NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

Health and social care directorate

Quality standards and indicators

Briefing paper

Quality standard topic: Homes: Preventing accident and unintentional injury among children and young people under 15.

Output: Prioritised quality improvement areas for development.

Date of Quality Standards Advisory Committee meeting: 26 March 2015

Contents

1 Introduction

This briefing paper presents a structured overview of potential quality improvement areas for Homes: Preventing accident and unintentional injury among children and young people under 15. It provides the Committee with a basis for discussing and prioritising quality improvement areas for development into draft quality statements and measures for public consultation.

1.1 Structure

This briefing paper includes a brief description of the topic, a summary of each of the suggested quality improvement areas and supporting information.

If relevant, recommendations selected from the key development source below are included to help the Committee in considering potential statements and measures.

1.2 Development source

The key development sources referenced in this briefing paper is:

- Strategies to prevent unintentional injuries among the under-15s NICE guideline PH29 (2010).

  Review decision made June 2014 not to update the guideline. Decision made to review part of guidance in 1 year and the remainder in 3 years.

- Preventing unintentional injuries among the under-15s in the home (2010) NICE guideline PH30.

  Review decision made June 2014 not to update the guideline. Next review date is June 2015.

2 Overview

2.1 Focus of quality standard

This quality standard will cover strategies for the prevention of unintentional injury among children and young people under the age of 15. These are 2 of 3 quality standards that will cover preventing unintentional injury in under 15s. One further quality standard is being developed. ‘Road safety’ will be developed in 2015. Therefore, this quality standard will not cover preventing unintentional injury on roads.

2.2 Definition

Unintentional injury

The term unintentional injury is used rather than 'accidents' in recognition that injuries are usually "predictable and preventable"[1]. A range of factors influence the likelihood of an unintentional injury, including personal attributes (such as age and medical conditions), behaviour (for example risk-taking) and the environment (such as poor quality housing). Children's physical, psychological and behavioural characteristics make them more vulnerable to injuries than adults.

2.3 Incidence and prevalence

The Audit Commission and Healthcare Commission reported in 2007 that unintentional injury was a leading cause of death among children and young people aged 1–14. Whilst child mortality from all causes, including unintentional injury has decreased over the past twenty years, more recent data indicates that injury is still the most frequent cause of death in children[2]. In analysis of UK death registration data from 1980 to 2010 it was found that a third of one in four year olds (31%) died from unintentional injuries[3]. The percentage of deaths from unintentional injuries for those aged 5-14 was reported at 20% by the Office for National Statistics data in 2010[4]. This data also indicates that there were higher numbers of males (68%) reported as dying from accident and injury.

Children and young people from lower socioeconomic groups are more likely to be affected by unintentional injuries[5]. Children whose parents are long-term unemployed (or have never worked) are 13 more times more likely to die from unintentional injury compared to children whose parents are in higher professional occupations.

Minor unintentional injuries are part of growing up and help children and young people to learn their boundaries and manage risks for themselves. The need to balance encouraging them to explore and develop, and managing the risks to prevent serious injury, was recognised in a government review published in 2009 by the Department for Children, Schools and Families.

Unintentional injury can affect a child or young person's social and emotional wellbeing. For example, those who survive a serious unintentional injury can

[1] Davis R, Pless B (2001) BMJ bans 'accidents'. Accidents are not unpredictable. BMJ 322:1320-21.
[2] Royal College of Paediatrics and Child Health and University College London (2013) Child Health Research UK – Clinical outcomes review programme. Overview of child deaths in four UK countries. 2013. London: RCPH.
[3] Ibid.
[4] http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-230730
[5] Towner E, Dowswell T, Errington G et al. (2005) Injuries in children aged 0–14 years and inequalities. London: Health Development Agency.

experience severe pain and may need lengthy treatment (including numerous stays in hospital).

In 2010 the Information Centre for Health and Social Care reported that in England alone, around 100,000 children and young people aged under 15 were admitted to hospital in 2009/10 as a result of such injuries. More recent data estimated that there are more than 108,000 hospital admissions of children under 15 each year from unintentional injury and approximately 2 million children under the age of 15 attend A&E due to unintentional injury[6]. The cost to the NHS of these attendances and admissions to A&E is estimated at £146m per year and £131m per year respectively[7]. The NICE Guidance costing report for NICE Guideline PH29 highlighted that an 11% national reduction in unintentional injuries for children under 15 could save £26.4 million and concluded that this could offset the cost of implementing the guidance.

2.4 Management

Many of the factors that create the conditions in which unintentional injuries occur are preventable[8]. There are a range of approaches to preventing unintentional injuries, including education (providing information and training) to product or environmental modifications and enforcement (regulations and legislation). Legislation has been identified as a powerful tool to help reduce unintentional injuries in all settings by the World Health Organization[9].

Interventions for injury prevention can be passive or active. Those that do not require an active change in behaviour (for example the presence of fire resistant materials or air bags in cars) are passive interventions. It has been suggested that the most effective strategies to address unintentional injuries use a combination of approaches[10]. Lessons from countries with the best safety records demonstrate that positive leadership, together with concerted efforts to provide safer physical and social environments can reduce unintentional injuries[11]. Both targeted and universal approaches are required to reduce the overall injury rate as well as health inequalities.

[6] Child Accident Prevention Trust. (2013) Tackling inequalities in childhood accidents.
[7] Ibid.
[8] Audit Commission/Healthcare Commission (2007) Better safe than sorry: preventing unintentional injury to children. London: Audit Commission.
[9] Peden M, Oyegbite K, Ozanne-Smith J et al. editors (2008) World report on child injury prevention. Geneva: World Health Organization.
[10] British Medical Association (2001) Injury prevention. London: British Medical Association Board of Science and Education.
[11] Sethi D, Towner E, Vincenten J et al. editors (2008) European report on child injury prevention. Copenhagen: World Health Organization Regional Office for Europe.

2.5 National Outcome Frameworks

Tables 1–2 show the outcomes, overarching indicators and improvement areas from the frameworks that the quality standard could contribute to achieving.

Table 1 NHS Outcomes Framework 2014–15

Domain	Overarching indicators and improvement areas
1 Preventing people from dying prematurely	***Improvement areas*** **Reducing deaths in babies and young children** 1.6 i Infant mortality* (PHOF 4.1)
3 Helping people to recover from episodes of ill health or following injury	***Improvement areas*** **Improving recovery from injuries and trauma** 3.3 Survival from major trauma
5 Treating and caring for people in a safe environment and protecting them from avoidable harm	***Improvement areas*** **Delivering safe care to children in acute settings** 5.6 Incidence of harm to children due to 'failure to monitor'
Alignment across the health and social care system * Indicator shared	

Table 2 Public health outcomes framework for England, 2013–2016

Domain	Objectives and indicators
2 Health improvement	***Objective*** People are helped to live healthy lifestyles, make healthy choices and reduce health inequalities ***Indicators*** 2.7 Hospital admissions caused by unintentional and deliberate injuries in children and young people aged 0-14 and 15-24 years
4 Healthcare public health and preventing premature mortality	***Objective*** Reduced numbers of people living with preventable ill health and people dying prematurely, whilst reducing the gap between communities ***Indicators*** 4.1 Infant mortality* (NHSOF 1.6i)
Alignment across the health and social care system * Indicator shared	

3 Summary of suggestions

3.1 Responses

In total 6 stakeholder organisations and 5 Specialist Committee Members responded to the 2-week engagement exercise 30/01/15-13/02/15. The following stakeholder organisations responded:

- Public Health Wales
- Public Health England
- The Royal Society for the Prevention of Accidents
- Royal College of Paediatrics and Child Health (no comment)
- Royal College of Nursing (no comment)
- NHS England

Stakeholders were asked to suggest up to 5 areas for quality improvement. Specialist committee members were also invited to provide suggestions. The responses have been merged and summarised in table 3 for further consideration by the Committee.

Full details of all the suggestions provided are given in appendix 1 for information.

