



The Royal Society for the Prevention of Accidents

**Response to the Department of Health's White Paper
*Healthy Lives, Healthy People: Our strategy for public
health in England***

www.dh.gov.uk/en/Publichealth/Healthyliveshealthypeople/

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Rt Hon Andrew Lansley MP
 Secretary of State
 Department of Health
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Dear Andrew

RoSPA Response to Public Health White Paper
Healthy Lives, Healthy People: Our strategy for public health in England

Please find enclosed the RoSPA response to the Department of Health's White Paper - *Healthy Lives, Healthy People: Our strategy for public health in England*.

We are concerned that the White Paper makes insufficient reference to the value and priority that should, we believe, be attributed to the prevention of accidental injury and death. This is a highly significant issue which is often overlooked because of its superficial complexity and its interdependence with other issues. This document highlights the importance of Government coordination, the effective gathering and use of data and the range of effective measures which can be applied to accident prevention.

In particular, we would like to highlight that:

- Accidents diminish the lives of nearly a third of people in England.
- Accidents are financially costly to Government and society.
- Accident prevention is, compared to other potential public health interventions, easy to implement and inexpensive to deliver.
- The return on investment, measured in Quality Adjusted Life Years, outstrips every other potential public health intervention.

We recognise that accidents are not the single largest public health issue. However in terms of their impact on society and their efficacy of intervention, **they should be the first priority** for your new strategy.

The staff at RoSPA are highly experienced and committed to our cause, which is to save lives and reduce injuries. With their engagement, you can realise tremendous social and financial benefits for the NHS and for the country. Please tap into their expertise and harvest this, the 'low-hanging fruit' of public health.

Yours sincerely

The Lord Jordan of Bournville CBE
 President
 RoSPA

Rt Hon The Lord Hunt of Wirral MBE
 Deputy President
 RoSPA

1. Introduction

- 1.1. RoSPA's mission is ***to save lives and reduce injuries***. Our vision is ***to lead the way on accident prevention***. We welcome the Government's decision to consult on its plans for the future of public health in England but we take the view that there needs to be a much stronger focus on accident prevention as part of overall public health policy and practice. The same clear focus needs to be established within the framework which the Government is proposing for tracking public health outcomes and for funding work in this area.
- 1.2. RoSPA has argued consistently that accidents are a major public health issue requiring a strategic approach to prevention. We remain steadfastly committed to promoting safety and the prevention of accidents in all areas of life: at work, at leisure, on the road, in the home and in schools. We were active participants in the 2002 Department of Health Accidental Injury Task Force. More recently, we have been part of the group which has developed the *Preventing unintentional injuries among under-15s* guidance, which was published last year (in three complementary guidance documents) by the National Institute for Health and Clinical Excellence (NICE). In addition to our extensive ongoing policy work in workplace, road, home, water and leisure safety and safety education, we have been delivering practical action such as the Department for Education-sponsored Safe at Home scheme (the national home safety equipment scheme) and the Child Safety Education Coalition - although sadly Government funding for these last two programmes has ended.
- 1.3. Despite our consistent lobbying and campaigning - along with the work of many other organisations - accident prevention has remained a worryingly low priority for successive governments and has still not received the level of attention it deserves. Not only were many of the 2002 Task Force recommendations largely ignored but, since that time, accident prevention - in the home particularly - has received scant attention. Thus, although there are injury indicators proposed in the accompanying Public Health Outcomes Framework document, in the White Paper itself, accidental injury is mentioned only twice: Section 1.45 mentions falls and hip fractures with reference to an ageing population and Section 1.23 mentions road accidents, particularly to children. Instead, the White Paper focuses on other important issues such as alcohol-related ill health, diet, exercise and mental health and the need to tackle lifestyle issues and health inequalities, but there is no recognition of the extent of the overall problem of accidental injury, including its distribution, severities, costs or preventability.
- 1.4. Despite welcome reductions in the number of casualties in areas such as workplaces and on the roads, the overall scale of the accident problem remains immense, involving around 14,000 deaths and three times as many serious, life-changing injuries - and costing the NHS more than £2.5 billion per annum in A&E and treatment costs. These are untimely, often violent events which blight families and communities but their effects are rarely measured in terms of their wider social and health impacts, including poverty and deprivation.
- 1.5. Relatively few accidents are wholly novel or unforeseeable and the majority are easily preventable through the application of proportionate safety measures. Whether in the home, on the road, in the workplace or in leisure or educational settings, the ever present potential for accidents to occur is to a large extent suppressed by good organisation, sound technology and safe behaviours. To be effective, these, in turn, need to be supported by good design and planning, suitable education and information and, where appropriate, by law, standards and

enforcement. However, wherever these primary barriers are weak or break down, accidents can and do occur. And if adequate secondary protective safety measures are not in place, injuries will occur too. A proportion of these will involve loss of life or be life-changing as a result of permanent disability or disfigurement. The resulting toll of pain, suffering, stress and economic loss to the victims and their families remains largely hidden.

- 1.6. Far from being burdensome or limiting enterprise and opportunity, a balanced and proportionate approach to safety is positive and liberating, enabling individuals, groups and organisations to pursue their goals, confident that hazards have been identified and risks adequately assessed and controlled.
- 1.7. There is considerable potential to further improve accidental injury prevention, at minimal cost. Examples of projects which have worked include:
 - home safety schemes
 - 24/7 safety programmes at the workplace
 - help for small and medium size enterprises
 - safety education and information in the community
 - road safety campaigns
 - safety and risk education in schools.
- 1.8. The low cost of these kinds of intervention, many of which can be supported by volunteers, can be recouped if only relatively few injuries are successfully prevented. In times of diminished resources, it must make sense to focus on those areas which can have the most effect and can be tackled successfully at the least cost. Prevention is obviously better than cure; it is also much cheaper.
- 1.9. The sections of this submission which follow set out not only RoSPA's views on issues and questions raised in the White Paper but also a series of key facts about accidents and the steps that are needed to make further progress in cutting casualties, suffering and costs.
- 1.10. RoSPA urges ministers and other leaders in the public health field to reflect on these arguments which, taken together, constitute an unassailable case for developing fresh action on accident and injury prevention and making this a permanently embedded feature of public health policy and practice in the UK.

2. History of accident prevention

- 2.1. Several times in the last two decades, accidents have been listed as a priority by the Department of Health. For example, Healthy Alliances to prevent accidents flourished briefly in the early 90s. But when there is a change of minister, the impetus often slows and suddenly the topic is dropped. Without Government leadership and vocal support, others will not keep up the momentum.
- 2.2. The Accidental Injury Task Force Report, *Preventing accidental injury - priorities for action* (2002), was one of those reports that was written but never fully put into action. It encapsulated everything that needed to be done and is still valid today. It would take limited effort to update and implement it.
- 2.3. The report identified priority areas and set out a framework for delivery and recognised that it will not be possible to deliver national targets on reducing accidents unless there is a more integrated approach to accident

prevention, coupled with a strong lead at every level. The Task Force concluded that “*the development and promulgation of a more united approach across Government and the NHS should be a priority*”¹ - this never really happened.

- 2.4. Recently, the NICE guidelines, *Strategies to prevent unintentional injuries among under-15s*, have echoed some of the Task Force recommendations in relation to child safety.²
- 2.5. Safety and risk education still awaits inclusion in the Personal, Social, Health and Economic (PSHE) education curriculum as a mandatory activity. Secondary school children, in particular, are not equipped with the life skills necessary to look after themselves at home, on the roads or while in leisure pursuits. Risk education is fundamental to ensuring a healthy active life. This theme lay at the heart of the work of the Child Safety Education Coalition (CSEC), established by RoSPA with funding from the Department for Children, Schools and Families (since renamed the Department for Education, DfE). Conscious of the need to avoid creating “cotton wool kids”, the coalition promoted learning about safety by experiencing risk underpinned by the principle that, unless risks were intolerable, activities for children should be made as safe as necessary, not as possible.

