

Health

National report

February 2007

 **audit**  
commission

Healthcare  
Commission 

# Better safe than sorry

Preventing unintentional  
injury to children



The Audit Commission is an independent body responsible for ensuring that public money is spent economically, efficiently and effectively, to achieve high-quality local services for the public. Our remit covers around 11,000 bodies in England, which between them spend more than £180 billion of public money each year. Our work covers local government, health, housing, community safety and fire and rescue services.

As an independent watchdog, we provide important information on the quality of public services. As a driving force for improvement in those services, we provide practical recommendations and spread best practice. As an independent auditor, we ensure that public services are good value for money and that public money is properly spent.

For further information about the Audit Commission, visit our website at [www.audit-commission.gov.uk](http://www.audit-commission.gov.uk)

The Healthcare Commission exists to promote improvements in the quality of healthcare and public health in England and Wales. In England we are responsible for assessing and reporting on the performance of both NHS and independent healthcare organisations, to ensure that they are providing a high standard of care. We also encourage providers to continually improve their services and the way they work.

For further information about the Healthcare Commission, visit our website at [www.healthcarecommission.org.uk](http://www.healthcarecommission.org.uk)



Photographs: Paul Dodd (front cover, p11, p27) and Getty Images (p51)

Printed in the UK for the Audit Commission by CW Print

Design and production by the Audit Commission Publishing Team

Executive summary	4
-------------------	---



<b>1 Introduction</b>	<b>11</b>
-----------------------	-----------



<b>2 The findings of the study</b>	<b>27</b>
------------------------------------	-----------



<b>3 Conclusions</b>	<b>51</b>
----------------------	-----------

Recommendations	59
-----------------	----

Appendix 1	61
------------	----

Appendix 2	63
------------	----

References	71
------------	----

© Audit Commission 2007

First published in February 2007 by the Audit Commission for local authorities and the National Health Service in England, 1st Floor, Millbank Tower, Millbank, London SW1P 4HQ

ISBN 1 86240 529 8

## Executive summary

- 1 Unintentional injury is a leading cause of death and illness among children aged 1-14 years, and causes more children to be admitted to hospital each year than any other reason. It is a major concern for all those seeking to improve health and reduce inequalities. Commitment to public health has gained momentum in recent years, particularly with the focus on promoting health, preventing ill-health, making long-term improvements to the health of the population and the need to control the rising costs of healthcare to the National Health Service (NHS).
- 2 This joint study by the Audit Commission and the Healthcare Commission examines the deployment of resources, arrangements for working in partnership and activities to prevent unintentional injury to children, especially the under fives.
- 3 Each year in the UK, unintentional injury results in more than six million visits to accident and emergency (A&E) departments. Approximately two million of these involve children. This costs the NHS approximately £146 million. Half of these injuries occur in the home. Unintentional injury therefore represents a significant burden to the NHS, to local government and to the families and individuals affected by it. For example, in England in 2004/05, unintentional injury resulted in approximately 120,000 admissions to hospital in the 0-14 age group alone. In 2004, 230 children under 15 years of age died in England and Wales from an unintentional injury. In 2001, across all age groups, unintentional injuries cost the NHS an estimated £2.2 billion a year. In addition, unintentional injury in the home costs society an estimated £25 billion a year.
- 4 Overall, deaths from unintentional injury have decreased. However, there are persistent and widening inequalities between socio-economic groups. Children of parents who have never worked, or who have been unemployed for a long time, are 13 times more likely to die from unintentional injury than children of parents in higher managerial and professional occupations.
- 5 Preventing unintentional injury is an important component of wider efforts to improve health. It is a complex area requiring a complex range of responses. Competing local priorities, together with limited resources, often result in short-term solutions which do not secure long-term gains in health. Increasingly, public health is not seen as just the responsibility of any one organisation. However, successful delivery is dependent on partnerships between the NHS, local government and others.

6 The study sought to identify:

- what activities are currently being undertaken to prevent unintentional injury to children; and
- how partnerships across the NHS and local government are working to prevent unintentional injury;

with a view to:

- sharing best practice to help local bodies address unintentional injury in their local area; and
- influencing policymakers to stimulate more effective action on the ground.

7 We visited nine sites across England, including large geographic areas such as Suffolk. Based on the findings from this work, we have identified five key themes where improvements could be made to prevent unintentional injury to children.

## National policy

8 In 1999, the White Paper *Saving Lives: Our Healthier Nation*, made the prevention of injury a priority. It highlighted unintentional injury at the time as the greatest single threat to the lives of children. It recognised that unintentional injury accounted for more children being admitted to hospital than for any other cause. The White Paper set two targets:

- 1) to reduce the death rates from accidents (in all age groups) by at least one-fifth; and
- 2) to reduce the rate of serious injury from accidents by at least one-tenth by 2010.

9 Data from the Department of Health (DH) for 2002-04 show that it is not on course to achieve either target for adults. Since 1995-97 (the baseline set for the targets) the death rate for all ages has risen by 1 per cent and the serious injury rate by 4 per cent. *Saving Lives* did not set a target specifically for children, but for those under five years of age there has been a decrease of 19 per cent in the death rate, and a decrease of 31 per cent in the rate of serious injury. The breakdown for children under 15 years similarly shows improvement, with a decrease of 29 per cent in the death rate, and a decrease of 34 per cent in serious injury. This progress is very welcome. One explanation for these reductions could be the improvements made in road safety as a result of the Public Service Agreement (PSA) set for a reduction in road traffic accidents. However, because of the complexity of the issues and the lack of relevant data, the full reasons for these changes remain unclear.

- 10 Since the White Paper in 1999, subsequent documents on health policy from the government have not given the same priority to injury prevention. At present, there is no single, clear cross-governmental statement which draws together what has to be done to reduce unintentional injury. As a result, those charged with developing and implementing strategies to prevent unintentional injury face a challenge in maintaining the profile of the issue at local level.

## Local strategy

- 11 In the absence of any high-priority, central requirements there were few incentives to identify individuals with the authority and resources to build and implement injury prevention strategies. Without high-level support, the long-term sustainability of programmes was threatened. A lack of strategic plans, local action plans and coordination resulted in duplication of effort, and a loss of focus and drive for some local approaches. We found little evidence of systematic strategic approaches to develop, implement and monitor programmes to prevent unintentional injury in children. This is an area in which considerable improvements need to be made if delivery of the longer-term objectives is to be successful.
- 12 Public health is increasingly the responsibility of local organisations. It is shared by a number of agencies that make up local strategic partnerships (LSPs) which have a duty to promote health and well-being. Local area agreements (LAAs) also provide a number of opportunities to address unintentional injuries.
- 13 *Every Child Matters*, which sets out ambitious plans for how children's services should be delivered locally, established local safeguarding children boards (LSCBs) with duties to ensure that young people are safeguarded and their welfare is promoted.
- 14 Engaging relevant local bodies in tackling unintentional injuries in some circumstances may be particularly challenging. We found that, with no clear direction from government, local agencies faced competing demands. Furthermore, local work often reflected the preferences of those charged with shaping strategy. For example, where directors of public health took a lead, programmes often had a strong focus on promoting health. Elsewhere, where directors of children's services led the work, activities often focused on the welfare of children and family relationships.

## Partnerships

- 15 Partnerships are the key to the delivery of strategies aimed at preventing unintentional injury and require cooperation at a local level. We found that the success of partnerships varied according to the longevity of the arrangements in place and the constitution of partnerships. Successful partnerships had a number of common characteristics including coterminous local authorities and primary care trusts (PCTs), strong leadership and project champions.
- 16 Building effective partnerships takes time and sustained commitment from all partners involved, particularly as benefits may not become apparent for many years. The recent restructuring of the NHS may have a potentially destabilising effect on some partnerships as they are dissolved and new ones established. However, it also provides opportunities to re-emphasise the priority to be given to the prevention of unintentional injury and to overcome difficulties caused by a lack of coterminous boundaries.

## Resources

- 17 Providing adequate resources for partnerships and strategies for prevention was a key issue. Between 2005 and 2008, the DH is investing £1 billion in addition to mainstream funding to encourage people to take responsibility for their own health. Concerns were expressed that funds earmarked for activities aimed at improving health were being used to relieve pressures elsewhere, for example, deficits in the acute sector. However, there are limited data to assess changes over time in resources allocated to public health so it is difficult to determine whether these concerns are warranted. This could be addressed through the DH's work on programme budgeting and on improving information for commissioning. Delivery of injury prevention strategies was often funded by short-term monies, with several partners pursuing similar sources of funding. On occasion there was duplication of effort, working in isolation and a tendency to pursue short-term solutions to long-term problems. Moreover, nationally available guidance on cost-effective interventions which were most likely to work was often not followed.

## Data

- 18 The availability of data was a key issue in relation to monitoring local trends in unintentional injury. Many participants were unclear about what data were available and which organisations held them. Data were held and collected by several local agencies including the NHS, the police and the local authorities, which resulted in duplication of effort. Sharing of good-quality, compatible data is crucial to create targeted, effective strategies to prevent unintentional injury across a local area. There was a perception that partners were unwilling to share data, even that which could be anonymised. Consequently, agencies held data in isolation.
- 19 The same problem also exists at a national level. Since 2003, with the exception of the fire and rescue service, national data on rates of unintentional injury have not been collected. This gap at a national level, coupled with a lack of data at a local level, caused difficulties for organisations in identifying the needs in their area and hence targeting resources appropriately. Furthermore, organisations were unable to monitor and evaluate prevention strategies.

## Conclusions

- 20 Overall, unintentional injury represents a serious risk to the health and well-being of children. Although the mortality rates due to unintentional injuries to children are declining, there is still a high number of injuries occurring, many of which are preventable. Inequalities in incidence and in the risk of unintentional injury continue to exist across geographical areas and socio-economic groups. Unless this situation is addressed at a local level, these health inequalities will continue. Unintentional injury has struggled to be a priority for many organisations as it competes for attention in a crowded public health agenda and has no specific, direct health policy imperative to drive action. The poor collection and sharing of data across organisations is, in part, a result of the lack of coherent national policy. Unintentional injury is one aspect of public health. If it is found to be a particular problem in a specific locality it is important that steps are taken by all local partners to identify the cause, reduce the rates of incidence and tackle associated inequalities.
- 21 This report demonstrates how improvement can be made nationally and locally. The recommendations made in this report could be applied to a number of public health topics providing a valuable contribution to the delivery of public health initiatives.

## Recommendations

**The DH and other central government departments including the Department for Education and Skills (DfES), Communities and Local Government (CLG), Department for Transport and the Children's Commissioner, should together re-focus their approach to unintentional injury by having a coordinated programme, which each can communicate to their relevant local bodies in a consistent way based on:**

- Clarifying the role of regional directors of public health in leading and coordinating the prevention of unintentional injury, as suggested in the report of the Accidental Injury Task Force.
- Re-emphasising the recommendations and strategy set out in the report by the Accidental Injury Task Force and encouraging local organisations to take up and follow the evidence-based guidance contained within the report.
- Commissioning the National Institute for Health and Clinical Excellence (NICE) to develop guidance on the prevention of unintentional injury for children under 15 years of age.
- Encouraging and enabling local government and the NHS to share timely, high-quality, relevant data across organisations.
- Providing support to restore and manage the Home Accidents Surveillance System and the Leisure Accidents Surveillance System currently held by the Royal Society for the Prevention of Accidents (RoSPA), which will enable data to be used in the prevention of unintentional injuries, including the design of safer products and environments as the databases were originally intended.

### **The Healthcare Commission should:**

- Identify opportunities to assess healthcare organisations' efforts to prevent unintentional injury through its process of assessment.

### **PCTs and local councils should:**

- Make maximum use of the financial flexibility open to them, including using Section 31 (1998 Health Act) to pool resources and consider the appointment of jointly funded posts to support and sustain prevention strategies.
- Review their existing partnership arrangements, particularly those that have been affected by the restructure of the NHS, in the areas of organisation, leadership, membership and delivery.

- Develop joint strategic plans and action plans for all strategies aimed at preventing unintentional injury, ensuring the regular review of these plans and the monitoring of outcomes. These plans should ensure that resources are directed towards sustainable evidence-based strategies, avoid duplication of work and are directed at reducing inequalities.
- Regularly review and develop a clear understanding of the rates and types of unintentional injury in their local area, to enable actions and resources to be directed accordingly.
- Determine what local sources of data are available and, where possible, record and share high-quality data across the NHS and local government.
- Influence LSPs to strengthen the focus on unintentional injury in local communities.
- Use local children's trust arrangements, such as children and young people strategic partnerships or LSCBs, as a vehicle to oversee and ensure delivery of prevention strategies. Where appropriate, include the prevention of unintentional injury in LAAs.
- Familiarise themselves and local practitioners with the evidence detailing what works (as outlined in the report of the Accidental Injury Task Force) and target strategies for preventing unintentional injury accordingly.

# 1



## Introduction

Unintentional injury is a leading cause of death and illness in children aged 1-14. There are numerous factors that create the conditions in which these injuries occur such as age, gender, social class, environment and behaviour. But, crucially, many of these injuries are preventable.

- 22 Unintentional injury is a major concern for those committed to improving the health of young people and reducing inequalities among them. The data suggest that while death from unintentional injury is reducing overall, stark inequalities persist. There are numerous factors which impede action. *Choosing Health* (**Ref. 1**) lessened the national impetus for local action. A changing landscape of service delivery raises concerns about the sustainability of activities and competing priorities mean that local organisations face a challenge in maintaining a focus on unintentional injury.
- 23 This report details findings from a joint study undertaken by the Audit Commission and the Healthcare Commission. It examines strategic and operational partnerships across local government and the NHS which seek to prevent unintentional injury to children, discusses the range of challenges and solutions found and provides recommendations for central government, inspectorates, PCTs and local authorities.
- 24 This chapter:
- defines unintentional injury and summarises its impact;
  - describes the policy context, including regulation and inspection;
  - discusses the evidence on what works in preventing unintentional injuries; and
  - sets out the aims and methodology of this study.

## What is unintentional injury?

- 25 For the purposes of this report, the term ‘unintentional injury’ is used in accordance with the forthcoming World Health Organisation (WHO) report on child injury (due in 2008, [www.who.int](http://www.who.int)). Previously, the term ‘accidental injury’ was used to describe ‘injury occurring as a result of an unplanned and unexpected event which occurs at a specific time from an external cause’ (**Ref. 2**). In this report, unintentional injury is used synonymously with accidental injury. Non-accidental and intentional injuries are excluded from this study, although we recognise that the boundaries are blurred when considering child safety. For the purposes of the study, children are defined as aged 0-14 years of age, in line with DH classification.