Table 3 Summary of suggested quality improvement areas

Suggested area for improvement	Stakeholders
Households at risk • Prioritising households at greater risk • Injury data from emergency departments	SCM, ROSPA PHW, NHSE
Home safety assessments	SCM, PHE, ROSPA
Home safety equipment	SCM, PHE
Injury prevention coordinator	SCM, ROSPA
Additional areas • Local strategies and partnerships • Workforce capacity and training • Road safety speed restrictions • E-cigarettes	PHW, SCM, ROSPA PHE

NHSE, NHS England
PHE, Public Health England
PHW, Public Health Wales
ROSPA, Royal Society for the Prevention of Accidents
SCM, Specialist Committee Member

4 Suggested improvement areas

4.1 Households at risk

4.1.1 Summary of suggestions

Prioritising households at greater risk

Stakeholders suggested that there is a social class gradient in terms of children most likely to die, require hospital admission or consult their GP as a result of unintentional injuries. The majority of unintentional injuries to children in the home are to children aged under 5 years. It is suggested that households at greater risk include those families living in rented or overcrowded conditions or families living on low income. Stakeholders also suggested that the safety equipment offered needs to reflect the most common risks to children and young people depending on age. Several stakeholders highlighted the most common risks/injuries to children which need to be considered when providing home safety equipment. Those risks are: blind cord strangulation, nappy sac suffocation, falls from heights, poisoning, chocking, burns, scalds and poisoning.

Some stakeholders suggested that all agencies involved in child safety should work together. Joined action to promote child safety in the home can maximise the number of families reached, ensure best use of resources and sharing of information and potentially reduce injuries and save lives.

Injury data from emergency departments

Stakeholders highlighted a need to focus prevention activities on injuries that are most serious and/or most numerous and to direct interventions towards populations in greatest need. One stakeholder recommended the recording of age, gender, postcode and ethnicity to inform inequalities activity. It was suggested that a proportion of attendances at A&E are due to preventable child injury, but emergency departments do not currently have a standardised electronic method for recording attendances that allows attendance data to be compared or collated.

4.1.2 Selected recommendations from development source

Table 4 below highlights recommendations that have been provisionally selected from the development sources that may support potential statement development. These are presented in full after table 4 to help inform the Committee's discussion.

Table 4 Specific areas for quality improvement

Suggested quality improvement area	Suggested source guidance recommendations
Prioritising households at greater risk	NICE PH30 Recommendation 1 & 4
Injury data from emergency departments	NICE PH29 Recommendation 3 & 8

NICE PH30 – Recommendation 1

Prioritising households at greatest risk.

Who should take action?

- Local safeguarding children boards.
- Local authority children's services and their partnerships.
- Local strategic partnerships.
- Local authority health and wellbeing boards and partnerships (where they are not part of the local strategic partnership).

What action should they take?

- Determine the types of household where children and young people aged under 15 are at greatest risk of unintentional injury based on surveys, needs assessments and existing datasets (such as local council housing records).
- Prioritise the households identified above for home safety assessments and the supply and installation of home safety equipment (see recommendations 2 and 3). 'Priority households' could include those with children aged under 5, families living in rented or overcrowded conditions or families living on a low income. It could also include those living in a property where there is a lack of appropriately installed safety equipment, or one where hazards have been identified through the Housing Health and Safety Rating System (HHSRS).
- Provide practitioners who visit children and young people at home with mechanisms[4] for sharing information about households that might need a home safety assessment. This includes health visitors, social workers and GPs.
- Ensure practitioners adhere to good practice on maintaining the confidentiality and security of personal information. (For example, this includes using end-to-end encryption when sharing data with other agencies.)

NICE PH30 – Recommendation 4

Follow-up on home safety assessments and interventions

Who should take action?

Those who carry out home safety assessments and provide home safety equipment (see recommendations 2 and 3).

What action should they take?

- Prevent duplication of effort by keeping a record of households that have been given safety advice or equipment. (It may be possible to use an existing local

database.) Ensure the records are accessible to all those with a direct or indirect responsibility for preventing unintentional injuries in the home.
- Adhere to the standards referred to in recommendation 1 in relation to the collection and sharing of information.
- Use the records to identify when maintenance and follow-up are required, to feed into strategic planning and to prioritise future interventions (see recommendation 1).
- Contact homes identified as being in need of an equipment maintenance check or follow-up. Offer to revisit them to see if the equipment is still appropriate and functional (and in case of a product recall or faults). Ascertain whether there are any new requirements (for example, due to changes in the building or the family). Reinforce home safety messages during these visits.

NICE PH29 – Recommendation 3

Identifying and responding to attendances at emergency departments and minor injury units.

Who should take action?

- Staff in emergency departments and minor injuries units, including triage nurses.
- Local child and young person injury prevention coordinators.
- Local safeguarding children boards.
- Liaison health visitors.
- Staff offering out-of-hours health services for children and young people (for example, in walk-in centres).

What action should they take?
- Ensure health visitors, school nurses and GPs are aware of families which might benefit from injury prevention advice and a home safety assessment. Do this by using local protocols to alert them when a child or young person repeatedly needs treatment for unintentional injuries at an emergency department or minor injuries unit. Do the same when a single attendance raises concerns.

NICE PH29 – Recommendation 8

Gathering high quality injury data from emergency departments

Who should take action?

Commissioners of health services.

What action should they take?

- Ensure all hospital trusts are made aware of the data collection requirements for the universal and mandatory A&E (minimum) commissioning dataset.

- Ensure commissioning contracts for emergency departments (including minor injury units and walk-in centres) stipulate that all required data are collected – and to the required A&E (minimum) commissioning dataset standard. Contracts should also stipulate which data collection and submission methods should be used.
- Ensure contracts include financial penalties for failure to meet the requirements of the A&E (minimum) commissioning dataset.
- Ensure all hospital trust injury data are submitted to the NHS Information Centre for Health and Social Care.

4.1.3 Current UK practice

Prioritising households at greater risk

Childhood injuries are closely linked with social deprivation. Children from poorer backgrounds are five times more likely to die as a result of an accident than children from better off families and 37 times more likely to die in a house fire. Therefore, reaching those most at risk can help to reduce those inequalities. (ROSPA)

Injury data from emergency departments

Studies have highlighted the need for good data on injuries.[12][13] More specifically, lack of data was found to be the most important barrier to injury prevention work.

[12] Watson & White (2001) Accident prevention activities: a national surveyof health inequalities. Health Education Journal 60 (3), 275-283.
[13] Kendrick, Groom, Hippisley-Cox, Savelyich, Webber & Coupland (2003) Accidental injury: a neglected area within primary care groups and trusts? Health Education Research 18 (3), 380-388.

4.2 Home safety assessments

4.2.1 Summary of suggestions

Home safety assessments

Stakeholders suggested that integration of home safety into other home visits can raise the profile of accidents at home and reduce injuries as a result. People that potentially have access to people's homes including health visitors, family support workers, social workers, fire officers etc.

A stakeholder highlighted the need for systematic risk assessments so that resources are directed to targeted, relevant and effective interventions. There should be a mechanism for onward referral of such assessments to organisations that can implement action, focusing particularly on disadvantaged families.

4.2.2 Selected recommendations from development source

Table 5 below highlights recommendations that have been provisionally selected from the development sources that may support potential statement development. These are presented in full after table 5 to help inform the Committee's discussion.

Table 5 Specific areas for quality improvement

Suggested quality improvement area	Suggested source guidance recommendations
Home safety assessments	NICE PH30 Recommendation 2, 3, 4 & 5 NICE PH29 Recommendation 11

<u>NICE PH30 – Recommendation 2</u>
Working in partnership

Who should take action?

- Strategic planners and leads with responsibility for child health.
- Fire and rescue services.
- Housing associations.
- Local authorities: leads of children's services, environmental health, accident prevention and home safety housing.
- Sure Start and children's services.

What action should they take?

- Establish local partnerships with relevant statutory and voluntary organisations or support existing ones. Partners could include:

- local community and parent groups
- organisations employing health and social practitioners who visit children and young
- people in their homes (for example, health visitors)
- child care agencies
- others with a remit to improve the health and wellbeing of children aged under 15
- local umbrella organisations for private and social landlords

- Use these partnerships to:

- help collect information on specific households where children and young people aged under 15 may be at greatest risk of an unintentional injury (see recommendation 1). The collection and sharing of information should adhere to the standards referred to in recommendation 1
- help determine and address barriers to creating a safe home environment. (For example, the cost of equipment, cultural norms, issues of trust or a lack of control over the home environment may all be barriers to installing safety equipment)
- get the community involved (as outlined in NICE public health guidance 9 'Community engagement'). For example, local 'community champions' could be used to promote home safety interventions and help practitioners gain the trust of householders
- carry out home safety assessments and supply and install home safety equipment, in line with recommendation 3.

