

Annex 4

TIIG Cheshire and Merseyside Themed Report

The use of Accident and Emergency data in the Licensing Process
April 2011 to March 2014

June 2015

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Nationally in 2013/14, 53% (704,000) of total violent incidents involving adults (1,327,000) were alcohol related¹. In addition to the implications for violence, alcohol is responsible for 8% of all hospital admissions². The impact on Emergency Departments (EDs), the police and the public wellbeing is considerable.

The Licensing Act 2003 aims to: target those who may be selling alcohol irresponsibly; reduce crime, disorder and harm; and, improve public safety. The Licensing Authority relies on robust multi-agency working and multi-source intelligence so that processes of licensing, application of conditions or revoking of licenses is to be efficient and effective. This report provides significant examples of the impact of robust data collection and sharing in effective decision-making and actual reduction in alcohol related assaults and hospital admissions.



While it is acknowledged that our EDs are under significant and multifaceted pressures, this report emphasises the positive effect that complete and enhanced ED data can have on the outcomes for public safety, violence prevention and ED admissions. Local partnership working and flexibility are key to this success.

It is imperative that Emergency Departments capitalise on the opportunity to enhance their assault data and to learn from those who are already achieving optimum standards in this area. The Trauma and Injury Intelligence Group (TIIG) are central to the intelligence gathering by local and regional EDs and the data sharing mechanisms which enable the data to be efficiently processed and presented to the appropriate local authorities.

In summary this report demonstrates the opportunity for real change in violence prevention and alcohol-related assaults based on enhanced and efficient intelligence gathering in our Emergency Departments.

A handwritten signature in black ink that reads 'Raphaela Kane'.

Dr Raphaela Kane
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(Former ED practitioner and Manager of ED services)

¹ Office for National Statistics. (2015). Available at: <http://www.ons.gov.uk/ons/rel/crime-stats/crime-statistics/focus-on-violent-crime-and-sexual-offences--2013-14/sty-facts-about-alcohol-related-violence.html>.

² Public Health England (2015). Available at: [http://www.alcohollearningcentre.org.uk/library/BACKUP/DH_docs/Hospital Admissions for Alcohol-related Harm.pdf](http://www.alcohollearningcentre.org.uk/library/BACKUP/DH_docs/Hospital%20Admissions%20for%20Alcohol-related%20Harm.pdf).

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KEY FINDINGS

- Licensing authorities have the responsibility of reviewing the licence of a premise if it has been found to breach the conditions of its licence. Health data from Emergency Departments (EDs) can be used to supplement police recorded crime data in a licence review, which is particularly useful where a violent incident has occurred but the victim has not informed the police.
- Both the College of Emergency Medicine (CEM) Guidelines and the Standard on Information Sharing to Tackle Violence recommend that EDs collect and share data on assault related attendances with local partners. In particular, a detailed assault location can be utilised to help and support a licence review process. Both CEM and Information Sharing to Tackle Violence recommend collection of:
 - Date and time of assault;
 - Specific location of assault; and,
 - The weapon used in the assault.
- The Trauma and Injury Intelligence Group (TIIG) also recommend that EDs collect and share data on:
 - Whether alcohol had been consumed prior to the assault;
 - Specific location of where the alcohol was consumed;
 - Whether the incident had or would be reported to the police; and,
 - Details of the attacker/s, including gender, number of attackers and relationship to the victim.
- Using Arrowe Park Hospital and The Royal Preston Hospital as examples, data collection and sharing appears to work most effectively when it is flexible and can be adapted to suit local partner needs. This could include additions or modifications to data items collected at the ED or changes to the way data is presented and shared with local partners.
- Multidisciplinary meetings, which include representatives from TIIG, the ED and local partners, also facilitate discussions on how data improvements can be made and how ED data can be used effectively in supporting licensing reviews.
- Where ED data has been used as part of a successful licence review process, the key enhanced assault fields utilised were:
 - Date and time of assault;
 - Weapon used;
 - Location of assault; and,
 - Whether the incident was reported to the police.
- Optimal data collection and sharing can allow those working in violence prevention and licensing to target their work more effectively.
- While not all EDs are collecting enhanced assault data to the optimum standard, lessons can be learnt from those who are. TIIG, the EDs and local partners should collaborate to ensure that the data collected is being used effectively, and work together to consider where improvements can be made.

INTRODUCTION

ALCOHOL LICENSING

Estimates suggest that approximately 1,000 per 100,000 people will be a victim of alcohol-related crime each year (Institute of Alcohol Studies, 2013). In terms of violent crime, during 2012/13 almost half (49%) of victims believed that their offender(s) was/were under the influence of alcohol during the incident (ONS, 2014). The overarching aims of the Licensing Act 2003 were to target those who may be selling alcohol irresponsibly, reduce crime, disorder and harm, and improve safety.

It is the responsibility of licensing authorities to manage and administer the Licensing Act in their local area, including issuing licenses and enforcing the conditions of the licence (Gov.UK, 2013). Under the Licensing Act 2003, on the 1st April 2013 the Primary Care Trusts' function as a responsible authority was transferred to Directors of Public Health (DsPH) in local authorities (Department of Health, 2012). In addition to DsPH other public bodies, which are responsible authorities entitled to make representations to the licensing authority in relation to applications under the Licensing Act, include the Police Licensing Unit, Planning and Building Control, Trading Standards, Fire and Rescue Service, Environmental Health, and the Safeguarding Children Board (Liverpool City Council, n.d.).

Across England and Wales, any businesses, organisations or individuals who wish to sell alcohol are legally required to apply for a premises licence³ or club premises certificate⁴ from their local licensing authority. On the 31st March 2014 in England and Wales, there were 204,282 premises licences in force which represented a 0.1% increase on the previous year. Throughout 2013/14, 97% (n=8,763) of new premise licences were granted (Home Office, 2014).

In addition to granting premise licences, it is the responsibility of licensing authorities to enforce the conditions of the licence which are:

- The prevention of crime and disorder;
- Public safety;
- The prevention of public nuisance; and,
- The protection of children from harm.

Where the licensing authority has evidence to show that a particular licensed premise is breaching one of the conditions of its licence, then an application may be submitted to review the licence of the premises. During 2013/14 across England and Wales, 838 completed reviews were carried out, of 3,435 which went to committee hearing, the majority of which (78%) were linked to issues around crime and disorder. Of the completed reviews, 56% of the premises had new conditions placed on their licence and 24% had their licence revoked (Home Office, 2014). As part of the licence review process, the licensing authority is required to provide evidence to support their claim and this information may come from a number of sources such as Emergency Department (ED) data and police recorded crime. Information on attendances to EDs may be useful in supplementing police recorded crime data particularly where a violent incident has occurred but the victim has not informed the police.

³ Any premises which sells alcohol. Applications must come from a personal licence holder.

⁴ For private members clubs which sell alcohol.

When collected to a high standard, data collected by EDs can be extremely useful in highlighting:

- Hotspot areas, where a high level of violent crime occurs in a particular licensed premises;
- Time periods, where certain times of the day may be more likely for violent incidents to occur⁵;
- Use of weapons, where particular weapons occur in a high number of assaults, such as glass bottles⁶;
- Underage drinking, where people under the age of 18 are using the licensed premise; and,
- High alcohol consumption, where perpetrators or victims of violence have been involved in excessive or risky levels of drinking.

This report considers how ED data, collected in line with the College of Emergency Medicine (CEM) guidelines, can be used effectively to support the licensing review process. This is illustrated using case studies which provide successful models of data sharing and usage and key figures on violence-related attendances from Arrowe Park Hospital, Merseyside and Royal Preston Hospital, Lancashire. This report also provides an overview of the current picture across Merseyside and Cheshire, specifically focusing on where data could be used to support licensing reviews and where improvements could be made.

NEW STANDARD ON INFORMATION SHARING TO TACKLE VIOLENCE

The Health and Social Care Information Centre published a new Standard in September 2014⁷. The *Standard on Information Sharing to Tackle Violence* will ensure EDs collect and share data about injury attendances involving violent crime with Community Safety Partnerships (CSPs), including:

- Time and date of incident;
- Time and date of arrival to ED;
- Specific location of incident; and,
- Primary means of assault (i.e. weapon or body part used).

This dataset is in line with the College of Emergency Medicine guidelines, with the addition of the time and date of arrival to the ED; however, this information is already collected by EDs via their patient management systems.

COLLEGE OF EMERGENCY MEDICINE GUIDELINES

The College of Emergency Medicine (CEM) produced guidelines to assist EDs sharing data with CSPs to reduce community violence. CEM recommends EDs routinely collect, electronically if possible, data about assault attendees; in particular the inclusion of a detailed assault location, which can be utilised to help and support the licence review process.

⁵ In such cases, restrictions on premises' opening hours may be beneficial. It has been suggested that the fixed and early closing times established under the Licensing Act 1964 was one of the key causes of rapid binge drinking prior to closing time which was linked to disorder and disturbances when customers were leaving premises simultaneously. One of the Licensing Act 2003 objectives was to reduce concentrations and achieve slower dispersal of customers from licensed premises through flexible opening times (Liverpool City Council, 2014).

⁶ In such cases glass drinking vessels may be replaced with polycarbonate alternatives.

