

Healthy Lives, Healthy People White Paper

Response on behalf of the Institute of Home Safety

Background

The Institute of Home Safety seeks to promote home safety at all levels and to support those working in the field whether they work full time in home safety or, as in most cases; it is just a small part of their remit. Our current membership includes people from local authorities, primary care trusts, safety related businesses, the research field, a retired member and safety related organisations including BRE, the Electrical Safety Council and RoSPA.

Our aims are:

- 1) to encourage the development of the highest standards of approach to Home Safety Education and Training;
- 2) to promote professional liaison and exchange of knowledge;
- 3) to provide representation of Home Safety professionals on other bodies;
- 4) to co-operate with other bodies; and
- 5) to provide a representative body of opinion in Home Safety matters.

We welcome the opportunity to participate in the consultation on the white paper. “Healthy Lives, Healthy People as we believe that unintentional injuries in the home are a key public health issue. Any national strategy aimed at improving public health should specifically include activity to reduce the intolerable burden of these injuries on people’s lives both in terms of the suffering they cause and the economic cost to society. We are concerned that the current white paper gives little attention to this issue and only makes one reference to injury prevention in paragraph 1.45 where it refers to falls and hip fractures. We do not believe this sends a strong enough signal to local partners of the critical need to include injury prevention in their public health planning.

The scale of the problem of unintentional injuries in the home highlights the importance of this as a public health issue. For example:

- Every year, 2.7 million home accident casualties occur in the UK every year, resulting in an estimated cost of £45.6 billion p.a.¹ There are around 4,000 deaths annually as a result of accidents in the home.
- Accidental injury is a leading cause of child death in England and Wales with some 200 children aged 0–14 years dying in 2009. In the UK, accidents are the principal cause of death up until age 39.
- Approximately 1,500 people over 75 years old die each year as a result of a fall. Over half a million will require hospital treatment.
- The annual cost of injury treatment to the NHS in England alone exceeds £2.5bn. The cost of treating a small child for a serious burn is estimated, for example, at £250,000.

¹ Transport and Road Laboratory report PPR 483

- Around 76,000 cases of hip fractures occur every year in the UK. NHS costs amount to around £1.4billion – a figure that is approximately doubled when the social care costs of hip fracture - related dependency are taken into account.²

The Institute believes that incorporating rigorous and consistent home injury prevention programmes into the national and local public health agendas is critical to saving lives and reducing the economic burden of unintentional injury to society.

Practitioners for injury prevention need to know where to go for evidence and guidance in implementing injury prevention work. Public Health England should be given a clear and identifiable responsibility for leading this work. Preventing injuries is intrinsic to health and wellbeing and in order to maximise effectiveness at the local level, it will need the support, co-ordination and expertise of appropriate national bodies. This needs to be acknowledged in the national strategy for public health and provision made to fund this.

The White paper states:

‘We know that people suffer a substantial burden of ill health from living with conditions that give them pain, affect their mental health, or prevent them from doing their usual activities, making them dependent on the care of others.’

Preventing injuries contributes to the lifting the burden of ill health as defined above.

1) Answers to specific consultation questions

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 which Public Health England will take responsibility?*

RESPONSE: The Institute believes that GP practices can make a key contribution to ensuring that home 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. They should 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 injury prevention in the community. This should be reflected as a key area of public health within local programmes developed and driven by GP consortia. Injury prevention needs to be embedded into Public Health so that GP’s see this as an important part of Health and Well Being and commission resources to sustain it.

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 home accident data at national and local level continues to hinder the development of evidence based interventions. There has been a range of local initiatives to improve data and to deliver evidence based home safety programmes. However activity has been patchy across the country. The danger of the localism approach is that responses will differ greatly in different localities and that the inconsistency in approaches will be perpetuated. This is something that needs a national lead, particularly in terms of providing clear guidance to GP consortia and Health and

² National Hip Fracture Database 2010. British Orthopaedic Association, Healthcare Quality Improvement Partnership, British Geriatric Society.
http://www.nhfd.co.uk/nhfd1.nsf/NHFD_National_Report_Extended_2010.pdf

Wellbeing Boards to ensure an appropriate level of priority and consistency of data collection and dissemination.

Where NICE evidence exists to support injury prevention work, then this should be linked into information supplied to GP consortia along with recommendations for implementation.