<u>NICE PH30 – Recommendation 3</u>

Coordinated delivery

Who should take action?

Those who carry out home safety assessments and provide home safety equipment (see recommendation 2).

What action should they take?

- Offer home safety assessments to the households prioritised in recommendations 1 and 2. Where appropriate, supply and install suitable, high quality home safety equipment. Home safety equipment should adhere to the British 'Kite mark' standards or the equivalent European standard. Where resources are limited, it may be necessary to narrow down further the households being prioritised (for example, to those with children under the age of 5 years).
- Ensure the assessment, supply and installation of equipment is tailored to meet the household's specific needs and circumstances. Factors to take into account include:
  - the developmental age of the children (in relation to any equipment installed)
  - whether or not a child or family member has a disability
  - cultural and religious beliefs
  - whether or not English is the first language
  - levels of literacy
  - the level of control people have over their home environment. (Many people may not

  - have the authority to agree to an installation, for example, tenants of social and
  - private landlords and those who are unable to make household or financial decisions)
  - the household's perception of, and degree of trust in, authority.

- Ensure education, advice and information is given during a home safety assessment, and during the supply and installation of home safety equipment. This should emphasise the need to be vigilant about home safety and explain how to maintain and check home safety equipment. It should also explain why safety equipment has been installed – and the danger of disabling it. In addition, useful links and contacts should be provided in case of a home safety problem.

NICE PH30 – Recommendation 4

Follow-up on home safety assessments and interventions

Who should take action?

Those who carry out home safety assessments and provide home safety equipment (see recommendations 2 and 3).

What action should they take?

- Prevent duplication of effort by keeping a record of households that have been given safety advice or equipment. (It may be possible to use an existing local database.) Ensure the records are accessible to all those with a direct or indirect responsibility for preventing unintentional injuries in the home.
- Adhere to the standards referred to in recommendation 1 in relation to the collection and sharing of information.
- Use the records to identify when maintenance and follow-up are required, to feed into strategic planning and to prioritise future interventions (see recommendation 1).
- Contact homes identified as being in need of an equipment maintenance check or follow-up. Offer to revisit them to see if the equipment is still appropriate and functional (and in case of a product recall or faults). Ascertain whether there are any new requirements (for example, due to changes in the building or the family). Reinforce home safety messages during these visits.

NICE PH30 – Recommendation 5

Integrating home safety into other home visits

Who should take action?

Practitioners who visit families and carers with children and young people aged under 15. This includes GPs, midwives, social workers and health visitors.

What action should they take?

- Recognise the importance of measures to prevent unintentional injuries in the home among children and young people aged under 15, particularly among those living in disadvantaged circumstances.
- Provide child-focused home safety advice. If the family or carers agree, refer them to agencies that can undertake a home safety assessment and can supply and install home safety equipment.
- Encourage parents, carers and others living with children and young people aged under 15 to conduct their own home safety assessment. They should use an appropriate tool, as outlined in recommendation 3.

NICE PH29 – Recommendation 11

Incorporating home safety assessments and equipment provision within local plans and strategies for children and young people's health and wellbeing.

Who should take action?
Local authority children's services and their partnerships, in consultation with local safeguarding children boards.

What action should they take?

- Ensure home safety assessments and educationare incorporated in local plans and strategies for children and young people's health and wellbeing. They should be aimed at families with a child under 5 or with other children who may be particularly vulnerable to unintentional injuries.
- Commission local agencies to offer home safety assessments and, where appropriate, supply and install suitable, high quality home safety equipment (whenever possible, adhering to British or equivalent European standards.)
- Ensure commissions specify that the assessment and the supply and installation of equipment needs to be tailored to meet the household's specific needs and circumstances. Factors to take into account include the developmental age of the children and whether or not a child or family member has a disability. Cultural and religious beliefs, whether or not English is the first language and levels of literacy within the household also need to be noted. In addition, the level of control people have over their home environment and the household's perception of, and degree of trust in, authority should be taken into account.
- Ensure commissions specify that the assessment needs to help parents, carers, older children and young people identify and address the potential risks from water in the home (this includes baths and garden ponds.

Ensure commissions specify that education, advice and information is needed both during a home safety assessment and during the supply and installation of home safety equipment. This should emphasise the need to be vigilant about home safety and explain how to maintain and check home safety equipment. It should also explain why safety equipment has been installed – and the danger of disabling it. In

addition, commissions should specify that useful links and contacts need to be given to householders as part of this provision, in case of a home safety problem.

4.2.3 Current UK practice

Home safety assessments

There are a number of people who potentially have access to people's homes including health visitors, family support workers, social workers, fire officers, etc. However, opportunities to promote home safety can be lost in the midst of other priorities and time pressures[14].

[14] http://www.rospa.com/

4.3 Home safety equipment

4.3.1 Summary of suggestions

Home safety equipment

Stakeholders reported that guidance and a number of examples of good practice around home safety equipment exist, but there are no formal quality standards for the delivery of schemes. The provision of safety equipment was viewed as inconsistent across the country and there are reportedly a limited number of authorities offering home safety equipment schemes. Responses suggested that the provision of a funded home equipment scheme for low income families could reduce the numbers of children aged 0-5 years killed and seriously injured within the home environment. It was suggested that families need to be educated on the delivery of home safety assessment and equipment fitting. One stakeholder suggested that families should be referred to the local fire and rescue service for fire safety checks.

Several stakeholders suggested that there should be a consideration of the most common types of unintentional injury and offer the relevant safety equipment to reduce the risk of those injuries. It was particularly highlighted that children under 5 years old suffer the highest incidence of unintentional injuries.

4.3.2 Selected recommendations from development source

Table 6 below highlights recommendations that have been provisionally selected from the development sources that may support potential statement development. These are presented in full after table 6 to help inform the Committee's discussion.

Table 6 Specific areas for quality improvement

Suggested quality improvement area	Suggested source guidance recommendations
Home safety equipment	NICE PH30 Recommendation 2, 3, 4 & 5 NICE PH29 Recommendation 9 & 11

<u>NICE PH30 – Recommendation 2</u>
Working in partnership

Who should take action?

- Strategic planners and leads with responsibility for child health.
- Fire and rescue services.
- Housing associations.

- Local authorities: leads of children's services, environmental health, accident prevention and home safety housing.
- Sure Start and children's services.

What action should they take?

- Establish local partnerships with relevant statutory and voluntary organisations or support existing ones. Partners could include:
  - local community and parent groups
  - organisations employing health and social practitioners who visit children and young
  - people in their homes (for example, health visitors)
  - child care agencies
  - others with a remit to improve the health and wellbeing of children aged under 15
  - local umbrella organisations for private and social landlords
- Use these partnerships to:
  - help collect information on specific households where children and young people aged under 15 may be at greatest risk of an unintentional injury (see recommendation 1). The collection and sharing of information should adhere to the standards referred to in recommendation 1
  - help determine and address barriers to creating a safe home environment. (For example, the cost of equipment, cultural norms, issues of trust or a lack of control over the home environment may all be barriers to installing safety equipment)
  - get the community involved (as outlined in NICE public health guidance 9 'Community engagement'). For example, local 'community champions' could be used to promote home safety interventions and help practitioners gain the trust of householders
  - carry out home safety assessments and supply and install home safety equipment, in line with recommendation 3.

<u>NICE PH30 – Recommendation 3</u>

Coordinated delivery

Who should take action?

Those who carry out home safety assessments and provide home safety equipment (see recommendation 2).

What action should they take?

- Offer home safety assessments to the households prioritised in recommendations 1 and 2. Where appropriate, supply and install suitable, high quality home safety equipment. Home safety equipment should adhere to the British 'Kite mark' standards or the equivalent European standard. Where resources are limited, it may be necessary to narrow down further the households being prioritised (for example, to those with children under the age of 5 years).

- Ensure the assessment, supply and installation of equipment is tailored to meet the household's specific needs and circumstances. Factors to take into account include:
  - the developmental age of the children (in relation to any equipment installed)
  - whether or not a child or family member has a disability
  - cultural and religious beliefs
  - whether or not English is the first language
  - levels of literacy
  - the level of control people have over their home environment. (Many people may not
  - have the authority to agree to an installation, for example, tenants of social and
  - private landlords and those who are unable to make household or financial decisions)
  - the household's perception of, and degree of trust in, authority.