⁷ <https://www.gov.uk/government/news/aes-and-police-to-share-information-to-help-tackle-violence>

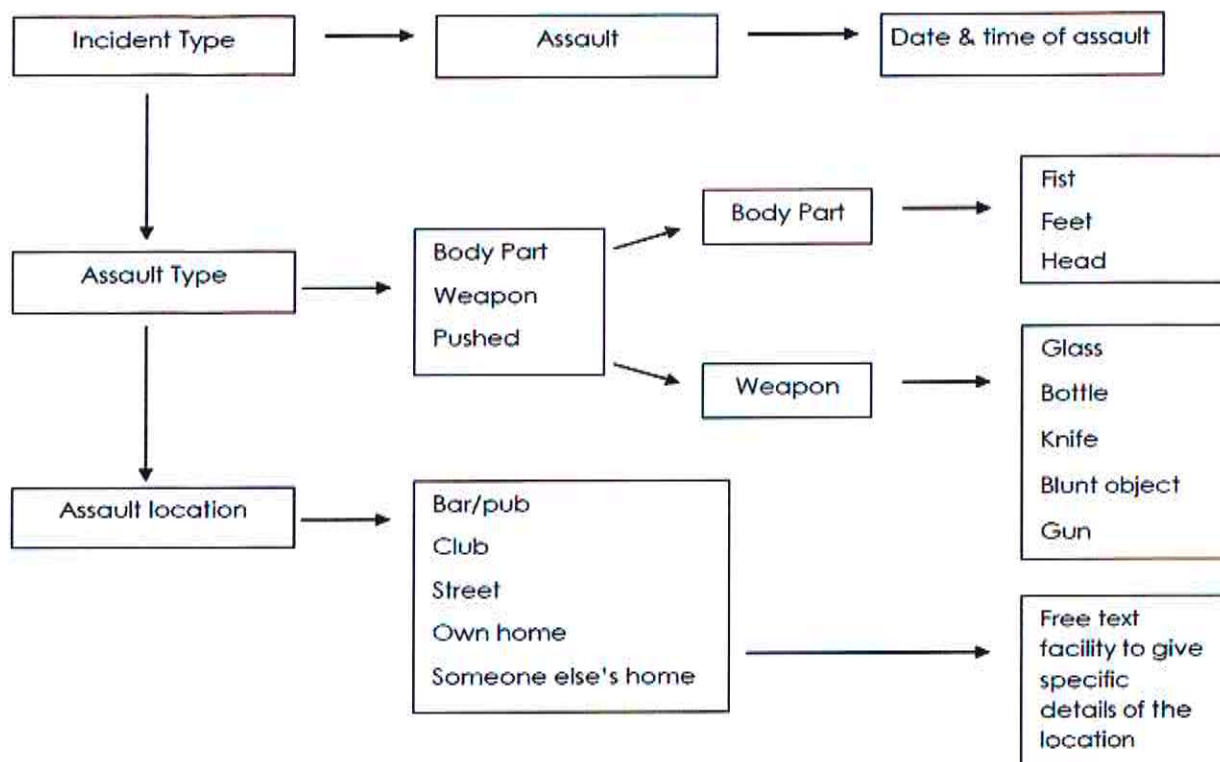


Figure 1 - Data Items to be collected by ED receptionists (CEM, 2011)

TIIG GUIDELINES

In addition to the CEM recommended dataset outlined above, TIIG also recommends the following data are recorded, as requested by local partners:

- Whether alcohol has been consumed in the 3 hours prior to the incident;
- Location of where alcohol was last consumed;
- Whether the incident has been or will be reported to the police; and,
- Number of attackers, gender of attacker/s and relationship to attacker/s.

In conjunction with CEM guidelines and the Information Sharing Standard, these additional questions can assist in the licensing review process by highlighting incidents the police may not have been made aware of and providing details of the last location alcohol has been consumed, where alcohol has been identified as a causal factor in an incident of violence.

CASE STUDY 1: ARROWE PARK HOSPITAL

BACKGROUND

Arrowe Park Hospital, located on the Wirral in Merseyside, is part of the Wirral University Teaching Hospital Trust. Arrowe Park Hospital has been sharing all injury ED attendance data with TIIG since 2005 and TIIG store data for Arrowe Park Hospital from April 2004 onwards. As well as routine biyearly injury reports, TIIG also share data with local partners on assault related ED attendances. Assault data were previously shared with local partners bi-weekly to inform police meetings which were arranged to meet the objectives of the Tackling Knives Action Programme (TKAP; Gov. UK, 2010). It was agreed in 2014 that data sharing was no longer needed on a biweekly basis and could occur on a monthly basis. In addition to the calendar month data file, a rolling data file is updated on a monthly basis which includes attendances made to the ED from 1st January 2014 to the current reporting month. Following discussions and to suit local partner needs, several amendments were implemented in November 2014 to the data summaries presented for both the monthly assault report and the rolling data. The changes made to the data summaries in the reports are outlined below.

MONTHLY ASSAULT REPORT

- The data summary now presents figures as numbers and percentages (not just percentages, as was the case previously).
- Now included in the summary is the number and percentage of assaults:
 - which occurred at a licensed premise (defined as public house or nightclub [inside/outside]);
 - involved a body part; and,
 - by relationship to attacker.
- The *Key locations* are now calculated from the number of attendances where the assault location was recorded as the Wirral (omitting those which occurred in Liverpool or the location was unknown, other or not recorded).

ROLLING DATA

- There are now two separate data summaries for this report; the first details all assault attendances and the second details those which occurred at licensed premises (defined as public house or nightclub [inside or outside] and where a premise name has been recorded under 'specific location').
- Figures, including those outlined above, are presented as numbers and percentages.
- The *Key locations* are now calculated from the number of attendances where the assault location was recorded as the Wirral (omitting those which occurred in Liverpool or the location was unknown, other or not recorded).
- The summary for all assault attendances is further broken down to detail incidents which occurred within Wirral local authority (omitting those which occurred in Liverpool or the location was unknown, other or not recorded).
- Hotspot locations for licensed premises remain unchanged:
 - Hotspot licensed premises where three or more assaults occurred, inside or outside the venue
 - Hotspot licensed premises where three or more assaults occurred, by assault weapon.

- All licensed premises, including the count and percentages of assaults that occurred in specifically named venues, as recorded by ED staff. Percentages are calculated from the sum of all assaults where the specific location of licensed premise was recorded.

Since data are shared with local partners on a monthly basis and the rolling data file is updated monthly, it may be beneficial for the two data files to be combined. This would involve TIIG providing one monthly data file rather than two, with a data summary added to the rolling data file which would detail attendances made in the past month. Monthly data could still be viewed at record level by using filters on the data tab to select the current year and month. If this was to be implemented, as decided by the Scrutiny Group, the rolling data file would have the following tabs:

- Cover sheet
- Summary – [current month]
- Summary – all assaults
- Summary – licensed premises
- Data – all assaults
- Data – licensed premises
- Hotspots – licensed premises
- Metadata

WIRRAL SCRUTINY GROUP

In September 2014, Wirral's Public Health Manager arranged a Scrutiny Group meeting to promote discussions around the use of TIIG data in local violence prevention. An informal meeting was held, attended by representatives from TIIG, Arrowe Park Hospital, Wirral Local Authority (public health and licensing) and Merseyside police, to outline the purpose of TIIG and provide examples of how data have been used in other areas within violence prevention and the licensing process. The meeting allowed local partners to meet and discuss the establishment of a Scrutiny Group and its purpose for future meetings. It was agreed that partners would meet again the following month and then on a quarterly basis from then on.

The meeting in October 2014 involved discussions around the frequency of reporting and how the summaries should be presented in the data files shared with local partners. Several amendments were agreed which are outlined above. The Licensing Sergeant discussed pending licensing applications, though it was later decided by the Public Health Manager and the TIIG Project Lead that this was not applicable to the Scrutiny Group meetings. Future meetings will continue to discuss licensing and how TIIG data can be improved and used to support the licensing function within Wirral, though the meetings will also discuss wider TIIG data uses in violence and injury prevention.

DATA ITEMS AND COMPLETION RATES

This section of the report presents data from Arrowe Park Hospital focussing on assault related attendances and provides figures on both the data collected and completion rates.

COMPLETION RATES

All data at Arrowe Park Hospital is collected to a high standard and the majority is in keeping with national guidance, which recommends that detailed assault data is collected for at least 70% of ED assault patients. Assault related data items go beyond both the CEM recommended guidelines and TIIG guidelines and thus provide a very detailed picture of assaults attendances to Arrowe Park Hospital.

Table 1 displays a list of assault related data items which are collected by Arrowe Park Hospital and the completeness of these items for the financial year 2013/14. Arrowe Park collects a wide range of information which allows local partners working in licensing to understand when, where and how an assault occurred as well as knowing whether it was alcohol related. Improvement of the completion of the assault date and time fields would be welcomed, since this information can be useful during the license review process in reviewing opening hours of off licences as well as licensed premises. This issue has recently been highlighted at the Wirral Scrutiny Group (see Wirral Scrutiny Group section of this report) and discussions are taking place between TIIG, Arrowe Park Hospital and local partners to consider ways of improving these fields.