3. The casualty toll

Fatalities

- 3.1. Accidents claimed the lives of 13,861 people in the UK in 2009. England and Wales accounted for 12,017 of these deaths³ (Scotland for 1,332⁴ and Northern Ireland for 512⁵).
- 3.2. In 2009, one death in 40 in England and Wales was caused by an accident. Roughly three times as many people suffer a serious, life-changing injury as are killed. These are untimely, often violent events which blight families and communities but their effects are rarely measured in terms of their wider social and health impacts, including poverty and deprivation. At least a third of the population have their lives diminished by accidents because of this “ripple” effect.
- 3.3. Despite steady progress in the reduction of some types of accidental death, for example, on the roads, the general picture revealed by the overarching mortality statistics is less encouraging.
- 3.4. The most recent five years worth of published mortality data for England and Wales (2005-2009)⁶, shown in Table 1, reveals that the trend in accidental deaths has been, rather disappointingly, upwards; although it should be noted that there was a reduction from 2008 to 2009.

Table 1: Accidental deaths in England and Wales, 2005-2009

Year	Total accidental deaths (England and Wales)	Deaths resulting from accidents in the home or residential institutions	% of accidental deaths resulting from accidents in the home or residential institutions
2005	11,053	3,774	34%
2006	11,824	3,959	33%
2007	11,883	4,030	34%
2008	12,306	4,587	37%
2009	12,017	4,732	39%

- 3.5. Home is the most common location for an accident resulting in death and, as Table 1 shows, the number of fatal home accidents across England and Wales is rising. More people die from accidents at home than on the roads, but this is rarely given public acknowledgement because home accidents, which by their very nature happen behind closed doors, tend not to find their way into official statistics and attract less media attention.
- 3.6. Accidents involving children are a leading cause of childhood mortality in England.⁷ In England and Wales in 2009, 193 children aged 0-14 years died as a result of an accident.⁸ Across the UK, accidents are the principal cause of death up until age 39.
- 3.7. Children under the age of five are one of the groups most vulnerable to home accidents. Deprivation also plays a role. Children of parents who are long-term unemployed or who have never worked are 13 times more likely to die as a result of unintentional injury and 37 times more likely to die from exposure to smoke, fire or flames than children of parents in higher managerial or professional occupations.⁹
- 3.8. Older people are also particularly vulnerable to home accidents. Indeed, among the causes of accidental death that have been increasing in recent years are falls and accidental threats to breathing, particularly among older people.¹⁰ With an ageing population and an emphasis on enabling older people to live as independently as possible, it is clear that older people's safety at home is an issue that cannot be ignored.
- 3.9. Fatal cases of "accidental poisoning by and exposure to noxious substances" have also increased significantly.¹¹ Some of these incidents are likely to fall into the realm of accidental drug overdoses but many others are due to other types of accidental poisoning e.g. children or adults ingesting poisonous substances by mistake or being overcome by gases or vapours.
- 3.10. On the roads, the fatal casualty trend has been downwards. In 2009, 1,880 people were killed in reported accidents on England's roads.¹² This represented a record low in road deaths.
- 3.11. In occupational safety, there have also been significant achievements. Across Britain in 2009/10, 152 workers were killed at work, continuing a general downward trend in accidental deaths at work.¹³ However, this figure does not recognise that up to a third of road deaths are associated with use of the road for work purposes; across Britain as a whole, work-related road accidents are estimated to claim the lives of some 700 people each year.

- 3.12. A new source of data has recently been launched by the National Water Safety Forum - WAID (the Water Incident Database). Figures from the new database reveal that there were 405 water-related fatalities, resulting from accidents or natural causes, across the UK in 2009.¹⁴ This is much higher than is generally understood.

Non-fatal injuries

- 3.13. The vast majority of accidents do not result in death. Many hundreds of thousands of people across the country are injured each year as a result of accidents, and a significant proportion of these injuries are life changing.
- 3.14. The Home Accident Surveillance System (HASS), operated by the former Department of Trade and Industry until 2002, estimates that 2.7 million people attend an A&E department in the UK following a home accident each year.¹⁵
- 3.15. A parallel system - the Leisure Accident Surveillance System (LASS) - estimates that 2.9 million people attend an A&E department in the UK following an accident in a "leisure" setting each year.¹⁶
- 3.16. Hospital Episode Statistics (HES) provide an overview of the number of people who are admitted to hospital in England following accidents. In 2009/10, there were 731,400 finished consultant episodes (spells of admitted patient care) that were first-time admissions related to accidents.¹⁷
- 3.17. Data for reported road accidents on England's roads in 2009 show that 21,326 people were seriously injured and a further 173,574 were slightly injured.¹⁸ However, these figures are just the tip of an iceberg because they only include casualties in road accidents that were reported to the police. Many more road casualties are recorded in hospital data. It should be noted that the significant differences between "reported road accidents" data (which are drawn from the police STATS19 system and published by the Department for Transport) and the HES admission data have been publicised in recent years. An article within *Road Casualties Great Britain: 2009* focuses on these differences. It says: "*In 2009 there were around 39 thousand admissions to hospitals in England resulting from road traffic accidents recorded, compared with 21 thousand serious injuries reported in STATS19. Although police and hospital data are not directly comparable, this illustrates the incompleteness of the police data for non-fatal casualties.*"¹⁹ This under-reporting of road casualties is much higher for the more vulnerable road users. For example, the number of pedal cyclist admissions in the hospital data is more than three times higher than the number of seriously injured cyclists in the police data. For child cyclists, the hospital figure is six times higher than the police data.
- 3.18. In the occupational sphere, in addition to fatal accidents at work in Britain in 2009/10, there were a further 121,430 injuries to employees reported under RIDDOR (The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995)²⁰, although there is acknowledged to be more than 40 per cent under-reporting under these regulations. In total, it is estimated that there were more than one million injuries of all severities as well as 1.3 million people who had worked during the last year who were suffering from an illness they believed was caused or made worse by their current or past work.²¹

Children and young people

- 3.19. Each year, home and leisure accidents lead to around two million A&E visits in the UK involving children and young people aged under 15 years.²² This equates to around 1.7 million visits involving children and young people in England, or to about 3,300 visits involving children and young people per 100,000 population each year.²³
- 3.20. Accidents put more children in hospital than any other cause. Each year, around 97,000 children and young people aged under 15 years are admitted to hospital in England because of an accident.²⁴ This means that around 200 children and young people per 100,000 population will be admitted each year.²⁵
- 3.21. As stated earlier, accidents are a leading cause of child death. And, in *Child Public Health*, Blair et al wrote: "Accidental injury continues to be the main cause of death after infancy. Although absolute rates have fallen by 25% over the last 40 years, death rates from other causes fell by nearly 75%, so that injuries represent a growing proportion of deaths among children and young people."²⁶

Older people

- 3.22. It is estimated that annually, more than 500,000 people over the age of 65 visit A&E after an accident in the home, 72 per cent of whom are injured in falls.²⁷

4. Costs: human and societal

- 4.1. The cost of accidents to individuals, the NHS, other agencies and society of accident-related deaths and injuries is truly enormous. Costs are both financial and human but for the most part remain hidden from view.
- 4.2. Looking first at the financial costs, the annual cost of accidental injury across all age groups to the NHS in England alone has been estimated to be £2.2 billion²⁸. With the cost of treating a child for a serious scald being up to £250,000²⁹, it is clear to see how accident-related costs can quickly mount up. The costs associated with hip fractures present a similar picture, with £1.4 billion spent on treatment.³⁰
- 4.3. The total cost of reported road accidents in 2009 was just under £16 billion. For all road accidents, including those not reported to the police, the cost was around £30 billion.³¹
- 4.4. In 2009/10, 28.5 million working days were lost overall (1.2 days per worker), 23.4 million due to work-related ill health and 5.1 million due to workplace injury³². The annual cost to society as a whole is estimated to be close to £30 billion - or nearly three per cent of Gross Domestic Product³³.
- 4.5. RoSPA commissioned research, published in 2010 by TRL, which found that the annual cost of the 2.7 million home accident casualties who visit A&E (drawn from HASS) was an estimated £45.6 billion, based on an average cost of £16,900 per victim.³⁴ The cost findings were based on: lost contribution to the economy (lost output); the value of avoidance of injury (the amount the community would be prepared to pay to avoid the chance of an injury happening); and the cost of medical, Social Security and other support services. Costs to the individual and long-term care are not included. This figure also does not include the cost of home accident deaths, for which the cost per fatality is estimated at £1.61 million.