- Ensure education, advice and information is given during a home safety assessment, and during the supply and installation of home safety equipment. This should emphasise the need to be vigilant about home safety and explain how to maintain and check home safety equipment. It should also explain why safety equipment has been installed – and the danger of disabling it. In addition, useful links and contacts should be provided in case of a home safety problem.

<u>NICE PH30 – Recommendation 4</u>

Follow-up on home safety assessments and interventions

Who should take action?

Those who carry out home safety assessments and provide home safety equipment (see recommendations 2 and 3).

What action should they take?

- Prevent duplication of effort by keeping a record of households that have been given safety advice or equipment. (It may be possible to use an existing local database.) Ensure the records are accessible to all those with a direct or indirect responsibility for preventing unintentional injuries in the home.
- Adhere to the standards referred to in recommendation 1 in relation to the collection and sharing of information.
- Use the records to identify when maintenance and follow-up are required, to feed into strategic planning and to prioritise future interventions (see recommendation 1).
- Contact homes identified as being in need of an equipment maintenance check or follow-up. Offer to revisit them to see if the equipment is still appropriate and functional (and in case of a product recall or faults). Ascertain whether there are any new requirements (for example, due to changes in the building or the family). Reinforce home safety messages during these visits.

NICE PH30 – Recommendation 5

Integrating home safety into other home visits
Who should take action?
Practitioners who visit families and carers with children and young people aged under 15. This includes GPs, midwives, social workers and health visitors.

What action should they take?

- Recognise the importance of measures to prevent unintentional injuries in the home among children and young people aged under 15, particularly among those living in disadvantaged circumstances.
- Provide child-focused home safety advice. If the family or carers agree, refer them to agencies that can undertake a home safety assessment and can supply and install home safety equipment.
- Encourage parents, carers and others living with children and young people aged under 15 to conduct their own home safety assessment. They should use an appropriate tool, as outlined in recommendation 3.

NICE PH29 – Recommendation 9

Installation and maintenance of permanent safety equipment in social and rented dwellings.

Who should take action?

Local authorities.

What action should they take?

- Consider developing local agreements with housing associations and landlords to ensure permanent home safety equipment is installed and maintained in all social and rented dwellings. Priority should be given to accommodation where children aged under 5 are living. Use the Housing Health and Safety Rating System (HHSRS)[7]. Permanent safety equipment includes:
    - hard-wired or 10-year, battery-operated smoke alarms
    - thermostatic mixer valves for baths
    - window restrictors
    - carbon monoxide alarms.
- Publicise any local agreements to install and maintain permanent safety equipment. Provide information about these agreements to the following groups and evaluate their awareness:
    - those responsible for social and rented dwellings, such as landlords and social housing providers

- practitioners with an injury prevention remit or who have an opportunity to help prevent injuries among children and young people
- practitioners with a role in assessing health and safety in residential properties
- residents in rented and social dwellings.

NICE PH29 – Recommendation 11

Incorporating home safety assessments and equipment provision within local plans and strategies for children and young people's health and wellbeing.

Who should take action?
Local authority children's services and their partnerships, in consultation with local safeguarding children boards.

What action should they take?

- Ensure home safety assessments and education are incorporated in local plans and strategies for children and young people's health and wellbeing. They should be aimed at families with a child under 5 or with other children who may be particularly vulnerable to unintentional injuries.
- Commission local agencies to offer home safety assessments and, where appropriate, supply and install suitable, high quality home safety equipment (whenever possible, adhering to British or equivalent European standards.)
- Ensure commissions specify that the assessment and the supply and installation of equipment needs to be tailored to meet the household's specific needs and circumstances. Factors to take into account include the developmental age of the children and whether or not a child or family member has a disability. Cultural and religious beliefs, whether or not English is the first language and levels of literacy within the household also need to be noted. In addition, the level of control people have over their home environment and the household's perception of, and degree of trust in, authority should be taken into account.
- Ensure commissions specify that the assessment needs to help parents, carers, older children and young people identify and address the potential risks from water in the home (this includes baths and garden ponds).

Ensure commissions specify that education, advice and information is needed both during a home safety assessment and during the supply and installation of home safety equipment. This should emphasise the need to be vigilant about home safety and explain how to maintain and check home safety equipment. It should also explain why safety equipment has been installed – and the danger of disabling it. In addition, commissions should specify that useful links and contacts need to be given to householders as part of this provision, in case of a home safety problem.

4.3.3 Current UK practice

Home safety equipment

Every year more than 4,200 children are involved in falls on the stairs and 4,000 children under the age of 15 are injured falling from windows[15].

[15] http://www.rospa.com/

4.4 Injury prevention co-ordinator

4.4.1 Summary of suggestions

Injury prevention co-ordinator

Responses suggested that cuts to budgets in local government have resulted in reduced capacity within local authorities to undertake strategic safety promotion activity. Although stakeholders indicated that it is not known to what extent funding cuts have affected this activity, it was suggested that the provision of injury prevention is not consistent across the UK. One stakeholder stated that many areas do not have an Injury Prevention Co-ordinator and the numbers in local areas are limited. The role was described as signposting to evidence-based activities, interpreting local injury data, and prioritising spending of limited resources. It was suggested that the appointment of a co-ordinator could help to establish local partnerships and create a local centre of knowledge and excellence, encouraging, supporting and coordinating effective local action.

4.4.2 Selected recommendations from development source

Table 7 below highlights recommendations that have been provisionally selected from the development sources that may support potential statement development. These are presented in full after table 7 to help inform the Committee's discussion.

Table 7 Specific areas for quality improvement

Suggested quality improvement area	Suggested source guidance recommendations
Injury prevention co-ordinator	NICE PH29 Recommendation 2

NICE PH29 – Recommendation 2

Coordinating unintentional injury prevention activities.

Who should take action?

- Local authority children's services and their partnerships, in consultation with local safeguarding children boards.
- Local highway authorities and their road safety partnerships.
- Other local authority services that may have a remit for preventing unintentional injuries such as education, environmental health and trading standards.

What action should they take?

- Ensure there is a child and young person injury prevention coordinator. The aim is to help achieve the commitments set out in local plans and strategies for

children and young people's health and wellbeing. The coordinator could be someone in the local authority, an NHS organisation or another local partner organisation (such as the fire and rescue service or a housing association). Alternatively, the coordinating role could be jointly funded by several local partners.

- Ensure the coordinator:
    - works with local partnerships that include organisations involved with children, young people, their parents and carers
    - develops a 2 to 3-year injury prevention strategy with these partners which is integrated into all relevant local plans and strategies for children and young people's health and wellbeing
    - networks at regional and national level with other child and young person injury prevention coordinators
    - raises local awareness about the need for prevention activities. This includes sitting on the local safeguarding children board. It also includes acting as a local source of information and advice on prevention
    - monitors progress made on the injury prevention commitments set out in local plans and strategies for children and young people's health and wellbeing. They should report progress to the director of children's services.
- Ensure the coordinator understands the range of preventive measures available and is trained – and has the skills – to carry out the above activities. Provide them with both informal and formal learning opportunities. (The former could include using peer support and 'cascade learning' within placements. The latter could include the acquisition of qualifications at different stages of a formal career pathway.)
- Ensure specialist learning and training is monitored and evaluated to see what effect it has on the coordinator's performance. Revise approaches that are found to be ineffective.

4.4.3 Current UK practice

Appointment of injury prevention coordinator

The prevention of unintentional injury can be more successful when a coordinator is in place. However, very few areas have a designated injury prevention coordinator and where these are in place they are often under threat due to budget constraints.

4.5 Additional areas

The improvement areas below were suggested as part of the stakeholder engagement exercise however they were felt to be outside the remit of this quality standard or are addressed by other NICE quality standard topics.

There will be an opportunity for the QSAC to discuss these areas at the end of the session.

Local strategies and partnerships

Stakeholders stated that if unintentional injury is not included in plans and strategies, it can be overlooked in programme development, budget allocations and staffing decisions. It was suggested that incorporation into plans and strategies would help to recognise the importance of this area as a public health priority.

Some stakeholders suggested that all agencies involved in child safety should work together. Joint action to promote child safety in the home can maximise the number of families reached, ensure best use of resources and sharing of information and potentially reduce injuries and save lives.