Data item	Completion rate
Date of assault	43%
Time of assault	47%
Location of assault, e.g. nightclub, pub, home	99%
Detailed location of assault, e.g. name of pub, club	98%
Number of attackers involved in the assault	99%
Whether the patient has been assaulted by the attacker before	99%
Relationship to attacker, e.g. stranger, partner	99%
Weapon used in the assault, e.g. body part, blunt object	99%
Whether the patient believes the attacker was drunk	99%
Whether the patient has or intends to inform the police of the assault	99%
Had the patient consumed alcohol up to three hours prior to the assault	100%
If alcohol had been consumed, where was it consumed, e.g. nightclub, pub, home	99%
Detailed location of last drink location, e.g. name of pub, club	80%

Table 1 - Arrowe Park assault data items and completion rates (2013/14)

ASSAULT-RELATED INJURY ATTENDANCES TO ARROWE PARK HOSPITAL (2011/12 TO 2013/14)

This section of the report presents an overview of assault related attendances to Arrowe Park Hospital between April 2011 and March 2014⁸ split by core data items (e.g. demographics of patient, how they arrived and discharge method), CEM guideline questions (e.g. weapon of assault and location of assault) and TIIG recommended questions (e.g. whether alcohol had been consumed prior to the assault).

⁸ For full details of assault attendances to Arrowe Park during this time period please visit <http://www.cph.org.uk/tiig/merseyside/#ED003>

CORE DATA ITEMS

Between April 2011 and March 2014 there were 4,467 assault attendances to Arrowe Park ED (Table 2) and during this time there was a 9% reduction in the number of assault attendances. Data from TIIGs violence trends report (Brizell, Critchley and Whitfield, 2014), demonstrates that there has been a significant reduction in assault attendances at Arrowe Park during the TIIG data sharing period; for example, between 2006/7 and 2012/13 Arrowe Park assault attendances have reduced by approximately 49%. Although other factors may have also influenced this drop, optimal data collection and sharing allow partners working in violence prevention and licensing to inform and target their work more effectively.

Financial year	Number of attendances
2011/12	1591
2012/13	1435
2013/14	1441
Total	4467

Table 2 - Arrowe Park assault attendances by financial year (April 2011 to March 2014)

Figure 2 shows that between April 2011 and March 2014, the majority of assault attendees were male (3,070; 69%). Females represented 31% of attendances (1,396)⁹.

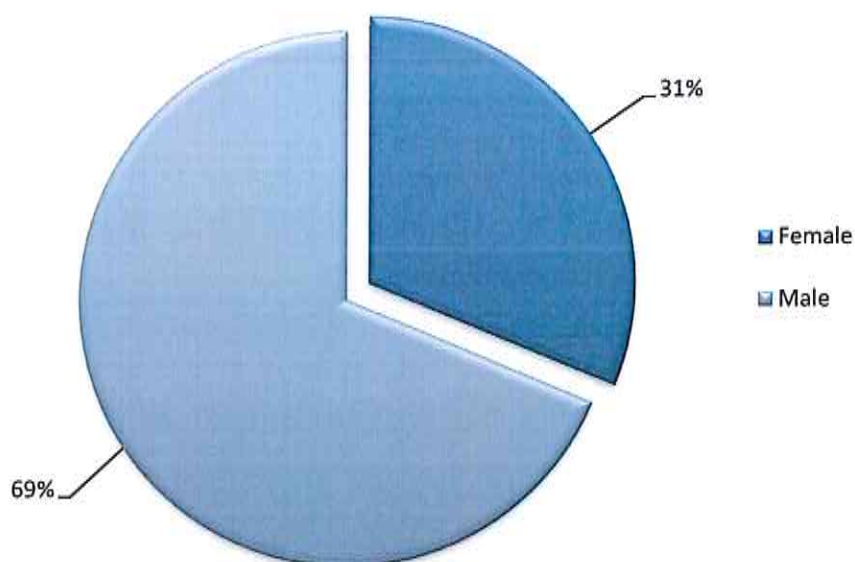


Figure 2 - Arrowe Park assault attendances by gender (April 2011 to March 2014)

The majority of assault attendances were comprised of those aged between 15 and 29 years of age (2,291; 51%) and 30 and 59 years (1,834; 41%). Less than one percent of attendances were made by those aged between 0 and four years of age (Figure 3). The largest proportion of attendances was made by males aged between 15 and 29 years (36%) and those aged between 30 and 59 years (27%).

⁹ Please note there was one attendee during this time who did not have a sex recorded.

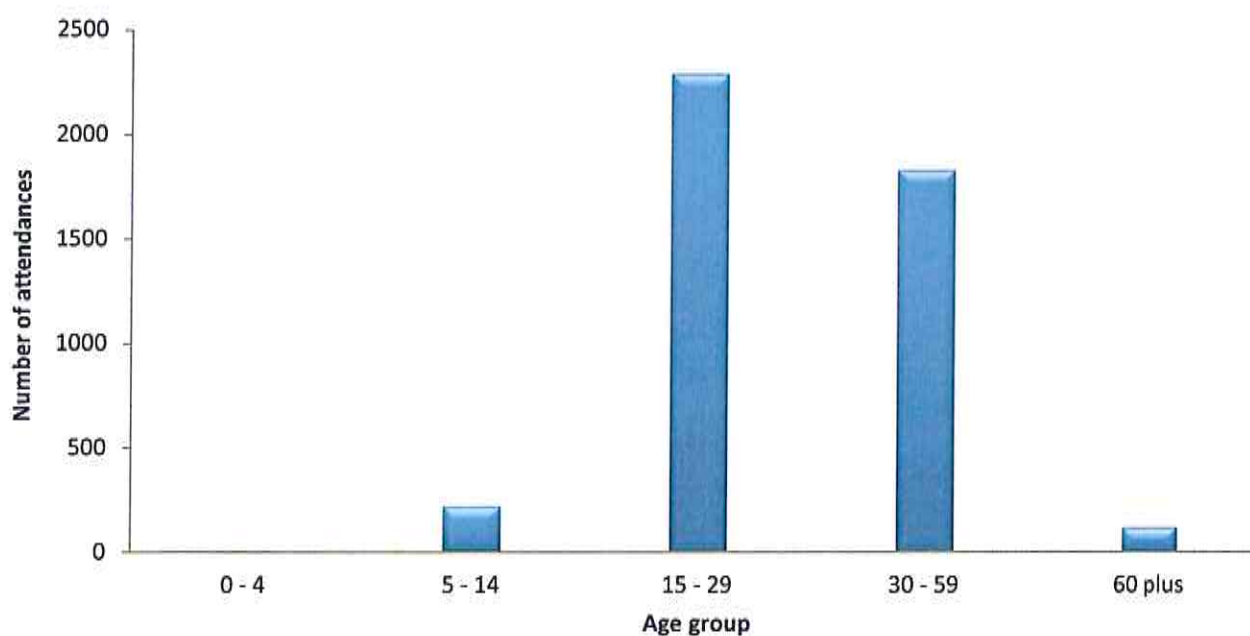


Figure 3 - Arrowe Park assault attendances by age group (April 2011 to March 2014)

Table 3 shows the method of arrival to Arrowe Park Hospital. Between April 2011 and March 2014, the majority of assault attendances arrived at the ED by private transport (2,034; 46%) or ambulance (1,970; 44%). The majority of patients self-referred to Arrowe Park ED (3,870; 87%, Table 4).

Arrival mode	Number of attendances	%
Private transport	2034	46
Ambulance	1970	44
Police vehicle	250	6
Public transport	134	3
Walked	52	1
Other	27	1
Total	4467	100

Table 3 - Arrowe Park assault attendances by arrival mode (April 2011 to March 2014)

Source of referral	Number of attendances	%
Self-referral	3870	87
Emergency services	283	6
Police	202	5
Other	74	2
Health care provider: same or other	16	0
Work	11	0
Educational establishment	6	0
Unknown	5	0
Total	4467	100

Table 4 - Arrowe Park assault attendances by source of referral (April 2011 to March 2014)

Almost half of patients (2,091; 47%) were discharged from Arrowe Park ED with no follow up required; 12% (528) were admitted into the hospital (Table 5).

Disposal method	Number of attendances	%
Discharged - No follow-up required	2091	47
Admitted	528	12
Left department before assessment	438	10
Discharged – General practitioner to follow up	394	9
Discharged – Maxillofacial clinic	222	5
Discharged – Ear, nose and throat clinic	184	4
Left department against advice	149	3
Discharged other	121	3
Discharged - Fracture clinic	104	2
Discharged – General practitioner practice nurse	82	2
Transferred to other health care provider	47	1
Discharged - Ophthalmology clinic	37	1
Discharged - Adult emergency department clinic review	36	1
Unknown	9	0
Discharged – Walk in centre to follow up	8	0
Discharged - Paediatric emergency department clinic review	5	0
Discharged - District nurse to follow up	***	0
Discharged - School nurse to follow up	***	0
Discharged - Physiotherapy follow up arranged	***	0
Discharged - Primary care assessment unit	***	0
Died in department	***	0
Discharged - To general practitioner out of hours	***	0
Total	4467	100

Table 5 - Arrowe Park assault attendances by disposal method (April 2011 to March 2014)¹⁰

¹⁰ Please note that, throughout this report, where attendance numbers are less than five and can be back calculated from totals they have been suppressed (***). Where there is only one number less than 5, two numbers will be suppressed at the next level (e.g.<10).

Arrowe Park Hospital routinely collects and shares information on the date and time a patient arrived at the ED. Between April 2011 and March 2014, 11% of assault patients attended Arrowe Park between 8pm (Friday evening) and 3:59am (Saturday morning) and 10% between 8pm (Saturday evening) and 3:59am (Sunday morning, Table 6).