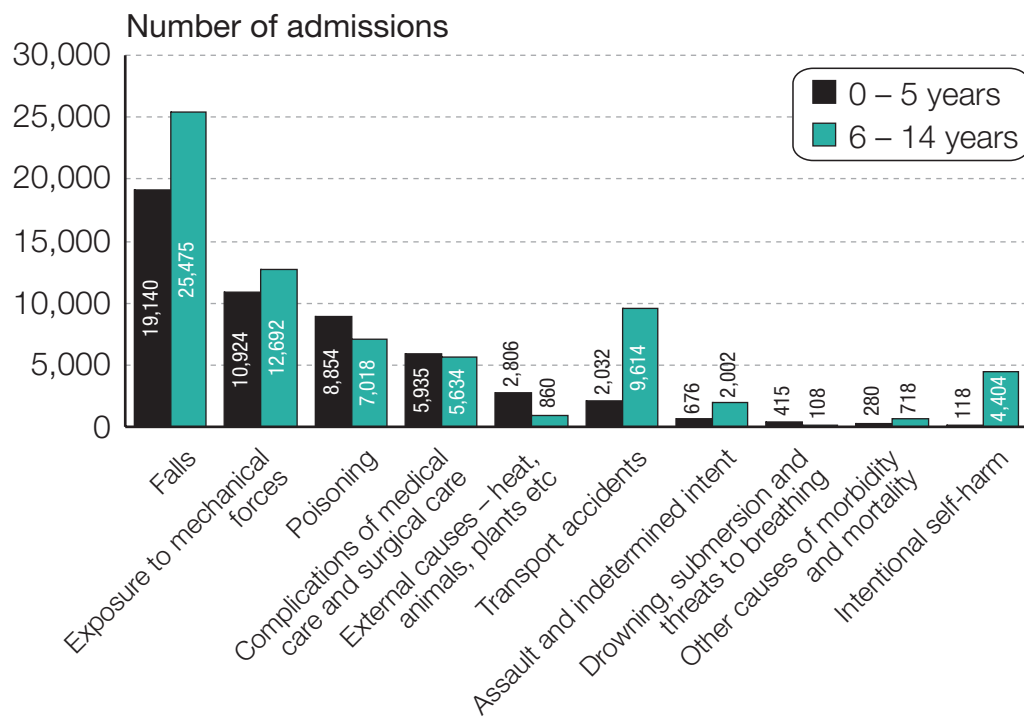
## Unintentional injury in children – the scale and size of the challenge

- 26 Epidemiological data paint a comprehensive picture of unintentional injury and its impact on society. It is a major cause of mortality and morbidity. The WHO estimates that by 2020, unintentional injury will account for the single largest loss of healthy human life years (**Ref. 3**).
- 27 Unintentional injury is a leading cause of death among children aged 1-14 years, and puts more children in hospital than any other cause. Unintentional injury kills three children per 100,000 population, a similar rate to that of cancer. The incidence of death from unintentional injury is marginally higher in boys than girls (**Ref. 4**). In 2004 alone, 230 children under 15 years died in England and Wales from an unintentional injury (**Ref. 5**). Every year, approximately 50 children die as a result of a fire in the home, but many more are injured (**Ref. 6**). Falls, poisonings and drowning are all significant causes of death among children. Five per cent of all road traffic accidents involve children and they are a leading cause of child fatalities. In 2005, 141 children were killed on the roads, and 3,472 were killed or seriously injured (**Ref. 7**).
- 28 Children under five years old carry a disproportionate burden of injuries from falls and fires. They suffer nearly 45 per cent of all severe burns and scalds (**Ref. 8**). About 50 per cent of these happen in the kitchen and approximately 50 per cent of all injuries to the under fives occur in the home. In 1997 and 1998, children under five represented 71 per cent of childhood fatalities from fire (**Ref. 9**).
- 29 Each year in the UK, non-fatal injury results in more than six million visits to A&E departments and approximately two million of them are children. This costs the NHS approximately £146 million.<sup>1</sup> However, these figures do not include children who are treated by family doctors or those treated at home and therefore should be regarded with caution in making judgements about the size of the problem. In England in 2004/05, unintentional injury resulted in 119,518 admissions to hospital for the 0-14 age group alone (**Ref. 10**). Rates for 2005/06 show an increase of 0.2 per cent. Recent evidence has shown that death rates among children as a result of unintentional injury are falling (**Ref. 11**). However, overall the incidence of unintentional injury is still high and, importantly, many of these injuries and related deaths are preventable. **Figure 1 (overleaf)** shows the breakdown of unintentional injury across the 0-14 age group resulting in admission to hospital.

---

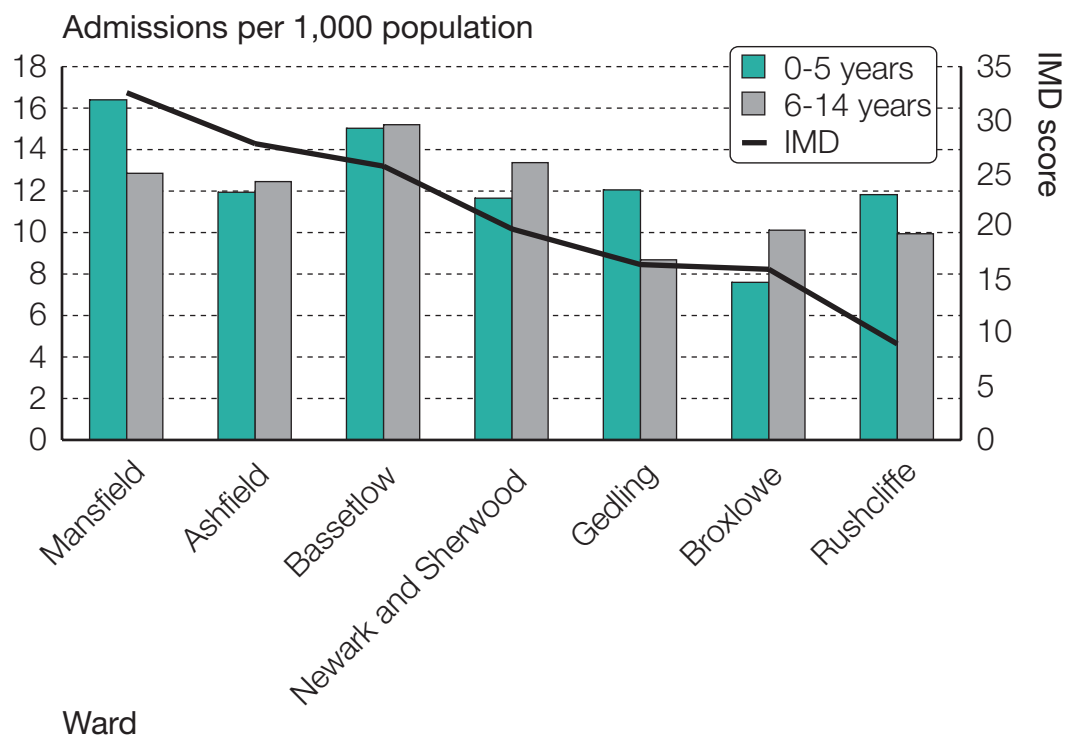
<sup>1</sup> Standard attendance at A&E costs £73.

**Figure 1**  
**Admissions to hospital by age and cause**



**Source:** Hospital Episode Statistics (HES) data 2005/06

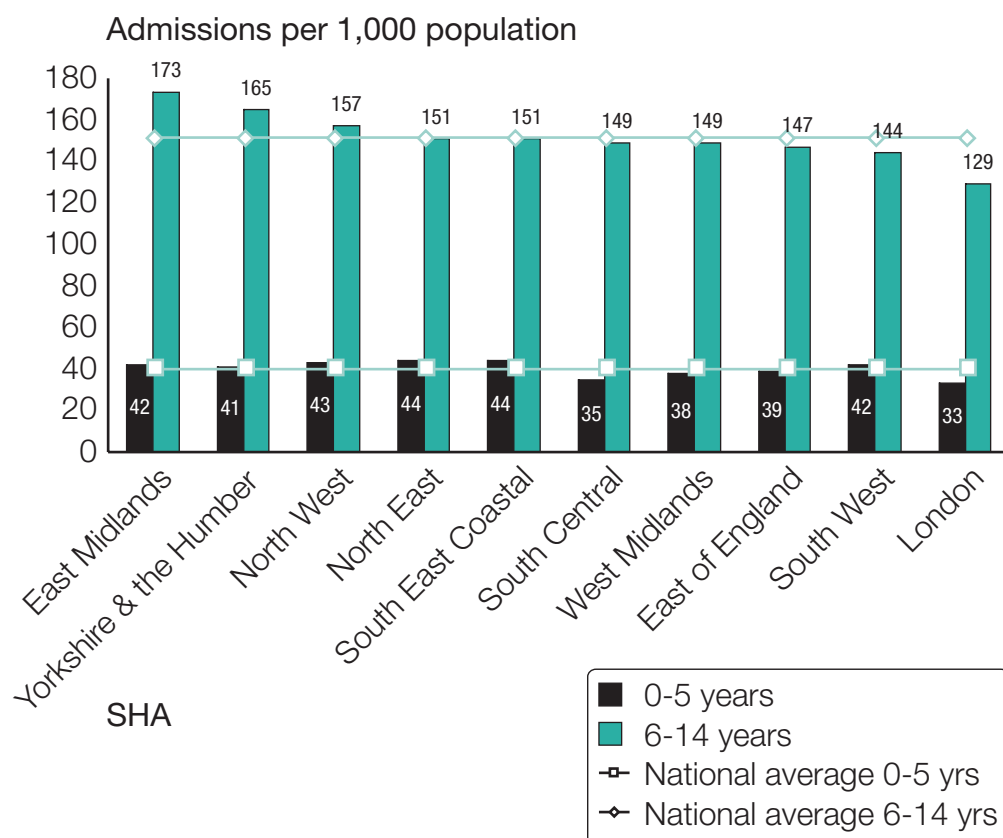
- 30 Rates of unintentional injury in children show strong and persistent inequalities. There are enduring and widening differences across ages, population groups and geographical areas.
- 31 The Department for Trade and Industry’s (DTI) Home Accidents Surveillance System revealed that residential areas with higher proportions of lower socio-economic groups have higher rates of unintentional injury. The statistical relationship is most marked for children under 16 years, and particularly the under fives. Children of parents who have never worked or who are long-term unemployed are 13 times more likely to die from unintentional injury, and 37 times more likely to die as a result of exposure to smoke, fire or flames than children of parents in higher managerial and professional occupations (Ref. 11). In England, children in the 10 per cent most-deprived wards are three times more likely to be hit by a car than children in the 10 per cent least-deprived wards (Ref. 12). In addition, fatality is twice as likely in boys as girls (aged 1-14), a gap that increases with age (Ref. 9).

**Figure 2****Admissions for children aged 0-5 and 6-14 by ward in Nottingham**

Source: HES data 2005/06

- 32** Figure 2 shows admissions for children aged 0-5 and 6-14 by ward for Nottingham with the wards' Index of Multiple Deprivation (IMD) score. This highlights that, on the whole, the higher the level of deprivation, the higher the incidence of unintentional injury.
- 33** Figure 3 (overleaf) shows the spread of unintentional injury for the 0-5 and 6-14 age groups across strategic health authorities (SHAs), which highlights that even in geographic areas as large as SHAs there are marked differences in hospital admissions. The lines which cut across the shaded boxes show the national average for each age group.

**Figure 3**  
**Admissions for children aged 0-5 and 6-14 by SHA**



Source: HES data 2005/06

### The cost of unintentional injury

- 34 Unintentional injury represents a significant burden to the NHS, local government and the families and individuals affected by it.
- 35 Across all age groups it costs the NHS £2.2 billion a year. Unintentional injury in the home costs society an estimated £25 billion a year (Ref. 13). Fire continues to impose significant costs on the economy of England and Wales. In 2004, the total cost was estimated at £7.03 billion (Ref. 14). The total cost of unintentional injury in London alone is estimated to be £19.7 billion, which includes indirect costs (direct costs for health and

social care are estimated at £290 million) **(Ref. 13)**. Individual treatment costs can be significant. For example, it can cost as much as £250,000 to treat one severe bath water scald **(Ref. 15)**.

- 36 Little is known about the value of prevention activities, but the total value of prevention of all road accidents in 2004 was estimated to be £18 billion alone **(Ref. 16)**. An annual report details the cost of fire prevention and is provided to central government by the fire and rescue service **(Ref. 14)**.
- 37 There are several indirect costs associated with unintentional injury to children, aside from the physical impact. Absence from school is the main indirect cost and in the case of those children aged 0-5 who are too young to attend school, or older children who require supervision, there is the added burden on family and carers, including absence from work.

## Background

### Children's policy

- 38 The health and well-being of children and young people is a continuing concern for policymakers. In 2000, the *NHS Plan: A Plan for Investment, a Plan for Reform* **(Ref. 17)** focused on improving the health of a number of groups, including children, highlighting the need for them to have a healthy start in life. The Children's National Service Framework **(Ref. 18)** (NSF) highlighted the importance of partnerships in the prevention of unintentional injury. Standard 1 requires PCTs and local councils to create strategies for preventing unintentional injuries in childhood, while Standard 4 highlights unintentional injury as an important focus for health promotion for young people aged 12-19.
- 39 The 2004 Children's Act **(Ref. 19)** set out the duty of local agencies to cooperate on delivering children's services which underpins the development of children's trust arrangements. These trusts bring together the local services provided for children and young people into one agency, including local authority services, community health services, and Sure Start (recently replaced by Children's Centres). Sure Start local programmes were established to work with families and very young children in the most disadvantaged geographical areas. *Every Child Matters: Change for Children* **(Ref. 20)** set out actions to be taken at a local level to promote the well-being of children from birth to age 19. It sought to ensure that every child, regardless of background or circumstance, has the support they need to lead a fulfilled life.

- 40 The document is organised around five outcomes:
- be healthy;
  - stay safe;
  - enjoy and achieve;
  - make a positive contribution; and
  - achieve economic well-being.
- 41 The 2004 Children's Act also created the duty for each local authority to have a local safeguarding children board (LSCB). The LSCBs contribute to the wider agenda of improving the well-being of children, but they also have a particular focus on the staying safe outcome of *Every Child Matters*. The LSCB has a duty to monitor the effectiveness of what is done to safeguard and promote the welfare of children, which is defined as the following:
- protecting children from maltreatment;
  - preventing impairment of children's health or development; and
  - ensuring that children are growing up in circumstances consistent with the provision of safe and effective care.
- 42 Furthermore, the LSCB undertakes this role 'so as to enable those children to have optimum life chances and enter adulthood successfully'.
- 43 In the light of this framework, unintentional injury should be a priority for those charged with delivery at a local level.