The collation of information on prevention initiatives underway locally was also suggested as an area for quality improvement. One response identified a need for local authorities to collate a register of injury prevention activities and suggested that this could then lead to the quality of implementation being assessed and best practice copied.

Capacity and training

Stakeholders identified the capacity and training of the workforce involved in injury prevention activities as an area for quality improvement. It was highlighted that there is currently no requirement for injury prevention training or a recognised level of training for practitioners who deliver injury prevention as part of their work. Moreover, responses suggested that all practitioners working with children and families could benefit from clear and consistent injury prevention training, including children centre staff, health visitors, fire services and third sector organisations.

Within the responses on workforce capacity one further specific suggestion concerned carbon monoxide poisoning. It was suggested that awareness of the dangers needed to be raised, particularly with families, but also for staff of children centres and health workers.

Road safety speed restrictions

One stakeholder suggested that many areas would benefit from the introduction of 20mph zones to reduce the numbers of pedestrian injury and death.

E-cigarettes

One response identified that the liquid content of e-cigarettes could prove hazardous and as there are limited regulations suggested that this should be discussed by the QSAC Committee.

Appendix 1: Suggestions from stakeholder engagement exercise

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
1	SCM	Ensure households at greatest risk are prioritised	Research and evidence shows that children under the age of 5 are most likely to die as a result of an accident in the home, homes most at risk are those where poverty is a major factor.	With the reduction on resources at all levels it is important that the correct households are identified Referral criteria could incorporate universal indicators such as low paid employment or employment/ receipt of benefits	ROSPA Health Profile locally and nationally
2	The Royal Society for the Prevention of Accidents	Key area for quality improvement 1 Prioritising those most at risk	Childhood injuries are closely linked with social deprivation. Children from poorer backgrounds are five times more likely to die as a result of an accident than children from better off families and 37 times more likely to die in a house fire.	Although it is important to share key home safety messages with all groups, action to target the most vulnerable groups will help to reduce social inequalities. Areas need to demonstrate how they are working to reach those most at need in relation to home injury prevention.	Delivering Accident Prevention in the new public health system. http://www.rospa.com/about/currentcampaigns/publichealth/
3	SCM	Focus on families at greatest risk of unintentional injury and on the safety of children under 5 years	It is well established that there is a social class gradient in terms of children most likely to die, require hospital admission or consult their GP as a result of unintentional injuries. The majority of unintentional injuries to children in the home are to children aged under 5 years.	Priority households could include those with families living in rented or overcrowded conditions or families living on a low income. It could also include those living in a property where there is a lack of appropriately installed safety equipment	This is a recommendation broadly based on NICE public health guidance 30: Preventing unintentional injuries among under-15s in the home.
4	Public Health Wales	Collection, collation and analysis of all A and E attendances for the treatment of unintentional injuries to under 15s	Data are needed to accurately identify and target priorities for intervention and to monitor the effectiveness of these interventions	There is little analysis, little collation of A&E data at any level; local, regional, national. Without this, and without setting national standards, data cannot be compared between regions and priorities cannot be adequately identified.	

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
5	SCM	Use of interventions for which there is good evidence of effectiveness and/or cost-effectiveness	In a climate where resources are limited, the use of interventions that are known to be effective and/or cost-effective is essential to limit the waste of resources.	Some agencies that have a significant opportunity to undertake child injury prevention promote the topic using interventions for which there is little or no evidence of effectiveness, such as the distribution of leaflets in isolation from other local programmes. (It is accepted that such an intervention might be relevant as part of interventions that are known to be effective in terms of behaviour and/or knowledge change.)	For example, see Watson MC, Mulvaney C, Kendrick D, Stewart J, Coupland C, Hayes M, Wynn P, on behalf of the Keeping Children Safe at Home programme. National survey of the injury prevention activities of sure start children's centres. Inj Prev 2012, 18, A103. (A second, more recent survey is currently being submitted for publication, showing little change in the practices of children's centres.)
6	SCM	Safety equipment offered needs to reflect the most common risks to children and young people depending on age	0-5 mostly harmed by falls, poisoning and choking. Equipment needs to support prevention School age children are mostly harmed by road accidents, poisoning	Needs to take into account the different needs for the age ranges as one size will not fit all, however there are strengths in the partners involved having appropriate opportunity for impact and outcomes over the whole age range with Childrens Services accessing right across	
7	SCM	Offer evidence based home safety assessments and advice from 0-19 services (children services, health visiting/school	Families that access these services are not Universal but Partnership Plus services, with risk and vulnerability to accidents increased. There is inequity in prioritising 'need' within the family and a home assessment offers and opportunity to empower them	Parents and carers may need support to recognise potential risk to their children and a professional with an evidence based approach can empower the parents to consider effective ways to manage potential risk	ROSPA

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
		nursing, Surestart children centres)	to have an impact on their child/rens safety.		

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
8	The Royal Society for the Prevention of Accidents	Key area for quality improvement 3 Integration of home safety into other visits	There are a number of people who potentially have access to people's homes including health visitors, family support workers, social workers, fire officers, etc. Opportunities to promote home safety maybe lost in the midst of other priorities and time pressures	Integration of home safety will raise the profile of the issue and could have a significant impact on saving lives and reducing injuries. Conversely there is evidence that home visits to carry out home safety assessments provide greater opportunities for services to raise other aspects of health and social care with families who have hitherto been regarded as "hard-to-reach"	Independent evaluation of the National Home Safety Equipment Scheme http://www.rospa.com/homesafety/safeathome/final-evaluation-report.pdf
9	The Royal Society for the Prevention of Accidents	Key area for quality improvement 5 Evaluation of home safety programmes	Developing robust evaluation demonstrating effective practice is often neglected in local programmes, largely due to lack of resources and limited understanding of evaluation techniques and approaches	Strong evaluations can lead to better investment in effective programmes that ultimately save lives and reduce accidents in the home. Investment in systematic evaluation for every injury prevention programme should form part of a quality improvement standard along with the use of effective approaches that can be tailored to local interventions. Although this will often preclude "gold standard" randomised control trials, and lack of data is often an inhibitor to producing robust quantitative evaluations, there are significant opportunities for informative qualitative approaches.	
10	SCM	Blind cord strangulation	28 deaths (+ 1 further awaiting coroners report) and 7 near misses recorded so far due to blind cord strangulation. Lack of accident prevention officers attached to local authorities leads to reduction in parent accident awareness sessions.	Several children's centres and other child care premises recently visited remain unaware of the hazard and still keep looped blind cords hanging in play areas which are sometimes only parent supervised. Education and training for staff and parents essential	British Blind and Shutter Association PO Box 232, Stowmarket, Suffolk, IP14 9AR E: info@bbsa.org.uk W: www.bbsa.org.uk
11	SCM	Nappy sac	**Background:** Nappy sacks have recently	Evident lack of knowledge in this area include	Nappy Sac campaign run

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
		suffocation	been implicated in causing suffocation and choking of babies less than one year old. In September 2010, the death of a local baby due to asphyxia from a nappy sack was brought to the attention of Beth Beynon, Child Accident Prevention Co-ordinator for NHS Cornwall and Isles of Scilly (NHS CIOS) via the local Safeguarding Children Board. NHS CIOS immediately set about gathering information to develop an understanding of the circumstances and identify whether similar deaths had occurred elsewhere. This exercise highlighted that asphyxia from nappy sacks had caused up to 14 known deaths in babies across England and Wales alone. However, none of these cases had come to the attention of the national accident prevention bodies, nor had they been logged on the national Trading Standards database. Each area had assumed their incidents were one-off, isolated cases. RoSPA 2015	health workers and children centre staff. Education and training for staff and families essential. There have been 3 further reported accidents since the figure of 14 was published.	by RoSPA, CAPT 7 Children in Wales.