Day	Time					
	00-03:59am	04-07:59am	08-11:59am	12-15:59pm	16-19:59pm	20-23:59pm
Sunday	293	153	117	154	140	172
Monday	100	41	73	117	104	156
Tuesday	98	23	57	100	94	116
Wednesday	70	26	65	68	80	91
Thursday	71	19	58	67	90	128
Friday	106	39	53	80	105	197
Saturday	273	149	115	133	111	165
Total	1011	450	538	719	724	1025

Table 6 - Arrowe Park assault attendances by day and time of attendance (April 2011 to March 2014)

COLLEGE OF EMERGENCY MEDICINE (CEM) DATA ITEMS

In addition to core data items such as a patient's gender, age, disposal method and source of referral, Arrowe Park also collect all data items recommended by the CEM guidelines. This includes date and time of assault, weapon used in the assault and location of assault. Table 7 shows the day and time when the assault happened; 43% (824) of assaults occurred on a Saturday or Sunday^{11 12}.

Day	Time					
	00-03:59am	04-07:59am	08-11:59am	12-15:59pm	16-19:59pm	20-23:59pm
Sunday	311	24	***	<10	27	36
Monday	143	6	***	<15	22	23
Tuesday	134	***	5	***	24	29
Wednesday	117	***	***	15	10	19
Thursday	124	***	6	<15	15	36
Friday	201	9	***	<10	29	60
Saturday	296	24	5	14	26	50
Total	1326	72	28	72	153	253

Table 7 - Arrowe Park assault attendances by day and time of assault (April 2011 to March 2014)

In the majority of assaults, a body part was used as the main weapon (3,368; 75%), 5% of assaults involved a blunt object and 3% involved a knife (Figure 4).

¹¹ This figure represents a percentage of where the data was collected which was in 43% of assault attendances.

¹² The high proportions of assault attendances recorded in the early hours on Saturday and Sunday morning are likely to reflect violent incidents which occurred during the night time economy on Friday and Saturday nights respectively.

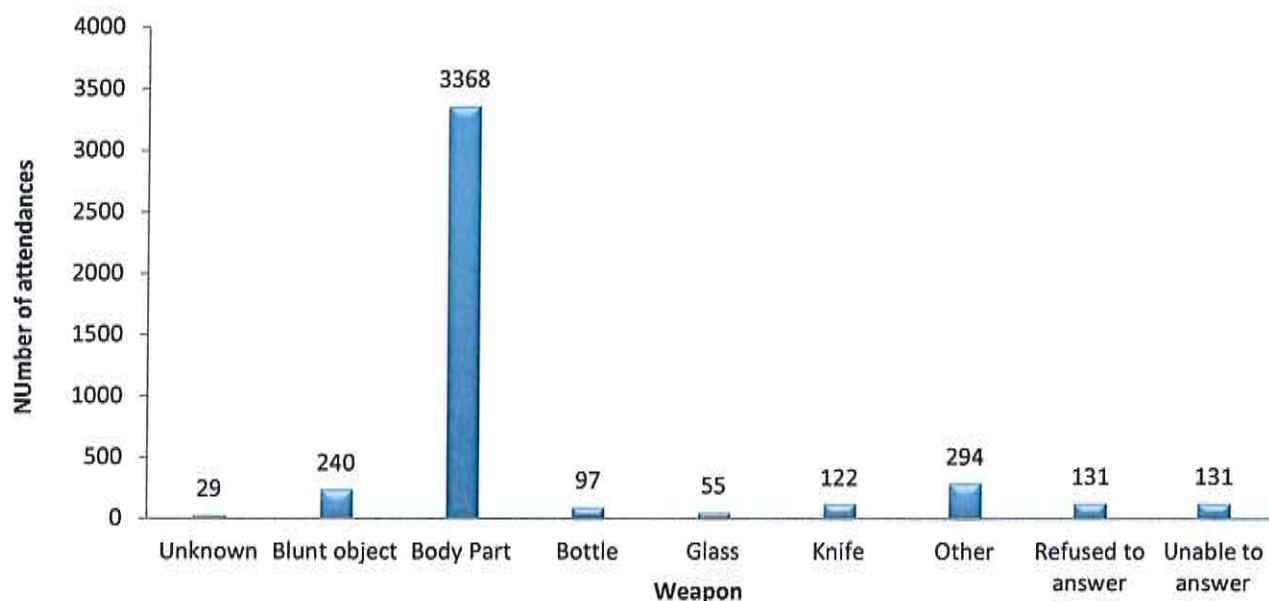


Figure 4 - Arrowe Park assault attendances by weapon (April 2011 to March 2014)

Arrowe Park Hospital collects data in line with the CEM guidelines regarding the location of an assault. Between April 2011 and March 2014, 37% (1,659) of assaults occurred in a public place, 17% (773) in the home and 16% (707) on a street/road. Four percent of assaults occurred in a nightclub and 6% in a public house¹³ (Figure 5).

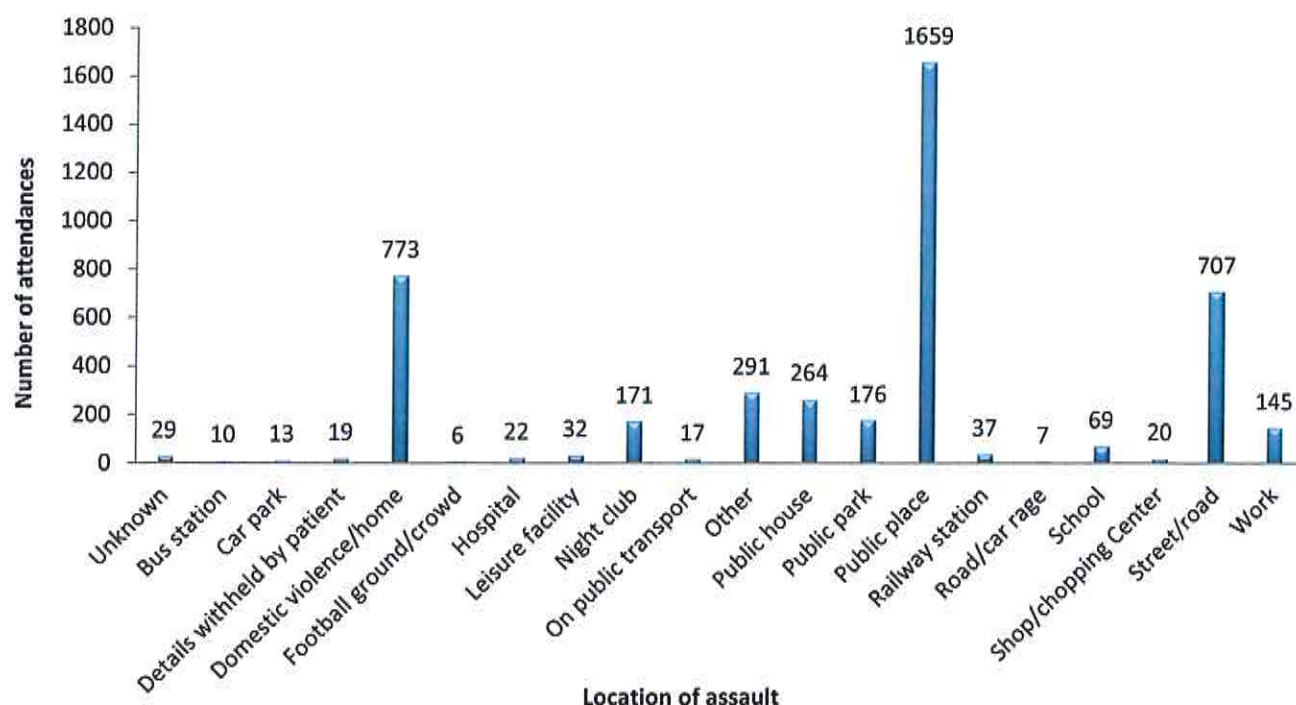


Figure 5 - Arrowe Park assault attendances by location of assault (April 2011 to March 2014)

¹³ Arrowe Park now collects data on whether the assault occurred inside or outside of a nightclub or public house but collection of this additional information was only implemented in October 2013 and was therefore not available for the full monitoring period covered in this report. Nightclub Inside (18) and Nightclub outside (9) have been merged into Nightclub and Public house inside (36) and Public house outside (10) have been merged into Public house.

Arrowe Park collect two further assault location fields; the first details the area in which an assault occurred, e.g. Birkenhead, Wallasey or Liverpool city centre, and the second describes the specific location, e.g. name of street, pub or club. The first of these fields allows local partners to determine in which areas the highest numbers of assaults are occurring and how trends are changing over time. Figure 6 shows that overall, the highest number of assaults occurred in Birkenhead city centre (1,246; 28%) and Wallasey/Seacombe (559; 13%). In addition, data used in conjunction with the general assault location and date and time of assault fields can allow identification of areas with a high number of assaults occurring in and around licensed premises and when these assaults are most likely to occur.