And it does not include the cost of people who seek GP treatment after a home accident.

- 4.6. When the leisure accident casualties from LASS are also taken into consideration, the figure becomes a staggering £94.6 billion, which is the total cost of home and leisure accidents.³⁵
- 4.7. Adding the costs of workplace, road, leisure and home accidents together suggests an annual cost to the country of more than £150 billion.
- 4.8. On a human level, accidents do not just cause immediate pain and suffering to the victim, the most stark of which being death in an untimely and often violent manner. Grief can last a lifetime and divorce and family breakdown are recognised as potential consequences of serious accidents. Families can suffer extreme financial hardship as a result of an accident, particularly if the person killed or injured is the main breadwinner, but the stress and strain of caring for an injured loved one should also not be underestimated. For families in which a loved one suffers a severe and debilitating injury, life can change forever.

5. Prevention works, prevention pays

- 5.1. RoSPA acknowledges that the White Paper has emphasised the importance of evidence-based practice. RoSPA has direct experience of successful accident prevention programmes in several spheres.
- 5.2. On Britain's roads, for example, despite massive increases in traffic over the last 20 years or so, the number of people killed each year has fallen from around 5,500 people to around 2,000. Injuries too have reduced from around 75,000 a year in the mid 1980s to 45,000 per annum in the mid 1990s. There are many reasons for these casualty reductions, including, for example, safer cars. But one of the most important is that Britain has had comprehensive national road safety strategies and casualty reduction targets, beginning in the mid 1980s, which have been evidence-led and based on data and research. Such strategies have embodied road safety policies and interventions which have harnessed the focus and energies of the wide range of agencies that deliver or promote road safety, including central and local government, the emergency services, road-related trade and user groups and the private and voluntary sectors, so that, on the whole, they have all been working towards the same shared goals, with agreed priorities and partnership working.
- 5.3. As stated earlier in this response, NICE recently published three pieces of complementary guidance which aim to help keep children and young people safe from serious harm. The documents consider: strategies to prevent unintentional injuries; home safety assessments and the provision of safety equipment; and, road design and modification.³⁶ RoSPA is pleased that the guidelines recognise the huge value of home safety assessment and equipment schemes and the importance of safety education, advice and information because these are areas for which there is evidence to show that prevention works.
- 5.4. In Burnley, Pendle and Rossendale, the Action on Children's Accident Project (ACAP), which commenced almost six years ago, is an example of an evidence-based approach that has contributed to a significant reduction in A&E attendance by local children aged under five years.³⁷ Its effectiveness is felt to be due to a targeted Home Safety Equipment Scheme being offered in disadvantaged areas and also the work of a Multi Agency Safety Network Group, which provides

accident prevention advice for all ages across the whole local population via events and regular press and radio coverage. This demonstrates the positive impact that the inclusion of such an approach in the public health strategy could have in reducing both the human and financial costs of injuries to young children. Programmes of this kind not only fit in well with the “starting well” and “developing well” themes of the White Paper, but also contribute to the accompanying “working well” and “living well” themes by reducing the impact of accidents on working lives and encouraging behaviour change to reduce accidents.

- 5.5. RoSPA is also fully supportive of the “ageing well” principles of the White Paper. Older people are at elevated risk of death or disability due to an accident, most commonly a fall. Following a fall, there is often a loss of independence and confidence among older people, which can diminish their resilience and quality of life and increase care costs.
- 5.6. The work of the Falls Collaborative Groups in Burnley, Pendle and Rossendale is an evidence-based example of activity that has led to a reduction in ambulance call outs as a result of a fall.³⁸
- 5.7. Further evidence shows that since a falls prevention programme was introduced in Dudley the number of hip fractures have reduced year on year.³⁹ The health and social care costs of a hip fracture are approximately £20,000, and the reduction in falls in the area has resulted in a saving of approximately £3 million.
- 5.8. RoSPA believes that the strategy for public health should build on the success of these and other initiatives that have developed across the country because - demonstrably - they save lives and reduce costs to the NHS, thus releasing resources to be spent in other areas of health need.
- 5.9. The NICE guidelines, *Preventing unintentional injuries in the home among children and young people aged under 15: providing safety equipment and home risk assessments*, recommend the supply and fit of safety equipment into the homes of those most at risk. This underpins the work carried out under Safe at Home which has, for the past two years, supplied and installed home safety equipment into the homes of more than 61,000 families across England, thus creating the potential to reduce accidents in the homes of those most at risk. The educational section of the project has left a legacy of more than 141 local partnerships and more than 4,000 trained professionals who have, in turn, been instrumental in delivering safety messages to more than 300,000 families.
- 5.10. The evaluation of the Safe at Home scheme, which will be available in June 2011, is already reporting the positive value of projects of this nature, and there is evidence of some sustainability. However, national support and guidance could still be needed if the recommendations made by NICE are to be successfully implemented.
- 5.11. It should also be noted that Return On Investment (ROI) calculations have been made for a variety of accidental injury prevention strategies⁴⁰:
 - £1 spent on smoke alarms saves £69
 - £1 spent on bicycle helmets saves £29
 - £1 spent on child safety seats saves £32
 - £1 spent on road safety improvements saves £3
 - £1 spent on prevention counselling by paediatricians saves £10

- £1 spent on poison control services saves £7.

5.12. Other examples of successful programmes can be provided if required.

Comparisons

5.13. To make more meaningful comparisons between deaths due to accidents and those due to serious, life limiting health conditions such as cancer, heart disease and stroke, it is necessary to consider quality-adjusted life years (QALYs) lost. The latter tend to dominate health policy discussion but are predominantly conditions of late middle age, whereas accidents affect the young disproportionately and victims have to live with the life limiting consequences for longer, as do their carers. Costs associated with long-term care have to be taken into account, as well as the loss of productive capacity. Looked at in this way, accidents are likely to be recognised overall as a bigger public health issue than is currently the case and understanding of the cost effectiveness of interventions, many very low cost, will be correspondingly enhanced.

6. Data matters

6.1. In July 2008, the European Union (EU) issued a Regulation⁴¹ requiring Member States to monitor accidents and harm to health caused by those products subject to European Community harmonisation legislation. The UK is a signatory to this and implementation was required by January 1, 2010.

6.2. The EU has also published a Recommendation⁴² to Member States which requires that each should make better use of existing data and develop injury surveillance and reporting systems to identify injury trends that are emerging all the time in new products, materials, and leisure/sports equipment. In addition, the data should be sent to the European Injury Database to assist with EU-wide public health surveillance, international benchmarking and prevention of injuries.

6.3. As well as the EU calling for improved data collection and dissemination, several UK Government reports and policies recognise the need for data to allow issues to be identified and interventions to be monitored and evaluated.

6.4. While much data is collected within the NHS, it is insufficient to establish the circumstances in which an injury occurs. The focus of the NHS data is on treatment and diagnosis. It is not designed to aid learning from experience to prevent injuries in the future.

