

The Health Committee's Public Health Inquiry

Submission from the Royal Society for the Prevention of Accidents (RoSPA)

Summary

- Accidents are a far greater public health issue than is currently recognised and a strategic approach to accident prevention, placed firmly at the heart of the Government's public health strategy, is required if lives are to be saved, injuries reduced and dramatic cost savings made. The rationale on which this perspective is based is explained fully at www.rosipa.com/about/currentcampaigns/publichealth/.
- The local-level assessment of needs and commissioning of public health services, based on robust data and evidence of best practice, is essential if appropriate services are to be delivered, but clear national leadership and guidance are fundamental if important aspects of public health, such as home accident prevention, are to receive the attention they deserve.
- At present, it is difficult to see how third sector organisations, particularly those which operate at a national level, could effectively access the proposed public health planning and commissioning arenas. Without a clear mechanism for participation, the third sector - acknowledged as a key service provider - could be severely damaged.

1. Context

- 1.1. RoSPA welcomes the development of Public Health England as a national body to drive forward change, but is concerned that there is no clear remit for accident prevention specified in *Healthy Lives, Healthy People: Our strategy for public health in England*.
- 1.2. Although injury indicators are proposed in the accompanying Public Health Outcomes Framework document, the White Paper itself barely mentions accidental injury, its distribution, severities, costs or preventability.
- 1.3. RoSPA hopes this serious omission will be rectified and that Public Health England will become a truly influential champion of accident prevention that:
 - leads on the development of an accidental injury strategy (with home accident prevention at its core) as an integral part of its overall strategy for public health
 - co-ordinates epidemiological work related to accidental injury
 - takes a national lead in establishing an accidental injury database and provides clear guidance to ensure that appropriate priority and consistency is applied to data collection and dissemination at a local level
 - provides, through its strategy document, a robust framework for the development of effective evidence-based accident prevention work at a local level, including the establishment of local accident prevention partnerships
 - encourages the robust evaluation of accident prevention work and promotes best practice
 - ensures that appropriate skills are developed locally by directing local providers to sources of suitable training e.g. home safety training
 - recognises the role of the third sector and provides clear national commissioning routes to ensure third sector organisations can participate fully in service provision.

- 1.4. When we talk about accident prevention, we do not mean “nanny statism” or excessive bureaucracy. On the contrary, we know and can demonstrate that a better informed, more empowered public - more conscious of the causes of accidents and how to prevent them - will be healthier, happier, and far less expensive for the taxpayer.

Responses to specific issues raised by the Health Committee

2. The creation of Public Health England within the Department of Health and the public health role of the Secretary of State

- 2.1. Accidents and their prevention can be found among the roles and responsibilities of a variety of “non-health” government departments, the key players being: Department for Transport; Department for Work and Pensions; Department for Communities and Local Government; Department for Business, Innovation and Skills; and, Department for Education.
- 2.2. However, primary responsibility for accident prevention lies - and, indeed, must lie - with the Department of Health and, at its helm, the Secretary of State.
- 2.3. As *Healthy Lives, Healthy People* makes clear, the NHS has a “critical role” in promoting health and preventing avoidable illness, and, indeed, injury. This role is critical, not just to improve health outcomes but also because a tremendous amount of money can be saved through prevention. In 2001, it was estimated that the cost of accidents to the NHS in England alone was £2.2 billion a year. Allowing for inflation, this figure could now be in the region of £5-7 billion. We are told the NHS needs to save £15-20 billion; it would therefore seem illogical for the Department of Health not to lead a strategic approach to accident prevention which could save a significant proportion of this sum.
- 2.4. National leadership has been proven to bring impressive results. Since the mid 1990s, evidence-based road safety strategies led by the DfT, and involving a wide variety of national and local groups, have contributed to a reduction in annual deaths and serious injuries on Great Britain’s roads by nearly 21,000 (44 per cent). Similarly, work by the Health and Safety Executive, supported again by many other groups, has helped cut the number of workers killed in occupational accidents in the UK by nearly half since 1996.
- 2.5. In 1992, there was a welcome increase in action on home and leisure safety at a local level following the publication of *The Health of the Nation*. Healthy Alliances were established, bringing together local authorities, health professionals and the third sector to address various aspects of public health including the prevention of accidents involving older people and children. In the immediately following years, there was a noticeable drop in home accident deaths. The number of children and older people visiting A&E after home or leisure-related falls also decreased.
- 2.6. However, national leadership on home and leisure accident prevention has been sporadic. The effects of this can be seen clearly because, while deaths from road and workplace accidents have fallen consistently, home accident deaths are now at their greatest number in England and Wales since 1985, and represent a growing proportion of total accidental deaths. This has contributed to the overall trend in accidental deaths being upwards during the last decade. The accident death rate in England has all but flat-lined since the late 1990s - strikingly at odds with the significant reductions in death rates from cancer, circulatory diseases and suicide.

Accidents are the principal cause of death up to the age of 39 and the main cause of death among children, post-infancy.