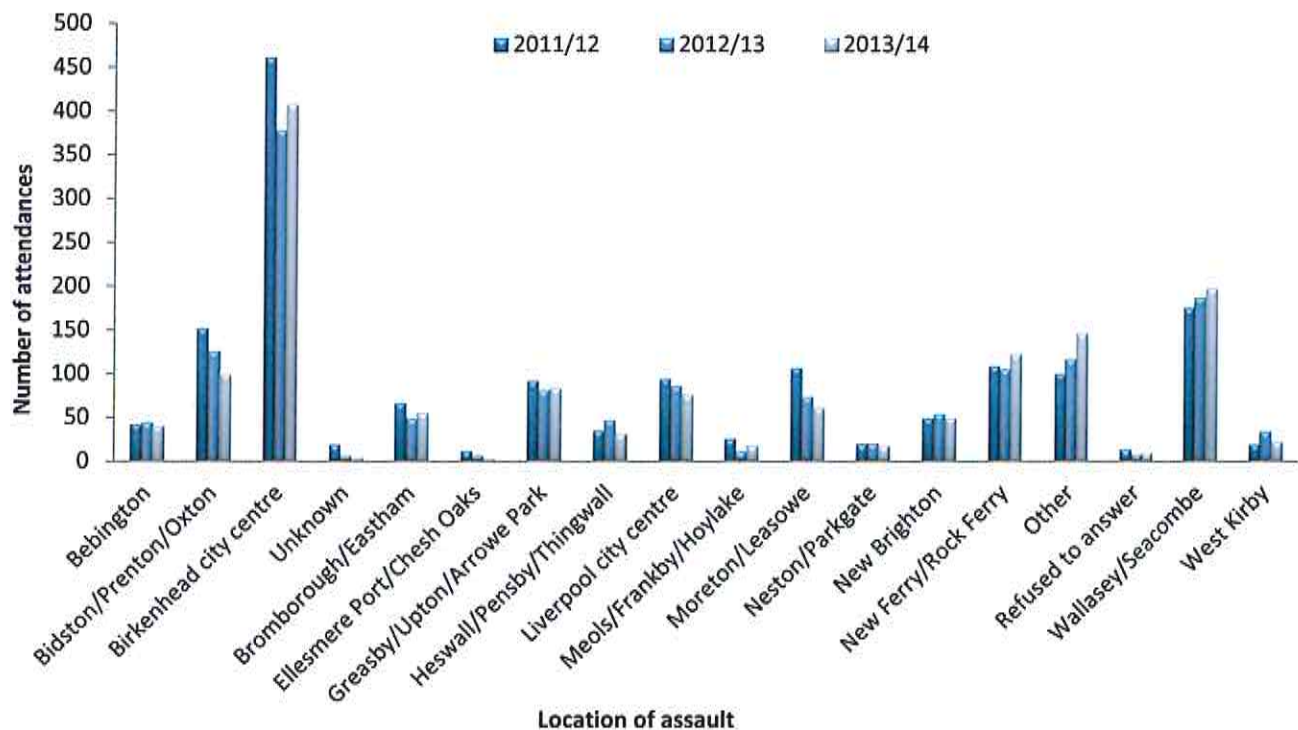


Figure 6 - Arrowe Park assault attendances by location of assault (April 2011 to March 2014)

While the detailed assault location field at Arrowe Park Hospital is collected to an extremely high standard, due to data sharing policy TIIG are unable to share the specifics of these data within this report,. However details on Arrowe Park Hospital assault location by Lower Super Output Area (LSOA) can be accessed via <http://www.cph.org.uk/tiig/merseyside/#ED003>. Furthermore data on the specific location of assault is made available to local partners working in community safety and licensing.¹⁴

TRAUMA AND INJURY INTELLIGENCE GROUP DATA ITEMS

In addition to the CEM data items, TIIG recommend that Emergency Departments collect additional information on whether alcohol had been consumed prior to the assault, where the alcohol was consumed, and whether the incident has or will be

¹⁴ Local partners working within community safety and licensing in Wirral local authority may be able to access anonymised patient level assault data; please contact tiig@lmu.ac.uk for further details.

reported to the police, along with details of the attacker, in terms of number of attackers, gender of attacker/s¹⁵ and the victim's relationship to attacker/s.

Between April 2011 and March 2014, 49% (2,199) of assault attendees had consumed alcohol in the three hours leading up to their assault, while 46% (2,039) had not. The remaining five percent were either unable to or refused to answer. Where an attendee said that they had consumed alcohol (2,199 attendances), they were asked where they consumed their last alcoholic drink. The majority of attendees consumed their last alcohol drink in a public house (576; 26%) or at home (434; 20%), 17% (373) consumed their last drink in a nightclub and 6% (140) in a public place (Figure 7). As well as asking about the patient's alcohol consumption, Arrowe Park Hospital also asks assault attendees whether they believe their attacker was drunk at the point of assault. Between April 2011 and March 2014, 37% (1,663) of attendees believed their attacker was drunk, while 31% did not (1,372). The remainder were either unable to or refused to answer (1,432; 32%).

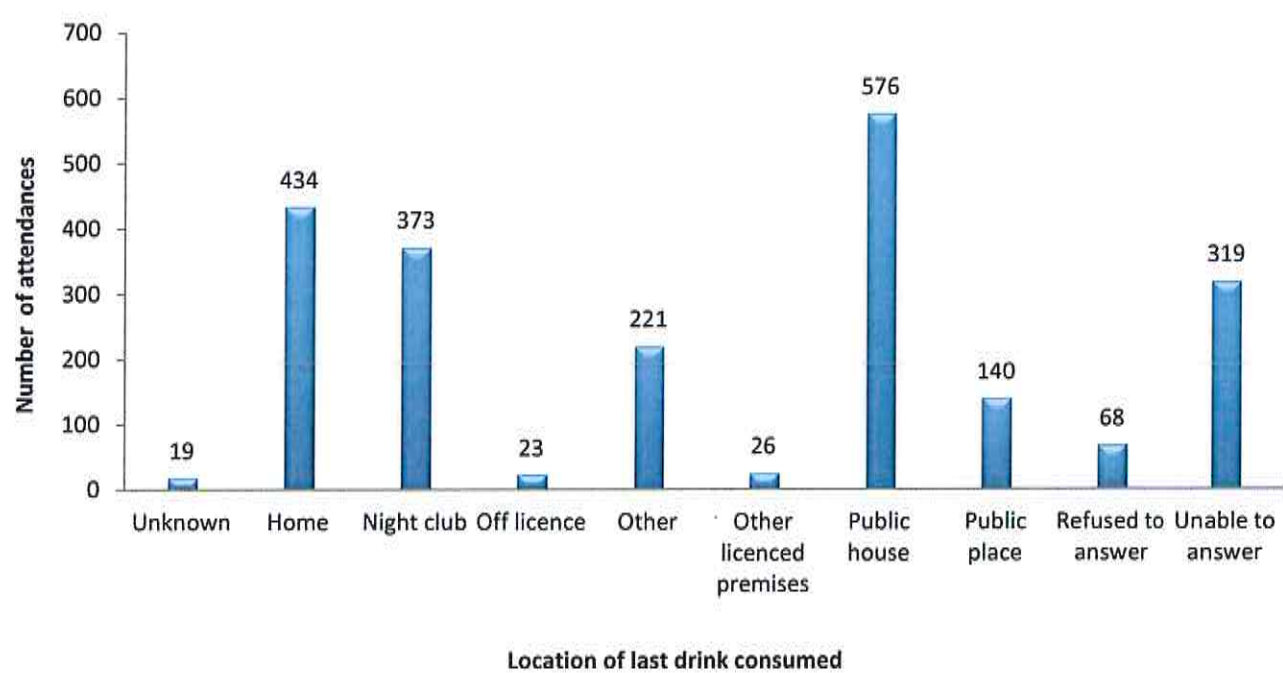


Figure 7 - Arrowe Park assault attendances by location of last drink consumed (April 2011 to March 2014)

Between April 2011 and March 2014, 67% (3,006) of assault attendees reported that they had informed or would be informing the police of their assault, 928 (21%) said they would not be informing the police and the rest were unable to or refused to answer (533; 12%). The majority of assault attendees were attacked by one person (2,662; 60%) and three quarters reported that they had not been attacked by the same person(s) previously (3,329; 75%). The majority of attendees were assaulted by a stranger (2,376; 53%), 18% (819) were assaulted by an acquaintance/friend and 8% (378) by their partner (Figure 8).

¹⁵ Arrowe Park Hospital do not collect data on the gender of the attacker.

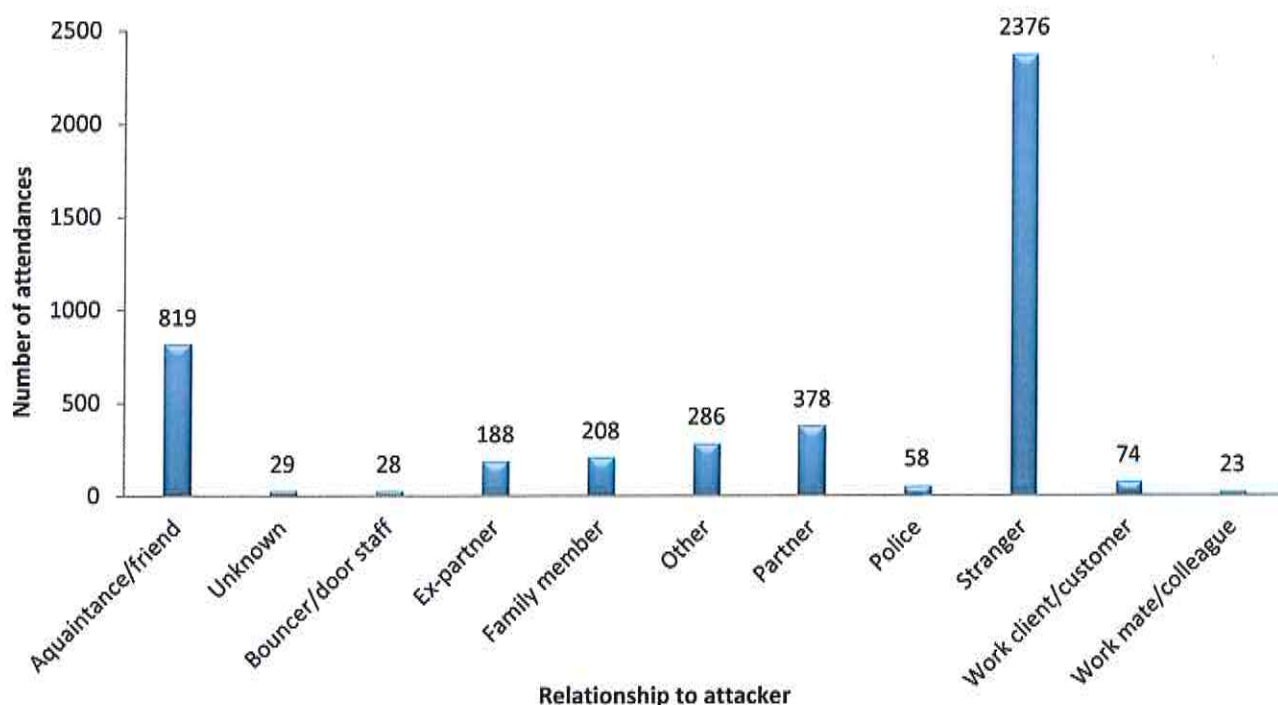


Figure 8 - Arrowe Park assault attendances by relationship to attacker (April 2011 to March 2014)