The multiple uses of injury surveillance data

6.5. Government departments need evidence to develop appropriate (rather than excessive) regulatory and legislative frameworks.

6.6. Cost-effective public health campaigns depend on injury surveillance data to identify priorities, develop campaigns and evaluate their effectiveness.

6.7. Private sector organisations ranging from designers and retailers to investors and insurers need to be able to understand how products are used and to evaluate the potential risks they cause to consumers.

- 6.8. The voluntary and community sector needs the data to target its limited resources to demographic and geographic areas where they will have the most beneficial impact on society.
- 6.9. Schools and universities use data to educate children and young people, teaching them how to manage rather than avoid risk.

The way ahead

- 6.10. In 2008, RoSPA presented a report to the Secretary of State for Health with a key recommendation to run a number of pilots in order to establish the relative merits of various types of data collection systems in busy hospital emergency departments.⁴³ This report was generated using RoSPA's charitable funds and supported by those of industry partners. RoSPA used its limited resources to prove the value to the Department of Health (DH) of its own management processes. As a result, the DH commissioned the South West Public Health Observatory to work with up to four hospitals to run pilots and evaluate their cost effectiveness. Almost two years on, none of these pilots has taken place, despite repeated pressure from RoSPA.
- 6.11. In the meantime and with RoSPA's support, the College of Emergency Medicine has agreed a new, enhanced dataset to be used in all hospital emergency departments. This needs to be tested to establish the value of the information compared with any impact on the productivity of clinical and administrative staff within the NHS.

7. Leadership and co-ordination

- 7.1. 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 the White Paper. We also welcome the lead commissioning role for Public Health England in relation to health intelligence and data and acknowledge that there are some instances in which local authorities will need to commission their own data. However, in some areas of accidental injury prevention, such as home accidents, data is not currently routinely collated, analysed or disseminated. We are concerned that, if this is left to local commissioning, at best it will be fragmented and at worst it will remain non-existent.
- 7.2. Public Health England can provide a strategic lead and support the development of effective evidence-based accident prevention work on the ground. This is essential to encourage activity at a local level. It is noted that NICE recommended that there should be a child injury prevention co-ordinator in every local authority. This is an ideal opportunity to take up that recommendation.
- 7.3. It is understood that the Joint Strategic Needs Assessment and Health and Wellbeing Strategy continue to be driven by local government and health staff and this will be reinforced by the proposed membership of the Health and Wellbeing Boards. 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 mentioned in proposed Health and Wellbeing Boards.

- 7.4. Potentially, GP services are an ideal location for the commissioning of a wide variety of prevention services because they are in a position to have contact with a wide cross-section of the local community. RoSPA would welcome the development of a mechanism that leads to GP services being more proactively involved in the prevention of accidental injury, particularly as priority tends to be given to services which attract payment. However, if this is to be a valid investment, there needs to be a very clear mechanism for measuring the outputs and outcomes of the work of GP led services. We would favour an approach whereby Public Health England commissions specific accident prevention work and provides opportunities to appropriate potential partners, including GP services, to undertake that work.
- 7.5. RoSPA welcomes the recognition of the long-standing role of local authorities in delivering the public health agenda. In relation to accidental prevention, for example, public health activity will need to range across many services including children's services, adult social care, environmental health services, trading standards, housing and transportation. We would hope that ring-fenced public health funding would specify the inclusion of accidental injury prevention work that will enhance any existing activity in these departments, rather than replacing it and simply moving the same levels of funding around. We believe the mandatory public health role of the local authority should include the responsibility to co-ordinate a multidisciplinary approach to the delivery of a local accidental injury prevention plan.

8. Where RoSPA can help

- 8.1. RoSPA is the only national organisation that strives to improve accident prevention across all spheres of life and for all vulnerable age groups. It seeks to develop an effective, co-ordinated and structured approach on accident prevention to consumers, the media, healthcare practitioners, employers, employees, retailers and manufacturers, as well as public authorities and other key stakeholders.
- 8.2. RoSPA works not only to raise awareness of the need for safety and accident prevention but **also** to bring about sustainable life and cost-saving changes in UK society by promoting key safety issues and providing relevant services. Activities include informing and educating, collecting data, undertaking research, developing policies, lobbying, auditing, providing expert consultancy advice and recognising outstanding safety performance.
- 8.3. RoSPA is ideally placed to raise awareness and deliver vital safety information, empowering people to make the right choices while at work or in their free time. These aims are fundamental in setting priorities for long-term strategic goals and day-to-day operations.
- 8.4. With experienced staff and influential National Committees covering work, home and road safety, as well the National Risk Education Committee and the National Water Safety Forum, RoSPA represents a substantial reservoir of expertise and a network of valued relationships. As stated earlier in this response, RoSPA has been able to play a pivotal role, for example, in vital initiatives such as the national Safe at Home scheme, delivered to more than 61,000 families. It has also led the delivery of CSEC and campaigns in response to emerging issues.
- 8.5. RoSPA's key strength in the areas of workplace, road, home, and water and leisure safety means it is able to provide support and expertise to local agencies,

partnerships and businesses to enable them to deliver high quality and effective accident prevention practice in line with local need and market demand.

- 8.6. It is in this context that RoSPA wants to work closely with the new structures and systems proposed in the White Paper.
- 8.7. RoSPA's mission statement and objectives link clearly to the priorities outlined in the White Paper, including the Government's commitments to "helping people live longer, healthier and more fulfilling lives" and to "improve the health of the poorest, fastest". There are also direct links to five areas identified for action in the White Paper - "starting well", "developing well", "living well", "working well" and "ageing well" - because many of RoSPA's programmes fit in with the proposed life course approach.
- 8.8. In the following paragraphs, examples of current RoSPA activity are given for each of the priority areas.
- 8.9. **Improving maternal health:** RoSPA provides practical advice, education and training for preparation for parenthood and bringing up babies safely.
- 8.10. **Taking better care of children's health and development:** RoSPA has just completed the delivery of Safe at Home for the DfE. The ongoing blind cord safety campaign, run in conjunction with the Department for Business, Innovation and Skills and the British Blind and Shutter Association, and RoSPA's leading role in managing and co-ordinating CSEC illustrate RoSPA's expertise in the delivery of wide ranging programmes aimed at keeping children healthy and safe.
- 8.11. **The impact of being in work on health and the need to reduce working age ill health:** As well as wide ranging programmes to promote health and safety in the workplace, RoSPA has developed the concept of safety 24/7 and worked with major employers to support their activities to promote the safety of their staff at home and leisure as well as at work.
- 8.12. **Changing adults' behaviour:** RoSPA has championed work to prevent falls among older people as well as raising awareness of the need to consider safety in all activities at home, leisure or on the road. Advanced Driver training is one very practical example of a programme providing the skills to enable adults to adopt safer practices on the road.
- 8.13. **Preventing excess deaths in winter:** RoSPA actively works to raise awareness of the impact of the cold on the safety of older people and, in particular, its links to falls and the incidence of carbon monoxide poisoning.
- 8.14. Initiatives to prevent accidental injury in all of these areas will have positive economic benefits as well as improving people's health and life expectancy. RoSPA believes there should be a clear and specific link to injury prevention in these areas.
- 8.15. However, without the explicit inclusion of accident prevention, there is a significant danger that it will be marginalised in these contexts and the opportunities for progress in reducing the cost and suffering caused by accidental injury will be lost.

9. Answers to specific consultation questions

9.1. Question a: role of GPs and GP practices in public health

- **QUESTION:** *Are there additional ways in which we can ensure that GPs and GP practices will continue to play a key role in areas for which Public Health England will take responsibility?*
- **RESPONSE:** GP practices could make a key contribution to ensuring that accidental injury prevention is included in the local public health agenda, particularly in relation to the most vulnerable in society, i.e. children under five and older people. With encouragement and support, they could ensure that provision of home safety information and advice is embedded into all services provided within their practice and that they provide a leading voice in relation to accident prevention in the community. This should be reflected as a key area of public health within local programmes developed and driven by GP consortia. Unfortunately, there is very little evidence that this kind of activity is being carried out by GPs at present and RoSPA is not confident that it will happen to any extent under the new arrangements unless there are strong mechanisms put in place to incentivise this sort of activity.