## Health policy

- 44 The 1999 White Paper *Saving Lives: Our Healthier Nation* (Ref. 21) made injury prevention a priority, a theme that has not continued in subsequent health policy. The paper highlighted unintentional injury at the time as the greatest single threat to the lives of children, noting that it resulted in more children being admitted to hospital than any other cause. As previously discussed, while unintentional injury is no longer the single greatest threat to children's lives, it is still one of the leading causes of death and illness in children. *Saving Lives* set two targets: 'to reduce the death rates from accidents (in all age groups) by at least one-fifth and to reduce the rate of serious injury from accidents by at least one-tenth by 2010 – saving up to 12,000 in total'. Data from the DH for 2004 show

slippage against the targets with a rise of 1 per cent from the 1995-97 baseline of the all-age death rate (to 15.9 per 100,000) and a 4 per cent increase to the serious injury rate (now 330.1 per 100,000 population) (**Ref. 22**).

- 45 Data from the DH show evidence of improvement in deaths for children under five, with a decrease of 19 per cent from the 1995-97 baseline and also for the serious injury rate, which showed a decrease of 31 per cent. Recent data have shown a sharp decline in deaths from road traffic accidents, which may be a factor in the decline in overall rates of death from unintentional injury.
- 46 Preventing unintentional injury in the home and on the road, as identified in *Tackling Health Inequalities: A Programme for Action* (**Ref. 23**), were among the key interventions expected to contribute to reducing the life expectancy gaps between disadvantaged groups and the population as a whole. However, the programme did not specifically address unintentional injuries in children.
- 47 In 2004, the Department for Transport set a PSA target to reduce the number of children killed or seriously injured in road traffic accidents by 50 per cent by 2010 compared with the average for 1994-98, tackling the significantly higher incidence in disadvantaged communities. This report does not specifically address road traffic accidents, as this is the focus of a forthcoming report by the Audit Commission (**Ref. 24**).
- 48 In 2004 a PSA was also set by the former Office of the Deputy Prime Minister (now CLG) to 'reduce the number of accidental fire-related deaths in the home by 20 per cent and the number of deliberate fires by 10 per cent', which are a leading cause of unintentional injury to children.
- 49 *Choosing Health* (**Ref. 1**) highlighted the importance of public health for the NHS and local government and identified that service delivery could not be achieved through a uniform approach. It emphasised the necessity of meeting local needs with local councils having a leading role through LSPs, LAAs and children's trusts (which are discussed on pages 24-25).
- 50 *Choosing Health* identified six key priorities for service delivery:
  - tackling health inequalities;
  - reducing the number of people who smoke;

- tackling obesity;
- improving sexual health;
- improving mental health and well-being; and
- reducing harm and encouraging sensible drinking.

51 These were identified with a view to specifically:

- helping children and young people live healthy lives; and
- promoting health and active life among older people.

52 *Choosing Health* contained few direct references to preventing unintentional injury, although a notable exception is a stated commitment to working with the Royal Society for the Prevention of Accidents (RoSPA). However, preventing unintentional injury is also a means of tackling health inequalities and helping children live healthier lives. For example, accessible and hazard-free environments are important in encouraging individuals to increase their physical activity, such as using parks for playing.

53 Between 2005 and 2008, the DH is investing £1 billion in addition to planned mainstream funding to encourage people to take responsibility for their own health. Approximately half of this was intended to be invested by PCTs through their local delivery plans (LDPs), which should be developed in close consultation with local councils and include locally agreed targets.

54 The recent White Paper *Our Health, Our Care, Our Say: A New Direction for Community Services* (Ref. 25) notes that ‘the main responsibility for developing services that improve health and well-being lies with local bodies: PCTs and local authorities’. It specifies a defined role for directors of public health to work with directors of children’s services and overview and scrutiny committees<sup>1</sup>, and to contribute to joint reviews of progress in improving the health and well-being of local people.

---

<sup>1</sup> From January 2003 overview and scrutiny committees set up in local authorities with social services responsibilities have had the power to scrutinise health services. This contributes to their wider role in health improvement and reducing health inequalities for their area and its inhabitants.

- 55 The commissioning frameworks of both the DH and the DfES provide guidance on the development of effective commissioning of services to support patient choice and ensure the best health outcomes and value for money. The second phase of the commissioning framework, expected in early 2007, will cover primary care; health and well-being; long-term conditions; and joint commissioning with local government. This could represent an important opportunity locally for work on unintentional injury.
- 56 The focus on developing responses to local issues is important in identifying opportunities to prevent unintentional injury. However, other than *Saving Lives*, there is no direct national priority given to reducing unintentional injury in children.

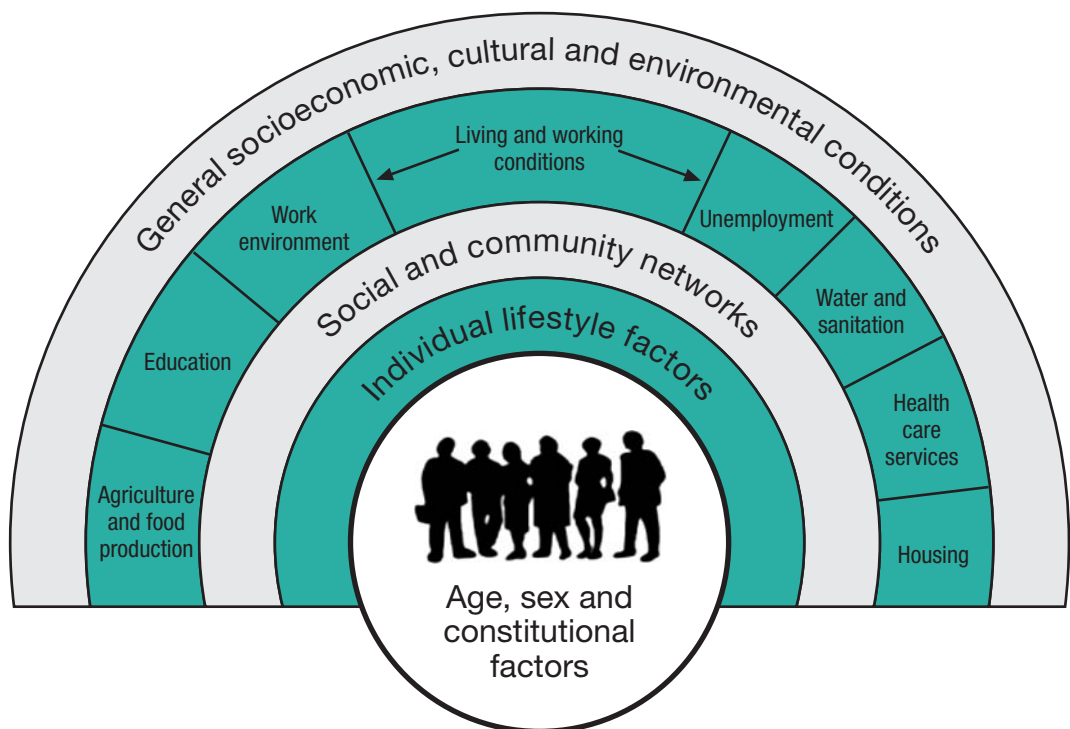
## Inspection and regulation

- 57 Comprehensive Performance Assessment (CPA) of local councils, undertaken by the Audit Commission, reflects local government's priorities and examines local service delivery against a number of specific themes. CPA places a sharp focus on the health and well-being of a council's population, and also requires an examination of work to reduce health inequalities. One of the main CPA drivers is the focus on partnership working. Following the Local Government White Paper *Strong and Prosperous Communities* (Ref. 26), in 2009 CPA will be replaced with Comprehensive Area Assessments (CAA) which will place an even greater emphasis on partnership working.
- 58 CPA currently asks councils 'what has the council, with its partners, done to achieve its ambitions for the promotion of healthier communities and the narrowing of health inequalities?'. This is assessed across seven distinct themes: health improvement, partnership working, vulnerable people, families, excluded communities, inequalities and decent homes. Local strategies to tackle unintentional injury could be relevant to each of these themes with consequent assessment acting as a driver for improvement.
- 59 The Healthcare Commission published its first Annual Health Check in October 2006. Its purpose is to generate useful information about the performance of the NHS. There is a strong focus on public health activity, notably in the assessment of progress in relation to the DH's *Standards for Better Health* (Ref. 27) which set out what is expected from healthcare organisations in relation to service delivery. The Standards highlight the need for cooperation between healthcare organisations and local councils to improve health and reduce health inequalities, and therefore can be used when planning strategies to prevent unintentional injury.

- 60 Joint Area Reviews (JARs) are also relevant to tackling unintentional injuries. Although JARs do not directly address unintentional injury, between 2005 and 2008, all children's services (which may include any unintentional injury strategies) in a local authority area will have been subject to a JAR. This is led by the Office for Standards in Education (Ofsted) in partnership with nine other inspectorates, including the Audit Commission and the Healthcare Commission. The review, which may include the prevention of unintentional injuries, aims to provide a comprehensive report on the outcomes for children and young people in a local area.

### What works in preventing unintentional injury in children?

- 61 Many unintentional injuries are preventable. There are numerous factors which create the conditions in which these injuries can occur including age, gender and social class, as well as environmental and behavioural factors. Families living in low-hazard environments on the whole minimise the potential for unintentional injury. For example good-quality houses are often safer and homes with smoke detectors have fewer fire-related deaths.
- 62 Health is affected by several factors illustrated in **Figure 4**. Broad, societal forces are tackled through international and national action: they are shown in the outer circles of the diagram. The circles that refer to working conditions and community factors represent the immediate conditions which impact on people's lives – including their social networks. Public services including health, education, social care, traffic and road safety, housing and environmental health figure strongly in this regard. At the core of the model are personal attributes affected by genetics as well as life experiences. Effective action to improve health is made up of coordinated activities at all the relevant levels.

**Figure 4****The factors that affect health – Dahlgren and Whitehead**

**Source:** Dahlgren, G, and Whitehead, M, *Policies and Strategies to Promote Social Equality in Health*, Institute of Future Studies, Stockholm, 1991

- 63 In 2001, the Accidental Injury Task Force was set up at the request of the DH with the explicit task of identifying the scale of unintentional injury in England and Wales, distilling what was known about effective prevention approaches and setting out recommendations (**Ref. 28**). These are detailed in **Appendix 1**. The Task Force identified a number of key areas where generally low-cost interventions would have the biggest impact on unintentional injury in the short term. For unintentional injury to children these areas were:

### Road accidents

- 20 mph speed limits in areas of higher pedestrian activity;
- local child pedestrian training schemes and safe travel plans;

- systematic road safety intervention in inner city areas; and
- advice and assessment programmes for elderly car drivers.

### Fires in the home

- Fire and rescue services installing smoke detectors;
- home fire risk assessments, safety checks and escape plans; and
- targeting action at deprived groups, particularly children and older people in privately rented and temporary accommodation, and households in which people smoke.

### Play and recreation

- Increasing the number of children undertaking cycle training and wearing cycle helmets;
- producing guidelines for safety in children's sports; and
- strengthening risk and safety education in schools.

64 The most successful strategies and programmes combine elements of environmental change, education and enforcement. Given the wide range of initiatives and programmes that potentially exist to prevent unintentional injury, delivery of a strategic, efficient and effective programme of work relies on partnerships to achieve change.

### Partnerships: delivering local services

- 65 Significant local problems, such as community safety, improving public health or the well-being of children, can only be tackled successfully through agencies working together to meet defined goals. No single agency can tackle the problems alone. Working in partnership can increase cost-effectiveness and reduce duplication of effort by providing a coordinated, coherent approach.
- 66 Two key mechanisms exist at the local level: LSPs and LAAs. LSPs are multi-agency bodies that match local authority boundaries, and bring together public sector agencies, such as PCTs, with the private and voluntary sectors. Through the use of contracts and agreements they ensure that local developments benefit local people and provide a coordinated approach to making major decisions about priorities and funding.
- 67 LAAs are three-year agreements, which give local agencies greater flexibility to deliver services and outcomes to meet local needs. They set out the priorities for a local area, agreed by the local authority and other key local partners including the health service and

children's trusts or children and young people's partnerships, which coordinate all services provided for children and young people in a given area. The objective of LAAs is to enable local partners to work together to provide an integrated approach to policy and delivery.

- 68 Preventing unintentional injury to children is therefore a very relevant subject for inclusion in LAAs and action by LSPs.

## Partnership research

- 69 The Audit Commission report *Governing Partnerships* (Ref. 29) found that local partnerships are a significant feature of public service delivery and are essential to deliver improvements in people's quality of life. However, they bring risks as well as opportunities. In an area such as unintentional injury, where there are multiple agencies involved in delivery, the need for partnerships is even more pronounced. Much of the research on partnerships considers how they operate, and seeks to identify the common characteristics of effective partnerships across a number of domains. There is little research that convincingly quantifies their effects.
- 70 Indicators which can attribute outcomes directly to collaboration are hard to define. There remains a fundamental tension throughout the literature; some studies focus on the governance aspects of partnerships and seek to understand how they function, others focus on the health outcomes that partnerships secure. These themes, as discussed in this report, should be taken on board by those working in partnership to improve health and well-being.

## Methodology

- 71 This joint study by the Audit Commission and the Healthcare Commission examined the deployment of resources, partnership arrangements and activities to prevent unintentional injury in children, especially the under fives.
- 72 The study sought to identify:
- what activities are currently being undertaken to prevent unintentional injury in children; and
  - how partnerships across the NHS and local government are working to prevent unintentional injury;
- with a view to:
- sharing best practice to help local bodies address unintentional injury in their local area; and

- influencing policymakers to stimulate more effective action on the ground.

Nine participating sites were selected on the basis of:

- high levels of deprivation (using as a proxy measure those with a LAA and/or with a spearhead PCT);
- coterminosity between local authorities and PCTs, where appropriate;
- geographical diversity including urban and rural settings; and
- a willingness to participate.

- 73** Prior to site visits we analysed the responses to a questionnaire which was completed in advance and other key documents. Workshops and semi-structured interviews were undertaken with representatives from the NHS, local authority, voluntary sector, fire and rescue services, universities, police, ambulance service and others.
- 74** The following chapter examines unintentional injury prevention strategy and operational activity at a local level; provides examples of good practice; and discusses the levers and barriers to partnerships seeking to prevent unintentional injury. In Chapter 3 we discuss our analysis of current practice in strategic and operational partnerships. This is followed by recommendations for government departments, PCTs and local authorities on how best to address unintentional injury.

# 2



## The findings of the study

Local partnerships are essential to deliver reductions in unintentional injury. Planning and operational activity at a local level are crucial to the delivery of unintentional injury prevention strategies. To be effective, partnerships need to consider national strategy, data and local delivery structures, as well as wider issues of community engagement, resourcing and evaluation.

- 75 Unintentional injury is an important and complex public health issue that requires effective partnership work to produce results. Under the 2004 Children Act there is a duty for local authorities and key partner bodies to address the well-being of children. This chapter presents the findings from fieldwork undertaken at nine sites under the following headings:
- the local impact of national policy;
  - data and local intelligence;
  - local strategy;
  - partnerships;
  - engaging communities and families;
  - delivery;
  - improving health and reducing health inequalities;
  - improving the environment; and
  - resourcing and evaluation.