DATA USES

The collection of good quality and detailed information regarding assault attendances to Emergency Departments can be used to support those working locally in policing, community safety and licensing. Data from Arrowe Park Hospital allows the identification and monitoring of where assaults are occurring, how they are occurring and potentially why they are occurring. Specifically for use in licensing reviews, the high level of detail collected around the location of assault allows local partners to easily identify licensed premises where a high level of violence is taking place. Accompanying data, such as the date and time of assault, whether the perpetrator or victim of violence had been drinking and whether the assault occurred inside or outside the premises creates a detailed picture of the circumstances under which an assault occurred. This data in conjunction with other health and police data sources can be used to strengthen a case during a license review process.

Box 1: The view from Wirral Borough Council

We in Wirral are doubly blessed in TIIG terms. Firstly, our major hospital, Wirral University teaching Hospital at Arrowe Park, is one of the most outstanding in the region at collecting data for TIIG. The tireless work of the A&E staff involved in this (in face of so many other challenges) provides the foundation of some of the most comprehensive and accurate TIIG reports available. Secondly, the excellence of the Centre for Public Health team who work on TIIG and the strength of the relationship we have with them has turned a comprehensive data set into a highly useful and adaptable report.

One direct outcome of this has been the establishment of the 'Wirral TIIG Scrutiny Group'. Spurred on by the availability of such excellent data, public health, the police, the local licencing team and key hospital staff have come together in the group to review TIIG reports and challenge each other about what we are doing about any trends identified.

A further outcome is that, by working with CPH TIIG team, the final reports Wirral receives have been adapted and modified to be better fit for our purposes. CPH recently made no fewer than nine changes to the way Wirral TIIG reports are presented including:

- The creation of a rolling data file;
- Data summaries now presented in numbers *and* percentages;
- Inclusion in the summary of number/percentage of assaults which occurred at licence premises; and,
- The summary for all assault attendances is further broken down to present figures for incidents which occurred within Wirral local authority as opposed to other areas such as Liverpool City Centre.

All in all, TIIG data and the way we have developed it in partnership with CPH leaves Wirral better informed and better able to act effectively be that targeting campaigns and resources more intelligently or getting actively involved in the licencing process and using TIIG data to support representations.

Gareth Hill, Public Health Manager, Wirral Borough Council

CASE STUDY 2: ROYAL PRESTON HOSPITAL

Royal Preston Hospital ED, situated in Lancashire, is part of Lancashire Teaching Hospitals NHS Foundation Trust. Lancashire joined TIIG in 2008 and data are available from April 2006. Data sharing is well established in Preston, with effective partnership working between the ED, the Community Safety Partnership, public health and the police. The data sharing process in Lancashire involves TIIG collating injury data from all the EDs across the county into one data file and sharing this with the Multi-Agency Data Exchange (MADE), a service delivered on behalf of Lancashire County Council, on a monthly basis. MADE is a collation and dissemination facility which provides a reliable multi-agency information exchange for local partners responsible for improving community safety across Lancashire. Information is disseminated via a secure microsite which is only accessible by members registered with the MADE Partnership.

Royal Preston Hospital ED is fully compliant with the CEM recommended dataset and also collects further data for assault-related injury attendances. The following enhanced data are collected electronically via their patient management system, QuadraMed:

- Assault date
- Assault time
- Assault weapon
 - Body part
 - Sharp object
- Assault location
- Assault location details [free-text]
- Whether alcohol has been consumed in the 3 hours prior to the incident
- Location of where alcohol was last consumed (general description and specific details [free-text] are collected)
- Whether the incident has been or will be reported to the police

As requested by partners, the Trust agreed in December 2014 to start collecting information regarding the victim's relationship to attacker. The data item was planned to be added to the QuadraMed IT system in January 2015 which would enable data collection via a drop-down menu¹⁶.

The majority of data items are collected by receptionists when they present at the ED, unless they arrive by ambulance. The assault weapon is collected by a clinician (e.g. triage nurse or doctor) and recorded in the patient's triage notes. This is then entered onto the IT system by reception staff.

¹⁶ As of March 2015 this is yet to come into effect.

Data item	Completion rate
Date of assault	97%
Time of assault	42%
Location of assault, e.g. nightclub, pub, home	100%
Detailed location of assault, e.g. name of pub, club	73%
Weapon used in the assault, e.g. body part, blunt object	57%
Specific body part used, e.g. fist, foot	93%*
Specific sharp object used, e.g. knife, bottle	94%*
Whether the patient has or intends to inform the police of the assault	23%
Had the patient consumed alcohol up to three hours prior to the assault	100%
If alcohol had been consumed, where was it consumed, e.g. nightclub, pub, home	56%^
Detailed location of last drink location, e.g. name of pub, club	41%^

* Percentage of records where body part/sharp object are specified as assault weapon.

^ Percentage of records where alcohol was consumed prior to the incident.

Table 8 - Royal Preston Hospital assault data items and completion rates (2013/14)

Box 2: Good practice: A&E Reception at Lancashire Teaching Hospitals

Engagement of A&E reception staff is crucial to the collection of comprehensive and high quality data. Given below is an overview of information collection processes at Lancashire Teaching Hospitals from the perspective of the Reception Manager.

"The receptionists are quite comfortable asking the questions for the assault data. Most of the time the patient is willing to answer the questions, the difficulties arise when the patient is drunk and not understanding what they are being asked. The only question they seem to have a problem with is when the patient is asked "have you reported the incident to the police" quite often the response the receptionist gets is "you're not going to ring them are you" but once it has been explained to them that we won't be ringing the police they are ok.

To help remind the receptionists about the importance of asking the assault data questions, I print off the reports that the TIIG team send to us highlighting the missing data, I have also put memos on the reception information clipboard to remind the staff about collecting the data." *Linda Simms, Acting Reception Manager, Lancashire Teaching Hospitals.*

TIIG data sharing and usage across Lancashire has benefitted greatly from the work of committed Reception Managers; the above is an example of good practice from Lancashire Teaching Hospitals. In addition to understanding and promoting the value of TIIG, practical solutions are offered to combat barriers encountered by both patients and reception staff. Providing patients with reassuring information about how the data is used can improve compliance and completion rates of data fields. Similarly, providing memos for staff which clearly outline what information is required and where improvements could be made, constitute good practice in terms of maintenance and development of the data collection process.

Multi-agency meetings take place at Royal Preston Hospital on a quarterly basis. These are well established and attended by the TIIG Project Lead, the Trust's Acting Reception Manager, Lancashire County Council's Senior Public Health Co-ordinator, Lancashire Constabulary's Licensing Sergeant for Preston, Chorley, South Ribble and West Lancashire and the Community Safety Manager for Preston's Community Safety Partnership. During these meetings, partners discuss completion rates and data quality, data collection in regards to meeting local public health priorities, examples of data use by local partners and receive a general update on the progress of TIIG across the county and regionally.

Box 3: The use of TIIG data in making Preston safer

In December 2012, Lancashire Constabulary submitted an application to review the licence of a nightclub in Preston city centre due to crime and disorder associated with the premises. The following month, public health at the PCT submitted information collected by Royal Preston Hospital ED (cleaned and processed by TIIG) to support this review, including:

Numbers attending Royal Preston Hospital ED following an assault which stated they occurred at the licensed premise;

Times and days of assaults;

Weapons used;

Age and gender of attendees;

Outcome of attendances e.g. admitted to hospital, discharged from hospital, referred for further treatment, left department without treatment; and,

Whether the incident was reported to the police.

Alongside police evidence, in June 2013 ED data were presented in an aggregated format at the licence hearing in line with the local information sharing protocol, with numbers less than five suppressed to ensure patient anonymity. The hearing resulted in 30 conditions being attached to the licence, including some at the request of Lancashire County Council Public Health Team:

Open drinking vessels to be made of polycarbonate material;

Adequate seating away from dance areas to promote a calmer drinking environment;

Bar staff to receive comprehensive bar server training upon commencement of post and monthly thereafter; and,

Adoption of the *Safer Clubbing Guidance for licensing authorities, club managers and promoters*.

