Royal College of Emergency Medicine

#ISTV

ISTV IS A GOOD THING TO DO

On my first weekend working as a consultant in the ED in 2005, I was looking after a young man who had been brutally punched in the face. He had a split lip, broken nose, broken cheekbone. This assault would most definitely be reported and end up in court.

But I was not called to provide a witness statement. I was not asked for medical records. His case did not go through the criminal justice system and I was to learn this is not unusual.

If we're serious about tackling violence as a society, relying on a criminal justice response and a police response will only have a marginal affect at best. The health service has an important role to play in reducing the consequences of intentional injury and violence – and so I started to look at what we can do to help.

There has been a lot of thinking on this over the years and a lot of good work done. Scotland has been really successful with what they call the public health approach to violence. Its unimpeachable and very logical. You identify and monitor the problem; you identify the risk and protective factors; you develop and test prevention strategies; and you ensure widespread adoption. It's a good framework but it does feel - like a lot of things in public health - quite nebulous and quite difficult to get hold of.

I like to think there are a number of things that can be done to try and help victims of violence, such as enforcement, alcohol control, early years interventions, school-based interventions, a reduction in social inequality and information sharing. Different agencies have their own responses, and emergency medicine has its part to play.

Adrian Boyle,
President, Royal College of Emergency Medicine
Consultant Emergency Physician, Addenbrookes Hospital

"Early intervention is key – incarceration does not work. If it were an effective strategy for dealing with violent crime, the United States would be the safest place in the world, with the lowest murder rate - and we all know that is not true."

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I think the biggest, easiest thing we can do, and certainly the most cost effective, is information sharing.

I know advocacy programmes work, but they don't work in all settings and they certainly don't work for everyone.

So, Information Sharing to Tackle Violence (ISTV), also known as the Cardiff Model, is one of these interventions. It should be very straightforward and simple – and ED receptionists play a pivotal role.

The answers to three core questions can go a long way and lead to meaningful action:

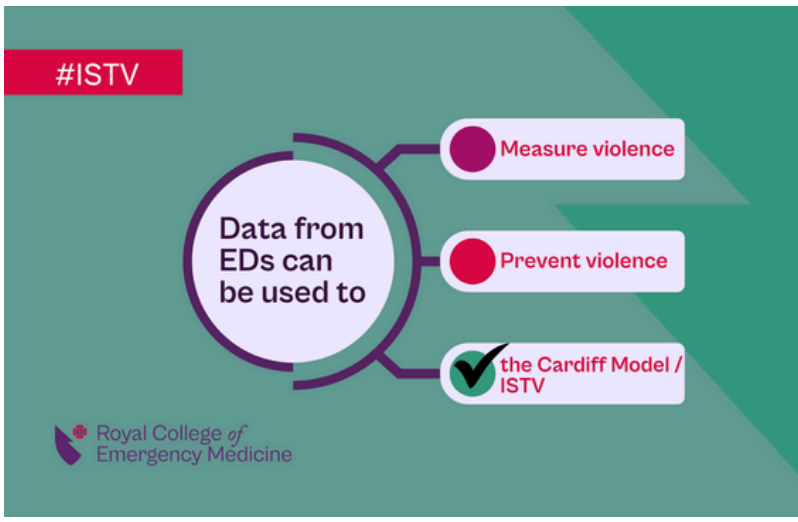
- **At what location did the assault take place?**
- **At what date/time?**
- **Was a weapon used?**

Consistent logging of the answers to these, gathered and shared anonymous on a monthly basis with community safety partnerships can help identify hotspots for crime and lead to interventions that can help make communities safer.

Success relies on a multi-agency approach - continuous tracking of trends and the implementation of a violence reduction plan.

Quite often the information we need is volunteered. It should not be onerous, and location is the most important question.

We should have a target and the College standard is that we should try and get about 70% of meaningful location data recorded. For many places that is a challenge.



When Cardiff implemented this in about 2003 – very quickly compared to other major English cities, they saw a reduction in the number of woundings. That's positive but it's police data, much as I love my police colleagues it doesn't necessarily help me.

But the benefit is also seen in Emergency Departments. Cardiff saw a reduction in both men and women going to emergency departments and Arrowe Park on the Wirral also showed this benefit. Both of them showed over a number of years, about a 30% reduction in the number of assault victims requiring ED treatment.

The evidence behind this is good, with a systematic review showing that wherever a data sharing programme is developed and effective, it leads to a reduction in the number of alcohol related assaults attending emergency departments.

My own local experience was a little bit more mixed when I tried to implement it in my own place.

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I started it in 2005 which was a good juncture. The Licencing Act 2003 had just got onto the statute books. Licensed premises could stay open for longer.

I collated data for two years that I found was not going to the person who could take action in the council. Lesson learned! It's important that we make sure the data goes to the right people, and almost like NICE, who should take action?

When this was sorted out we started seeing a reduction in the number of assaults almost immediately, having initiated some or all of the following:

- **Targeted policing**
- **Informed licensing applications and appeals**
- **Targeted problem premises**

We identified a number of hotspots. There is a fast-food restaurant in our city centre which is notorious for being a dangerous place after 3am on a Sunday. It was the place for people to congregate who were too drunk to get into nightclubs. Police persuaded the owners to implement CCTV and the problem disappeared.

It has undoubtedly benefited Cambridge. The purple flag scheme, which is a kite mark for tourism, uses our data to show that Cambridge is a safe place.

I've been invited to go to Magistrates Court twice in my career - a licensing court where two organisations – a well-known supermarket and small corner shop wanted to sell alcohol 24 hours a day opposite a homeless shelter. This quickly became a local cause, including objections from the primary school campaigning against attracting more homeless people drunk to the vicinity in the middle of the afternoon. Both retailers lost their licensing application and ED data was a contributor to this.

Implementing ISTV is hard – there are barriers such as IT infrastructure, governance, time, lack of incentives. And inter-agency work is hard.

Personal information must be used responsibility – we have strong guidance in place if you are worried about referral to GMC, and RCEM has a specimen data sharing agreement to use if nervous. Remember, this is for crime prevention NOT detection.

When we tried to get ISTV embedded into practice throughout the UK, Croydon Hospital wanted opinion from the Information Commissioner's Office (ICO), who published assurance in 2012 that the Act is not a barrier when our job is to promote health.

> "The Data Protection Act 1998 is not a barrier to the appropriate sharing of personal information. It should not be seen as preventing any trust from sharing this anonymised information in a responsible manner."
>
> ICO

We have the evidence and we need widespread adoption.

If we get this working properly across the UK, we could save a lot of human misery.

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