### The local impact of national policy

- 76 Unintentional injury, excluding road traffic accidents, has received little national attention since the 1999 *Saving Lives* (Ref. 21) White Paper and is currently not explicitly part of the government's priorities. In the study sites, we identified a widespread frustration among those involved in the subject at the lack of coherent national policy drivers. Although there was recognition of the *Saving Lives* target, there was a belief that its impact had been lost and its content superseded by *Choosing Health* (Ref. 1), which makes little reference to unintentional injury.
- 77 Changes in national policy have lessened the impetus to address unintentional injury locally. *Every Child Matters* (Ref. 20) and the NSF for children (Ref. 18) were widely discussed. Participants generally welcomed them and saw them as helpful. However, there were concerns that the children's agenda, as well as the overarching one for public health, were congested. As a result there were challenges in giving sufficient priority to work to prevent unintentional injury with so many other competing issues. As one participant asked: 'In a climate where money is being clawed back, what hope have we in maintaining action in areas that are not seen as priorities, despite strong evidence?' However, several sites pointed out that the newly created LSCBs provided opportunities to increase the profile of prevention of unintentional injury.

- 78 The work of the Accidental Injury Task Force was seen to be important, but there had been challenges in implementing the Task Force's recommendations at a local level because other topics, including tobacco control, promoting physical activity, and reducing teenage pregnancy, had taken priority.
- 79 The new focus on commissioning and the potential of joint health service and local government commissioning of programmes to prevent unintentional injury was discussed by those we interviewed. There were concerns that there was not enough information to make appropriate decisions, and that the absence of national direction would not encourage commitments to prevent unintentional injury when faced with other, competing, high-priority national requirements.

## Data and local intelligence

- 80 The second Wanless report, *Securing Good Health for the Whole Population* (Ref. 30), concluded that good information is required to identify health problems early and will affect relative investment in individual areas. The report further stated that:
- ‘There is no regular mechanism by which a PCT or local authority can gather reliable information on its own population... given the multi-sectored nature of public health, the current lack of effective mechanisms for data sharing between organisations at local and national levels is a major impediment to more targeted and responsive public health actions.’
- 81 This key area was previously highlighted in *Preventing and Reducing Accidental Injury in Children and Older People*, a report by the Health Development Agency (HDA) (Ref. 31), and the importance of data was also confirmed overwhelmingly during our site visits. The 2002 report of the Accidental Injury Task Force also made a series of recommendations on data collection and monitoring.
- 82 To be useful, data have four key characteristics: accuracy, timeliness, relevance and completeness. Data problems were a prominent barrier to implementing unintentional injury prevention strategies. Without baseline data it is difficult to create, implement, monitor and evaluate a targeted strategy. There was seldom a shared awareness or understanding of the rates of unintentional injury at a local level. Sharing data can be a powerful and useful tool, highlighting where resources can be best directed.
- 83 Overwhelmingly, sites complained of their frustration over the variability of data quality. Participants were also unaware of what data were available and who held them. We

identified that data were collected by multiple agencies for various purposes and yet the same information was often interpreted differently. For example, the police classification of a serious injury differs from that of an A&E department. In addition, in A&E the type of injury is recorded upon arrival (for example, a broken arm), but the cause of the injury is seldom noted – exceptions were poisonings, where the cause was evident. A lack of common classification impeded action. Consequently, without data, performance monitoring and evaluation to gauge the success of prevention strategies was difficult. Hard data were necessary to describe success and assess performance.

- 84 A&E data were consistently inadequate for identifying trends. We found that the existing data fields within A&E were not always completed. Without these data, sites were unable to assess what preventative actions could reduce A&E attendance and overall injury and mortality rates. Additional data fields were said by many to be needed despite our finding that the current fields were not always complete. Some participants suggested the inclusion of the WHO's core minimum data for reporting any case of injury (**Ref. 32**), which asks the following questions:
1. Where were you when you were injured?
  2. What were you doing when you were injured?
  3. How were you hurt? Or how was the injury inflicted?
  4. Was the injury intentional?
  5. What was the nature of the injury?
- 85 Across most sites, information was seldom aggregated and used to form population-based intelligence, which would have been useful in defining strategies.
- 86 Several participants cited difficulty in accessing others' data which led to the perception that partners were unwilling to cooperate. Many participants reported that the NHS appeared particularly unwilling to share data, even that which could be anonymised. Caldicott guidelines<sup>1</sup> for ensuring patient confidentiality were perceived as a barrier among

---

<sup>1</sup> Created as a result of the 2001 Caldicott Committee into the use and disclosure of patient information. Caldicott Guardians are responsible for approving and ensuring that national and local guidelines and protocols on the handling and management of information are in place in accordance with HSC 1999/12 and liaising with departmental records managers as appropriate and are responsible for governing the disclosure of patient information.

participants. However, there were a few examples where data had been generated and shared productively. In Suffolk, Stockton and North Tyneside, practitioners in A&E liaison posts shared information with children's health visitors. In Burnley, Pendle and Rossendale, the A&E liaison post also included the collection of additional A&E data documenting how injuries had occurred (**Case study 1**). This then enabled the Action on Children's Accidents Project (ACAP) team to collate and analyse the data in terms of incidence, prevalence and trends in service use. As a result, significant levels of injuries were identified, for example, injuries to babies in baby walkers and burns from hair straighteners. Consequently, this information was included in health education messages to parents and carers.

---

### Case study 1

#### **Jointly funded post between Burnley, Pendle and Rossendale Primary Care Trust and Burnley Acute Hospital Trust**

The work of the jointly funded post provided a dedicated resource to collect and collate the additional information and forward it to the ACAP where it was analysed and used to influence the interventions.

Around the country, A&E information about individual children is fed back to that child's health visitor. This scheme goes further by:

- persuading A&E to include additional data fields for injuries and their location;
- producing more accurate data, by removing the minor ailments figures from 'other types of injury';
- manually collating the data into trends; and
- feeding the aggregated data to the PCT.

The development of the data was initiated by ACAP, run by Burnley, Pendle and Rossendale PCT.

It was started by a nurse consultant responsible for ambulatory care. Her work related to A&E and the children's observations and admissions unit rather than the children's ward. This gave her knowledge of the large numbers of children who came to A&E but did not go on to the ward.

The work was further developed by the joint postholder, who continues to help A&E to pick up the right information to enable injury prevention. The existence of the jointly funded post was crucial for the collection of the additional data which ensured the interventions developed were evidence based.

Good personal relationships with A&E staff were vital for gaining acceptance of the need to ask very busy staff to collect additional information. In addition, the way that this A&E department collected its information had enabled further development – departments do not collect data in the same way around the country.

Data confidentiality had been a barrier to overcome. The team had placed a poster in A&E saying that data would be shared and all staff involved accepted that the approach was necessary in order to act in the best interests of the children.

**Source:** Audit Commission/Healthcare Commission

---

- 87 Several participants made the point that interpretation and analysis of data demanded considerable time and expertise. For example, in a Sure Start area in Ipswich, an increase of 340 per cent in attendances at A&E for children under the age of one was a cause for concern. After considerable interrogation of the data by public health staff, assumptions on the baseline data were revised and adjustments for the change in demography of the population had to be made, putting the changes in context and accounting for the apparent increase.
- 88 There were examples of good practice in the use of information and data. The fire and rescue service had developed national information management systems which allowed them to map local fires and identify clusters, enabling targeting of prevention activities including awareness training and smoke detector distribution in particularly vulnerable neighbourhoods. The service was keen to share data, although there were concerns over the apparent unwillingness of other organisations to reciprocate.
- 89 In Brighton and Hove, a comprehensive audit of childhood injuries had created a firm foundation upon which an unintentional injury strategy could be built (**Case study 2**).

---

## Case study 2

### Audit of children and young people's safety in Brighton and Hove

The children and young people's safety audit, requested by the LSCB, sought to map the incidence of unintentional and intentional injury among the children of Brighton and Hove aged 0-18 and to develop a strategy as a result. It was intended that the strategy would join up various other developments including the Children's Trust, and the Family Support and Community Safety strategies. The audit encompassed the wide-ranging, cross-cutting areas under the LSCB's safeguarding remit. Although unintentional injury comprised only a small part, it was included.

Representatives of the Partnership Community Safety Team and of the Children, Families and Schools Directorate successfully undertook the comprehensive audit of safety issues facing children and young people in Brighton. Consultation was broad and included key statutory, voluntary and community groups and surveys of young people, parents and youth groups. As a result of the audit a cross-agency Accident Prevention Working Party was established and a well-founded strategy drafted.

This was the only site visited which had undertaken a comprehensive audit of safety issues facing children and young people. The LSCB had provided links across relevant cross-cutting areas and strategies. The combined knowledge and networks of staff from Community Safety and Families and Schools was important.

**Source:** Audit Commission/Healthcare Commission

- 90 In the absence of sound and accessible data, there were numerous factors which influenced how decisions were made. These included: the interests of local leaders and champions who had maintained relentless lobbying for the work; the political will of local elected members; community and media responses to significant events (for example, the death of a child); and historical precedent, where services were long-established and thought to be effective, although there were seldom data to substantiate claims of effectiveness.
- 91 Overall, there were few coordinated approaches to data collection and analysis. Notably, there was a lack of accessible national data on unintentional injury. RoSPA now hosts the Home Accidents Surveillance System and the Leisure Accidents Surveillance system, created to inform the design of safer products and environments and which were initially funded by the DTI. Only data until 2003 are contained within it and at the time of our study there were no plans, or allocated funding, to update these databases. The lack of national data has had an impact locally on the need for, and ability to implement, unintentional injury prevention strategies.

### Local strategy

- 92 In the absence of any established national requirement, responsibility for preventing unintentional injury lies predominantly at a local level. LAAs provide a number of opportunities to address unintentional injury and some participants pointed to agreements to reduce road traffic accidents that kept unintentional injury high on the local agenda. In addition, we found that the duty of local authorities in England to have a nominated lead on road traffic accidents was considered significant in maintaining organisational

commitment. The potential to develop similar duties in relation to unintentional injury in the home was explored during the site visits. Mirroring the duty for road traffic accidents, this would include a named lead in local authorities with the responsibility to ensure delivery of programmes of work to prevent unintentional injury in the home. This would signal commitment to, and recognition of, the importance of unintentional injury.

- 93 Participants from the sites we visited recognised that preventing unintentional injury was an important element to three distinct areas of work. First, it was a key facet in plans to improve health and reduce inequalities. Second, it was a concern of partnerships seeking to improve community safety, notably reducing fires. Third, it was identified as a key element of plans to improve children's services and achieve the objectives of *Every Child Matters* (Ref. 20). Several participants thought action to prevent unintentional injuries was relevant to local authorities' duties to promote well-being, as defined in the Local Government Act 2000 (Ref. 33).
- 94 However, at a local level we found little evidence of systematic strategic approaches to develop, implement and monitor programmes to prevent unintentional injury in children. Notably, participants often found it difficult to articulate a clear vision of what a local strategy would look like or what it would seek to achieve. There was little consensus as to how strategy could be developed or who should be responsible, although there was widespread recognition that a range of partners should be involved.
- 95 Few sites could provide any defined plan detailing local need and resultant action. Often disparate details of their strategic intentions were found in other local documents, such as the public health annual report, the *Every Child Matters* action plan, or the work programme for delivering the Children's NSF. This lack of central policy at a local level contributed to the sense of fragmentation and underscored the importance of shared priorities.
- 96 A number of sites implemented schemes that delivered unintentional injury prevention, albeit not explicitly, as part of wider work on health and well-being. For example, travel plans and attempts to increase safety for cyclists through the provision of dedicated routes and lanes and promoting the use of cycle helmets, were seen as important for reducing unintentional injuries, promoting physical health and reducing obesity.
- 97 There were, however, some sites that had well-established unintentional injury prevention strategies in response to the prevalence of unintentional injury in their areas, as can be seen in **Case studies 3 and 4**.

---

### Case study 3

#### Promoting a safer East Midlands

The East Midlands has approximately 130 all-age deaths over and above the national average, including an average of 30 child deaths per year. Regional intelligence provided by the East Midlands Public Health Observatory demonstrated that the local authorities in the region with higher levels of child poverty have higher hospital admission rates for unintentional injury. As a result, the East Midlands Avoidable Injury Strategic Overview Group was established, led by the Chief Fire Officer of the Nottinghamshire Fire and Rescue Service. The Group has wide representation, including from the NHS, Government Office, Nottinghamshire Fire and Rescue Service and local leadership from LSPs. The resultant East Midlands Avoidable Injury Strategy identified vulnerable groups and where the greatest number of unintentional injuries occurred and included an action plan.

The structure of the strategy allowed it to be adapted to the local context across the region. It provided a framework, grounded in local intelligence, to stimulate multi-agency action and the development of local networks.

**Source:** Audit Commission/Healthcare Commission

---

- 98 Unsurprisingly, where action plans were defined and encompassed both injury inside and outside the home, greater progress was made in unintentional injury prevention.
- 

### Case study 4

#### Safety First – accident prevention in children, young people and adults living in Telford and Wrekin

Telford and Wrekin also had a clear strategic approach with a five-year plan (2005-2010) for preventing unintentional injury. The multi-agency Accident Prevention Steering Group drove the implementation of the plan. It focused on four priority areas: children and young people, adults and older people, road safety and fire safety. The strategy was linked to the PCT's local delivery plan, a three-year plan that identified local priorities for the health service, with specific priorities identified by the Group.

Problems they encountered included the lack of priority given by some organisations to the issue and having few systems to support the work. An example was difficulty obtaining data from A&E and primary care. Collaborative work with the West Midlands Accident and Emergency Surveillance Centre is planned to improve access to A&E information, and enhance the local needs analysis already undertaken.

The Director of Public Health in Telford and Wrekin had secured funding for the establishment of a dedicated post with the remit for preventing unintentional injury. Locally, a small number of committed practitioners was credited with maintaining the profile of the work. Early results showed that having a dedicated worker was having a positive effect.

**Source:** Audit Commission/Healthcare Commission

---

- 99 However, shared visions and enthusiasm for strategy are not always easy to achieve. The majority of sites struggled to develop strategies because of the diversity of their partners and the breadth of concerns and approaches. Some participants described strategy development as a distraction, which was often time-consuming and inhibited progress.

## Partnerships

- 100 Appropriate partnership structures and clarity of purpose are important to address unintentional injury successfully. Overall, we found a range of agencies working together to prevent unintentional injury in children. As discussed previously, LSPs may potentially be used to strengthen focus, galvanise support and provide governance for complex local issues. However, we identified little work focused on the under fives and their families, and found that local partnerships to prevent unintentional injury used their LSPs with varying success and frequency. We identified three principal approaches for working with LSPs, based around the following service areas:
- **health improvement** including monitoring progress of the local target population in relation to health inequalities in LAAs;
  - **community safety** where interest has been extended from crime and disorder to other safety concerns; and
  - **children's services** including the children's trusts/children and young people's strategic partnerships, LSCBs, and child death panels.
- 101 Throughout the fieldwork, participants discussed what they perceived to be the barriers and levers to achieving successful unintentional injury prevention through a partnership approach.
- 102 Coterminous local authorities and PCTs were considered helpful in achieving progress, whereas complex partnership arrangements (with agencies responsible for several different localities working together) were generally considered a hindrance. Participants

from county councils, for example, described the challenging nature of working with district councils because of the number of groups which they were asked to attend, and the breadth and variety of local issues with which they had to become familiar, in addition to demands for resources.