Moreover, the hearing resulted in the commitment of the venue's operator to carry out a significant refurbishment, installation of additional closed-circuit television (CCTV) cameras at the entrances and exits and increased security personnel. The nightclub re-opened in August 2013.

In the year following this review, compared to the preceding year there was a 59% decrease in the number of individuals attending Royal Preston Hospital ED following an assault in this nightclub (see Appendix 1).

With thanks to Andy Ashcroft, Senior Public Health Coordinator, Lancashire County Council

Local partners have access to Royal Preston Hospital ED's data on a monthly basis and data contributes to various public health objectives, including the maintenance of a responsible licensing authority in Preston. TIIG data allows for the identification of problematic premises based on the number and nature of assaults that take place within them. The drop-down menu on the Trust's IT system allows staff to capture whether the incident occurred inside or outside of a venue, with free-text space to record specific location details. The ability to confirm that incidents have occurred inside an establishment supports public health by providing robust evidence within licence hearings. A specific example of TIIG data being used in the licensing process is presented in Box 3.

As the focus of this report is on Merseyside and Cheshire, data from Royal Preston Hospital has not been provided¹⁷. However the information provided on data items and sharing practices can be used to highlight how well collected and shared data can be used effectively to support the licence review process (see Box 3 for a detailed example). While it is not possible to fully attribute a reduction in violence to improved data sharing, Royal Preston Hospital has experienced a 16% reduction in the number of assault related attendances since they began collecting enhanced assault data¹⁸.

THE CURRENT PICTURE IN MERSEYSIDE AND CHESHIRE

This report highlights how effective data collection and sharing regarding assaults and alcohol can be used to help support the licence review process. Examples have been provided of both good data collection and sharing practices from two EDs across the North West. However both Arrowe Park Hospital and Royal Preston Hospital have been part of the TIIG surveillance system for many years and reaching this standard of data collection and sharing has been a gradual process. While not all EDs are currently collecting data to the same levels, work is being undertaken to improve data quality across the whole of Merseyside and Cheshire. Table 9 shows the extent of assault and alcohol related data collection across Merseyside and Cheshire. While some EDs are not collecting assault data, ongoing measures are being undertaken to improve the level of data collection across Merseyside and Cheshire. This includes:

- Multidisciplinary meetings at ED sites which are attended by representatives from TIIG, ED receptions, those working with the patient information systems and local partners and are used to discuss the potential for additional questions to be included on the ED information systems. From these meetings:
 - The potential for Aintree Hospital to share assault data has been discussed.
 - Whiston ED, who began collecting enhanced assault data in April 2014, now shares data with local partners on a monthly basis.
 - The Countess of Chester Hospital has commenced sharing all attendance data with TIIG during 2014 which includes enhanced assault data. This enhanced data is now being shared on a monthly basis with local partners.
 - Warrington Hospital commenced sharing all attendance data with TIIG during 2014 which includes enhanced assault data. This enhanced data is now being shared on a monthly basis with local partners.

¹⁷ For those working locally in violence who wish to access Royal Preston Hospital assault data please contact tiig@lpmu.ac.uk for details. To see an overview of all attendances to Royal Preston Hospital please visit <http://www.cph.org.uk/tiig/lancashire/#ED011>.

¹⁸ Royal Preston Hospital began collecting enhanced assault data in January 2011. The percentage given compares the financial year 2011/12 to 2013/14.

- Modifications were made to enhanced assault data collection; both Arrowe Park Hospital and The Royal Liverpool University Hospital began collecting whether an assault occurred inside or outside a licenced premise in early 2014; and assault date, time and whether alcohol had been consumed prior to an assault, began to be collected at Southport District General Hospital from October 2014.
 - Identification of IT system limits are discussed with EDs. It was identified at some sites that their IT system did not allow modifications to existing data items or additions of new data items. Such limitations inhibit the ED in improving data quality and completeness but open dialogue between TIIG and EDs in question raise awareness and assist in initiating improvements to IT systems. In these instances discussions will be kept open and the opportunities for potential improvements will be explored.
- Monthly completion rates for assault data items are shared with local partners on a monthly basis where requested or required. These overview files allow for easy documentation of progress and identification of where improvements need to be made.
- The design, production and distribution of posters for both ED staff and patients who have been victims of assaults. Posters, placed in the ED waiting areas, have been designed to reassure victims of assaults that the information they volunteer will remain confidential and that shared information will be anonymised. According to ED staff, such reassurance is likely to help overcome barriers relating to non-compliance in the data collection process. Posters for staff, placed behind reception desks, have been designed to address the reported reluctance among ED staff to ask questions relating to assaults by providing information regarding how the data is used and where data use had successfully reduced community violence and therefore hospital admissions (see Appendices 2 and 3).

Area	Emergency Department	Date of assault	Time of assault	Assault location	Specific location	No. of attackers	Gender of attackers	Assaulted by attacker before	Relationship to attacker	Weapon	Was attacker drunk	Inform the Police	Consumed alcohol 3 hours previously	Location of last drink consumed	Specific location of last drink
Merseyside	Alder Hey Children's Hospital	N	N	N	N	N	N	N	N	N	N	N	N	N	N
	Aintree University Hospital	Y	Y	Y	Y	N	N	Y	Y	Y	N	Y	Y	Y	Y
	Arrowe Park Hospital	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	Y
	Southport District General Hospital	Y	Y	Y	Y	Y	Y	N	Y	Y	N	Y	Y	Y	Y
	Royal Liverpool University Hospital	Y	Y	Y	Y	N	N	N	Y	Y	N	N	Y	Y	Y
	Whiston Hospital	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Cheshire	Countess of Chester Hospital	N	N	Y	Y	N	N	N	Y	N	N	N	N	Y	Y
	Leighton Hospital	N	N	N	N	N	N	N	N	N	N	N	N	N	N
	Macclesfield Hospital	N	N	N	N	N	N	N	N	N	N	N	N	N	N
	Warrington Hospital	Y	Y	Y	Y	N	N	N	N	Y	N	N	N	N	N

Table 9 - Assault data items collected across Merseyside and Cheshire

RECOMMENDATIONS

1. Health data should be used alongside other data sources to support injury and violence prevention work at a local level.

As the co-ordinators of Emergency Department (ED) injury data across the North West of England, the Trauma and Injury Intelligence Group (TIIG) are aware of the potential uses of ED data within licence review processes. ED data can be used to identify the number of incidents and the nature of violence which has not been reported to the police, data which would not otherwise be available and which supplements existing data sources. Effective, detailed data collection with a specific focus on when, where, how (i.e. weapon used) and why (i.e. whether the assault was alcohol related) an incident of violence has occurred from EDs across Merseyside and Cheshire can greatly assist the identification of problematic licenced premises and the specific issues associated with that venue. From this information specifically derived conditions can be attached to the renewal of particular licenses, which can help prevent assaults in the future.

2. Area wide meetings should be held to discuss the collection of ED data to support the licence review process. The licence review process is an increasingly collaborative process with local health bodies such as hospitals being able to initiate a licence review (Government's alcohol strategy, 2012). The licence review process should not be considered the sole responsibility of those working in licencing; rather a multidisciplinary approach should be undertaken to help improve the quality of ED data which could help support a licence review. In this recommendation, proposed meetings would bring together representatives from TIIG, the EDs and those working in the licence review process from across Merseyside and Cheshire. For each area, meetings could be held quarterly throughout 2015/16, each with a specific focus and with different representatives taking the lead for separate meetings. The meetings would comprise:

- a. Learning about licensing – the aim of this meeting would be to discuss what the licensing process involves, why it is important, the impact effective license reviews can have and why the inclusion of ED data is important for the licence review process.
- b. Learning from the experts – Arrowe Park Hospital has been collecting detailed high level assault data for a number of years. This second session would involve the identification of barriers to the collection of enhanced assault data at other EDs and insight from Arrowe Park Hospital on how such barriers could be overcome.
- c. Learning about data sharing – the aim of this meeting would be to emphasise TIIG's role in the data sharing process with a particular focus on how TIIG can support EDs in collecting new data items through training sessions, meetings, delivery of completion rates and local partner feedback regarding data use.
- d. Bringing it all together – this final meeting would be to focus on collating what has been learnt and discussing the next steps in improving assault data collection across Merseyside and Cheshire.

3. Action plans should be developed for each ED. Alongside the meetings detailed above, TIIG could develop individual action plans for each ED across Merseyside and Cheshire. The action plans would be developed with the EDs involvement, and seek to investigate where the potential for improvements could be made, setting realistic and time-bound goals. Potential areas for development may include the improvement in the level of completion of data items, the addition of extra data items, the detail of information recorded and the timeliness of data provided.

4. **Data which are currently being collected should be utilised by local partners.** While not all EDs across Merseyside and Cheshire are collecting enhanced assault data to optimum standards, most are collecting at least partial datasets. It is estimated that around 80% of assaults which require ED treatment are not reported to the police and even those ED datasets with low completion rates may still provide useful data which would not otherwise be reported or shared. TIIG could also ensure that local partners understand the level of data which is available from EDs and ensure that data is shared in a timely manner.
5. **A constant feedback cycle should be employed.** There are increasing pressures on EDs to meet targets and there should be an acknowledgement that asking EDs to collect more information is adding to those pressures. Previous discussions between TIIG and EDs have identified that notification of where ED data has been used effectively could be a motivating factor in the continued collection and improvement of information. TIIG could ensure that ED staff are kept up to date on where data has been used by local partners and what the consequences have been; this should not be exclusively limited to where data has been used in the licensing process. In addition, local partners are often best placed to identify shortfalls in the data. For example the recent inclusion of inside/outside to licenced premises assault location was first identified and requested by those working in the licence review process. Local partners, TIIG and the EDs should ensure they are working cooperatively to proactively address changing policy and demands by considering where data can be used or modified to address emerging issues.
6. **ED data collection should go beyond the guidelines.** The guidelines set by the College of Emergency Medicine and the Standard on Information Sharing to Tackle Violence recommend that data collected on assault attendances should include date/time of assault, location of assault and weapon used in the assault. However additional data items, for example whether the incident was reported to the police, have also been used as part of a successful licence review. Beyond licensing, information such as the relationship between victim and perpetrator of violence could be useful in identifying and preventing incidents of domestic violence. Similarly, understanding whether the assault was a repeat offence by the same perpetrator could be useful in identifying and preventing incidents of bullying, especially among young people.

