

Institute of Home Safety Response
To
Healthy Lives, Healthy People
Consultation on the Funding and Commissioning Routes for Public Health

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 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.

Consultation Questions

1. Is the health and wellbeing board the right place to bring together ring-fenced public health and other budgets?
 - a) The Institute of Home Safety accepts that 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 & Wellbeing Boards. In previous arrangements within local strategic partnerships, departmental plans such as the children and young people’s service plans, have often taken precedence over wider partnership plans and the targets attached to them by national Government has ensured that they are always given the budgetary priority. The new framework will need to ensure that such conflicts do not exist.
 - b) The diagram in 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 & Wellbeing boards appears to be only discretionary.
 - c) The social care primary prevention activities mentioned in 2.6 are examples of services that are discretionary and therefore not universal. Institute members are involved in the delivery of some of these programmes and are

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

aware of the very differing levels of activity across the country. For example, to exercise and balance classes, which help to prevent falls, are an example of services that are most likely to be reduced or discontinued as a result of the current local funding reductions. Neither the funding paper or the healthy lives white paper appear to provide any protection to this type of work but rather suggest that they are building on activity that is at best limited and at worst non-existent. The likelihood is that if these activities are to continue or expand that there will be an expectation that they compete for the limited funding available from the public health budget.

- d) It is needs to be clear to practitioners where injury prevention in the home sits from a commissioning perspective. The consultation document indicates that some work is currently being provided under 'Social Care' and a further £2 Billion per year is being allocated to Social Care 2014/15, specifically £1 billion per annum is to support evidence based primary prevention within social care. It is not clear how much injury prevention work would be included within this work or what mechanisms will exist to raise awareness of this as a priority. There needs to be a mechanism to feed injury prevention issues and priorities into Health and Well Being Boards and Joint Strategic Needs Assessments and to make sure that strategic plans to tackle needs identified in the JSNA include injury prevention.
 - e) How does HealthWatch England fit into the commissioning role from a social care perspective?
 - f) Injury prevention in the home, by definition, has housing at its core. Understanding risks in the home also includes housing which is fit for purpose and it is welcomed that this is mentioned as a contributor to Health and Well Being and is being noted to be included under Public Health and Social care as part of wider health determinants.
 - g) 2.10 emphasises the need to support local delivery of Health and Well Being services through inclusion of VCSE, however currently this support is being with-drawn, not expanded, even when voluntary projects are delivering evidence based programmes. Words are easy; understanding the reality at local level and changing it are what is needed.
2. 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?
- a) The Institute of Home Safety is aware from many of its members that by the time the PH 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. Institute members who mainly work in the public sector and often act as links to potential local service partners from third sector organisations are also finding their posts under threat. This will reduce opportunities to develop close working with such organisations. The Government need very clear plans to protect services provided by the third sector in the short term and to ensure that local authorities and primary care trusts have capacity to build further links during the interim period. This paper does not appear to address the transition arrangements.

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

As a national body principally serving local members the Institute would be keen to extend its support to members charged with preventing unintentional injuries in the home in the new context. However, the Institute notes that there is no mechanism in the current proposals for bodies that fulfil a national role in supporting local role to seek support in developing that role.

- d) 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 & Wellbeing boards. The mechanism enabling this agenda to become 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 & Wellbeing Boards.
- e) The Institute of Home Safety is concerned that the emphasis on commissioning services from non statutory providers in 2.8, 2.10, and 2.11. does not take into account the expertise built up within the public sector, including Institute members, for delivering many of these services. Specifically in relation to home safety there will be a need for training and development and much local expertise is likely to be lost as posts that carried a responsibility for this area are made redundant or left unfilled. It is important to retain and develop a level of expertise within the public sector in order to know what to commission and to monitor it effectively. National bodies such as the Institute, might help to fill some of that gap, but, as already indicated, there is currently no mechanism for them to do so. The commitment in 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 especially once the expertise in the local public sector is lost..
- f) There are some aspects of injury prevention that do not have local specialists, and therefore the commissioning process would need to address this nationally.

3. How can we best ensure that NHS commissioning is underpinned by the necessary public health advice?

- a) There needs to be a significant investment in organisations that can provide clear, up to date and relevant advice on home injury prevention. Currently

there does not seem to be any provision within the white paper or this document to ensure that this takes place.

- b) There needs to be a specific remit within Public Health England to lead on injury prevention. This does not exist within the current NHS structure.
 - c) There needs to be significant investment in research and continuous development in relation to home injury prevention. This is vital if local services are to be commissioned to deliver programmes founded on evidence based best practice.
 - d) 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.
 - e) Table A on page 16 is proposing the commissioning route for Accidental Injury Prevention by the local authority (LA). More detailed information needs to be given as to where injury prevention sits within the LA. This will allow practitioners in the field of injury prevention to know how to present evidence to be considered for the Joint Strategic Needs Assessment leading to the strategy moving forward. However, we support the proposal within the NICE guidance that each local authority should have a injury prevention coordinator and that they should be able to access national specialists for up to date knowledge in this area and lead on incorporating injury prevention into the JSNA and any consequent public health plans and programmes.
 - f) Page 18 confuses this matter further by listing Children's Public Health for the under 5's to be commissioned by the NHS Commissioning Board. Such confusion will make it difficult as one body will simply say that injury prevention is another body's responsibility.
 - g) The paper makes reference to the public health and forthcoming Health and Social Care Bill. It is very important for practitioners to know whether injury prevention sits under social care which in turn sits under public health, or whether it is a public health direct responsibility commissioned by the relevant department in LA's/ NHS Commissioning Body.
 - h) Injury Prevention coordinators should have access to Director's of Public Health through the Joint Strategic Needs Assessment to present their knowledge and evidence.
 - i) Public Health Awards should also be searchable on the proposed public health web portal.
 - j) The 'Healthy Child Programme' currently refers to home safety equipment schemes, which were supported previously by the National Safe At Home Scheme facilitated by RoSPA and funded by the DfE. This is ceasing due to end of funding – how will this be available to practitioners in future?
4. 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?