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12	SCM	Falls from height Including balconies	Every year more than 4,200 children are involved in falls on the stairs and 4,000 children under the age of 15 are injured falling from windows. RoSPA	Evident lack of knowledge in this area which include health workers and children centre staff. Education and training for staff and families essential. BRE highlights areas of concern re. Juliette balconies.	http://www.rospa.com/homesafety/adviceandinformation/gene...
13	SCM	To reduce the risk of poisoning, commission children's centres, health visiting teams and other providers of family support, including voluntary sector organisations, to teach children rules about what to do or not do if medicines are left in places they can reach, such as on worktops	Poisoning is a frequent and occasionally very serious type of unintentional injury among the under 5s.	It is an intervention of known effectiveness.	This intervention derives from work undertaken during the Keeping Children Safe at Home programme led by Nottingham University. See http://www.nottingham.ac.uk/research/groups/injuryresearch/projects/kcs/index.aspx.
14	Public Health England	Under 5s: poisoning;	Identified amongst the top five preventable Unintentional injuries in the home to those aged 0-5.		https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/322210/Reducing_unintentional_injuries_in_and_around_the_home_among_children_under_five_years.pdf
15	Public Health	Under 5s: Burns	Identified amongst the top five		https://www.gov.uk/govern

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
	England	and scalds;	preventable Unintentional injuries in the home to those aged 0-5.		ment/uploads/system/uploads/attachment_data/file/322210/Reducing_unintentional_injuries_in_and_around_the_home_among_children_under_five_years.pdf

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
16	Public Health England	Under 5s: Drowning	Identified amongst the top five preventable Unintentional injuries in the home to those aged 0-5.		https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/322210/Reducing_unintentional_injuries_in_and_around_the_home_among_children_under_five_years.pdf
17	Public Health England	Under 5s: unintentional Injury prevention support and training for early years workforce	Health visitors lead and support delivery of the Healthy Child Programme (HCP), which has injury prevention at its core, and children's centres are key partners. Further opportunities will arise when public health commissioning responsibilities for under fives transfers from NHS England to local authorities in October 2015. Staff training to further develop confidence and competence in this area is important. With appropriate training and supervision, voluntary and community organisations will also be able to focus more explicitly on injury prevention in their work with families.		https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/322210/Reducing_unintentional_injuries_in_and_around_the_home_among_children_under_five_years.pdf
18	Public Health England	Under 5s: choking, suffocation and strangulation;	Identified amongst the top five preventable Unintentional injuries in the home to those aged 0-5.		https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/322210/Reducing_unintentional_injuries_in_and_around_the_home_among_children_under_five_years.pdf
19	Public Health	Under 5s: falls;	Identified amongst the top five		https://www.gov.uk/govern

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
	England		preventable Unintentional injuries in the home to those aged 0-5.		ment/uploads/system/uploads/attachment_data/file/322210/Reducing_unintentional_injuries_in_and_around_the_home_among_children_under_five_years.pdf

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
20	SCM	Commission social housing providers to fit thermostatic mixing valves (TMVs) to reduce the risk of bath water scalds	Bath water scalds are particularly serious injuries. Fitting a TMV and providing education is much more effective in reducing bath water temperature to a safe level (one that will not cause serious and rapid injury (usually about 46°C) than education alone or than giving parents thermometers to test their water temperature and lower it if it is too high.	It is an intervention of known effectiveness.	This intervention derives from work undertaken during the Keeping Children Safe at Home programme led by Nottingham University. See http://www.nottingham.ac.uk/research/groups/injuryresearch/projects/kcs/index.aspx.
21	SCM	Injury prevention coordinator post in local areas to inform and drive local provision.	It is noted within NICE guidance that the provision of an injury prevention coordinator in local areas would likely improve the delivery of local injury prevention services and help coordinate already existing services.	There are a limited number of injury prevention coordinators within local areas. Provision is not consistent across the UK. Many areas do not have an injury prevention coordinator at all. Opportunities for development of the role and recognised training, CPD are also limited.	
22	The Royal Society for the Prevention of Accidents	Local areas have an injury prevention co-ordinator	An injury prevention co-ordinator is recommended by NICE Guidance PH21 Co-ordination of programmes and strategies to reduce unintentional injury is a key factor in their success	Very few areas have a designated injury prevention co-ordinator and where these are in place they are often under constant threat due to budget constraints. Evidence shows that activity is most successful and consistent where a co-ordinator is in place	NICE Guidance PH29 Delivering Accident Prevention in the new public health system. http://www.rospa.com/about/currentcampaigns/publichealth/
23	SCM	Key area for quality improvement 2 Injury Prevention co-ordinator posts recognised.	Accident Prevention co-ordinator posts recognised as valuable. Role be recognised by public health teams. Posts are beginning to develop already in certain areas such as Stockport but need	There is currently no requirement for injury prevention training or a recognised level of training for practitioners who deliver injury prevention as part of their work	

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
			to rolled out to other areas.		

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
24	SCM	Strategic safety partnerships	Local road safety partnerships have historically been led / contributed to, but road safety officers from Local Authorities Injury prevention coordinators in Public Health teams have transferred to local authorities following NHS Reforms in 2013.	Funding cuts from central to local government have resulted in reduced capacity within local authorities to undertake strategic safety promotion activity in partnership, both within local authorities and externally with partners. It is not known to what extent funding cuts have affected this activity. The role of the injury prevention coordinator is likely to be more important in times of financial hardship to signpost to evidence-based activities to prevent injury, interpret local injury data, and prioritise spending of limited resources	
25	Public Health Wales	Injury needs to be recognised as a Public Health priority	Injuries are the leading cause of health and health services burden in this age group. To reduce them, their importance needs to be adequately recognised.	Injuries are the leading cause of health and health services burden in this age group. To reduce them, their importance needs to be adequately recognised.	
26	SCM	Incorporation of unintentional injury prevention within local plans and strategies for children and young people's health and wellbeing	The need for incorporating injury prevention into local plans and strategies is recommended in NICE guidance (PH29, part of recommendation 1).	Without the inclusion of the subject in high level plans and strategies, this significant cause of child mortality and morbidity can be overlooked in programme development, budget allocations, staffing responsibilities, etc.	
27	SCM	Incorporation of unintentional injury prevention within local plans and strategies for children and young	The need for incorporating injury prevention into local plans and strategies is recommended in NICE guidance (PH29, part of recommendation 1).	Without the inclusion of the subject in high level plans and strategies, this significant cause of child mortality and morbidity can be overlooked in programme development, budget allocations, staffing responsibilities, etc.	

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
		people's health and wellbeing			

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
28	SCM	Incorporation of home safety assessments within local plans and strategies for children and young people's health and wellbeing, and establishment of a mechanism for onward referral of such assessments to organisations that can implement action, focussing particularly on disadvantaged families	This key area is recommended in NICE guidance (PH29, recommendation 11, and PH30).	Although this might be regarded as an intervention and therefore outside the scope of this quality standard, the need for systematic risk assessments is a strategic approach that can lead to targeted, relevant and effective interventions. Without risk assessments, there is a possibility of resources being inappropriately directed. Many agencies provide family support and therefore have the opportunity to undertake risk assessments (and provide relevant advice) with basic training. Risk assessments per se do not prevent accidents. It is the actions that follows from the assessments that can make a difference, hence the need for a referral mechanism.	
29	SCM	Key area for quality improvement 1 Home Safety Assessments & Equipment Schemes (HSA)	Need for practice guidelines for practitioners on how best to design and deliver HSA's for their particular catchment areas which differ from region to region. To recognise the need for family education on delivery of HSA and equipment delivery / fitting.	There is a need for a universal home safety check form plus training on how best to deliver and access the families in a friendly non-judgemental way.	
30	The Royal Society for the Prevention of Accidents	Providing home safety assessments	Provision of home safety assessments to families with young children is a key service which enables them to make informed choices about keeping their families safe and preventing unintentional injury. This has been recognised by, for	There is no consistent provision of home safety assessments across the country although there are significant examples of good practice from which quality standards could be developed and applied nationally. The development of a standard assessment	

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
			example, Fire Services, with the provision of home fire safety checks but there is the potential for much wider application.	tool could make a significant contribution to the reduction of unintentional injury	

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
31	The Royal Society for the Prevention of Accidents	Providing home safety equipment	Evidence has shown that the provision of home safety equipment in conjunction with education and home assessments is effective in reducing accidents	Whilst guidance and a number of examples of good practice exist (including the National Home Safety Equipment Scheme delivered by RoSPA on behalf of the DfE, 2009-11) there are no formal quality standards for the delivery of such schemes. Provision of safety equipment is not consistent across the country. There is an opportunity to develop quality standards for these types of services and, in turn, the provision of an accredited home safety equipment scheme could form part of an overall quality standard for the delivery of injury prevention services in a local area.	NICE Guidance PH30 Evaluation of National home Safety Equipment Scheme http://www.rospa.com/homesafety/safeathome/final-evaluation-report.pdf
32	SCM	Commission or undertake home safety checks leading to the home safety education and the provision and fitting of safety equipment, especially safety gates, free or low cost smoke alarms and cupboard locks. Such checks should be carried out in a coordinated way	House fires can have fatal consequences. Stair falls are numerous and can be various injuries. Poisoning is a frequent and occasionally very serious type of unintentional injury among the under 5s. Such checks and the provision of safety equipment improve safety behaviours and may reduce injuries. Families without smoke alarms are more likely to die in a house fire than those with smoke alarms. The most effective method for increasing the number of families with a functioning smoke alarm is to educate families, provide and fit free or low cost alarms and do a home safety check. Where fitting smoke alarms and doing home safety checks is not	It is an intervention of known effectiveness, at least in terms of improving safety behaviours. This intervention can cover a number of types of injury	This intervention derives from work undertaken during the Keeping Children Safe at Home programme led by Nottingham University. See http://www.nottingham.ac.uk/research/groups/injuryresearch/projects/kcs/index.aspx.

