

Establishing a Data Sharing Initiative in an Emergency Department

Set out below, in rough chronological order, are the actions associated with establishing a data sharing initiative within an acute hospital Emergency Department. It is based on the learning gleaned from establishing the initiative in a number of EDs in the South East and attempts to incorporate good practice as identified by ED staff in these hospitals.

1. Formal launch of the initiative within the ED and Trust which could involve local media – would anticipate this being done with CDRP key stakeholders like police and Community Safety rather than a low-key affair involving clinical staff confined to the ED. This assumes that there is an explicit sign-up from acute hospital Trust management should reinforce initiative being deployed in ED;
2. Produce posters and leaflets for ED reception area to inform patients and staff about new focus on assaults (*examples are available*);
3. Assess if ED software can be changed to capture data electronically – if not use manual collection (a number of formats exist);
4. Change software to collect Cardiff or similar dataset;
5. Train ED Reception staff to collect dataset – probably the single most important step in the process;
6. Educate/train all ED staff about assaults and the importance of the initiative. Bring a new focus on assaults which can have potential impact on their workload and improved patient care, i.e. clinical care pathways;
7. Announce and sell initiative to other hospital departments who may have relationship with ED in respect of patients who are assaulted - principally Obstetrics & Gynaecology, mental health especially CAMHs, maxillofacial, X-ray and the psychology dept. Consider developing cross-department referral protocols;
8. Agree and sign-off data sharing protocols between ED and CDRP via hospital Trust data protection manager;
9. Establish system to collate data from ED – IT Dept. task ideally but overseen by senior member of ED team. Some colleagues have found that with the electronic systems there is benefit in asking IT to send the data reports with the patient identifiers (e.g. patient number) and then ED staff remove this column. It enables any subsequent audits of some notes to be found quickly;
10. Establish regular interrogation, by a member of the ED team, of collated data for relevance to care pathways, e.g. follow-up especially for referral to domestic abuse support services and the police. Again, some areas have a policy about proactive referral to services for victims of domestic abuse which could be made available also. Other referrals to mental health, CAMHs, child protection should also be considered;

11. Establish system to transfer depersonalised aggregate data package as soon as possible, i.e. weekly, to analysts in CDRP for further scrutiny;
12. Establish regular feedback or briefing sessions to ED staff in relation to the assault data being transferred – patterns and type of assault activity with locations. This maintains profile of the initiative and sensitises ED staff to clinical presentations related to assaults, e.g. serial presentations that are DV etc. Can also enhance existing CPD by linking clinical activity of ED to wider social phenomena like binge drinking, youth violence etc.;
13. Consider employing additional ED clinical staff, e.g. a senior nurse or registrar, to provide additional services to the department. This can include follow-up of patients suspected of being abused/battered, liaison with other agencies in and outside hospital in relation to assaulted patients, e.g. links to domestic abuse MARACs, research on the cohort of assaulted patients and quality assurance of clinical care pathways. Other tasks like ED continuing professional development (CPD) could also be incorporated into the role;
14. Senior ED staff member attends local CDRP(s) to comment on nature of data transferred and learn how it is being used in crime reduction efforts. This liaison is important for a number of reasons (see Shepherd papers) but senior clinicians can have a significant impact on local alcohol licensing committees in respect of patterns of injuries, e.g. glassings. Other areas have set up standard project management framework with ED representation;
15. Establish reflexive process in the ED associated with the assault data. Critically evaluate ED's ability/efficiency in detecting and responding to the different presentations of assault. Assess also relationships with other agencies in responding to patients needs particularly onward referral to specialist agencies;
16. Regularly peer review all the above actions with colleagues at least annually.
17. CDRPs should endeavour to:
 - Receive data: ensure data will always be received even if staff are on leave;
 - Set up analytical framework/system to analyse and contextualise the data;
 - Distribute raw data and analysis to stakeholders – PCT, ED, Trading Standards, Licensing Teams (police and council);
 - Ensure the analytical product is actioned within CDRP for example, by Tasking and Coordinating groups, Violent Crime Groups, Licensing;
 - Consider including in the analysis a range of secondary and supporting partnership data sources, e.g. trading standards, Pubwatch, walk in centres, ambulance, drug litter;
 - Some thought should be given to link with national intelligence model.

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Other Relevant Resources:

Maguire M et al – Reducing alcohol related violence and disorder: an evaluation of TASC project. Home Office Research Study 265.

Shepherd, J – Preventing violence – caring for victims.
Surgeon 2007; 5 (2) 114-121

Shepherd, JP – Emergency medicine and police collaboration to prevent community violence.
Annals of Emergency Medicine Oct 2001 38: 4 430-437

Shepherd, JP – Violence: the relation between seriousness of injury and outcome in the criminal justice system.
Journal Accident & Emergency Medicine 1997; 14: 204-208

Shepherd, JP et al – Recording by the police of violent offences: an accident & emergency dept perspective.
Medicine, Science and Law 1989; 29: (3) 251-257

Warburton, AL & Shepherd, JP – Development, utilisation and importance of accident and emergency department derived assault data in violence management.
Emergency Medicine Journal 2004; 21: 473-477

Websites:

Dr Jonathan Shepherd : <http://tinyurl.com/22tkf8>

Cardiff Violence Prevention Group: <http://tinyurl.com/3yrmg7>

Cardiff Violence & Society Research Group: <http://tinyurl.com/3czfdf>

Data Protection Info:

Safety and Justice: sharing personal information in the context of domestic violence - an overview (2004) by N. Douglas et al. Home Office Development and Practice Report No. 30 - available online from the Home Office Research Development and Statistics publications website:

http://uk.sitestat.com/homeoffice/homeoffice/s?rds.dpr30pdf&ns_type=pdf&ns_url=%5Bhttp://www.homeoffice.gov.uk/rds/pdfs04/dpr30.pdf%5D

Also seek out *Public Sector Data Sharing: Guidance and the Law* published by the Dept for Constitutional Affairs (November 2003)

<http://www.dca.gov.uk/foi/sharing/toolkit/lawguide.pdf>