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NICE Public Health Intervention Guidance

Preventing unintentional injuries in the home among under 15s: providing safety equipment and home-risk assessments

FIELDWORK REPORT

15th December 2009

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NICE Public Health Intervention Guidance

Preventing unintentional injuries in the home among under 15s: providing safety equipment and home-risk assessments

FIELDWORK REPORT

National Institute for Health and Clinical Excellence

A report submitted by GHK (with Noble Denton)

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EXECUTIVE SUMMARY

1 Purpose and methodology

GHK Consulting Ltd was commissioned by the Centre for Public Health Excellence (CPHE) at the National Institute for Health and Clinical Excellence (NICE) to test draft recommendations on **preventing unintentional injuries in the home among under 15s: providing safety equipment and home-risk assessments**.

The purpose of the fieldwork was to test the three draft recommendations in order to assess their relevance and usefulness, as well as exploring the barriers and facilitators to implementation and how any barriers might be overcome. It should be noted that the fieldwork did not invite comment on the rest of the draft guidance, although a number of the findings are relevant to the section on considerations.

The fieldwork was carried out with **65 practitioners**. In total, nine focus groups (in different local authority areas in each of the English regions) and one in-depth interview were carried out with a range of practitioners across the NHS, local authority, police and fire services, and voluntary sector organisations. Participants in the fieldwork included specialists in unintentional injury or accident prevention; practitioners working on local home safety initiatives or equipment distribution schemes; and practitioners with a broader remit for the welfare of children aged 0-15, such as social workers, children's centre managers, public health practitioners, housing managers, health visitors and school nurses.

2 Headline findings

The main conclusions from the fieldwork consultation are set out below.

Practitioners were welcoming of the recommendations, but thought that they represented an ideal, some elements of which were currently unfeasible

The recommendations as a whole were welcomed by the vast majority of practitioners, who thought that they addressed a neglected public health issue. Many of them welcomed any central guidance that might help to address the seemingly low priority of unintentional injury prevention in the home among commissioners, and the fragmented ownership of the issue in many of the focus group areas.

However, the view that some parts of the recommendations were unrealistic was equally strongly held, particularly in relation to:

- targeting individual households and sharing data among local agencies about the risks in specific households (all recommendations);
- the feasibility of collecting data of sufficient quality (recommendations 1 and 2);
- the cost of providing what practitioners perceived to be a comprehensive home safety service (recommendation 3);
- all practitioners carrying out risk assessments of sufficient quality to identify specific items of safety equipment to be installed in households (recommendation 3);
- following up all households that had received home safety equipment was thought to be too costly (recommendation 3); and
- taking on responsibility for the ongoing maintenance of safety equipment raised concerns among practitioners as to whether agencies would be held liable for the failure of supplied equipment.

Practitioners thought that lack of resources was a key issue

The vast majority of practitioners thought that a lack of resources was a critical barrier to fully implementing the draft recommendations. This reflected the lack of resources (or lack

of joined-up services) for unintentional injury prevention in the home at the present time in many of the focus group areas.

Practitioners' views on the implementability of the draft recommendations were often coloured by how costly an action was thought to be, and while some elements (e.g. identifying barriers and risk factors to creating a safe home or establishing partnerships) were thought to be achievable, others (e.g. establishing a shared database that could identify specific households at risk, or install and maintain large volumes of home safety equipment) were felt to be more costly and less achievable.

In particular, most practitioners interpreted recommendation 3 as a call for a separate home safety service that was linked into the different local agencies, or thought that this was the only realistic way to achieve the outcomes that recommendation 3 proposed. While they thought that this was a laudable idea, such a service was considered to be costly to establish.

Practitioners wanted the draft recommendations to acknowledge that there were different issues and needs for children aged under 5, and for older children

The vast majority of practitioners thought that one of the key issues not covered or acknowledged explicitly by the draft recommendations was that different interventions might be required, and different barriers and facilitators to implementation exist, for children of different ages. Most practitioners thought that different interventions might be more effective with older children.

For example, children under 5 are seen at home by a range of different services, such as health visitors – which are a statutory and universal service; but for older children the only regular visitors may be social services, who visit as a result of other problems in the household being brought to their attention. Agencies / groups that practitioners thought would be central to effective interventions to prevent unintentional injury to children under 5 included: local children's centres and Sure Start programmes; childminders; as well as health visitors and community midwives. For households with children over 5: school nursing services; parent support advisers (PSAs) or parent liaison officers attached to schools; environmental health; and social workers were all highlighted as possible agencies that might have a role in carrying out home visits as part of implementing the recommendations. Some practitioners stated that occupational therapy and services for disabled children would visit children of all ages at home, as well as voluntary and community sector organisations.