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
		between organisations to avoid duplication and should use agreed checking protocols.	possible, providing education and free or low cost alarms is a cost effective option. The home safety checks and fitting of safety gates as part of the package are particularly important as families receiving both of these components in the package are much more likely to have a fitted safety gate than those provided with education or safety gates without the home safety checks and the fitting of safety gates. An overview of the evidence on preventing falls and the analysis of different combinations of falls prevention strategies reveal that the combination of education, low cost or free safety gates, home safety checks and fitting of safety gates is the most effective way of increasing the possession of a fitted safety gate.		

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
33	SCM	Reducing the number of injuries to children under the age of 5 within their homes by providing a funded home safety equipment scheme.	There is good evidence that providing a funded home safety equipment scheme for low income families can reduce the numbers of children aged 0-5 years killed and seriously injured within the home environment. Home safety equipment schemes are recommended within NICE guidance.	There are a limited number of authorities within the UK offering home safety equipment schemes to local families. The schemes are variable in nature in terms of eligibility criteria, the installation of equipment and the type of equipment provided. Some areas do not have any such scheme.	Please see research regarding the RoSPA home safety equipment scheme and NICE guidance regarding this issue.
34	SCM	Working in collaboration with fire and rescue services, commission or undertake home fire safety checks	House fires can have fatal consequences for children and adults. There is strong evidence to suggest that home fire safety checks reduce domestic fires and related injuries. Children's centres and others can refer families to their local fire and rescue service for such checks.	It is an intervention of known effectiveness.	This intervention derives from work undertaken during the Keeping Children Safe at Home programme led by Nottingham University. See http://www.nottingham.ac.uk/research/groups/injuryresearch/projects/kcs/index.aspx.
35	Public Health Wales	Injury preventions should be evidence based or, for innovative interventions, accompanied by a robust evaluative framework. Those interventions that do not have an evidence base should be stopped	There are many areas of injury prevention in which 'pet' projects are being undertaken at significant cost, but either with no accompanying evidence of effectiveness or even evidence of harm. With so few resources available to injury prevention as a whole, what resources that are available need to be channelled appropriately.	Too many injury prevention projects have been developed out of ideas that they "may work" and have continued even though there may be evidence to the contrary.	

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
36	Public Health Wales	Delivery of injury prevention initiatives needs to be robust and evidence based to ensure that those that are effective are implemented correctly	The evidence base relates to specific approaches to the implementation of interventions. Too often, adaptations are made locally that risk the fidelity of the intervention.	Injuries are the leading cause of health and health services burden in this age group. To reduce them, the interventions that are implemented need to be done so properly.	Children in Wales have produced a document that guides practitioners step by step through implementation. This should be a model for quality improvement.
37	Public Health Wales	Local authorities should be encouraged to collate a register of injury prevention initiatives underway in their area	Only when there is good understanding of what interventions are being implemented can the fidelity of implementation be assessed and best practice copied.	Only when there is good understanding of what interventions are being implemented can the fidelity of implementation be assessed and best practice copied.	
38	SCM	Establish effective Partnerships within agencies eg Children Services, Fire and Rescue, Third sector eg Homestart, and local council housing depts, Schools) for joint training and delivery of safety advice to 0-15	Due to the current economic climate and changes in Commissioning arrangements in Oct 2015 for health visiting all agencies have this as a key performance indicator including the Fire and Rescue, with reduction in death by fire. This would -strengthen the partnership working in achieving the KPI -provide possible local arrangement s for the fitting of safety equipment -provide families with consistent joined up approach from all partners -meet the needs of a diverse age range in a diversity of settings	All services within Health and Children services are looking at a joint approach going forward. As 'Neighbourhood' teams, providing evidence based opportunities to raise the profile of safety with families and young people they work with. Safety equipment can be provided for those families at most risk but if not correctly fitted or sold on or local housing does not support the fitting of the equipment then it is of no use. There needs to be a agreement with all partners of the clear expectation of reducing	The Call to Action (2011) ROSPA

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
				the risk of accidents	

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
39	The Royal Society for the Prevention of Accidents	Key area for quality improvement 2 Working together in partnership	There are potentially many agencies who have an involvement in child safety. Working together can help to save lives and reduce injuries	Concerted action to promote child safety in the home can maximise the number of families reached, ensure best use of resources and sharing of information that will help all organisations to provide better local services	Delivering Accident Prevention in the new public health system. http://www.rospa.com/about/currentcampaigns/publichealth/
40	SCM	Workforce training and capacity	Health visitors are public health practitioners who historically have provided child injury prevention information to parents of young children. The Health Visitors Implementation Plan has increased the number of health visitors qualifying but these have tended to replace retiring staff rather than increasing capacity.	The responsibility for commissioning Health visiting services is transferring from the NHS to Local Authorities from October 2015. As service specifications are re-written for the new commissioning authorities it will be important that injury prevention remains specified within these contracts. The Healthy Child Programme is the public health guidance that has historically determined the role of health visitors and school nurses. The Healthy Child Programme is currently being re-written and it is not know to what extent this may alter the existing content on child injury prevention.	The Healthy Child Programme is not currently on your list of Key Policy Documents. The Dept of Health and Public Health England are currently working with an Expert Advisory Group to review the evidence supporting the Healthy Child Programme. I understand that a new programme is due to be released in 2015. Perhaps it would be appropriate to invite someone from this panel to update us at the meeting on 13th February?
41	The Royal Society for the Prevention of Accidents	Training for Injury Prevention Practitioners	Injury prevention is a key public health issue which can be addressed by a range of practitioners including family support and children centre staff, health visitors, fire services, third sector organisations. All those involved in working with children and families would benefit from clear and	There is currently no requirement for injury prevention training or a recognised level of training for practitioners who deliver injury prevention as part of their work. A recognised level of training, such as the RoSPA City and Guilds home safety training, would increase the standard and consistency of advice and	

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
			consistent injury prevention training	support given to children under 15 and their families to help them prevent injuries	

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
42	SCM	Provision of introductory and on-going training for the childcare workforce	This key area is recommended in NICE guidance (PH29, recommendation 6).	This is fundamental to other key areas to ensure that they are carried out consistently and are based on sound knowledge and practice.	
43	SCM	Key area for quality improvement 4 Practitioner training in injury prevention in the home.	As a deliverer of home accident prevention it is evident that a large number of practitioners are out of date with current accidental injury trends and/ or are unaware of how best to deliver advice to families in their care.	Very few areas see this as a priority and it is not required at any level.	
44	SCM	Additional evidence sources for consideration			Carbon Monoxide - Gas Safe Charity www.gassafecharity.org.uk E-Cigarette – Trading Standards Institute – www.tradingstandards.gov.uk Eurosafe – www.eurosafe.eu.com
45	SCM	Carbon Monoxide poisoning	There are approximately 400 admissions to hospital with carbon monoxide (CO) poisoning in England each year and around 40-50 deaths. It is not widely known that CO exposure can lead to hypoxic brain injury and the effects of this can be as disabling as any other form of acquired brain injury, such as traumatic brain injury or stroke. The Brain Injury Association.	Evident lack of knowledge in this area which include health workers and children centre staff. Education and training for staff and families essential.	
46	The Royal	National and local	National and local data are essential to	The current levels of data collection and	NICE Guidance PH29 and

