Summary of recommendations

1. 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.)

2. There is no need for a formal information sharing agreement between the Emergency department and the Community Safety Partnership (CSP).

3. This data should be shared with the local CSP and crime analysts in an anonymous and aggregate form.

4. Senior emergency physicians should be supported to participate in CSP meetings.
Scope
This guideline is to assist Emergency Physicians sharing data with Community Safety Partnerships (formerly known as Crime and Disorder Reduction Partnerships in England) to reduce community violence.

Reason for development
This guideline has been prepared to help implement Best Practice.

Introduction
Around 80% of assault victims requiring emergency department treatment do not report their assault to the police. 1 2 Work from Cardiff and the South East of England has shown that data collection by emergency department receptionists that is shared with Community Safety Partnerships (CSPs) is very effective in reducing the number of assaults requiring emergency department treatment. 3 (Level 3 evidence) At best, this can lead to 30% reductions in the number of attendances for assault. Anonymous data needs to be shared monthly with local crime analysts. This informs targeted policing of ‘problem premises’ and violence hotspots. An example of the data format is shown below.

Receptionists are the best people to collect this data at registration. Only three additional items are required. These are shown in the figure below. The data should be shared monthly with the crime analysts. There is no need for a formal information sharing agreement as the data is anonymous.

The effectiveness of this information sharing process is considerably enhanced if a senior emergency physician from the emergency department attends the CSP meetings.

This guidance does not replace the responsibilities of emergency physicians to promptly inform the police in cases of firearms and stabbings. The GMC guidance on reporting gunshot wounds and knife wounds should be followed.

www.gmc-uk.org/guidance/ethical_guidance/confidentiality.asp

Useful information about implementing this can be found on the Department of Health website:


More information about Community Safety Partnerships can be found on the Home Office website:

http://www.homeoffice.gov.uk/crime/partnerships/
Data items to be collected by ED receptionists

- Incident Type
- Assault Type
- Assault location
- Date & time of assault

Body Part
- Fist
- Feet
- Head

Weapon
- Glass
- Bottle
- Knife
- Blunt object
- Gun
- Other
- Free text facility to give specific details of the location

Body Part
- Pushed

Weapon
- Blunt object
- Gun
- Other

Bar/pub
- Club
- Street
- Own home
- Someone else’s home
REFERENCES:


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Review
The Clinical Effectiveness Committee approved this guideline in 2009. It has been revised and updated in May 2010 and August 2011. It will be reviewed in September 2012 or sooner if important evidence becomes available.

Disclaimers
The College recognises that patients, their situations, Emergency Departments and staff all vary. This guideline cannot cover all possible scenarios. The ultimate responsibility for the interpretation and application of this guideline, the use of current information and a patient’s overall care and wellbeing resides with the treating clinician.

Research Recommendations
None identified.

Audit standards
Completeness of location recording should be 70% of assault cases.

Key words for search
Violence, assault, information sharing.
Appendix 1

Methodology
Where possible, appropriate evidence has been sought and appraised using standard appraisal methods. High quality evidence is not always available to inform recommendations. Best Practice Guidelines rely heavily on the consensus of senior emergency physicians and invited experts.

Evidence Levels
1. Evidence from at least one systematic review of multiple well designed randomised control trials
2. Evidence from at least one published properly designed randomised control trials of appropriate size and setting
3. Evidence from well designed trials without randomisation, single group pre/post, cohort, time series or matched case control studies
4. Evidence from well designed non experimental studies from more than one centre or research group
5. Opinions, respected authority, clinical evidence, descriptive studies or consensus reports.
## Appendix 2

### Specimen data output

<table>
<thead>
<tr>
<th>Arrival Date</th>
<th>Arrival Time</th>
<th>Incident Location</th>
<th>Incident Date</th>
<th>Incident Time</th>
<th>Weapon</th>
</tr>
</thead>
<tbody>
<tr>
<td>01/03/2009</td>
<td>04:34</td>
<td>WHITE HORSE</td>
<td>01-Mar-09</td>
<td>05:04</td>
<td>Knife</td>
</tr>
<tr>
<td>01/03/2009</td>
<td>11:44</td>
<td>WHITE HORSE</td>
<td>01-Mar-09</td>
<td>15:00</td>
<td>Gun</td>
</tr>
<tr>
<td>02/03/2009</td>
<td>05:27</td>
<td>WHITE HORSE</td>
<td>02-Mar-09</td>
<td>08:12</td>
<td>Bottle</td>
</tr>
<tr>
<td>02/03/2009</td>
<td>13:18</td>
<td>REGENT STREET</td>
<td>02-Mar-09</td>
<td>17:05</td>
<td>Fist</td>
</tr>
<tr>
<td>02/03/2009</td>
<td>14:35</td>
<td>OXYGEN NIGHTCLUB</td>
<td>02-Mar-09</td>
<td>17:09</td>
<td>Feet</td>
</tr>
<tr>
<td>02/03/2009</td>
<td>18:11</td>
<td>RED LION PUB</td>
<td>02-Mar-09</td>
<td>19:06</td>
<td>Club</td>
</tr>
<tr>
<td>03/03/2009</td>
<td>19:26</td>
<td>OUTSIDE OXYGEN NIGHTCLUB</td>
<td>03-Feb-09</td>
<td>23:09</td>
<td>Fist</td>
</tr>
<tr>
<td>03/03/2009</td>
<td>21:55</td>
<td>REGENT STREET</td>
<td>03-Mar-09</td>
<td>22:45</td>
<td>Fist</td>
</tr>
<tr>
<td>05/03/2009</td>
<td>05:18</td>
<td>HOME</td>
<td>05-Mar-09</td>
<td>08:18</td>
<td>Axe</td>
</tr>
</tbody>
</table>