- 103** However, we identified some innovative and effective work in the middle of some complex arrangements, for example, in Suffolk where, despite multi-faceted partnership arrangements, both the police and the fire and rescue service have managed to provide safety training in schools and nurseries. Nevertheless, unitary status did not necessarily ensure progress; where agencies were coterminous, structures may have been simpler, but joint priorities and actions were still hard to secure. Where participants were able to articulate a similar set of aims and objectives and identify clear roles and responsibilities, progress was more likely to be made.
- 104** Close working relationships with partners were linked to issues of trust and respect. Where people had worked together over a period of time there were fewer suspicions about motives. Longevity of arrangements did not, however, always guarantee progress. On occasion, familiarity resulted in apathy and slow progress. The challenge lies in keeping the partnership fresh and focused. Where preventing unintentional injury is a sustained organisational priority, networks have been broadened and responsibilities shared across the local system, leading to improvements in service delivery. Some colleagues found it difficult to be accepted into an area that was dominated by a small number of well-established individuals.
- 105** There was a perception among participants that successful partnerships require the enthusiasm and commitment of a small number of colleagues across sectors who work to drive the agenda and keep the momentum going in the absence of central government targets and scarcity of dedicated resources. Communication was a key element in securing success: 'Data and evidence are important,' said one participant, 'but what makes it work is being able to pick up the phone and get it sorted out'. There was widespread recognition that building effective operational partnerships takes time. Participants said that they worked well with colleagues in climates of trust and respect, where there were high levels of understanding of others' roles and responsibilities and of the organisational priorities that drove delivery.

- 106** However, we found that, on the whole, strong leadership was lacking. Projects or initiatives often worked more effectively where specific leaders could be identified. For example, the manager of the ACAP project in Burnley, Pendle and Rossendale kept the issue of home safety alive by seizing opportunities to secure funding. Organisational support was key to building productive relationships. In Nottingham, initiatives to prevent unintentional injuries were coordinated through the PCT, which worked closely in partnership with senior officers from a number of agencies including Nottinghamshire Fire and Rescue Service and Nottingham City Council. Nottinghamshire Fire and Rescue Service has played a major part in supporting initiatives to reduce unintentional injuries through its commitment to fund two health promotion posts in the PCT that work closely with a newly developed and dedicated policy unit within the fire service.
- 107** Participants reported that they did not always feel supported by their employing organisations in driving forward work. Inaction was not necessarily the result of a lack of individual commitment, but sometimes a lack of organisational priority, particularly where there was little history of productive collaboration.

## Engaging communities and families

- 108** One of the challenges in delivering public health programmes is the need to target directly specific sections of the population. The success of preventing unintentional injury relies heavily on engaging communities and families. Across the sites, we identified a number of diverse methods deployed systematically to engage communities in identifying need, designing solutions and monitoring progress.
- 109** A number of participants made community engagement a local priority. In Suffolk, the Children's and Young People's Strategic Partnership implemented Having My Say, a strategy to involve children and young people in the design, delivery and review of services that affect them, which aimed to embrace the different local communities. For example, the PCT worked with two mosques in Ipswich, consulting on culturally appropriate services and offering advice about child safety, which yielded positive results. The strategy covered four key areas:
- creating an empowering service user environment;
  - involvement in consultative exercises;
  - involvement in service delivery and planning; and
  - involvement in governance.

Having systematic approaches to engagement enabled parents and children to shape strategy across the county.

- 110** There were additional mechanisms which sought to integrate the views of communities into the planning process. In 2004, Nottingham City Council's Health and Social Care Overview and Scrutiny Committee undertook an in-depth review examining how to prevent avoidable injury. It recommended that 'the issue of avoidable injury in the home should be given greater prominence by the City Council and its key local partners and be tackled by adopting a strategic and well-resourced approach to the analysis of the problem and to the planning and coordination of interventions designed to reduce accidental deaths and injuries'. This stimulated action. However, despite this review, we identified variable levels of awareness of the Committee's work and it was not clear how much impact the recommendations had had on PCT priorities.
- 111** Transient populations posed a problem for a number of sites in our study including, for example, working systematically with travellers and asylum seekers. It is particularly hard to build and sustain trust within these groups. Furthermore, the under fives are always a particularly difficult group to target as access is achieved principally through their parents and carers. The fire and rescue service has successfully accessed some of these groups. On the whole the service is respected and well received in the community and people's homes. However, without intervention from these services, access to these vulnerable groups can become a significant problem.
- 112** Multicultural and refugee communities occasionally featured prominently in participating sites' strategies. However, overall it was unclear whether their needs were being met. In Lambeth, more than 140 languages are spoken in schools, highlighting the cultural and ethnic diversity of the local population which is challenging to target. In Stockton, the Refugee Welfare Association worked with local families who lived in poor-quality and overcrowded private housing to identify safety needs. Stockton also operated a multi-lingual service for predominantly Indian and Chinese ethnic minority communities. In Nottingham, Sure Start schemes worked with a refugee housing association to fit safety equipment, and picture guides had been developed to explain how to maintain and use equipment. Neighbourhood renewal funding was used to target black and minority ethnic communities specifically. Although this was welcomed, it was noted that one-off funding was not the solution to issues that demanded whole system initiatives and organisational change.

## Delivery

**113** Throughout our fieldwork, activities to promote health and prevent unintentional injury were prominent. They fell into three distinct categories:

- those initiatives which sought to increase knowledge, change attitudes and behaviour, including campaigns and one-off awareness-raising events;
- initiatives to educate staff on evidence-based approaches; and
- those which aimed to make physical environments safer, creating opportunities for individuals to act on their knowledge – for example, making play and leisure spaces accessible and hazard-free, and preventing access to dangerous sites.

However, these activities were seldom coordinated.

## Knowledge, attitudes and behaviour

**114** Promoting risk awareness of unintentional injury and developing techniques for managing them was a common theme among participants. Some sites used the Healthy Schools initiative as a vehicle and one approach within this was Smartrisk, which aims ‘to help people see the risks in their everyday lives and to show them how to take those risks in the smartest way possible’. In many of the sites, there were local Crucial Crew<sup>I</sup> events: multi-agency workshops held in sites across England, aimed at schoolchildren aged 8-11 years. The events involved interactive presentations from major agencies including the NHS, local authorities, RoSPA, police and fire and rescue and ambulance services, which covered diverse scenarios (for example, playing on building sites, and witnessing accidents). Participants were offered advice on how to manage risks and deal with difficult situations.

**115** Such events demand considerable organisation and provide a focus for agencies to work in partnership. However, it is unclear what long-term impact they have on knowledge, attitudes and behaviour towards unintentional injury. None of the participating sites had systematically evaluated the long-term effects of Crucial Crew events, although several provided anecdotes about pupils expressing enthusiasm some time after the event. On occasion, there were concerns about the value for money of these events, as they were

---

<sup>I</sup> This is a series of multi-agency workshops held nationally and aimed at schoolchildren aged 8-11 years. The events involve interactive presentations covering various real-life scenarios. The children are offered advice on the best way of dealing with certain safety situations. Crucial Crew also goes under other pseudonyms depending on the location, for example Kidalert and Junior Citizen.

resource-intensive and time-limited. However, collaboration often stimulated networks and additional work was developed as a result.

- 116** The fire and rescue service was a key partner for delivering unintentional injury programmes in all sites, due to its statutory duty to undertake community-based, preventative work. Several participants commented that not only was the presence of the fire service important to promote community safety and reduce unintentional injury, but the presence of a fire engine and officers at community events was also a draw for local residents: ‘young people are fascinated by the fire brigade, they’ll come for miles to see them’, commented a Sure Start volunteer.
- 117** Across several sites, fire and rescue services undertook school-based activities to increase understanding about unintentional injury and develop skills which were well received by teachers and pupils. For example, Frances the Firefly booklets told humorous stories to capture the imagination of young children. In the absence of school and nursery visits, booklets and colouring books were provided and teachers were directed to the ‘Fire kills’ website which contained resources (**Ref. 34**).
- 118** The police were also involved in the delivery of unintentional injury initiatives. Local stations had a broad interest in community safety work, and sought to engage residents in their delivery. For example, Suffolk Education Authority worked with Suffolk Constabulary to undertake personal and social development in schools. Generally, community police officers were involved in planning and delivering lessons, workshops and awareness events. Personal safety lessons encompassed the themes of playing safely, identifying unsafe areas, how to call for help, cycle safety and road safety.

### Developing staff

- 119** The Child Accident Prevention Trust (CAPT) piloted the provision of staff training, which was funded by the DH and culminated in a certificate from the University of Newcastle. However, despite the fact that the training was well received and found to be a valuable resource, the provision did not continue beyond the pilot stages. In the absence of national training, some local initiatives which sought to educate staff to enable them to deliver unintentional injury programmes have been developed. Examples of two such schemes are given in **Case studies 5 and 6, overleaf**.

---

## Case study 5

### The Focus on Safety Award Scheme – Hull

The Focus on Safety Award in Hull is highly regarded in the local community and draws together a wide range of partners such as the fire and rescue service, the police, Network Rail and the Ambulance Trust, to target pre-school children and their carers by developing an accredited curriculum for early years childcare providers and nurseries. The activities are designed to fit into the foundation stage of the national curriculum and, upon completion of planned work programmes with children and carers, participating partners receive awards, subject to unintentional injury being built into the curriculum on a permanent basis. Participation in the scheme was voluntary, free and contributed towards Ofsted assessment.

The scheme cost £15,000 per annum plus evaluation work estimated at £5,000. Between 2000 and 2004 over 5,000 children and their parents and carers had participated in the scheme. The scheme was well received by the early years providers and partners were keen to be involved as it provided a mechanism to communicate and influence the behaviours of the very young, especially in relation to fire safety.

An evaluation carried out in 2004 stated that 95 per cent of participating groups felt the scheme helped raise awareness of safety issues with children and carers. However, there had been no evaluation undertaken which might have attributed reductions in unintentional injury to the intervention.

**Source:** Audit Commission/Healthcare Commission

---

## Case study 6

### Avoidable Injury Home Visitor Training Programme – Nottingham

Nottingham City Council developed the Home Visitor Training Programme CD-ROM and supporting information manual. This is a training resource aimed at staff who undertake home visits specifically concerning children and older people. The programme helps home visitors acquire knowledge about identifying safety hazards in the home and common safety practices. It aims to increase awareness of how parents may react to information from health professionals, and explains the complex relationship between knowledge and behaviour. It also sets out the different approaches to reducing injury and the difficulties of implementing avoidable injury campaigns.

However, at the time of our study, evaluation of the project was unlikely to happen. The project lead had developed links through the East Midlands Avoidable Injury Group and

the Health Scrutiny Panel to galvanise support for this resource and keep a focus on unintentional injury within the Council. However, sustainability remained an issue.

**Source:** Audit Commission/Healthcare Commission

---

## Improving the environment

- 120** Unintentional injury prevention is not simply about educating individuals on how to avoid unintentional injury. We also identified actions which aimed to make environments safer, creating opportunities for individuals to put their knowledge into practice and reduce unintentional injuries.
- 121** Following the death of a child who fell off a swing in Stockton, the local community, along with elected council members, campaigned to improve safety in public spaces . Consequently, the council included the risks for young people in using parks and waterways in their overarching strategy to improve the quality of public spaces. Ambitious plans were created by a committed officer to develop parks, reduce unsafe playgrounds and engage young people in designing new facilities. His work was supported by the fire and rescue service and the police, but the progress he made relied heavily on the cooperation of a range of partners.
- 122** Railway safety has been another area of concern. For example, Hull has been reported to have the highest levels of railway crime in England with perpetrators mainly aged between 9 and 16 years. Children as young as five years old were found playing on the railway lines and therefore at risk of serious injury, particularly during school summer holidays when they were more likely to be outdoors. In response Network Rail ran a national campaign called 'No Messin' which promoted responsible behaviour on trains and tracks. This campaign was developed alongside a database of all rail incidents across the country. Network Rail analysed the data and was able to pinpoint hotspots to inform focused campaigns in schools and homes within a two-mile radius of incidents, asking parents 'Do you know where your child is?'. The campaign was complemented by a programme of work which prevented access to tracks.

## Home safety

- 123** Participants regularly commented on the importance of home safety schemes as part of unintentional injury prevention programmes.

**124** In our fieldwork, we identified home safety initiatives as having some, if not all, of the following components:

- links made between practitioners and families to help inform assessments made about the level of intervention required;
- provision of information to families to increase knowledge and awareness about risks and how unintentional injury could be prevented;
- provision of safety equipment, often at reduced cost;
- safety equipment fitted by contractors; and
- home inspection to ensure that equipment, once provided, is used appropriately.

**125** An example of a home safety initiative is given in **Case study 7**.

---

### Case study 7

#### **The Action on Children's Accidents Project in Burnley, Pendle and Rossendale**

This programme aims to reduce unintentional injury in the home and provides information and safety equipment to families in Sure Start areas in Burnley, Pendle and Rossendale.

- ACAP provided information and safety equipment to families and fitted it using trained fitters contracted from a local housing association.
- The project used campaigns and awareness raising techniques. Local residents communicated news of the project by word of mouth.
- The project worked with families from black and minority ethnic communities, and had an in-depth awareness of cultural and literacy issues in the local area and had developed communication methods to overcome them. Messages were simple and accessible – the team used brief newsletters, games and pictures to convey information.
- There was little systematic sharing of data, especially between the NHS and council departments, such as housing. The project sought to overcome barriers, for example, by collecting and using data from the local A&E department. Collaboration with East Lancashire Public Health Research and Information Group had resulted in headline statistics to quantify the effects of the scheme. An external researcher had also undertaken an evaluation.

- The success of the project was widely attributed to the leadership shown by the manager of the project; she was heralded as a local champion.
- The project accessed funds from Sure Start, the Neighbourhood Renewal Fund and the PCT. Amid widespread anticipated changes, sustainability of funding was a concern.
- Despite limited funds for formal research, the project was able to broadly calculate its impact. Three years after the project began, the number of children under five attending A&E had fallen by 21 per cent (660 attendances). Based on calculated cost estimates and assumptions, and taking into account the cost of running the project, the estimated saving was £1.9 million.