The NICE Public Health Intervention Guidance on preventing unintentional injuries in the home among under 15s: providing safety equipment and home-risk assessments³ highlights the savings that could be made per 150,000 population. For example:

Preventing 10% of unintentional injuries among under-15s could:

- 1) save up to £80,000 by reducing emergency department visits and hospital admissions
- 2) lead to savings for GPs
- 3) lead to savings for the ambulance, police and fire and rescue services

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 achieve evaluation that is sufficiently robust to add to the overall evidence base. Because of the very limited resources available to home injury prevention there is often a reluctance to invest appropriately in evaluation and local evaluations are often dismissed by academic bodies on the grounds of credibility or robustness of evaluation design and implementation.

From the paper- 'Childhood Injuries - A review of evidence for prevention'⁴

We know that it has been shown that multi-component interventions: interventions that combine strategies (e.g. education programmes with intervention) have been successful in reducing injuries and accidents.

The paper also goes on to tell us that in 'The United Nations Convention on the Rights of the Child' it states that 'a child has the right to a safe environment and to protection from injuries and violence'. Children and young people are a politically powerless group and need others to champion their cause in the prevention of injuries. The majority of childhood accidents are preventable, through changing the environment in which children live and play, encouraging the use of safety devices and protective equipment, the provision of education and skills training and strong legislation.⁵

³ NICE Public Health Intervention Guidance on preventing unintentional injuries in the home among under 15s: providing safety equipment and home-risk assessments. Slide set <http://guidance.nice.org.uk/PH30/SlideSet/ppt/English>

⁴ Childhood Injuries - A review of evidence for prevention' S. Wood, M.A. Bellis, E. Towner, A. Higgins <http://www.cph.org.uk/showPublication.aspx?pubid=664>

⁵ United Nations Convention on the Rights of a child. Cit. Childhood Injuries - A review of evidence for prevention' S. Wood, M.A. Bellis, E. Towner, A. Higgins <http://www.cph.org.uk/showPublication.aspx?pubid=664>

Recent investment by the DfE into supporting evidence based child accident prevention work targeted in areas of high deprivation has been allowed to stall due to lack of funding. Public Health England should see this as an investment for a cost effective return in the future.

Older People and Accident Prevention will become a greater issue as the population lives longer and Public Health England needs to incorporate injury prevention as a core role for a cost effective long term measure.

There is a danger that many good local initiatives are being lost because they have not been sufficiently evaluated and 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. Whilst programme delivery might be determined locally it is absolutely clear that programme evaluation cannot be left entirely to the local approach.

d. Public health evidence: QUESTION: *What can wider partners nationally and locally contribute to improving the use of evidence in public health?*

RESPONSE: Many of our members are involved in the delivery of programmes according to evidence based good practice. Organisations such as the Institute of Home Safety can play a significant role in disseminating these approaches through its contacts with practitioners across the country. The difficulty in the current proposed model is identifying how such organisations can be resourced to continue to deliver their pivotal role in leading the development work in critical areas. Currently the Institute relies on fees from members to continue its supporting role. This is subject to the fluctuations in local activity and employment of staff with a remit for home safety. As this fluctuates, membership declines, reducing opportunities to contribute. Staffs working in this non-statutory area of work are often the first casualties of local budget cuts, and where they remain, organisations are often reluctant to fund continued membership of professional bodies. More clarification is needed on the support that will be available to utilise the expertise of organisation such as the Institute of Home Safety and ensure that they can continue to play a major role in supporting the delivery of the local agenda.

Public Health England needs to set up pathways for the delivery of information on injuries and their prevention so that practitioners know what works and that Public Health England is the department to turn to for information on injury prevention. Wider partners can be the catalysts to help deliver this.

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: The Institute of Home Safety recognises that the government is not currently in favour of further statutory regulation and accepts in principle the argument of Dr Scally's report that a system of voluntary regulation will strengthen the public health profession and the quality of its work. Whilst the institute of Home Safety has no particular views on the bodies identified as potential regulators, the proposal of the Health Professions Council identified in Dr Scally's report would seem to be the most logical as this body is already regulating many health professions that have direct links into public health. Given the multidisciplinary nature of public health, the Institute would have concerns about any option that would move public health specialists back into a solely medical arena. The strength of the public health workforce must continue to be its diversity in terms of background and

experience. Although it is acknowledged that every public health directorate will require medical expertise, this multi-disciplinary approach should operate to the top level. The need for statutory regulation of the most senior posts is acknowledged, but once again the Institute would agree that this should sit with the body best able to reflect the diversity of the agenda.