9.2. Question b: public health evidence

- **QUESTION:** *What are the best opportunities to develop and enhance the availability, accessibility and utility of public health information and intelligence?*
- **RESPONSE:** The absence of good quality accident data at national and local level continues to hinder the development of evidence-based interventions. The Safe at Home programme has helped to generate some national and local evidence as part of the evaluation process and there is an opportunity to build on this. The danger of the localism approach is that responses will differ greatly in different localities. This is something that needs a national lead, particularly in terms of providing clear guidance to GP consortia and Health and Wellbeing Boards to ensure an appropriate level of priority and consistency of data collection and dissemination.

9.3. Question c: public health evidence

- **QUESTION:** *How can Public Health England address current gaps such as using the insights of behavioural science, tackling wider determinants of health, achieving cost effectiveness, and tackling inequalities?*
- **RESPONSE:** Public Health England should provide clear guidance and support to localities on developing appropriate levels of local evaluation and the skills necessary to secure data that is sufficiently robust to add to the overall evidence base. Experience of delivery of the Safe at Home scheme has shown that there are skills or resources gaps in many localities hindering development of effective local evaluations to monitor and measure programmes. There is a danger that many good local initiatives are being lost because they have not been informed by local epidemiological data on accidents and have been insufficiently evaluated. Unless they are underpinned by rational decision making there is the danger that the provision of local services will become patchy and of questionable quality. Investment in local home safety training, support in setting up local accident prevention partnerships and assistance with evaluation will help

localities to develop programmes that can truly deliver the outcomes outlined in the Public Health Outcomes Framework.

9.4. Question d: public health evidence

- **QUESTION:** *What can wider partners nationally and locally contribute to improving the use of evidence in public health?*
- **RESPONSE:** Organisations such as RoSPA can play a significant role in disseminating evidence-based good practice through its extensive portfolio of training programmes and the potential support it can offer to local and regional partnerships. The difficulty in the current proposed model is in identifying how such organisations can continue to deliver their pivotal role in leading the development work in critical areas. More clarification is needed on the support that will be available to utilise the expertise of such organisations and ensure that they can continue to play a major role in supporting the delivery of the local agenda. It is also difficult to see how national organisations can maintain contacts with a multiplicity of local ones such as Health and Wellbeing Boards.

9.5. Question e: regulation of public health professionals

- **QUESTION:** *We would welcome views on Dr Gabriel Scally's report. If we were to pursue voluntary registration, which organisation would be best suited to provide a system of voluntary regulation for public health specialists?*
- **RESPONSE:** Whatever the system of regulation, RoSPA believes it is critical for key members of the public health workforce to have a clear understanding of the issues around accident prevention. RoSPA can contribute expertise to the design and delivery of modules covering the key skills needed to tackle accidental injury prevention in public health training courses.

9.6. RoSPA's answers to the specific consultation questions contained within *Healthy lives, healthy people: consultation on the funding and commissioning routes for public health* and *Healthy Lives, Healthy People: transparency in outcomes - proposals for a public health outcomes framework* can be found in the Annexes at the end of this document.

10. Conclusions and recommendations

Conclusions

- 10.1. Accidental injury should be a major priority for public health action.
- 10.2. Accident prevention is cost effective.
- 10.3. Accident prevention should be underpinned by good quality causation data and evaluation.
- 10.4. Accident prevention should be unified under a co-ordinator in each local authority.
- 10.5. Home accident prevention needs a much higher priority.

- 10.6. GP practices should make a key contribution by ensuring that accident prevention is included in the local public health agenda, particularly in relation to the most vulnerable in society, i.e. children under five and older people.

Recommendations

- 10.7. Public Health England should lead on the development of an accidental injury prevention strategy as an integral part of its overall strategy for public health.
- 10.8. The national strategy for public health should provide incentives to local authorities and partners to reflect the need to apply NICE guidance in local plans for accidental injury prevention.
- 10.9. Public Health England should establish a special unit to co-ordinate epidemiological work related to accidental injury.
- 10.10. Public Health England should take a national lead in establishing an accidental injury prevention database. In order to ensure consistency, this should not be left at a local level.
- 10.11. Public Health England should also take a national lead in providing clear guidance to GP consortia and Health and Wellbeing Boards to ensure an appropriate level of priority and consistency in data collection and dissemination.
- 10.12. Public Health England should recognise the need for home safety training and provide support to appropriate national bodies to ensure its delivery.
- 10.13. Public Health England should take the lead in ensuring that local accident prevention partnerships are set up in accordance with evidence of best practice. These partnerships should be co-ordinated and clearly linked to the Health and Wellbeing boards and the opportunity to feed into Joint Strategic Needs Assessments.
- 10.14. Public Health England should lead on the implementation of robust evaluation and ensure that appropriate skill levels are developed at a local level. This will help localities to develop evidenced-based programmes that can truly deliver the outcomes outlined in the Public Health Outcomes Framework.
- 10.15. The Government needs to recognise the role of the third sector in improving public health in relation to accidental injury prevention and provide clear national commissioning routes to ensure that these services continue to be provided.
- 10.16. In this context, relevant third sector organisations concerned with accident prevention should be closely involved in JSNAs and the work of Health and Wellbeing Boards.
- 10.17. The Government needs very clear plans to protect services provided by the third sector in the short term to enable it to carry out its critical public health role at a local level.

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Annex A: *Healthy lives, healthy people: consultation on the funding and commissioning routes for public health* - RoSPA's answers to specific consultation questions

Question 1

- **QUESTION:** Is the health and wellbeing board the right place to bring together ring-fenced public health and other budgets?
- **ANSWER:** Health and Wellbeing Boards may be the right place for bringing together ring-fenced public health and other budgets but it is not clear what incentive other budget holders would have to bring their budgets to the consideration of Health and Wellbeing Boards. The diagram in paragraph 2.3 illustrates arrangements for statutory organisations but gives no indication as to how the business or third sector will participate in this process. Although in the various White Papers, business and third sector organisations appear to be regarded as the key delivery agents for services, their involvement in Health and Wellbeing Boards appears to be only discretionary.

The social care primary prevention activities mentioned in paragraph 2.6 are examples of services that are discretionary and therefore not universal. Very differing levels of activity in relation, for example, to exercise and balance classes, operate across the country and the services mentioned are examples of those most likely to be reduced or discontinued as a result of the current local funding cuts. Neither the funding paper or the *Healthy Lives, Healthy People* White Paper appear to give an impression of any protection to this type of work but rather suggest that they are building on activity that is at best limited and at worst nonexistent. The likelihood is that if these activities are to continue or expand, there will be an expectation that they are funded from the public health budget.

Question 2

- **QUESTION:** What mechanisms would best enable local authorities to utilise voluntary and independent sector capacity to support health improvement plans? What can be done to ensure the widest possible range of providers are supported to play a full part in providing health and wellbeing services and minimise barriers to such involvement?
- **ANSWER:** By the time the public health White Paper plans come to fruition in 2013, many potential local providers will no longer exist because of the loss of local public sector funding in the meantime. The Government needs very clear plans to protect services provided by the third sector in the short term. This paper does not appear to address the transition arrangements.

Including a mechanism where organisations responsible for service delivery can feed directly into health and wellbeing boards will be crucial.

The DH expects that "the majority of services will be commissioned, given the opportunities this would bring to engage local communities more widely". Although it is welcome that has been recognised that some service providers may be more in touch with local communities than statutory agencies, there is no guarantee of this. Measures will need to be introduced to ensure that, particularly,

private sector profit driven companies are truly engaging with their local communities.