In theory GP services are an ideal location for the commissioning of home safety interventions as they are in a position to have contact with a wide cross section of the local community. The Institute of Home Safety would welcome the development of a mechanism that leads to GP services being more proactively involved in the prevention of unintentional injury, but there would need to be clear and measurable outcomes in return for investment into these services. Public Health England should have the widest possible flexibility in terms of who it commissions to provide services.

5. 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?

No comments

6. 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?

- a) We welcome the inclusion of accident prevention in the list of activities that should be funded at a local authority level but as the home is the principle location of accidents we would like to see this specifically mentioned.
- b) We welcome the mention of falls prevention services but are concerned that this would lead to an exclusion of other types of evidence based accident prevention activity implemented by our members, for example home safety equipment schemes, injury prevention training and advice for both professionals and the public, activities in schools and interactive centres providing experiential training (LASER) schemes.
- c) 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 paras 3.12 – 3.34. Whilst 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, raising a barrier to the inclusion of injury prevention in local commissioning plans.
- d) We would also seek clarification on the proposed funding arrangements for 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? We are concerned that there is likely to be confusion in splitting the public health commissioning routes for the under fives and the 5-19 age groups which will lead to a disjointedness in planning.
- e) Para 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”. The Institute of Home Safety believes that children’s Centres are a vital component in the work to prevent unintentional injury in the home and would like to see them have a more central role. The Institute is aware of the high level of home safety training that has recently taken place as part of the National Home Safety Equipment Scheme funded by the Department of Education and believes that the benefits of this investment should be maximise by confirming the role of Sure Start Children’s centres with additional funding and support rather than redirecting it elsewhere. The rolling out of similar training across children’s centres not involved in the National Home Safety Equipment Scheme should be considered.
- f) 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 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.

We recognise that national attempts to improve unintentional 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 injury prevention 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?

The Institute of Home Safety regrets the decision by the Government in 2002 to end the Home Accident Surveillance System (HASS). Although by no means perfect in recording accident data, HASS gave practitioners vital information on the key risks and helped them to formulate policy and programmes as well as enforcing consumer safety legislation. It was also a critical tool to businesses in identifying products implicated in unintentional injuries and stimulated changes in design and product advice. The financial savings from discontinuing HASS were insignificant compared to the cost of injuries. The Institute is concerned that there appears to be no priority given to filling this gap in any of the consultation documents and believes that there should be a clear funding and commissioning route to establish a new home injury prevention database.

7. 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?

Please see answers to 3-6 above.

8. Which services should be mandatory for local authorities to provide or commission?

In recognition of the significant social class gradient in the death and injury rate of children from accidental injury (the death rate of those in NS-SEC Class 8 being 13 times higher than in NS-SEC Class 1) and the scale of the problem (NICE Public Health Guidance 30 estimates more than 2 million visits to accident and emergency departments costing those departments alone a £146 million a year, alongside other NHS social and economic costs) it should be mandatory:

- a) for local authorities to commission services to reduce accidental injury in the home
- b) for local authorities to commission local data on unintentional injuries and their causation in order to inform progress in reducing unintentional injury and plan future services and in accordance with data requirements specified by Public Health England/ The NHS Commissioning Board
- c) For local authorities to have a mandatory post of Injury Prevention Coordinator as recommended by NICE Guidance.

9. Which essential conditions should be placed on the grant to ensure the successful transition of responsibility for public health to local authorities?

- a) We welcome the suggested provisions outlined in 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, broadly we welcome the recognition of the longstanding role of local authorities in delivering the public health agenda. In relation to injury 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 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 injury prevention plan.

10. Consultation question: Which approaches to developing an allocation formula should we ask ACRA to consider?

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.

11. Which approach should we take to pace-of-change?

No comments

12. Who should be represented in the group developing the formula?

The Institute of Home Safety believes that there should be a health premium attached to indicators around injury prevention as interventions in this area can, in line with the requirements stated in para 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 injury prevention work in the future.

13. Which factors do we need to consider when considering how to apply elements of the Public Health Outcomes Framework to the health premium?

- a) Whilst we acknowledge the statement in 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 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. We therefore believe it would be important to ensure there are injury prevention indicators that link to funding offered through the health premium.

14. How should we design the health premium to ensure that it incentivises reductions in inequalities?

The Health Premium should highlight those areas where there clear inequalities in health. As already highlighted, injury prevention is one of these. The NICE guidance and other evidence highlight the effectiveness of approaches that combine physical or environmental changes with educational programmes, such as home safety equipment schemes. The health premium should incentivise local authorities to adopt such schemes in areas with the most significant health inequalities.

15. Would linking access to growth in health improvement budgets to progress on elements of the Public Health Outcomes Framework provide an effective incentive mechanism?

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 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.

16. What are the key issues the group developing the formula will need to consider?

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 that 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, 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.