Practitioners wanted to see a greater emphasis on educational interventions that go alongside the installation of home safety equipment

In addition to the examples of barriers to creating a safe home given throughout the draft recommendations, parental understanding was also thought by the vast majority of practitioners to be a major barrier to the effectiveness of home safety equipment and home safety advice / risk assessments.

The vast majority of practitioners thought that the planning and delivery of educational interventions ought to have a higher profile throughout the recommendations, as they were considered inseparable from overcoming barriers to the uptake of risk assessments and the installation of home safety equipment in households (even though the scope of the recommendations was clearly explained). Practitioners pointed to education / training with three groups: professionals, parents and carers, and children themselves.

Overcoming the possible stigmatisation of particular households or communities was thought to be important

Most practitioners were concerned that if individual households were to be targeted, this needed to be introduced in a sensitive and 'universalising' way (e.g. accompanied by a local campaign on home safety). Practitioners were glad that recommendation 2 in

particular emphasised the importance of community involvement. This was thought to be particularly important, if the interventions outlined in draft recommendation 3 were not to be perceived as 'singling out' parents and carers as being unable to keep a safe home. Good quality community engagement – from local information campaigns to the use of 'community champions' as suggested by draft recommendation 2 - could play a part in gaining the trust of householders.

Most practitioners were able to give examples of local initiatives where the use of community workers, voluntary and community sector agencies, or schools had been effective in helping to communicate home safety messages.

3 Implications for the implementation and dissemination process

When asked about potential barriers to disseminating the final guidance, the fragmented nature of responsibility at a local level was thought by practitioners to be a key barrier.

Although the responsibility for unintentional injury to children in the focus group areas usually lay with local safeguarding children's boards, several other stakeholders were suggested as being equally important to target for dissemination activities:

- health and wellbeing boards / partnerships, where these existed in the local strategic partnership;
- children's centres;
- schools;
- environmental health leads;
- the voluntary and community sector; and
- young people's organisations.

Gaining the support of local authority elected members (for instance, through the local authority health scrutiny process) was also felt by some practitioners to be crucial, particularly where practitioners knew about recent negative media coverage.

In addition, the vast majority of practitioners thought that the lack of leadership at a local level was due to the lack of specific national targets and indicators for reducing unintentional injury to children in the home.

4 Summary of suggested changes

This table consolidates the main changes suggested by practitioners to the text.

Recommendation	Suggested changes to the text
General comments	▪ Clear leadership and ownership of unintentional injury prevention to children in the home setting should be emphasised throughout the recommendations (e.g. dedicated home safety officers) ▪ Consider what ought to be a priority for implementation within the recommendations, given the cost and feasibility of implementing some elements ▪ The recommendations ought to acknowledge that children under 5 and children over 5 are likely to need different interventions and make use of different services ▪ Consider giving greater emphasis to educational interventions (for parents and carers, children and practitioners) alongside risk assessment and the supply and installation of home safety equipment ▪ The guidance ought to show how the issues raised by practitioners in relation to data gathering and sharing might be resolved

	▪ The layout / 'flow' of the recommendations was not entirely clear for all readers ▪ 'Window locks' should perhaps be changed to 'window guards'
Recommendation 1	▪ Consider clarifying whether targeting of individual households is necessary to achieve the desired outcome ▪ Consider giving more detail on what constitutes 'high-risk' ▪ Consider giving greater weight to the importance of maintaining trusted relationships when data sharing is proposed
Recommendation 2	▪ The recommendation ought to emphasise that this work can be done through existing as well as new partnerships ▪ More detail on best practice in community engagement may be needed, including more about the role that community champions or other community workers can play in building up trust and reducing potential stigmatisation of particular households
Recommendation 3	▪ The recommendation ought to clarify whether a separate home safety service is required in order to achieve the desired outcome ▪ The recommendation ought to acknowledge that frontline health (and other practitioners) would not be able to do more than refer to an appropriate service which would then carry out a full household risk assessment ▪ 'Disability' ought to be added to the factors listed in the second bullet ▪ The issues around agencies' liability need to be resolved and clarified in the recommendation, in relation to the ongoing maintenance of safety equipment ▪ The final guidance should be mindful of the cost of follow up and tracking (or explain how this might be done in a feasible way)

1 INTRODUCTION

1.1 Overview and purpose of fieldwork

GHK and Noble Denton were commissioned by the Centre for Public Health Excellence (CPHE) at the National Institute for Health and Clinical Excellence (NICE) to test draft recommendations on **preventing unintentional injuries in the home among under 15s: providing safety equipment and home-risk assessments**.