The localism agenda and the paper as a whole fail to address the question of funding for nationally-led organisations. Organisations such as RoSPA provide key support to local delivery in terms of providing training, consultancy, advice and information. There appears to be no mechanism for these organisations to bring their skills and expertise to the table.

The JSNA, and Health and Wellbeing Strategy continue to be driven by local government and health staff and this is reinforced by the proposed membership of the Health and Wellbeing Boards. 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 mentioned in proposed Health and Wellbeing Boards.

Paragraph 2.9 describes the obligations placed on local authorities, the NHS and GP consortia. Paragraph 2.10 calls them new “freedoms”. It is not clear how an obligation can be regarded as a freedom.

The emphasis on commissioning services from non-statutory providers is mentioned three times in paragraphs 2.8, 2.10, and 2.11. While this is a welcome approach, it seems to be based on a presumption that it will be possible to offer services currently provided by the statutory sector more cheaply. The commitment in paragraph 2.10 that the DH will “work to ensure that voluntary, community and social enterprise organisations will play a full part in providing health and wellbeing services” is welcome but there is no clarity as to how this will be achieved.

Question 3

- **QUESTION:** How can we best ensure that NHS commissioning is underpinned by the necessary public health advice?
- **ANSWER:** Organisations such as RoSPA, with more than 90 years of experience in tackling the key public health issue of accident prevention, can play a pivotal role on advising national and local commissioners on the leading causes of accidental injury and the best evidence-based practice to tackle this. However, at the moment, there does not appear to be any mechanism in the proposed structure to facilitate best use of this expertise or for such organisations to secure funding to continue this role. The emphasis on the localism agenda with all resources being distributed at this level does not allow national bodies such as RoSPA to develop the appropriate mechanisms to support, advise and provide training and consultancy with all the economies of scale that can be achieved at a national level. Without a clear route to investment in these national providers and facilitators, much expertise will be lost, with a resultant duplication of effort at a local level and the failure to adopt practices in some areas that have already been demonstrated as best practice in others.

Question 4

- **QUESTION:** Is there a case for Public Health England to have greater flexibility in future on commissioning services currently provided through the GP contract, and if so how might this be achieved?
- **ANSWER:** GP services are an ideal location for the commissioning of a wide variety of services because they are in a position to have contact with a wide cross-section of the local community. RoSPA would welcome the development of a mechanism that leads to GP services being more proactively involved in the prevention of accidental injury, particularly as priority tends to be given to services which attract payment. However, if this is to be a valid investment, there needs to be a very clear mechanism for measuring the outputs and outcomes of the work of GP services. We would favour an approach whereby Public Health England commissions specific accidental injury prevention work and provides opportunities to appropriate potential partners, including GP services, to undertake that work.

Question 5

- **QUESTION:** Are there any additional positive or negative impacts of our proposals that are not described in the equality impact assessment and that we should take account of when developing the policy?
- **ANSWER:** No comments.

Question 6

- **QUESTION:** Do you agree that the public health budget should be responsible for funding the remaining functions and services in the areas listed in the second column of Table A?
- **ANSWER:** We welcome the inclusion of accident prevention in the list of activities that should be funded at a local authority level. We welcome the mention of falls prevention services but are concerned that this would lead to an exclusion of other types of accident prevention activity, for example home safety equipment schemes, injury prevention training and advice for both professionals and the public, and activities in schools and interactive centres providing experiential training (LASER) schemes. Because the home is the principal location of accidents, we would like to see this specifically mentioned.

We note that, unlike virtually every other area mentioned in Table A, there is no paragraph describing in more detail arrangements for accident prevention in paragraphs 3.12 - 3.34. While we acknowledge that this document is not meant to be exhaustive, we are concerned that this indicates a low priority given to accident prevention work and that this signal will be picked up at a local level, creating a barrier to the inclusion of accidental injury prevention in local commissioning plans.

We would also seek clarification on the proposed funding arrangements for accidental injury prevention among under fives. Children's public health, for example, is listed as being a responsibility of the NHS Commissioning Board. How does this relate to all the activity currently being delivered at a local authority

level? How does this fit in with the localism agenda? Is there likely to be confusion in splitting the public health commissioning routes for the under fives and the 5-19 age groups?

Paragraph 3.27 expands on this area of commissioning and states that local areas will need to “consider how they join up with Sure Start Children’s Centres to ensure effective links”. Rather than placing children’s centres at the heart of developing children’s public health within the community, this appears to move them to the sidelines. Our experience in working with more than 1,500 children’s centres across the country in delivering Safe at Home has taught us that children’s centres are often best placed to know the needs of families within their local communities and to deliver key public health interventions. We are surprised that in relation to the commissioning of services there seems to be a split responsibility which may in turn lead to a fragmentation and a duplication of services. We are also concerned that the current levels of disinvestment in children’s centres will reduce the opportunities for the newly-funded services, such as the expansion in health visitors, to link up to previously-established services that have ceased to exist. At best, they may end up replacing what has been lost.

We welcome the lead commissioning role for Public Health England in relation to health intelligence and data and acknowledge that there are some instances in which local authorities will need to commission their own data. However, in some areas of accidental injury prevention, such as home accidents, data is not currently routinely collated, analysed or disseminated. We are concerned that if this is left to local commissioning, at best it will be fragmented and at worst it will remain nonexistent.

We recognise that national attempts to improve accidental home injury surveillance have so far proved largely unfruitful. However, we believe that this is an area on which Public Health England will need to provide a strong lead. We note that NHS data collection will remain within the NHS budget and that it will be the responsibility of the NHS Commissioning Board to establish standards of data collection and ensure that these are conformed to. However, we would suggest that unless impetus and incentive is given to collect appropriate accidental injury data within the NHS, this situation will not improve and will remain fragmented with different levels of activity from area to area. We are concerned that both Public Health England and the NHS Commissioning Board appear to have “lead” roles in this area which may lead to conflict or lack of clarity on responsibilities.

We note that the intention is to deliver the public health agenda based on local priority setting driven by the JSNA and Health and Wellbeing Strategy. It is difficult to see how this priority setting can be achieved if accurate data is not collected routinely and systematically in each area. How can communities truly determine what the priorities are if they do not have access to appropriate, relevant data or the means to compare current status and progress with other areas because data, if collected at all, is commissioned and collated in different ways?

For many years, RoSPA has provided an expert role in this field, leading on a variety of projects aimed at improving the situation with regard to injury data. We are responsible for managing the old Home Accident Surveillance System (HASS) database, discarded by the previous Government in 2002. The fact that this data is still widely used is evidence of the need for it to be replaced with a

more up-to-date system. We have led on research to find an appropriate replacement. We would welcome the opportunity to explore this area further with the DH and ultimately with Public Health England when it is established. We do not believe this is an area that can be left to the vagaries of local commissioning or even solely within the NHS given the need for this data to inform product safety, building design and improvement, behavioural approaches, inequalities and many other factors involved in preventing accidental injuries.

Question 7

- **QUESTION:** Do you consider the proposed primary routes for commissioning of public health funded activity (the third column) to be the best way to: a) ensure the best possible outcomes for the population as a whole, including the most vulnerable; and b) reduce avoidable inequalities in health between population groups and communities? If not, what would work better?
- **ANSWER:** Please see answers to questions 3-6 above.

Question 8

- **QUESTION:** Which services should be mandatory for local authorities to provide or commission?

ANSWER: There is a 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) and the scale of the overall accident problem is huge (e.g. the NICE guidance, *Preventing unintentional injuries among under-15s in the home*, states that accidental injury results in two million visits to A&E by children each year, costing £146 million, alongside other NHS social and economic costs)*. Therefore, RoSPA believes it should be mandatory:

- a) for local authorities to commission services to reduce accidental injury in the home
- a) for local authorities to commission local data on accidental injuries and their causation in order to inform progress on reducing accidental injury and plan future services, and in accordance with data requirements specified by Public Health England/The NHS Commissioning Board.