**Source:** Audit Commission/Healthcare Commission

---

- 126** A sense of ownership and personal investment were considered essential in ensuring parents' adherence to home safety schemes. This has been achieved in some cases by charging parents for safety equipment, which has been found to encourage use. Where equipment had been provided free of charge, interviewees suggested that it had been abused, as well as creating legal concerns. If equipment was provided on loan rather than sold or given away, it remained the property of the issuing agency, and as such the agency was liable for equipment failure and operator error.
- 127** Local variations to home safety schemes ensured a more tailored approach to local circumstances. In Hull, for example, partnership working on the Safe Home, Safe Streets initiative saw Sure Start workers, community wardens and local tradespeople collaborating to reduce unintentional injury. They developed protocols to assess risk, which resulted in safety equipment being fitted in vulnerable homes. In addition, they initiated an incentive programme where awards were given to families who reduced the number of rooms in which they smoked, thus protecting their children from the effects of passive smoking and reducing the risk of fire.
- 128** Other schemes employed innovative approaches to improving home safety. In Suffolk, local champions, 'safety buddies' and community parents were recruited from local neighbourhoods. They have proved helpful in supporting teenage and vulnerable mothers. In parts of the county, health visitors invited the St John's Ambulance to work with parents in post-natal groups and train them in dealing with choking and resuscitation.

- 129** Developing and sustaining schemes such as these have brought several challenges. We have identified serious concerns about underfunding and the instability of funding streams although this is not unique to unintentional injury. However, there were notable exceptions. In Brighton and Hove, the council had calculated some basic costs of a proposed home equipment scheme. It was estimated that the set up costs of the scheme would be approximately £60,000 with a subsequent annual cost of £40,000. Based on these calculations a saving of £200,000 would be achieved for every 200 children's unintentional injury prevented. Our fieldwork has also shown, with few exceptions, varying levels of coordination of activities and considerable duplication of effort in relation to the provision of safety equipment, with several agencies offering the same services.
- 130** Home safety schemes were not universally available. At several sites we identified that health visitors only undertook selected visits and therefore not all families were reached. Since home safety schemes were often components of Sure Start programmes, provision is confined to specific neighbourhoods given that schemes are linked to areas of health inequalities.
- 131** On occasion, pockets of relative affluence existed where some families which were not deprived were able to access free and reduced-price services. Conversely, in relatively affluent areas, there were occasionally pockets of deprivation, where families in need have been unable to access Sure Start services because of their geographical location. Several participants commented that these issues were likely to exacerbate existing inequalities. Some herald the move from Sure Start provision to Children's Centres as positive in tackling this inequality, although others feared that home safety schemes may be lost in the transition. Home safety schemes were thought to provide a crucial service to local communities and should continue, whether Sure Start existed or not, in any area where the more deprived section of society requires their services.
- 132** At the sites where directors of public health drove activities, projects had a strong health promotion flavour. They focused on the dissemination of information which detailed potential hazards inside and outside the home and outlined practical steps that could be taken. These were often accompanied by projects that provided safety equipment, such as cupboard locks, stair gates and smoke detectors, either on a loan basis, or at reduced cost. In addition, for example in Nottingham, training was provided for front line staff to take on broader prevention roles, integrating questions about safety and unintentional injury into their encounters with residents. In Nottingham this training was undertaken by the City Council.

**133** At sites where directors of children’s services led delivery, initiatives focused on improving the quality of relationships between children and their parents. This approach worked on the premise that developing a general climate of safety for children is as much about the way members of the family interact, as it is about the home and wider environment such as schools and nurseries. Where partnerships were particularly strong, hybrid approaches, which included both public health and inequalities work and integrated children’s services, were deployed, for example, in Nottingham.

## Restructuring

**134** The impact of the changes in NHS structures, including closer working between health and children’s services, was an overarching concern for operational staff both inside and outside public services. There were widespread fears that good will and effective action would be lost. From October 2006, the number of PCTs in England reduced from 303 to 152, a restructuring which presented a considerable challenge. The restructuring may dissolve existing partnerships and require new partnerships to be formed, potentially bringing together partners with a history of different approaches. Organisations will be challenged by the alignment of new partnerships with conflicting priorities, compounded by a potential lack of clarity over roles and responsibilities. Ultimately, however, the increased coterminosity between PCTs and local authorities should also bring benefits, as noted earlier.

**135** Across all sites, new systems for multi-agency delivery were being developed through Children’s Services, including the establishment of Children’s Centres. In addition, the prevention of unintentional injury was being considered under general safeguarding measures and protocols. Participants considered there were opportunities to strengthen their work in the midst of such changes which included the possibility of rolling out approaches that had been effectively piloted in previous arrangements, and the potential to broaden the coverage of services that had previously been targeted at certain neighbourhoods. However, they also identified potential risks and threats during this transition. The reconfiguration of Children’s Services, and the move from Sure Start to Children’s Centres were important changes to the landscape. However, it was also noted that reorganisations had had a negative impact on progress, as priorities shifted and joint work programmes were affected.

**136** Some participants were worried that in the absence of national direction and local policy, existing work programmes would be lost: ‘It takes five years to build a partnership,’ one participant observed, ‘and five minutes to destroy it’. Others were confident that

reconfiguration would result in more resources, but were concerned about the transition to new partnerships. In several sites, participants noted the potential positive and negative impacts of changes in local government, where authorities were devolving decision making and service delivery to neighbourhoods.

## Resourcing

- 137** Overall, we identified a lack of dedicated and sustained resources for unintentional injury prevention activities. There was also a high level of doubt that monies earmarked for health improvement activities would be maintained, as pressures elsewhere in the system took precedence. In particular, there was concern about the use of monies allocated to support *Choosing Health* activities (**Ref. 1**), which were being used to relieve pressure elsewhere, for example deficits in the acute sector. There were anxieties that resources were dwindling while the demands of coverage were expanding: ‘It’s like we’re trying to pull the skin on the drum ever tighter, but still hoping to achieve the same depth of tone’, as one participant commented.
- 138** However, in some places, having to use limited resources to best effect stimulated innovation and some interesting models emerged. For example, joint public health posts have been established across PCTs and local authorities. In Nottingham the fire and rescue service funded health promotion posts, and in Brighton and Hove the Council and the PCT jointly funded the Director of Public Health and the Children’s Commissioner for the Pathfinder Children’s Trust. Elsewhere, joint posts were typically short term and funded from ‘soft’ monies, creating frustration and anxiety among participants. Where this was the case, staff recruitment was challenging as only short-term job security could be assured. There was also little time to embed the work.
- 139** A lack of coordination and short-term funding combined to have wide-ranging effects. They led to duplication of effort and similar groups attempting to access limited sources of money. Short-term funding provides little incentive to forward plan or promote long-term change, as there is no guarantee that resources will be available to fund activities beyond their initial lifespan.
- 140** Efforts to provide training to staff and address injury prevention were often thwarted by costs. For example, two of the sites had approached national training providers but the cost was considered prohibitive. In addition, approaches to injury prevention were often duplicated by a range of services including Sure Start, fire and rescue and the voluntary

sector, for example in relation to distributing and fitting smoke detectors, therefore increasing costs overall. Agencies were often resistant to stopping activities which were popular despite duplication of effort and potential lack of cost-effectiveness. Short-term funding means that the success and implementation of many initiatives relied on the overall effectiveness of the partnerships. However, paradoxically, it encouraged silo working and duplication of effort – this can be exacerbated if partnerships are fragmented with poor communication and low awareness of other partners' efforts.

## Evaluation

- 141 Local evaluation of programmes and initiatives is crucial to support strategies and deploy resources. However, very few participants were able to point to concrete examples of how evaluation had systematically recorded the impact of work and longer-term outcomes, or how evaluation findings had shaped their future plans. Evaluation is particularly pertinent given that participants were not confident that effective approaches were being adopted to prevent unintentional injury. Evaluation can also be used to inform future service developments and change practice and delivery.
- 142 The national evaluation of Sure Start reported that it was difficult to assess the impact of Sure Start on injury rates. Although injury prevention appeared in the list of national targets for improving health, it was not a priority issue in the specific aims of Sure Start and was unlikely to be a top priority for Sure Start local programmes. Measuring progress towards the goal of 'achieving a 10 per cent reduction in children aged 0-3 years admitted to hospitals as an emergency with severe injury' was complicated by problems in classification of injuries; the large number of health service facilities where parents have requested treatment; the small geographical area that each Sure Start local programme covered; and the lack of comparable A&E injury surveillance systems.
- 143 A number of small-scale local evaluations were undertaken by established programmes such as Sure Start, via user satisfaction surveys. However, these evaluations lacked economic content or cost-effectiveness assessments and therefore it was difficult to measure the cost-effectiveness of the schemes.
- 144 There were also difficulties in linking cause and effect. In Burnley, Pendle and Rossendale, basic evaluation indicated a 21 per cent decrease in children's A&E attendance for the under fives but it was difficult to demonstrate that this was a direct result of unintentional injury prevention initiatives. Calculating savings, evaluating the benefits and costing the

impact of the prevention work were challenging due to an acknowledged lack of staff with these skills in their project team. However, based on calculated cost estimates and assumptions and taking into account the running of the project, the estimated saving was £1.9 million. This work was carried out by the East Lancashire Public Health Network. A masters student was also asked to undertake some of this work. Similarly, Nottingham and North Tyneside both used links with the local university to carry out evaluations and monitor projects.

- 145 Elsewhere, we identified change management issues. Any change in practice and assimilation of key messages takes time but we identified that findings from evaluations were seldom communicated, and occasionally rejected by practitioners who preferred to work in their established ways. This raises questions about how practitioners should best be supported to change their practice, in line with evidence of what works. This is a question which is particularly pertinent given the extensive evidence base behind the Accidental Injury Task Force recommendations which, on the whole, sites involved in this study had not implemented.
- 146 Evaluation of strategies to prevent unintentional injury did not occur regularly at the sites we visited. We identified a lack of skills to undertake evaluation, and a lack of dedicated resources. One site explained that the funding they received only covered the project costs but did not allow for any evaluation. This presented a considerable risk, namely that resources were targeted at programmes which may not be cost-effective in preventing unintentional injury.

# 3



## Conclusions

There are five key areas where improvements could be made to prevent unintentional injury to children: national policy, local strategy, partnership, delivery and evidence and evaluation.

**147** Preventing unintentional injury is a complex task requiring coordination among, input from, and delivery by, a wide range of partners and agencies. Partnership is the key to effective delivery. No unintentional injury prevention strategy can be delivered in isolation. Relationships between the NHS and local authorities are crucial to maximising the health of the local population, and for the commissioning and delivery of many services. Nevertheless, as we have identified within the sites we visited, the strength and breadth of partnerships vary.

**148** This chapter outlines our conclusions under the following headings:

- national policy;
- local strategy;
- partnership;
- delivery; and
- evidence and evaluation.

## National policy

**149** Despite the size and scale of the challenge, there are few national drivers to steer work at a local level. At present there are two national targets which were set out in the *Saving Lives: Our Healthier Nation* White Paper (**Ref. 21**). Neither is specifically directed at children as both concern unintentional injury affecting all ages and, as discussed in Chapter 2, limited progress has been made at a local level towards the achievement of the targets.

**150** Participants from the sites we visited stated that the lack of a clear cross-governmental statement, which draws together targets and sets out required actions to prevent unintentional injury, had impeded progress. When faced with numerous other public health priorities such as smoking cessation and obesity, many participants had struggled to address unintentional injury.

**151** Several participants talked about the DH's Accidental Injury Task Force, but expressed regret that despite the Task Force providing a detailed list of what works in preventing unintentional injury, much of this had not been implemented at a local level. The reasons for this remained unclear throughout our fieldwork.

- 152 The structural changes in the NHS were widely discussed among participants. They expressed concerns that the restructure would mean that work to prevent unintentional injury would be lost and the formation of new partnerships would take time to work successfully. However, a number of respondents welcomed the new, mostly coterminous, geographical areas which would enable greater focus in neighbourhoods of high deprivation.
- 153 In addition, the dissolution of Sure Start and the development of Children's Centres was also cause for concern for many participants, particularly during the transition period. However, there was a general agreement that single universal provision through Children's Centres would facilitate a greater number of opportunities for more children and their families.
- 154 The reform of public services, as exemplified by the Education Act and *Commissioning a Patient-led NHS (Ref. 35)*, will also have considerable impact on the delivery of unintentional injury prevention strategies. Both local authorities and the NHS will take on greater commissioning roles, which will also include commissioning more services from the voluntary sector and managing a local market economy. We identified a number of examples of productive work in commissioning services from the voluntary sector. Among the fieldwork sites, there were calls for more systematic approaches to commissioning health improvement services generally, particularly joint commissioning between the health service and the local authorities.
- 155 CPA, undertaken by the Audit Commission, will continue to focus the attention of local government on capturing the quality of systems, including partnerships, as well as outcomes for residents. The transition to CAA in 2009 will make this need for effective partnerships even more acute. The impact of these developments will be significant and will contribute substantially towards the drive to address health issues locally. There was a consensus that greater performance management in unintentional injury prevention would increase its profile locally. However, there were also views that the burden of regulation and inspection should be kept to a minimum. How best to achieve this balance remained unanswered.
- 156 The Annual Health Check, undertaken by the Healthcare Commission, which reports on the progress of PCTs in relation to the DH core and developmental standards, as outlined in *Standards for Better Health (Ref. 27)*, will encourage PCTs to have comprehensive health improvement services and, in particular, focus on partnerships and wider public

health issues. This will help promote work on unintentional injury at a local level. The Annual Health Check will examine the strength of PCT partnerships with other agencies on public health issues including their contribution to LSPs.

- 157** Preventing unintentional injury is only one aspect of improving public health. It is important that steps are taken locally to identify the cause, reduce incident rates and tackle the associated inequalities if unintentional injury is found to be prevalent in an individual locality. As this report has highlighted, this task can only be successfully achieved by working in partnership.

### Local strategy

- 158** Overall, clear strategic action relating to unintentional injury in children was uncommon. In the absence of any high-priority, central requirements there was little local impetus to identify individuals with authority and resources to build and implement a strategy. Without high-level support, the long-term sustainability of programmes was threatened. A lack of strategic plans, local action plans and overall coordination resulted in duplication of effort and loss of focus and overall drive for some local approaches. There were notable exceptions such as Telford and Wrekin and Nottingham where concerted effort and effective partnership working had brought about clear strategies and positive changes.
- 159** There were high levels of operational activity at the majority of sites, even if a defined strategy was not evident. The lack of clear strategic intent threatened the sustainability of action, because funding was seldom found in mainstream budgets, but rather identified from one-off funding initiatives.
- 160** Data were a significant issue across all sites. Without adequate data, the prevalence of unintentional injury was unknown, potentially masking high levels of incidence. Consequently, unintentional injury was not viewed as a priority by many. This is a key risk which needs to be minimised. Quite simply, without good data there is little guidance on where best to direct resources. There were very few effective systems to collect and share useful and intelligent information, although it was noted that this was not peculiar to unintentional injury. The limited data that were available were seldom complete, accurate, relevant or timely. In particular, poor quality and the lack of access to available data prevented the generation and collection of intelligent information about the prevalence of particular types of injury, service use and projected demand.