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	Society for the Prevention of Accidents	data collection	strategic local planning and evaluation of strategies and programmes	analysis are not sufficient to be able to accurately measure progress in preventing unintentional injuries. The best source, Injury Profiles, is no longer being updated and PHOF outcomes data do not give sufficient richness of data for effective service planning. Accident and Emergency data, particularly for home injuries is not available apart from a recent pilot led by Oxford hospitals and RoSPA. In the absence of a strong national dataset a quality standard should be developed to encourage the development of improved local injury prevention data (perhaps building on the Oxford approach but with a more robust dataset) which can contribute to local strategic development and evaluation and feed into a more robust national picture.	30 Injury Profiles http://www.apho.org.uk/injuryprofiles

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47	The Royal Society for the Prevention of Accidents	Key area for quality improvement 4 Improvement of data collection, analysis and dissemination	It is difficult for local and national organisations to prioritise home safety in the absence of robust, systematically collected and analysed data which gives the opportunity to demonstrate trends and establish the effectiveness or otherwise of interventions	Public Health Outcomes Framework indicators and data on injury prevention are insufficiently detailed. The failure to continue to update Injury Profiles is a major obstacle to the delivery and targeting of home safety programmes. The complete absence of robust A&E data which specifies location in the home of an accident and activity taking place at the time of the accident is a missed opportunity that prevents better targeting and reduction. The current pressures on A& E departments and significant resources could be saved if such data was available. In the absence of any impetus to tackle this issue at a national level a quality improvement standard focused on local services developing improved datasets could lead to effective models of good practice that could be developed into a national approach.	Injury Profiles http://www.apho.org.uk/injuryprofiles
48	SCM	Provision of a national database of accidental deaths and injuries to children.	Providing a national database detailing the causes and types of injuries and deaths in relation to unintentional injury would assist local authorities to prioritise areas for prevention. The importance of information regarding deaths and injuries is noted within NICE guidance.	There is currently no comprehensive national database of unintentional injury and death. Local areas are not required to provide detailed information and any information held by local areas is not collated in a comprehensive database.	
49	SCM	Key area for quality improvement 3 Universal injury data collection	More local data on costs and types of injuries to be made readily available to LA's to support their case in adopting injury prevention posts and schemes. Recommendation that the same	Current data collation differs throughout the country and makes it almost impossible to gain a true picture.	

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			collection format is used country wide.		

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50	SCM	Data on injury occurrence	High quality data on child injury epidemiology is required for both national and local decision making, with regard to a) prevention services, b) acute care c) potential demand for rehabilitative care and support.	) Absence of a national injury surveillance ystem since 2002.2) Mortality data and Hospital Episode Statistics only provide a icture of the severe end of the spectrum of hild injuries (both demographics and injury ypes). 3) Emergency departments currently xperiencing excessive demands on capacity. A proportion of attendances are due to reventable child injury. EDs do not currently ave a standardised electronic method for ecording attendances that allows attendance ata to be compared / collated4) Other ources of potential acute care data (e.g. from Minor Injury Units and Ambulance service) are arely considered when collating data. The Ambulance Service is no longer simply a ervice to convey patients to hospital. An ncreasing proportion of their workload is reatment and discharge at the scene5) to nform activity to address inequality in child njury occurrence these sources should record ge, gender, postcode, ethnicity (the latter in articular is poorly recorded)	Other national sources of severe injury data that could contribute more than they currently appear to be used (and not currently included on your list of national audit sources) include1) TARN (Trauma Audit and Research Network) https://www.tarn.ac.uk/Home.aspx 2) IBID (international burn injury database) http://www.ibidb.org/ The Children's Burns Research Centre http://www.bristol.ac.uk/social-community-medicine/childrens-burns/ are currently developing a Burns and Scalds Assessment Tool (BASAT) for use in EDs. This tool provides both a model for clinical history taking but links to an electronic database for epidemiological studies. Currently being implemented in EDs in

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					Cardiff and Bristol, discussions are ongoing regarding implementation in Manchester, Liverpool and Nottingham. I am a member of the Children's Burns Research Centre and can provide more information if required.The Child Death Review process http://www.workingtogetheronline.co.uk/chapters/chapter_five.html provides a mechanism whereby potentially modifiable causes of death can be identified. In 2013/4 HQIP http://www.hqip.org.uk/ put out a call for bids to develop the process to collate data from local Child Death Overview Panels into a national data resource. I do not know if this contract was awarded or timescales for completion. National collation of information on traumatic deaths could be particularly valuable.

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51	SCM	Data sharing for injury prevention	njury prevention is currently within the emit of the Director of Public Health in ocal Authorities. However much of the lata that is collected on child injuries particularly at a local level) is held by NHS trusts (acute trusts, ambulance rusts) or by clinical Commissioning Groups.	)ata sharing between NHS and local uthorities has been challenging since the NHS reforms of April 2013. In some instances lata flows have ceased. Local arrangements or data sharing are dependent on trusting elationships between data owners and ontrollers. The Director of Public Health eeds local data to provide evidence of need nd equality within the Joint Strategic Needs Assessment, which in turn informs the Health nd Wellbeing Strategy which the CCG is equired to take note of when making ommissioning decisions. The ability to link amed individual data between health and ocal authorities would enable evidence to be ollected of the outcomes of injury (e.g. time bsent from school, need for social care / isability support services).	
52	NHS England	My most important observation is that NICE are not using the Trauma Audit and Research Network database as a source of information. This is far more accurate and far, far more detailed than the HES data that they are relying upon. At			

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		the very least, it would allow them to triangulate data. It would be a real shame for NICE not to use the best national resource we have. TARN have also done specific national reports on severe childhood injuries. The vast majority of severe accidents occur in the home and on the road and these are covered in other QS. For other severe injuries, the next biggest group is sports related (especially trampolines at all age groups and off-road motor-sports for teenagers) and these also need to be covered. It is also essential that burns prevention is			

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		covered.			

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53	Public Health Wales	Collection, collation and analysis of all A and E attendances for the treatment of unintentional injuries to under 15s	Data are needed to accurately identify and target priorities for intervention and to monitor the effectiveness of these interventions	There is little analysis, little collation of A&E data at any level; local, regional, national. Without this, and without setting national standards, data cannot be compared between regions and priorities cannot be adequately identified.	
54	SCM	Collection and dissemination of high quality local A&E and admissions data	This key area is recommended in NICE guidance (PH29, recommendation 8).	In a climate where resources are limited, there is a need to focus prevention activities on injuries that are most serious and/or most numerous and to direct interventions towards populations in greatest need. Such data is also needed to allow programme monitoring and evaluation to be undertaken, although at very local levels and for short term interventions, changes in injury rates might be difficult to identify or to attribute to the intervention.	
55	SCM	Provision of 20 MPH zones within local areas where there are a high number of pedestrian child injuries/ deaths and where appropriate.	There is a strong evidence base that the provision of 20 MPH zones can reduce the numbers of pedestrian injury and death. This is a recommendation within NICE guidance.	There are a limited number of 20 MPH zones within local areas. Provision of these is not consistent and many areas that would potentially benefit from 20 MPH zones currently do not have them.	
56	Public Health England	RTCs: safe school travel	Analysis has identified peaks in RTCs at school travel times.		https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/3

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					22212/Reducing_unintentional_injuries_on_the_roads_among_children_and_young_people_under_25_years.pdf

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57	Public Health England	RTCs: co-ordinated action to reduce RTCs and improve health (e.g. active travel & liveable street initiatives)	Actions to prevent traffic injury are most effective when co-ordinated within local authorities with the efforts to encourage active travel and create liveable streets. The evidence shows that strong local partnerships are better placed than a single agency to tackle the wide range of factors that cause these inequalities in unintentional Injury		https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/322212/Reducing_unintentional_injuries_on_the_roads_among_children_and_young_people_under_25_years.pdf
58	SCM	E-cigarette poisonings	For discussion with committee	There are concerns that due to limited regulations the liquid content could prove hazardous and therefore general public need further information. Several Local Authorities and Trading Standards highlight the hazards associated with the e-cigs and liquid refill.	The Brain Injury Association www.headway.org.uk Carbon Monoxide poisoning
59	The Royal College of Nursing	This is to inform you that the Royal College of Nursing have no comments to submit to inform on the above consultation at this time.			
60	Royal College of Paediatrics and Child Health	Thank you for inviting the Royal College of Paediatrics and Child Health to comment on the Preventing			

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		unintentional injury topic engagement exercise. We have not received any responses for either of these consultations.			