Question 9

- **QUESTION:** Which essential conditions should be placed on the grant to ensure the successful transition of responsibility for public health to local authorities?
- **ANSWER:** We welcome the suggested provisions outlined in paragraph 3.48 for defining the purpose of the ring-fenced grant and broadly what it can be spent on. Given the recognition in the White Papers that public health finances have often been squeezed by other NHS priorities, it should be recognised that potentially the same pressures will operate within local authorities, necessitating clear guidance and protection for ring-fenced public health funds. However, we broadly welcome the recognition of the longstanding role of local authorities in delivering the public health agenda. In relation to accident prevention, for example, public

health activity will need to range across many services including children's services, adult social care, environmental health services, trading standards, housing and transportation. We would hope that ring-fenced public health funding would specify the inclusion of accidental injury prevention work that will enhance any existing activity in these departments rather than replacing it and simply moving the same levels of funding around. We believe the mandatory public health role of the local authority should include the responsibility to co-ordinate a multidisciplinary approach to the delivery of a local accidental injury prevention plan.

Question 10

- **QUESTION:** Which approaches to developing an allocation formula should we ask ACRA to consider?
- **ANSWER:** We would agree that the "population health measures" approach taking into account health inequalities 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 does not sound a feasible method of determining local allocations but may be more appropriate for use by local areas in determining how they spend their allocations and ensuring that spending is directed to the most cost-effective and evidence-based programmes.

Question 11

- **QUESTION:** Which approach should we take to pace-of-change?
- **ANSWER:** No comments.

Question 12

- **QUESTION:** Who should be represented in the group developing the formula?
- **ANSWER:** RoSPA believes that there should be a health premium attached to indicators around accidental injury prevention as interventions in this area can, in line with the requirements stated in paragraph 5.3, offer long-term benefits in terms of reduction of injuries and the corresponding cost savings. We would welcome the opportunity to be consulted on the proposed formula to support local accident prevention work in the future.

Question 13

- **QUESTION:** Which factors do we need to consider when considering how to apply elements of the Public Health Outcomes Framework to the health premium?
- **ANSWER:** While we acknowledge the statement in paragraph 3.50 that there will be no centrally imposed targets or performance management, we believe that it is likely that local authorities will be driven by the availability of the additional funding offered by the health premium. This presumably is the intention. However, we are concerned that key areas will be undermined if they do not have an indicator linked to the health premium. In relation to accidental injury

prevention, for example, only when the previous Government introduced a national indicator did local strategic partnerships give more consideration to inclusion of injury prevention in their local area agreements. Similarly, the key driver to much falls prevention work in recent years was the existence of a National Service Framework for Falls. Therefore, we believe it would be important to ensure there are accidental injury prevention indicators that link to funding offered through the health premium.

Question 14

- **QUESTION:** How should we design the health premium to ensure that it incentivises reductions in inequalities?
- **ANSWER:** RoSPA has experience, through the Safe at Home scheme, of developing a programme based on a formula that has incentivised work in the areas with the highest accident admission rates linked to levels of disadvantage. At the same time, by providing a supporting education programme, the scheme aimed to improve the health of all sectors of the population while giving most active support to those in most need. RoSPA would welcome further dialogue on how this tailored approach can be adapted to other areas in line with the requirements outlined in paragraph 5.3 to incentivise improvement across the whole population while at the same time reducing inequalities.

Question 15

- **QUESTION:** Would linking access to growth in health improvement budgets to progress on elements of the Public Health Outcomes Framework provide an effective incentive mechanism?
- **ANSWER:** It is not clear how this approach will ensure that improvements are achieved in areas that are proving less successful in making progress on elements of the Public Health Outcomes Framework. Nor is it clear how it will be ensured that this does not become another performance management tool with only those areas included in the framework being considered for local activity. The linking of these to funding makes this all the more likely.

Question 16

- **QUESTION:** What are the key issues the group developing the formula will need to consider?
- **ANSWER:** The emphasis on evidence-based approaches both in determining the funding formula and the key indicators in the outcomes framework is acknowledged but it will also be important to build in opportunities for innovative approaches and allow for their evaluation in order to build a body of evidence as to their effectiveness. Failure to do this will stifle creativity both at the local level and within national organisations which are in a position to lead on delivering and evaluating innovating approaches. It needs to be remembered that all evidence-based practice started with an idea, a pilot and a small-scale initiative that grew and developed. Those designing the formula and the outcomes framework need to provide incentive to promote innovation and its effective evaluation rather than just limiting activity to what is already known to work. Part of the health premium should revolve around 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.

* National Institute for Health and Clinical Excellence, *Preventing unintentional injuries in the home among children and young people aged under 15: home safety assessments and providing safety equipment*, www.nice.org.uk/nicemedia/live/13274/51669/51669.pdf

Annex B: *Healthy Lives, Healthy People: transparency in outcomes - proposals for a public health outcomes framework - RoSPA's answers to specific consultation questions*

Question 1

- **QUESTION:** How can we ensure that the Outcomes Framework enables local partnerships to work together on health and wellbeing priorities, and does not act as a barrier?
- **ANSWER:** The Government commitment to partnership and co-production is welcome and its commitment to the localism agenda acknowledged. All areas have had local strategic partnerships for some time and these have often included health partnerships. It is important for the Government to strengthen existing partnerships rather than dismantle and rebuild from scratch.

Paragraph 12 mentions a number of organisations, describing them as “the public health community”. With the exception of the Local Government Association, the list is exclusively comprised of NHS-based public health organisations. There is no mention of the wide range of organisations which, like RoSPA, have a key role to play in shaping the public health agenda (as illustrated in the later list of proposed indicators which will require wide-ranging input from a variety of organisations to be delivered effectively). It is hoped that as the Government has indicated that this consultation is just the beginning, it will take steps to ensure that the widest possible range of interested bodies will be involved in the future shaping and delivery of public health, and not just the bodies mentioned or the local partnerships.

Given that public health funding is to be distributed at county and unitary level, it will need to be ensured that district council partnerships are not left out and made to feel “junior” partners as has been the case in some previous partnership working arrangements especially as they are well placed to deliver on localism and community involvement. Indicators will need to be meaningful at this district and local level.

Question 2

- **QUESTION:** Do you feel these are the right criteria to use in determining indicators for public health?
- **ANSWER:** We raise two questions as part of our response: What if there are not currently strong evidence-based interventions for a particular area of public health activity? Does this mean that work to develop the evidence base is not going to be supported?

Criteria 2-6 are valid criteria. Criteria 1 and 7 are valid, but the absence of existing data systems or current evidence, while they may affect the precise indicator, should not mean that no activity takes place. It might be necessary to set indicators that will ensure that the evidence base and data systems are developed. It would not be satisfactory, for example, to say that there is a problem with accidental injuries in a particular area but, because we don't currently have a clear evidence-based intervention to adopt, this problem can simply be ignored.

Insisting on indicators where data can only be reported quarterly and can show results within a year is likely to lead to a continuation of the short-termist practices that have been barriers to effective interventions in the past.

Paragraph 20 - It is not clear how the current reduction in funding being devolved to the local level will “enable” local communities to improve health across people’s lives.

Question 3

- **QUESTION:** How can we ensure that the Outcomes Framework and the health premium are designed to ensure they contribute fully to health inequality reduction and advancing equality?
- **ANSWER:** Paragraph 21 - The Marmot Review provides further confirmation of the inequalities in health that have been understood for many years. This is not new information. However, we agree that the indicators developed should reflect the need to tackle this. 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. It will then be necessary to look closely at the numbers that make up this indicator in order to determine action necessary to reduce inequalities.