The Institute of Home Safety believes it is critical for key members of the public health workforce to have a clear understanding of the issues around injury prevention. The Institute has access to home safety practitioners across the country who can contribute expertise to the design, testing and delivery of modules covering the key skills needed to tackle injury prevention in public health training courses. The Institute would actively support any moves to embed home safety into training for public health specialists and other health professionals. Given the importance of injury prevention as a public health issue, the Institute would also welcome the opportunity for home safety and injury prevention specialists to be considered for registration within the system of voluntary public health regulation.

Other comments

1. We welcome the “life-course” approach which we agree gives opportunities to tackle key public health issues throughout the different stages of life. We believe that there should be a clear and explicit programme for injury prevention at each of these stages. For example, in relation to “Starting Well” and “Developing Well” there is a need to build on the successful child injury prevention work being delivered by children’s centres, health visitors and others? Staffs working in these areas have reported that injury prevention work is often marginalised because it is not seen as a priority. We hope that the role of these staff in working with families to promote injury prevention will be confirmed and developed.
2. Similarly in relation to “working well”, we recognise the desire of the white paper to support people of working age to remain healthy and able to work. We are aware of the costs to society of lost working days due to unintentional injuries sustained in the home. We believe that employers should be encouraged to give a similar priority to promoting the concept of 24/7 “off the job” safety to that given to health and safety at work as the costs of injuries outside of work far outweigh the costs of work related accidents.
3. As we have already illustrated, the process of “ageing well” and people being able to live a healthy independent life in their own homes for as long as possible, can often be interrupted by a fall or other unintentional injury in the home. Ensuring that local authorities and partners implement radical, evidence based injury prevention programmes for this age group, building on much of the falls prevention work developed across the country in recent years, will save lives and dramatically reduce NHS costs, as well as reducing other social costs by helping older people to maintain their independence.
4. We are concerned that, unless there is a very clear national strategic lead, the emphasis on “localism” will inevitably lead to a continuation of the often fragmented approaches to home injury prevention that we have seen over the years with an exacerbation of the postcode lottery. Experience shows, for example, that only when falls were included as a key area of the National Service Framework for Older People

did extensive and consistent falls prevention programmes begin to emerge across the country. Similarly, child injury prevention has only been given any kind of priority when it has been established as an area for action in key national strategies. We recognise the need for local decision making driven by local priorities, but given that unintentional injuries in the home are a widespread problem across the country, we don't believe that action to address this should be left to chance.

5. We welcome the establishment of Public Health England as the lead national body responsible for driving forward the public health agenda. Currently there is no clear indication within the Department of Health organisational structures as to where injury prevention sits. We hope that once Public Health England is established, there will be a clearly accountable, properly resourced team responsible for providing a national lead on the injury prevention agenda. We would also seek clarification on the Department of Health's current commitment to injury prevention and the interim arrangements while Public Health England and the local structures outlined in the white paper are established.
6. We are concerned that the combined effects of public health and NHS reorganisation and the current severe budget cuts will mean that much of the current infrastructure at the local level will disappear before the new arrangements have time to take effect. This includes work currently driven by national bodies for whom there is no longer any clear route to funding, as well as work at the local level which is being severely reduced, for example, by cuts in children centre services and adult social services. We believe that these reductions will not only have an adverse effect on current activity in injury prevention but will potentially lead to an increase in unintentional injuries among vulnerable groups.
7. Public Health England should engage with Local Safeguarding Children Boards (LSCB's) and Child Death Overview Panels (CDOP's). These bodies should know who to turn to for information on accidental injuries and deaths. Could the injury have been prevented?

Conclusion

The Institute of Home Safety recognises the unacceptable toll of unintentional home injuries on society both in terms of the suffering of those affected by these injuries and the economic burden to the NHS, local services and business. The Institute urges that this is fully recognised in the Public Health Strategy for England with recommendations for clear action at both a national and local level. We would welcome the opportunity to comment or provide further input in the future development of the strategy.