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Role of Public Health in Licensing

Using Accident and Emergency Department Intelligence to Inform the Public Health Function as a Responsible Authority in Licensing in Preston, Lancashire
Andrew Ascroft Senior Public Health Co-ordinator Lancashire County Council

Background

The Police Reform and Social Responsibility Act 2011 outlined changes to the Licensing Act 2003. These changes included the addition of Primary Care Trusts (PCTs) as Responsible Authorities. On 1st April 2013 this function transferred to Directors of Public Health in Local Authorities. During the transition the PCT (Central Lancashire) and Public Health at Lancashire County Council implemented this role effectively to support the review of a Preston city centre nightclub licence, resulting in a reduction in the number of individuals attending the local Accident and Emergency Department due to assaults at the nightclub.

The Information Sharing Process

- 1 When individuals attend Lancashire Teaching Hospitals NHS Foundation Trust Accident and Emergency Department following an assault the following information is recorded:
 - Assault weapon used
 - Detailed assault location
 - Incident date
 - Incident time
 - Whether police have been informed
 - Whether alcohol was consumed prior to incident
 - Location that last drink was consumed

The Licence Review Process

December 2012: Lancashire Constabulary submitted an application to review the licence of a nightclub in Preston city centre due to crime and disorder associated with the premises.

January 2013: Public Health at the PCT submitted information to support this review outlining numbers of individuals attending Lancashire Teaching Hospitals Accident and Emergency Department following an assault when they stated took place in the nightclub.

June 2013: Representatives from Lancashire Constabulary and the Public Health Team at Lancashire County Council presented their evidence at a licensing hearing.

Hearing Outcome: The hearing resulted in a new licence being granted for the premises with new conditions attached, and a commitment by the premises operator to carry out a refurbishment.

- 2 This information is shared monthly with the Trauma Injury Intelligence Group (TIIG) at Central Lancashire who share the data.

- 3 TIIG forward the cleaned data to Lancashire Multi-Agency Data Exchange (MADE) who make it available to relevant Lancashire Community Safety Partnership organisations.

- 4 Lancashire Constabulary and Public Health at Lancashire County Council jointly review this data each month to inform their joint licensing activity.

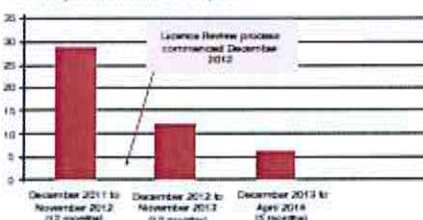
Licence Conditions

There are now 30 conditions attached to the licence for Nightclub X. At the request of the Public Health Team at Lancashire County Council these include the following evidence based conditions:

1. Open drinking vessels will be made of polycarbonate material
2. The design of the venue will ensure adequate seating is provided away from dance areas to promote a calmer drinking environment
3. All bar staff to receive comprehensive responsible server training at commencement of post and every month thereafter
4. 'Safer Clubbing Guidance' for licensing authorities, club managers and promoters will be adopted by the venue

Impact

Number of individuals attending Lancashire Teaching Hospitals NHS Foundation Trust Accident and Emergency Department Following an Assault at Nightclub X in Preston City Centre December 2011 to April 2014



Lessons Learnt

- Implement accident and emergency department data sharing in line with College of Emergency Medicine 'Guidelines for Information sharing to reduce community violence'
- Establish information sharing protocols that allow aggregated accident and emergency department information to be shared in the public domain as part of the licensing process
- Identify evidence based interventions that can be utilised as licensing conditions
- Establish good working relationships between police licensing teams, accident and emergency departments and public health teams

Lancashire Teaching Hospitals
NHS Foundation Trust



Lancashire
Constabulary



Lancashire
County Council



www.lancashire.gov.uk

For patients who have been assaulted...



Hospital A&E staff may ask you questions about your assault. This includes:

- Where you were assaulted
- When you were assaulted
- How you were assaulted
- Whether alcohol was involved
- Details about your attacker

While this information is shared with other agencies, **your personal information is not.**

Information collected is used to help target:

Interventions to
prevent violence



Police safety in
hotspot areas



Alcohol licensing
rules



For more information please contact Simon Russell
(Trauma & Injury Intelligence Group)

Tel: 0151 231 4500 | Email: s.j.russell@lmu.ac.uk



ED Staff - Assault Injuries

We understand that Hospital EDs are very busy but the data you collect in relation to assaults is vitally important. Data you collect allows police and community partners to develop and implement targeted prevention activities in your local area. Prevention activities can lead to reductions in violence in the community and reductions in assault attendances in your A&E. In the last 3 years, since additional data has been collected, some EDs have experienced a **45% reduction** in the number of assault-related injury attendances.

The Process...



Assault-related data is collected in the ED and is sent to the Trauma and Injury Intelligence Group (TIIG) on a monthly basis



TIIG collates, processes and shares the assault data.



Assault data is shared with public health practitioners, Community Safety Partnerships, local police, licensing authorities and NHS Trusts

Please check you have recorded:

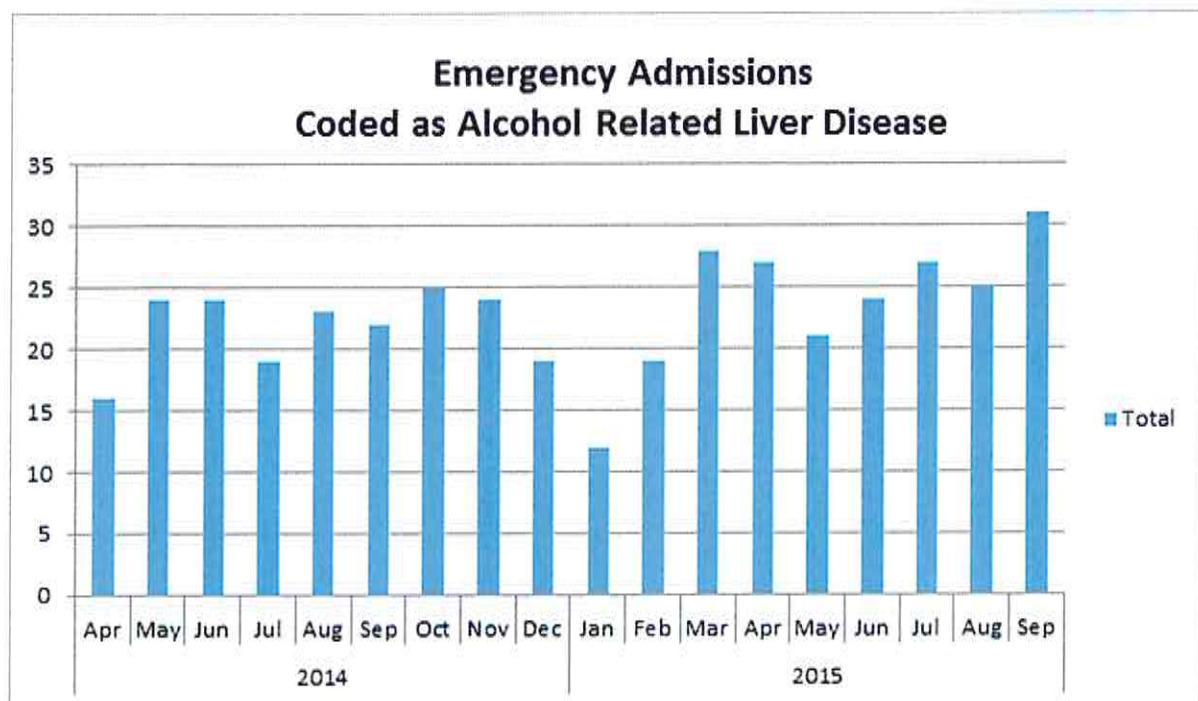
- ✓ Date and Time of assault
- ✓ Assault location and detailed description of location
- ✓ No of attackers, relationship to attacker and whether patient had been attacked by them before
- ✓ Assault weapon
- ✓ Whether attack was reported to the police
- ✓ Whether or not, how much and where alcohol was consumed prior to the attack

Assault data is used for targeting interventions to prevent violence, targeting police enforcement in hotspot areas and targeting alcohol licensing enforcement.



For more information please contact Simon Russell (TIIG Project Lead)
Tel: 0151 231 4500 | Email: s.j.russell@lmu.ac.uk





Row Labels	Count of PATIENT_ID
2014	
Apr	16
May	24
Jun	24
Jul	19
Aug	23
Sep	22
Oct	25
Nov	24
Dec	19
2015	
Jan	12
Feb	19
Mar	28
Apr	27
May	21
Jun	24
Jul	27
Aug	25
Sep	31
Grand Total	410