

Public Health Outcomes Framework

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:

- to encourage the development of the highest standards of approach to Home Safety Education and Training;
- to promote professional liaison and exchange of knowledge;
- to provide representation of Home Safety professionals on other bodies;
- to co-operate with other bodies; and
- 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 highlight 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 4000 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 1500 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.
- 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

¹ Transport and Road Laboratory report PPR 483

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.

Questions for consultation

Question 1. 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?

Many of the Institutes members work in partnerships that have been in place for some time. It is important for the government to strengthen existing partnerships rather than dismantle and rebuild from scratch. It is important that Health and Wellbeing Boards are given a clear remit for home injury prevention.

Joint Strategic Needs Assessments need to involve all those parties who wish to present evidence for inclusion as a priority. Health and Well Boards therefore must be aware of and extend involvement to injury prevention partnerships.

We support the NICE guidance PH29 which describes evidence based strategies reduce and prevent injuries among children under 15 years old and believe these strategies should be incorporated into local plans. We believe that these proposals should not just be limited to children but should also include older people and other vulnerable groups. Specifically Local plans should:

- include a commitment to preventing unintentional injuries with a focus on those most at risk.
- Ensure there are injury prevention co-ordinators in each locality.
- Provide a wider childcare workforce with access to injury prevention training.
- Implement nationally agreed standards of competency in relation to injury prevention
- Establish local agreements with housing associations and landlords on installing home safety equipment for older people and children.
- Provide practitioners with mechanisms for sharing information.

We believe that the implementation of NICE Public Health guidance on injury prevention should be mandatory.

There is a need to develop skills and understanding of injury prevention at a local level. A mechanism needs to be created within the Public Health Outcomes Framework which ensures that local partnerships access support from third sector organisations that can provide guidance and coordination

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

Question 2. Do you feel these are the right criteria to use in determining indicators for public health?

- 1) 1 and 7 are valid and we support the use of evidence based interventions but are concerned that these proposals might lead to insufficient investment to develop, implement and test new approaches. 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 unintentional injuries in a particular area but because we don't currently have a clear evidence based intervention to implement this problem can simply be ignored.
- 2) 2-6 are valid criteria.
- 3) 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.

Para 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. We are aware, for example, that many of our members who are involved in injury prevention work as part of their local authority or health service role are either threatened with redundancy or are in services facing severe cutbacks which will make it less likely that they will be able to continue with their injury prevention activities as they are required to cover wider workloads which do not prioritise injury prevention.

Para 21 – We welcome the recognition in the paper that there are significant inequalities in health. This has been understood for many years and was confirmed in the Marmot Review. We would also highlight that inequalities are a significant factor in relation to home accidents. For example 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 occupations³. We believe this provides a compelling argument for addressing injury prevention as a priority with a focus on health inequalities.

The recent evaluation of the Family Nurse Partnership⁴ highlighted on Page 73 the high rates of attendance at Accident and Emergency units in those families who are most disadvantaged. The majority of the children attending more than once did so for injuries. Targeting prevention of accidental injuries at these families has long term cost benefits. Safe At Home, the National Home Safety Equipment Scheme has targeted disadvantaged families in the areas with the highest admission rates for accidental injury to under fives and the recent NICE guidance⁴ highlights this as an evidence based approach as well as providing confirmation of the potential cost savings. This confirms the importance of including injury prevention in work to address health inequalities

Question 3. 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?

³ Better Safe Than Sorry report: February 2007 - Audit Commission/Healthcare Commission

⁴ The Family-Nurse Partnership Programme in England: Wave 1 implementation in toddlerhood & a comparison between Waves 1 and 2a of implementation in pregnancy and infancy Report prepared by Professor Jacqueline Barnes, Mog Ball, Pam Meadows, Beth Howden, Angela Jackson, Juliet Henderson and Lisa Niven Birkbeck , University of London

⁴ NICE Public Health Guidance 30: Preventing unintentional injuries in the home among children and young people aged under 15: home safety assessments and providing safety equipment. November 2010

Actions to reduce health inequalities must continue to be a priority. The emphasis on communities needs to be better explained – for example how are the activities that are no longer seen as priorities to be delivered directly by local authorities going to be supported if the expectation is that community and voluntary groups will take these up?

Para 25 discusses comparing with other areas. 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.

Injury Prevention data currently available is limited. However databases such as The Burns Injury Database <http://www.ibidb.org/> should be included in the Public Health Central Data Portal. Information on accidental deaths and injuries from all sources need to be fed into a central source and then be searchable in a user friendly manner to extrapolate relevant information for targeting prevention work.

Child Death Overview Panels also have reports of accidental deaths that need to be shared for prevention purposes.

Rule 43 requests by Coroners should also form a part of this search facility.

Input from injury prevention specialists should be called up to facilitate information on all existing data in this area.

How will the new ‘National Institute for Health Research’ link to data information?

We note that paragraph 27 states that the outcomes framework is not a performance management tool. We are not sure how this 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. We believe that there is a danger that this will create a hierarchy of outcomes where local partnerships focus on the ones that give most reward at the expense of others.

Question 4. Is this the right approach to alignment across the NHS, Adult Social Care and Public Health frameworks?

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.

We believe that district councils also have a vital role to play across all public health issues including injury prevention. Given that it is envisaged that Public Health responsibility will sit at county and unitary level, it will be important to ensure 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. There will also be a need for guidance, education and support in order to achieve results.

Question 5. Do you agree with the overall framework and domains?

Injury prevention 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. There is 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. This may hinder the development of a clear and co-ordinated strategy.

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

Question 6. Have we missed out any indicators that you think we should include?

Hospital admissions as a result on unintentional 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

The mixing of data for unintentional 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 unintentional injuries can be sidelined or trivialised. Whilst it is acknowledged that it can sometimes be difficult in the early stages of treatment or investigating to distinguish between intentional and unintentional injuries it is important to find ways of establishing clearer indicators that separate these two distinct categories of injury.

Question 7. 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?

As an organisation that represents home safety professionals our key focus is on the prevention of unintentional injuries in the home. 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.

Question 8. Are there indicators here that you think we should not include?

We have no comments on this.

Question 9. How can we improve indicators we have proposed here?

See answer to question 6 above.

D3.4 Hospital admissions per 100,000 for alcohol related harm – a distinction should be made in terms of admissions following alcohol related unintentional 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 unintentional injury and provide a picture of the extent to which alcohol contributes to these types of injury.

Question 10. Which indicators do you think we should incentivise? (consultation on this will be through the accompanying consultation on public health finance and systems)

Unintentional 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. What do you think of the proposal to share a specific domain on preventable mortality between the NHS and Public Health Outcomes Frameworks?

This makes complete sense as action taken in either one of these settings will not fully address the issues.

We would also like to see this shared with reference to preventable morbidity.

Question 12. How well do the indicators promote a life-course approach to public health?

In relation to the life-course approach there are no indicators to address unintentional or deliberate injury to adults between 18 and 64. Whilst 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. 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.

Further comments:

If we are looking at measuring success in Public Health as part of the outcomes framework, then there has to be the funding for data collection and evaluation for it to be measurable. The absence of high quality, consistently collected unintentional injury data continues to be a significant barrier to the effective implementation of evidence based programmes to reduce the burden on the NHS and society of unintentional injury. The relatively small investment necessary to establish and maintain a robust system would be more than met by cost savings resulting from a reduction in such injuries achieved by consistent implementation of evidence based programmes. Neither the development of robust data systems nor the prioritisation of injury prevention in local programmes can be left solely to the process of local decision making. There will need to be national impetus led by Public Health England, to ensure that these priorities are addressed.