We agree that actions to reduce health inequalities must continue to be a priority. The emphasis on communities needs to be better explained. How are activities going to be supported if they are no longer seen as priorities to be delivered directly by local authorities? What support is going to be available to community and voluntary groups to continue this valuable work? This will have significant implications for how action is delivered to address the indicators.

Paragraph 25 - Will there continue to be comparison of “like with like”? There are clearly huge differences in social context, population make up, urban vs rural etc. which will lead to some false comparisons if these are not taken into account. If the key driver for data collection is through commissioning at the local level, as suggested in other papers, there may also be a problem in comparing very different datasets collated in very different ways with significantly different resources.

Paragraph 27 - We are concerned about how the statement that the outcomes framework is not a performance management tool squares itself with the notion of health premiums which will reward local areas with additional funding if they meet certain outcomes, as described in paragraph 28. As with previous national indicator approaches, there is a danger that this will create a hierarchy of outcomes where local partnerships focus on the ones that give most financial reward at the expense of other indicators.

Question 4

- **QUESTION:** Is this the right approach to alignment across the NHS, Adult Social Care and Public Health frameworks?

- **ANSWER:** Alignment across the NHS, Adult Care and Public Health frameworks is welcome and critical to the success of the new approach. The broader model including Children's Services in particular but also embracing other local authority functions needs to be further explored. The idea of these areas working together is not new and is already embedded in many current working arrangements. There is no clarity here as to how it will work better and avoid the common problem of different agencies and departments working to protect their own budgets and interests rather than working in true partnership. The Public Health Indicators will need to be embedded into the other relevant frameworks and given sufficient weighting to ensure that they are not lost among other priorities for those services. For example, there are numerous public health indicators targeted towards children but it is not clear what priority children's services will give to these indicators compared to indicators that will no doubt appear in their own plans.

Question 5

- **QUESTION:** Do you agree with the overall framework and domains?
- **ANSWER:** Accident prevention, which is RoSPA's core activity, potentially sits in at least four of the five domains. The later lists of proposed indicators confirm an injury prevention aspect in at least three of them. Is there a danger in structuring the work in this way that certain areas will become: a) marginalised; and b) fragmented? (For example hospital admission due to injuries is in Domain 3 for 5-18 yr olds and Domain 4 for all other age groups).

It is not clear whether all five areas will be accorded the same priority.

Question 6

- **QUESTION:** Have we missed out any indicators that you think we should include?
- **ANSWER:** In addition to the indicator in Domain 2 for "killed and seriously injured casualties on England's roads", there should be an indicator to mirror this for "killed and seriously injured in England's homes". It is now well established that death and injury in the home is as costly in terms of human suffering, health and wellbeing and the economy as death and injury on the road. The failure to recognise this area holistically has led to fragmentation of strategies and interventions to deal with home accidents effectively. The other indicators in domains 3 and 4 further fragment this area by placing different age groups in different domains and lumping accidental home injury with all other types of intentional and accidental injury. The bulk of the working age population is left out altogether.

The mixing of data for accidental and intentional injuries is unfortunate and prevents the establishment of a clear picture that can help to develop effective policies on injury prevention. It also plays to the widely held view, particularly in the area of child safety, that the predominant injuries arise from child protection issues. As a result, work to prevent accidental injuries can be sidelined or trivialised. There need to be clearer indicators that separate these two distinct categories of injury.

While we recognise that there may often be difficulty in determining whether an injury has been accidental or deliberate, we should strive for indicators that encourage the professionals involved to make this distinction given the very different responses that will be required to these categories of injury.

Hospital admissions as a result of accidental or intentional injury will not give a full picture to inform injury prevention. Hospital admissions are influenced by a variety of factors, not least the variations in policy from hospital to hospital and area to area on the criteria for admission. It is difficult to propose an alternative, for example A&E data, when it is known that this is not collected in a systematic way that would enable analysis and dissemination but urgent attention should be given to establishing more robust data collection and analysis to inform injury prevention. An interim indicator could be a requirement for local public health partners to develop and improve home accident data systems, including A&E data, setting key dates as milestones.

Question 7

- **QUESTION:** We have stated in this document that we need to arrive at a smaller set of indicators than we have had previously. Which would you rank as the most important?
- **ANSWER:** As a leading safety organisation, our key focus is on the prevention of accidental injuries. We believe that the indicators specified are the absolute minimum requirement in order to ensure that local service providers, Health and Wellbeing Boards and Directors of Public Health give due priority to this area and can discharge their responsibilities effectively. We believe that the absence of these indicators would be interpreted locally as confirming that accident prevention has a very low national priority and that local work to reduce accidental injuries is therefore, at best, optional.

Question 8

- **QUESTION:** Are there indicators here that you think we should not include?
- **ANSWER:** We acknowledge the Government's desire to reduce and avoid, where possible, the creation of new data burdens. However, we believe a greater burden to society is that presented by accidental injuries. We believe that improved data collection, analysis and dissemination at local and national level can help to inform measures to reduce this burden with consequent savings in terms of health and wellbeing, the economy and the economic productivity of the working age population that far outweighs the cost of the burden of additional data collection.

We would not want to suggest removing indicators that may be critical to areas outside of our expertise. However, we have noted that there are a number of indicators, such as "social connectedness" and "self reported wellbeing" that will be difficult to measure and, presumably based on sampling, may have little meaning to the population as a whole.

Question 9

- **QUESTION:** How can we improve indicators we have proposed here?
- **ANSWER:** See answer to question 6 above.

“Acute admissions as a result of falls or fall injuries for over 65s” is an important indicator for assessing the scale of this issue but it does not provide sufficient data to inform the prevention agenda. A fall resulting in an admission might follow numerous minor falls that, had they been picked up, could have resulted in an intervention preventing the more serious event. Admission policies vary across the country and so will not provide a uniform picture. They may also be skewed by social considerations such as personal circumstances, whether there is a carer at home, etc. An additional indicator highlighting A&E attendances or ambulance calls, for example, would be a more practical indicator of the scale of the problem and of the intervention that could be taken to reduce falls and the injuries that result from them.

D3.4 Hospital admissions per 100,000 for alcohol related harm - a distinction should be made in terms of admissions following alcohol related accidental injury and admissions due to medical conditions caused by longer term alcohol abuse. This would enable the development of clearer strategies to address the effects of alcohol on accidental injury and provide a picture of the extent to which alcohol contributes to these types of injury.

Question 10

- **QUESTION:** Which indicators do you think we should incentivise? (Consultation on this will be through the accompanying consultation on public health finance and systems).
- **ANSWER:** Accidental injuries are the most immediately preventable public health issue and have the potential to realise returns in terms of savings to the NHS and the economy in the short term compared to some of the more complex health issues. It would, therefore, make sense to incentivise these indicators as preventive work in this area is under developed in many localities.

Question 11

- **QUESTION:** What do you think of the proposal to share a specific domain on preventable mortality between the NHS and Public Health Outcomes Frameworks?
- **ANSWER:** This makes complete sense because action taken in either one of these settings will not fully address the issues.

Question 12

- **QUESTION:** How well do the indicators promote a life-course approach to public health?
- **ANSWER:** In relation to the life-course approach, there are no indicators to address accidental injury to adults between the ages of 18 and 64. While it is

right to prioritise other age groups because of the higher prevalence of injury, injuries to this large group within the working population have significant consequences for family, life, businesses and the economy. Given the economic imperative and the priority given in the *Healthy Lives, Healthy People* paper to ensuring a healthy workforce and keeping people in work, it is surprising that this is not recognised in the indicators. Aside from the social and economic benefit to the individual, the health sector and society, actions taken to reinforce safety messages with this group will often ensure greater safety over the whole life-course, especially given its responsibility for the 0-18 population and often for those at the older end of the age spectrum. A similar indicator to other age groups should therefore be developed.