**161** Data were rarely shared between partners. This was primarily attributed to a lack of information systems capable of generating and sharing data. This in turn encouraged silo working among various agencies. Data need to be generated, shared, stored and analysed among all partners. However, NHS protocols such as Caldicott Guardian status were occasionally cited as reasons not to share data, an approach which was seen as restrictive and impeding progress. Some agencies, including the fire and rescue services, had developed useful information systems, and shared the resulting data. Participants called for national action to improve the quality of data. Connecting for Health, formerly known as the National Programme for Information Technology, was considered to have the potential to share data across the NHS and social services, but how to share data across wider organisations involved in unintentional injury prevention, such as the police, remains a complex issue. In the absence of information systems which allow data to be shared electronically, partnerships should be open to other ways of sharing data, information and knowledge to make progress in preventing unintentional injuries.

## Partnership

- 162** Partnerships in this study varied significantly in size, membership and success, depending on the focus of local strategies. Effective joint working can be difficult to achieve. Where there was no imperative to collaborate, a common finding in this study, partnerships relied heavily on the personality and determination of enthusiastic, driven individuals. The modernisation and restructure of NHS services will in some cases result in the dissolution of boundaries between directorates and organisations and of many established partnerships. This was important because longevity was identified as a key factor in securing effective partnership action.
- 163** Consequently, new partnerships face a challenge in maintaining a focus on preventing unintentional injury while they establish themselves and grapple with other competing priorities. While the study recognises that NHS restructuring presents a challenge to delivery, it should also be viewed as an opportunity to establish new working arrangements, identify new leaders and develop new approaches. However, children's trusts, children and young people's strategic partnerships and, to some extent, LSCBs also provide a stable, secure delivery vehicle during this time of change, as they cover the whole of *Every Child Matters* (Ref. 20) outcomes including a focus on unintentional as well as intentional injuries under 'staying safe'. **Appendix 2** demonstrates the diversity of agencies involved in the delivery of unintentional injury strategies. This checklist should be used when establishing and reviewing partnership arrangements to ensure that all appropriate agencies are involved.

- 164** Generally, we identified scant engagement of elected members, Cabinet and overview and scrutiny committees, patients, the public or their representatives. Nottingham was one of the few examples where the Council's Health and Social Care Overview and Scrutiny Committee helped to stimulate action.
- 165** Engagement of vulnerable communities is crucial to the success of unintentional injury strategies. The active engagement of black and minority ethnic communities in the areas we researched was particularly poor. Partners should consider how best to engage and target these communities, and consider their individual needs when designing strategies to reduce unintentional injury.
- 166** This report has identified that partnerships do not need to be complex structures. The conditions which facilitated progress included an agreed vision and approach and simplicity of structure. Other factors which contributed to successful partnerships included the quality of relationships between partner agencies and the levels of trust and leadership shown. All of these factors should be considered when establishing partnerships. It is vital that involvement in partnerships is formalised and agreed at the top level within an organisation, no matter how long the partnership has been in place. Partners should clarify their roles and responsibilities and agree a set of shared objectives in order to ensure they meet their aims.

## Delivery

- 167** Overall, available resources were often poorly deployed in relation to the size and scale of unintentional injury and sometimes inadequate. Due to the long-term nature of improvements in public health and the lack of ear-marked monies to support the implementation of programmes, limited resources were a common feature. The recent renewed focus on public health, including obesity, sexual health and smoking cessation, has led to competition for priority and resources. In this study, the lack of dedicated funding meant that it was often difficult to maintain organisational commitment. Posts were often funded from short-term 'soft' monies, which consequently prevented a long-term approach being implemented. In the areas where commitment had been maintained, it was driven by individuals who not only identified the importance of work in this area, but also secured adequate funding to follow through on delivery of prevention strategies. In an environment of limited resources and competing priorities, resources could be more effectively deployed if they were shared between partners and distributed according to demand.

- 168** Nevertheless, local action often continued despite a lack of dedicated resources. Champions, who were found throughout local systems, not just at senior officer level, often kept activity alive by sheer determination and enthusiasm for the subject matter. The champions were seen as a valuable resource, but relying on individuals to keep momentum is also a risk and, if not appropriately managed, could also bias the overall approach. However, when appropriately managed, this approach has worked very well and, as a result, we recommend that councils nominate a safety champion for their local area, with a focus on safety in public spaces and maximising the potential of partnership working.
- 169** We identified substantial pockets of work occurring. But work was occasionally duplicated, for example several local agencies providing similar equipment services such as the installation of smoke detectors in an area, or often occurred in isolation. But in some cases services directed towards the prevention of injuries were absent and substantial gaps were evident. We found there were few activities aimed specifically at the under fives, although there were more aimed at school-aged children.

## Evidence and evaluation

- 170** Evaluation of unintentional injury prevention strategies was rare, leaving little scope for assessment of their impact and effectiveness. On those occasions where evaluation was undertaken, it was seldom systematic and findings were rarely used to refine current or future work programmes. Without continued funding there is little incentive to learn from past projects and implement the lessons learned.
- 171** The Accidental Injury Task Force provided a comprehensive evidence-based list of what is known to work when addressing unintentional injury. There were concerns that practitioners who had not actively implemented the suggested Task Force intervention could not be confident that they were taking appropriate action to prevent unintentional injury. However, the Task Force report was issued in 2002 and participants at our study sites felt there was a need to update its scope and refresh practitioner knowledge about what works. Clear challenges exist in asking practitioners to change their behaviour in the light of compelling evidence, and changes in behaviour take time to assimilate in practice. But in an environment of limited resources, resources must be directed towards programmes and interventions which are known to be effective rather than short-term solutions. A clear, authoritative steer on specific interventions which work in preventing unintentional injury in children and tackling inequalities in health is clearly required.

**172** While recognising that the implementation of a strategy to address unintentional injury to children is undoubtedly challenging, the good practice contained within this report, together with the following recommendations, highlight the practical steps that PCTs and local authorities can take.

## Conclusion

**173** Although, according to recent DH data, there are evident improvements in the rates of and deaths from unintentional injury in the under fives, there are still high levels of unintentional injury. Unintentional injury remains one of the leading causes of mortality and morbidity in children. This report has demonstrated that a number of arrangements exist to address unintentional injury effectively within the local community through children's trusts and children and young people strategic partnerships, LSCBs, LAAs and LSPs. Unintentional injury prevention is not considered a top priority by many local authorities or PCTs. Consequently, in an environment of competing priorities and limited resources, alongside the restructuring of the NHS, the strategic drive to address the issue has, on the whole, been absent. We have identified a series of programmes occurring in localities with varying degrees of success. But we also found evidence of a lack of programme evaluation, disjointed working, and duplication of effort, much of which could be substantially reduced with improved partnership arrangements. This report makes a series of recommendations that, if implemented, could effectively help address unintentional injury within local communities.

# Recommendations

The DH and other central government departments including the DfES, CLG, Department for Transport and the Children's Commissioner, should together re-focus their approach to unintentional injury by having a coordinated programme, which each can communicate to their relevant local bodies in a consistent way based on:

- Clarifying the role of regional directors of public health in leading and coordinating the prevention of unintentional injury, as suggested in the report of the Accidental Injury Task Force.
- Re-emphasising the recommendations and strategy set out in the report by the Accidental Injury Task Force and encouraging local organisations to take up and follow the evidence-based guidance contained within the report.
- Commissioning NICE to develop guidance on the prevention of unintentional injury for children under 15 years of age.
- Encouraging and enabling local government and the NHS to share timely, high-quality, relevant data across organisations.
- Providing support to restore and manage the Home Accidents Surveillance System and the Leisure Accidents Surveillance System currently held by RoSPA, which will enable data to be used in the prevention of unintentional injuries, including the design of safer products and environments as the databases were originally intended.

**The Healthcare Commission should:**

- Identify opportunities to assess healthcare organisations' efforts to prevent unintentional injury through its process of assessment.

**PCTs and local councils should:**

- Make maximum use of the financial flexibilities open to them, including using Section 31 (1998 Health Act) to pool resources and consider the appointment of jointly funded posts to support and sustain prevention strategies.
- Review their existing partnership arrangements, particularly those which have been affected by the restructure of the NHS, in the areas of organisation, leadership, membership and delivery.

- Develop joint strategic plans and action plans for all strategies aimed at preventing unintentional injury, and ensure the regular review of these plans and monitoring of outcomes. These plans should ensure that resources are directed towards sustainable evidence-based strategies, that they avoid duplication of work and that they are directed at reducing inequalities.
- Regularly review and develop a clear understanding of the rates and types of unintentional injury in their local area, to enable actions and resources to be directed accordingly.
- Determine what sources of local data are available and, where possible, record and share high-quality data across the NHS and local government.
- Influence LSPs to strengthen the focus on unintentional injury in local communities.
- Use local children's trust arrangements, such as children and young people strategic partnerships or LSCBs, as a vehicle to oversee and ensure delivery of prevention strategies. Where appropriate include the prevention of unintentional injury in LAAs.
- Familiarise themselves and local practitioners with the evidence base detailing what works (as outlined in the report of the Accidental Injury Task Force) and target strategies for preventing unintentional injury accordingly.

# Appendix 1

## Summary of recommendations of the report to the Chief Medical Officer from the Accidental Injury Task Force (Ref. 24)

The Task Force identified a number of wide-ranging recommendations and principles to support successful implementation including:

- using focused data to show where action is needed most;
- adapting key interventions to specific local needs where they have the greatest impact;
- developing and disseminating good practice to show what can be done;
- showing how these interventions can help deliver other programmes and meet targets elsewhere (for example, Health Inequalities, Sure Start, etc);
- involving all stakeholders in producing a local action plan;
- developing a well-trained workforce with the capacity to undertake injury prevention work;
- recruiting high-level support;
- recruiting support from the voluntary sector;
- identifying sources of additional funding; and
- identifying indicators to monitor performance.

The structures recommended for implementation included support for PCTs from directors of public health working in government offices of the regions as well as from the regional public health observatories.

Longer-term actions recommended to improve the infrastructure included a fully trained workforce working to set priorities in a system with good mechanisms for monitoring progress in a cost-effective way. Several areas of research were recommended as essential for strengthening what is known, as well as for identifying gaps in our knowledge. These infrastructure issues produced a number of recommendations at a national, regional and local level, including the following:

- **Better data and injury surveillance**
  - Work collaboratively to make better use of data currently available – from local practitioners' use to linking up national databases.
  - Improve data on injury collected, for example, by working to an agreed core data set and standard definitions.
  - Undertake longer-term work to improve comparability of data and fill gaps in knowledge, including the introduction of new indicators like assessing the burden of injury.
  - Identify a national information lead to monitor progress and lead developments.
  - Undertake research to support better data, ranging from identifying practicable ways of capturing data from different sources, to evaluating the benefits of implementing data changes.
- **A well-trained workforce with capacity to undertake injury prevention work**
  - Develop training which contributes to the needs of multi-disciplinary and multi-agency working, providing more depth than is usual.
  - Undertake research to assess the impact of safety training on various groups in various settings.
- **A research infrastructure** and capacity to undertake and disseminate multi-disciplinary research to the highest international standards, especially on reducing inequalities and on cost-effective interventions. Recommendations included the following:
  - Action by researchers to make research more accessible in order to change professional practice.
  - Central government should lead on research into accidental injury prevention.
  - Systematically review inequalities to examine the effectiveness of interventions across social groups and to identify research gaps.
  - Undertake further research focusing on inequalities, procedures for evaluation and assessing cost-effectiveness, rural safety, changing unsafe behaviour and exposure to risk.

## Appendix 2

This appendix provides a list of agencies who contribute to the delivery of unintentional injury prevention.

It is hoped that this table will support strategists and practitioners in developing programmes of work.

Partner	Contribution to strategy	Contribution to delivery
Patients, the public and their representatives	<ul style="list-style-type: none"> <li>Define strategic priorities</li> </ul>	<ul style="list-style-type: none"> <li>Collaborate with local agencies to deliver relevant campaigns, make their homes safer, protect children from hazards</li> <li>Feedback what works in their homes, families, neighbourhoods</li> </ul>
Government office	<ul style="list-style-type: none"> <li>Build regional strategy with regional directors of public health and public health observatories</li> </ul>	
Local authority	<ul style="list-style-type: none"> <li>Build robust frameworks to elicit the views of local residents about unintentional injury, including communities which are seldom heard</li> <li>Ensure the prevention of unintentional injury is a priority across the community strategy and that the LSP keeps a close eye on progress</li> <li>Clarify local need and ensure provision meets it</li> <li>Identify sustainable resources, not one-off or 'soft' monies – pool where appropriate</li> <li>Develop systems to evaluate local programmes</li> </ul>	<ul style="list-style-type: none"> <li>Feature unintentional injury issues in council newsletters, use regular communications (for example, council tax bills) to reinforce prevention messages</li> <li>Promote awareness about unintentional injury through shared, one-point-of-contact services to a wide range of inquirers, target specific messages to communities</li> <li>Post information in waiting areas</li> <li>Tailor national campaigns to a local context, reinforce overarching message with local information, for example, RoSPA and CAPT</li> <li>Develop the potential of joint posts</li> </ul>

Partner	Contribution to strategy	Contribution to delivery
Elected members	<ul style="list-style-type: none"> <li>• Bring views of communities to priority setting discussions</li> <li>• Champion unintentional injury prevention issues</li> <li>• Ensure funding is prioritised</li> </ul>	<ul style="list-style-type: none"> <li>• Scrutinise progress in relation to strategic priorities</li> <li>• Promote campaigns locally, using the media to spread the message</li> </ul>
Children's directorate	<ul style="list-style-type: none"> <li>• Ensure unintentional injury is central priority of children and young people's strategy</li> <li>• Action plan for prevention work and resource appropriately</li> <li>• Resource LSCB to focus on injury</li> <li>• Develop systems to evaluate local programmes</li> <li>• Identify sustainable resources, not one-off or 'soft' monies</li> </ul>	<ul style="list-style-type: none"> <li>• Ensure Child Death Panel members have high level of awareness about injury</li> <li>• Resource Children's Centres to promote safety in the home, for example, deliver home safety schemes (in partnership with health promotion)</li> <li>• Tailor national campaigns to local context, reinforce overarching message with local information, for example, RoSPA and CAPT</li> <li>• Ensure schools have attained Healthy Schools status and that preventing unintentional injury is high on the agenda</li> <li>• Deliver Crucial Crew events</li> <li>• Develop protocols with housing departments for vulnerable families</li> <li>• Accredite local nursery providers once to encompass safety and unintentional injury issues on their curricula</li> <li>• Undertake risk assessments in homes and alert relevant service providers</li> <li>• Work with youth services to deliver awareness events to young people (for example, Smartrisk)</li> <li>• Post information in waiting areas</li> </ul>