- 2.7.** Accidents do not just result in untimely and often violent deaths - they also cause millions of injuries that require trips to a GP or hospital. For example, across the UK, accidents result in more than two million visits to A&E departments by children every year, of whom half are injured in the home. A&E attendance following accidents is rising. Hospital admissions for treatment of accidental injuries are also increasing. To give just one example - in 12 years, the number of over-60s requiring inpatient care for falls-related injuries has doubled, standing at more than 333,000 in 2009/10 in NHS hospitals in England alone.
- 2.8.** To provide the strong national leadership that public health, and accident prevention as part of it, warrants, RoSPA favours the creation of Public Health England as a semi-autonomous body within the overarching structure of the Department of Health, its board members representing the full range of public health issues and its chairman reporting directly to the Secretary of State. Without obvious political leadership and vocal support, others involved in the delivery of accident prevention (or wider public health) will not keep up the necessary momentum.
- 2.9.** If Public Health England became a fully independent body, it might be too detached from the budget-holding Department that stands to save billions of pounds from its work and become merely one of many competing lobby organisations. As just another directorate of the Department of Health, it would be constantly vulnerable to the effects of ministerial change and perhaps less able to speak freely about important matters.
- 3. The future role of local government in public health (including arrangements for the appointment of Directors of Public Health; and the role of Health and Wellbeing Boards, Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategy)**
- 3.1.** Local authorities, with their responsibilities for education, transportation, housing, environmental health, social care, children's services and trading standards, are well placed to understand the factors leading to accidental injury within their populations. They have played an important role in accident prevention for many years, and there are numerous examples of successful joint working between local government and the NHS, often with the involvement of the third sector too.
- 3.2.** Earlier, we mentioned the Healthy Alliances that flourished in the early 1990s. A more recent example of successful partnership working can be found in Dudley where a falls prevention initiative, the £158k a year costs of which were funded by the Primary Care Trust and the council, saved £3 million over five years due to the corresponding reduction in hip fractures.
- 3.3.** Additionally, Safe At Home, the national home safety equipment scheme, funded by the DfE and delivered by RoSPA from February 2009 to March 2011, involved local authority, NHS and third sector partners in areas with the highest accident rates in England, all working to help disadvantaged families prevent accidents among under-fives.
- 3.4.** RoSPA believes local authorities, guided by the Directors of Public Health employed by them, should have the freedom to develop accident prevention strategies that are tailored to the needs of local people. The Joint Strategic Needs Assessment (JSNA), from which a Health and Wellbeing Strategy will be formed, provides the opportunity

for this. To ensure joined-up commissioning at a local level, RoSPA advocates a multidisciplinary approach to this process, considering wider health determinants such as housing, transportation and education.

- 3.5. Although localism is crucial in developing relevant and effective strategies, a clear national steer is required to counter the risk that valuable life-saving - and cost-saving - work will either not happen, or will begin but then fizzle out. As recognised by the *Healthy Lives, Healthy People* consultation, finances have often been squeezed by other NHS priorities, and it must be recognised that the same pressures will operate within local authorities, necessitating clear guidance and protection for public health funds. RoSPA believes Public Health England should be the body to provide this guidance and that, while not defining the detail, it should specify the need to include accident prevention work, and specifically home safety, in Health and Wellbeing Strategies, with the focus on enhancing existing activity.
- 3.6. Locally, the health and wellbeing agenda will be driven by local authority and health professionals, which is reinforced by the proposed membership of Health and Wellbeing Boards. However, the mechanism enabling this agenda to be influenced, let alone owned, by local communities is not clear. Nor is it clear how the proposed process differs from the current Local Strategic Partnership approach, which often already includes Health Partnership Boards comprising the partners proposed for Health and Wellbeing Boards. RoSPA believes it is important to strengthen existing partnerships rather than dismantle and rebuild from scratch.
- 3.7. Although third sector and private business organisations appear to be regarded as key delivery agents for services, their involvement in Health and Wellbeing Boards appears to be only discretionary. RoSPA advocates that relevant third sector organisations, including those concerned with accident prevention, should be properly involved in JSNAs and the work of Health and Wellbeing Boards.

4. Arrangements for public health involvement in the commissioning of NHS services

- 4.1. Given the number of people being killed or injured in accidents - and the huge financial burden that injury treatment imposes on the NHS - it is imperative that accident prevention is considered when NHS services are being commissioned. We are told regularly that the choice for the NHS is: spend less or do less. But there is a third way - investing in accident prevention would not only save lives and reduce injuries, but would enable the NHS to continue to deliver its vital services and save money. Accident prevention projects are easy to implement, inexpensive to deliver and have impressive return on investment potential. They can bring about immediate savings within the very first year.

