection and sharing of data. However when ISTV was implemented nationally in England in 2014, there was not a consistent distribution of passionate clinical staff to support the work and success was very patchy. Unfortunately, there was no central oversight of the programme after implementation, and no visibility of the data captured or success in preventing violence.

Historically, ISTV data is collected in EDs, processed and anonymised within the IT infrastructure of the acute trust, and shared in anonymised form, often at patient level with no aggregation, and often in individual manually prepared spreadsheets, with end user organisations (e.g. local authorities, mayoral offices, Police forces, VRUs, CSPs). End user organisation then perform local analyses to create ISTV based reports. The capacity of the multiple end user organisation to generate reports is dependent on their own resource constrictions and so at times the shared data was not analysed and therefore not usable for violence reduction.

Furthermore, there is no governance supervising this process, there is variation in the quality (both completeness and accuracy) across providers and regions, and no standardised reporting system.

The current work aims to address these factors by incorporating the capture and flow of ISTV into routine ED data using the ECDS data set that was implemented in 2017, together with a system of cleaning and distributing the data which is visible centrally. This process needs to be supported by a means of oversight

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and sharing good practice. Clinical data should stay within NHSE but the overall governance of the process might best sit with the Home Office, as end-users of the data.

ECDS is a national data set managed by a clinically led technical team at NHS England and is subject to close scrutiny and governance to ensure high quality data is being flowed from providers to NHS England. Including all ISTV data items within ECDS creates an opportunity to support providers that have not in the past been able to submit high quality injuries information, and to support end user organisation with potential resource constraints to make regular, frequent usable aggregated injuries data reports available to inform policies for violence reduction.

Action: a system of governance and assurance of the programme needs to be agreed between the key stakeholders in the collection, processing, and use of the data.

10.2.2 Suggested data flow from provider organisations to NHS England

All ECDS data items, including those in ISTV and those injuries data items in ECDS and not in ISTV are flowed daily from reporting UEC providers (EDs and UTCs, Types 1, 2, and 3) to NHS England every day before 0800hrs. These data are held in the Secondary Uses Service (SUS)¹. These data are available upon request via Data Access Request Service (DARS)²Daily data flows have enabled other near real time public health projects such as the Emergency Department Syndromic Surveillance System³.

¹ [Secondary Uses Service \(SUS\) - NHS Digital](#)

² [Data Access Request Service \(DARS\) - NHS Digital](#)

³ <https://www.gov.uk/government/publications/emergency-department-weekly-bulletins-for-2023>

10.2.3 Pilot programme outcomes

10.2.3.1 Data quality

Fully integrating collection of ISTV information and collecting injury data as a routine has doubled the number of patients identified as having suffered violence related injury

10.2.3.2 Geolocation

The freetext geographical place of injury data is currently being cleaned at Barts / Royal London as part of the pilot process initiated by the previous National Clinical Director for Violence Prevention, Martin Griffiths CBE based on previous work done at Barts / Royal London as part of the London ISTV data collection. The pilot Developed (on Barts Health data) developed an automatic geocoding methodology with up to 93% accuracy. This translates the free text assault location description to a point (with a specified resolution) using a combination of extraction of postcode, machine learning to identify descriptions of the patient's home and fuzzy matching to identify public locations. Anonymization of this data is achieved by describing the point as a small geography (LSOA, MSOA) as appropriate to enable efficient suppression of small numbers for the end user.

10.2.3.3 Anonymisation

A process to automate the anonymisation of the Assault Location Description field in ECDS and ISTV has been developed and shown to be successful. The pilot programme has developed automated tools to clean the free text geographical place of injury data to remove patient identifiable data and to categorise it using standard data science tools for analysing and categorising freetext data using natural language processing (NLP).

Action: this work needs to be assured and covered by its own SOP. For data flow and governance reasons it may be more practical for NHSE to bring this work in-house.

10.2.3.4 Exploratory Data Analysis

A draft data product has been developed using ECDS including all ISTV data items. This includes anonymised aggregated information on violent injury hotspots, and age, sex, ethnicity and deprivation. Because this report is based on national data, it can be repurposed for any ICB for dissemination to secondary users including VRUs, CSPs etc.

Action: to consider opportunities from faster data flow.

10.2.3.5 Data assurance and measurement of data quality

The pilot programme has developed measures of data quality that can be used to assess data completeness (expected vs observed data collected for an organisation), data validity (is the data useful) and data reliability (is the data consistent).

Action: this work should be covered by its own SOP. For data flow and governance reasons it may be more practical for NHSE to bring this work in-house.

10.2.3.6 Data flow to / from data cleaning centre

It is likely that for most violence reduction purposes, a standardised detailed aggregated report would be useful and applicable across all regions. Were local reports to be generated, either a process of anonymisation must occur at each of the ~200 providers, or a formal Data Sharing Agreement (to share personal identifiable data) between each provider and the end users (42 ICBs, 317 local authorities, 18 VRUs, >300 CSPs, 43 Police Forces) would have to be signed. Centralising the production of the violent injuries report, is therefore the most efficient solution.

There is an opportunity for NHS England to produce an analysis similar to the pilot analysis, within its Secure Data Environment. This would allow processing of non-anonymised data within a legal and ethical framework.

Action: to consider options to put a DARS agreement or for data cleaning as part of NHSE

10.2.4 Data flow to correct organisation with statutory responsibility for preventing violence (the Integrated Care Boards)

There is a process for distributing ECDS data to the Integrated Care Boards under existing DARS processes, however this does not cover the geographical 'place of injury' freetext data that is essential for ISTV to function. In the short term the data flow of the freetext items may continue locally but it is unrealistic to expect that each ED / ICB will have the expertise to develop automated processes to ensure all patient identifiable data is removed.

Action: The existing DARS agreements between NHSE and the ICBs must be upgraded to allow cleaned freetext data to flow from NHSD to the ICBs.

10.2.5 Analysing the ISTV data to inform violence prevention

There must be an agreed process for analysing the data and using proven techniques for violence prevention, and this should be supported by a learning and governance framework detailed in the following point. The pilot data analysis should inform future standardised data product development.

Action: this work needs to be assured and covered by its own SOP, which is out of scope for this document.

10.2.6 Governance and Assurance of the ISTV process.

The chain of processes from a patient injured due to violence to a usable report being available at ICB level is complex, and involves accurate and complete information recording in EDs, timely flow of those data to NHS England (SUS), anonymisation of the assault location description data item, and the production of a usable report (including geolocation and demographic information). These processes must be subject to a system of scrutiny and governance such that the public are assured that the data flow and analysis is safe, and that end users have actionable information that can be used to reduce violence.

Action: a system of governance and assurance of the programme needs to be agreed between the key stakeholders in the collection, processing, and use of the data.