Partner	Contribution to strategy	Contribution to delivery
Schools and colleges	<ul style="list-style-type: none"> <li>Representation on partnership bodies to define priorities</li> </ul>	<ul style="list-style-type: none"> <li>Ensure schools have attained Healthy Schools status and that preventing unintentional injury is high on the agenda</li> <li>Integrate safety and unintentional injury issues into curricula eg. injury minimisation programme for schools</li> <li>Reinforce and tailor national campaigns to a local context, reinforce overarching message with local information</li> </ul>
Trading standards	<ul style="list-style-type: none"> <li>Integrate safety issues into trading standards strategies</li> <li>Prioritise sales of children's merchandise for action</li> </ul>	<ul style="list-style-type: none"> <li>Campaign with local traders</li> <li>Undertake spot-checks on rogue merchants</li> <li>Accredit local suppliers as providers of safe home equipment</li> </ul>
Parks and leisure	<ul style="list-style-type: none"> <li>Integrate safety issues into parks and leisure strategies</li> <li>Identify sustainable resources, not one-off or 'soft' monies</li> </ul>	<ul style="list-style-type: none"> <li>Ensure green spaces and playgrounds are accessible and safe</li> <li>Provide supervision, park rangers, etc</li> <li>Post information in information stations</li> </ul>
Community safety	<ul style="list-style-type: none"> <li>Encapsulate fire prevention and safe homes into the community safety agenda – identify lead person to link with other strategic priorities across the community strategy</li> <li>Develop systems to evaluate local programmes</li> <li>Identify sustainable resources, not one-off or 'soft' monies</li> </ul>	<ul style="list-style-type: none"> <li>Ensure community wardens work with front-line health and social services staff to identify risks inside and outside the home</li> <li>Tailor national campaigns to local context, reinforce overarching message with local information, for example, 'Think'</li> </ul>

Partner	Contribution to strategy	Contribution to delivery
Housing	<ul style="list-style-type: none"> <li>• Ensure decent homes standard is implemented</li> <li>• Integrate safety issues into housing strategies</li> <li>• Identify sustainable resources, not one-off or 'soft' monies – pool where appropriate</li> </ul>	<ul style="list-style-type: none"> <li>• Work with private housing providers to improve standards, including those allocated for asylum seekers and refugees in dispersal areas</li> <li>• Ensure that there are hard-wired smoke detectors in all newly built housing</li> <li>• Disseminate and fit home safety equipment</li> <li>• Post information in waiting areas</li> </ul>
Regeneration	<ul style="list-style-type: none"> <li>• Identify safety and unintentional injury concerns throughout plans to develop social, economic and cultural well-being</li> <li>• Identify sustainable resources, not one-off or 'soft' monies – pool where appropriate</li> <li>• Identify the relationship between unintentional injury and community cohesion issues</li> </ul>	<ul style="list-style-type: none"> <li>• Fund schemes through area-based initiatives (for example, New Deal for Communities)</li> <li>• Develop consultation processes with local people and integrate topics about safety and unintentional injury</li> </ul>
Town and spatial planning	<ul style="list-style-type: none"> <li>• Ensure safety issues central to development plans</li> </ul>	
Transport	<ul style="list-style-type: none"> <li>• Integrate safety issues into transport strategies</li> <li>• Provide data about local incidents, hotspots</li> <li>• Identify sustainable resources, not one-off or 'soft' monies – pool where appropriate</li> </ul>	<ul style="list-style-type: none"> <li>• Tailor national campaigns to a local context, reinforce overarching message with local information</li> <li>• Design traffic calming measures</li> <li>• Provide car seat checks</li> <li>• Develop systematic programme of cycling proficiency work</li> <li>• Promote awareness about wearing cycle helmets</li> <li>• Contribute to Crucial Crew events</li> <li>• Post information on buses, trains, etc</li> </ul>

Partner	Contribution to strategy	Contribution to delivery
Libraries		<ul style="list-style-type: none"> <li>• Provide information in hard copy and signpost service users to virtual sites</li> <li>• Link with small families and build safety and unintentional injury topics into literacy work</li> </ul>
Health service	<ul style="list-style-type: none"> <li>• Clarify local need and ensure provision meets it</li> <li>• Achieve local sign-up to prioritise the prevention of unintentional injury</li> <li>• Identify sustainable resources, not one-off or 'soft' monies – pool where appropriate</li> </ul>	<ul style="list-style-type: none"> <li>• Post information in waiting areas</li> <li>• Develop the potential of joint posts</li> </ul>
Public health observatory	<ul style="list-style-type: none"> <li>• Provide timely, accurate and relevant data</li> <li>• Provide information on the availability of injury data</li> <li>• Encourage local, regional and national developments to improve injury data</li> </ul>	<ul style="list-style-type: none"> <li>• Feed back evaluative information to PCTs and local authorities in relation to delivery plans, etc</li> </ul>
Public health/ commissioning	<ul style="list-style-type: none"> <li>• Ensure the prevention of unintentional injury accidental is a priority for high-level public health strategy and keep a close eye on progress</li> <li>• Identify sustainable resources, not one-off or 'soft' monies – pool where appropriate</li> <li>• Define local protocols for sharing data</li> <li>• Generate local intelligence about prevalence and incidence of unintentional injury</li> <li>• Bring latest information about what works in prevention programmes</li> <li>• Develop commissioning protocols for health improvement/unintentional injury prevention</li> <li>• Develop systems to evaluate local programmes</li> </ul>	<ul style="list-style-type: none"> <li>• Disseminate information about what works in preventing injuries to front-line staff</li> </ul>

Partner	Contribution to strategy	Contribution to delivery
Health promotion	<ul style="list-style-type: none"> <li>Provide information about what works in preventing unintentional injury</li> </ul>	<ul style="list-style-type: none"> <li>Tailor national campaigns to a local context, reinforce overarching message with local information</li> <li>Lead campaigns in the community and in primary care</li> <li>Work with community development colleagues to raise issues with families</li> <li>Manage, deliver and evaluate home safety equipment schemes</li> <li>Contribute to Crucial Crew type events</li> <li>Deliver training to increase the awareness of front-line staff</li> </ul>
General practice	<ul style="list-style-type: none"> <li>Provide data on service use and trends in local injuries</li> </ul>	<ul style="list-style-type: none"> <li>Raise safety issues with new parents</li> <li>Intervene with patients who report repeat minor injuries</li> <li>Post information in waiting areas</li> </ul>
Community pharmacy	<ul style="list-style-type: none"> <li>Provide data on service use and trends in local injuries</li> </ul>	<ul style="list-style-type: none"> <li>Identify patients in minor injury clinics and respond to queries regarding preventing unintentional injury</li> <li>Provide information in leaflet form</li> <li>Signpost to appropriate agencies</li> <li>Post information in waiting areas</li> </ul>
Health visitors	<ul style="list-style-type: none"> <li>Provide data about local incidents, hotspots</li> </ul>	<ul style="list-style-type: none"> <li>Provide information</li> <li>Nurture positive relationships between parents and their children</li> <li>Undertake risk assessments in homes and alert relevant service providers</li> </ul>
Midwives	<ul style="list-style-type: none"> <li>Provide data about local incidents, hotspots</li> </ul>	<ul style="list-style-type: none"> <li>Provide information for soon-to-be, new and vulnerable parents</li> <li>Undertake risk assessments in homes and alert relevant service providers</li> </ul>

Partner	Contribution to strategy	Contribution to delivery
A&E	<ul style="list-style-type: none"> <li>● Provide data about local incidents, hotspots</li> <li>● Ensure completeness of data recording and availability of data for sharing in the nationally advised format</li> <li>● Seek to enhance recorded information on injuries</li> </ul>	<ul style="list-style-type: none"> <li>● Provide information to patients attending with injuries to prevent future injuries</li> <li>● Notify PCTs/children’s directorates/ children's trusts about repeat visits, suspected child protection issues, etc</li> <li>● Link to trading standards if particular merchandise features</li> <li>● Post information in waiting areas</li> <li>● Contribute to Crucial Crew type events</li> </ul>
Police	<ul style="list-style-type: none"> <li>● Provide data about local incidents, hotspots</li> <li>● Develop systems to evaluate local programmes</li> <li>● Identify sustainable resources, not one-off or ‘soft’ monies – pool where appropriate</li> </ul>	<ul style="list-style-type: none"> <li>● Contribute to Crucial Crew type events</li> <li>● Alert other agencies for child protection/vulnerable families issues</li> <li>● Undertake risk assessments in homes and alert relevant service providers</li> <li>● Post information in waiting areas</li> <li>● Develop the potential of joint posts</li> </ul>
Transport police	<ul style="list-style-type: none"> <li>● Provide data about local incidents, hotspots</li> <li>● Keep unintentional injury issues ‘live’ in speed camera initiatives</li> <li>● Develop systems to evaluate local programmes</li> </ul>	<ul style="list-style-type: none"> <li>● Contribute to Crucial Crew type events</li> <li>● Promote awareness of safe driving</li> </ul>
Fire and rescue services	<ul style="list-style-type: none"> <li>● Provide data about local incidents, hotspots</li> <li>● Develop systems to evaluate local programmes</li> <li>● Identify sustainable resources, not one-off or ‘soft’ monies – pool where appropriate</li> </ul>	<ul style="list-style-type: none"> <li>● Tailor national campaigns to local context, reinforce overarching message with local information, for example, Fire Kills</li> <li>● Deliver prevention work in schools and nurseries – Fireman Sam and Frances the Firefly, etc</li> <li>● Develop the potential of joint posts</li> <li>● Hold open days to introduce prevention issues to neighbourhoods</li> <li>● Disseminate and fit smoke detectors</li> <li>● Contribute to Crucial Crew type events</li> <li>● Undertake risk assessments in homes and alert relevant service providers</li> </ul>

Partner	Contribution to strategy	Contribution to delivery
Ambulance	<ul style="list-style-type: none"> <li>Provide data about local incidents, hotspots</li> </ul>	<ul style="list-style-type: none"> <li>Contribute to Crucial Crew events</li> <li>Post information in ambulances</li> <li>Undertake risk assessments in homes and alert relevant service providers</li> </ul>
Voluntary and community sector	<ul style="list-style-type: none"> <li>Contribute to LSP-wide strategies, especially for engaging families from hard-to-reach communities</li> <li>Formulate strategies to improve engagement</li> </ul>	<ul style="list-style-type: none"> <li>Work with hard-to-reach communities and families</li> <li>Engage residents from hard-to-reach groups, including black and ethnic minorities, travellers and people with disabilities and mental health issues</li> <li>Undertake risk assessments in homes and alert relevant service providers</li> <li>Deliver home safety equipment schemes, engaging local people, etc</li> </ul>
St John's Ambulance		<ul style="list-style-type: none"> <li>Tailor national campaigns to a local context, reinforce overarching message with local information</li> <li>Deliver programmes to increase skills in first aid, baby resuscitation, awareness of injuries (for example, Ginger Monkey), etc</li> </ul>
RoSPA	<ul style="list-style-type: none"> <li>Build national networks</li> </ul>	<ul style="list-style-type: none"> <li>Support local strategy development</li> </ul>

Source: Audit Commission/Healthcare Commission

## References

- 1 DH, *Choosing Health: Making Healthy Choices Easier*, 2004.
- 2 Ward, H, and Christie, N, *Strategic Review of Research: Priorities for Accidental Injury*, report for the DH, University College London, 2000.
- 3 Towner et al, *What Works in Preventing Unintentional Injuries in Children and Young Adolescents?*, HDA, 2001.
- 4 Office of National Statistics (ONS), 2003.
- 5 ONS 2004.
- 6 [www.firekills.gov.uk](http://www.firekills.gov.uk), ONS.
- 7 Department for Transport, 2006.
- 8 Children's Fire and Burn Trust, [www.childrensfireandburntrust.org.uk](http://www.childrensfireandburntrust.org.uk)
- 9 Towner, E, and Dowswell, T, *What Works to Prevent Unintentional Injury Amongst Children?*, a report prepared for the HDA, University of Newcastle, 2001.
- 10 Hospital Episode Statistics data 2005.
- 11 Edwards et al, *Deaths from Injury in Children and Employment Status in Family Analysis in Class Specific Death Rates*, *British Medical Journal*, Oct 2006.
- 12 Grayling et al, *Streets Ahead: Safe and Liveable Streets for Children*, Institute for Public Policy Research, 2002.
- 13 HDA, *Evidence Briefing: Prevention and Reduction of Accidental Injury in Children and Older People*, 2003.
- 14 Office of the Deputy Prime Minister, *The Economic Cost of Fire: Estimates for 2004*, 2006.
- 15 Child Accident Prevention Trust – [www.capt.org.uk](http://www.capt.org.uk).
- 16 Department for Transport, *Highways Economics Note No. 1*, 2004.
- 17 DH, *The NHS Plan: A Plan for Investment, a Plan for Reform*, 2000.
- 18 Children's NSF, 2004.
- 19 Her Majesty's Government, Children's Act 2004.
- 20 DfES, *Every Child Matters: Change for Children*, 2004.
- 21 DH, *Saving Lives: Our Healthier Nation*, 1999.
- 22 DH, personal correspondence, 2006.

- 23 DH, *Tackling Health Inequalities: A Programme for Action*, 2003.
- 24 Audit Commission, *report on road safety*, due to publish in February 2007.
- 25 DH, *Our Health, Our Care, Our Say: A New Direction for Community Services*, 2006.
- 26 CLG, *Strong and Prosperous Communities: The Local Government Paper*, 2006.
- 27 DH, *Standards for Better Health*, 2004.
- 28 Report of the Accidental Injury Task Force, *Preventing Accidental Injury: Priorities for Action*, 2002.
- 29 Audit Commission, *Governing Partnerships: Bridging the Accountability Gap*, 2005.
- 30 Wanless, D, *Securing Good Health for the Whole Population*, Her Majesty's Stationery Office, 2004.
- 31 HDA, *Preventing and Reducing Accidental Injury in Children and Older People*, 2003.
- 32 Holder, Y, et al, *Injury Surveillance Guidelines*, WHO, 2001.
- 33 Her Majesty's Government, Local Government Act 2000.
- 34 [www.firekills.gov.uk](http://www.firekills.gov.uk).
- 35 DH, *Commissioning a Patient-led NHS*, 2005.



This report is available on our website at [www.audit-commission.gov.uk](http://www.audit-commission.gov.uk). Our website contains a searchable version of this report, as well as a text-only version that can easily be copied into other software for wider accessibility.

If you require a copy of this report in large print, in braille, on tape, or in a language other than English, please call **0845 0522613**.

To order additional copies of this report or other Audit Commission publications please contact **Audit Commission Publications, PO Box 99, Wetherby, LS23 7SA Tel 0800 502030**.

Audit Commission  
1st Floor, Millbank Tower,  
Millbank, London SW1P 4HQ  
Tel: 020 7828 1212 Fax: 020 7976 6187  
Textphone (minicom): 020 7630 0421  
[www.audit-commission.gov.uk](http://www.audit-commission.gov.uk)

Price £25  
Stock code: HNR3371