5. Arrangements for commissioning public health services

- 5.1. The commissioning of accident prevention services must be based on robust data that indicates what the priorities should be. There are clear roles for both Public Health England and local government in this. RoSPA welcomes the lead commissioning role for Public Health England in relation to health intelligence and data, while acknowledging that there are some instances in which local authorities will need to commission their own data. At present, data relating to home and leisure accidents is not routinely collected, and therefore is not analysed or disseminated on a local or national scale. This situation needs to be rectified if appropriate services are to be commissioned. Left to those operating at a local level, such data collection will, at best, be fragmented and, at worst, remain non-existent. Public Health England

should provide clear guidance on the appropriate level of priority and consistency in data collection and dissemination.

- 5.2. The third sector is hugely important in providing services that improve public health, and clear commissioning routes are required to ensure these valuable services can continue. At the moment, it is difficult to see how third sector organisations could effectively access the commissioning arena. A national mechanism is needed whereby third sector organisations, and private firms, that deliver services can feed into Health and Wellbeing Boards.
- 5.3. It will be particularly difficult for national charities to operate within the proposed arrangements for public health, and some way is needed to lessen the challenges that such organisations will face in maintaining contacts with a multiplicity of local Health and Wellbeing Boards. For example, RoSPA, which has more than 90 years' experience in accident prevention, plays a pivotal role in advising national and local commissioners on the leading causes of accidental injury and the best evidence-based practice to tackle them. The proposed structure - with its emphasis on the localism agenda - does not appear to have a mechanism for organisations like this to bring their skills and expertise to the table or to secure funding to continue their role.
- 5.4. Without clear third sector participation routes, expertise will be lost, there will be duplication of effort at a local level and a failure to share and adopt best practice. Public Health England could play an important role in alleviating the problem by signposting Health and Wellbeing Boards to key national service providers. The Government also needs very clear plans to protect services provided by the third sector in the short term and to properly acknowledge the need for transition arrangements.

6. The structure and purpose of the Public Health Outcomes Framework

- 6.1. RoSPA welcomes the inclusion of indicators related to injury prevention in the Outcomes Framework. The inclusion is vital to ensure that action is taken on accident prevention.
- 6.2. RoSPA believes Public Health England should lead on the implementation of robust evaluation of public health interventions and ensure that appropriate skills for this are developed at a local level. This will help local areas develop evidenced-based programmes that can truly deliver the outcomes outlined in the framework.
- 6.3. However, while the emphasis on evidence-based approaches is acknowledged, it will also be important to build in opportunities for innovative approaches. Failure to do this will stifle creativity. It should be remembered that all evidence-based practice started with an idea, a pilot and a small-scale initiative that grew and developed. Therefore, incentives are needed to promote innovation and its evaluation rather than just limiting activity to what is already known to work.

7. Arrangements for funding public health services (including the Health Premium)

- 7.1. RoSPA supports the "population health measures" approach for allocating public health funding, taking into account health inequalities, because it appears the most pragmatic means of deciding allocations and of ensuring those in the greatest areas of public health need receive the higher levels of funding. The "cost-effectiveness" approach may be more appropriate for use by local areas in determining how they spend their allocations.

- 7.2.** While RoSPA acknowledges that there will be no centrally-imposed targets or performance management, we believe it is likely that local authorities will be driven by the availability of additional funding through the Health Premium. However, we are concerned that key areas will be undermined if they do not have an indicator linked to the Health Premium.
- 7.3.** On accident prevention, it should be noted that only when the previous Government introduced a “national indicator” did Local Strategic Partnerships give more consideration to the inclusion of injury prevention in their local area agreements. Similarly, the key driver for much falls prevention work in recent years was the National Service Framework for Older People. Therefore, RoSPA believes it is important to ensure that accident prevention indicators are linked to funding offered through the Health Premium, recognising that interventions in this area can offer long-term benefits in terms of fewer injuries and corresponding cost savings.
- 7.4.** Part of the Health Premium should focus on rewarding areas that are willing to pilot innovative approaches in order to further develop the base of evidence and good practice available to local practitioners.
- 8. The future of the public health workforce (including the regulation of public health professionals)**
- 8.1.** The need for accident prevention co-ordinators in every local authority area was highlighted recently by NICE guidance. In its *Strategies to prevent unintentional injuries among under-15s* - published in November 2010 - it said that “local injury prevention co-ordinators” could promote a strategic framework for action and encourage local agencies to work together. To help make this happen, it is important that opportunities for training and funding are made available, and Public Health England could play a valuable co-ordination role.
- 9. How the Government is responding to the Marmot Review on health inequalities**
- 9.1.** The Marmot Review provided further confirmation of the inequalities in health that have been understood for many years and RoSPA agrees that the indicators outlined in the Outcomes Framework should reflect the need to tackle these as a priority.
- 9.2.** We are aware of the significant social gradient in relation to accidental injury and regard the proposed injury prevention indicators as essential first steps to tackling this.
- 9.3.** Given the scale of the home accident problem involving children and the significant social class gradient in the death and injury rate of children from accidental injury (the death rate of those in NS-SEC Class 8 being 13 times higher than in NS-SEC Class 1), RoSPA proposes that a clear national steer on preventing home accidents involving young children from disadvantaged families would be a highly appropriate response to the Marmot Review.