Fieldwork is an integral part of the public health guidance development process. This report presents the findings of a series of consultations undertaken with a sample of the target audience outlined in the draft recommendations. The aim of fieldwork is to gather practitioner knowledge to understand how 'evidence translates into practice', and to provide the basis for understanding whether and how public health interventions will work.

In this fieldwork consultation, **nine focus groups** (in different local authority areas in each of the English regions) and **one in-depth interview** were carried out with a range of practitioners across the NHS, local authority, police and fire services, and voluntary sector organisations. Participant feedback was gathered from a total of **65 practitioners**, including specialists in unintentional injury or accident prevention; practitioners working on local home safety initiatives or equipment distribution schemes; and practitioners with a broader remit for the welfare of children aged 0-15 (including social workers, children's centre managers, public health practitioners, housing managers, health visitors and school nurses).

As part of the fieldwork, **practitioners were asked questions about the relevance, utility and implementability of the recommendations on preventing unintentional injuries in the home among under 15s**. The barriers to, and facilitators of, change in current practice in this area were also explored.

In keeping with established practice in carrying out NICE fieldwork, the views contained in this report and the conclusions derived from them are entirely based on the evidence given by the practitioners to whom we spoke. Practitioners were given summaries of the feedback provided at each focus group in order to verify that their comments were accurately recorded and understood. Where we have quoted practitioners verbatim in this report, their comments have been anonymised.

GHK and Noble Denton would like to thank all the practitioners who committed their valuable time in order to give their feedback.

1.2 Background and scope

NICE were asked by the Department of Health (DH) to develop guidance on preventing unintentional injuries in the home among under 15s, and this initial referral was refined to focus on the supply and installation of home safety equipment and home risk assessments.

The **scope of the guidance**[1] envisaged the provision of recommendations for good practice, based on the best available evidence of effectiveness, including cost effectiveness. Although the scope makes it clear that the guidance will not cover policy or legislative interventions, campaigns to reduce unintentional injury or educational interventions (NICE 2009, 6); "educational interventions, reward and incentive schemes, and hazard and risk counselling delivered alongside the supply and installation of safety equipment and home risk assessments" are within the scope of this guidance.

It should also be noted that the guidance forms part of a wider suite of five pieces of guidance on preventing unintentional injuries among children and young people aged under

[1] NICE (2009) *Preventing unintentional injuries among under 15s in the home: Final Scope* London: NICE.

15. A number of these other pieces of complementary guidance are still under development, and some of the comments given by participants during this fieldwork consultation may be of relevance to them. In particular, practitioners gave a number of comments related to broader educational interventions and unintentional injury outside the home (see chapters 3 to 6 of this report) which, whilst indirectly related to the prevention of injuries in the home setting may be relevant considerations in future guidance development.

The guidance is aimed at a wide range of professionals, commissioners and managers with public health as part of their remit working within the NHS, local authorities and the wider public, private, voluntary and community sectors. It is particularly aimed at primary care trusts, environmental health, education, children's services, police, fire and rescue services and youth services, representatives of which were all consulted during this fieldwork. The guidance is intended to complement the National Service Framework (NSF) on children, young people and maternity services.

1.3 Structure of this report

This report continues in the following chapters:

- **Methodology** (chapter 2), describing the selection of the sample, recruitment, and the analysis of data;
- **Responses to the recommendations as a whole** (chapter 3), analysing the evidence given by practitioners that is pertinent to the content and form of all the recommendations;
- **Responses to individual recommendations** (chapters 4 – 6), analysing responses to each individual recommendation; and
- **Conclusions** (chapter 7), summarising the most important findings.

This report also features six annexes, providing:

- **Annex A** – the final discussion guide used in the consultations;
- **Annex B** – the consent letter signed by the consultation participants;
- **Annex C** – the prior reading task set for the participants;
- **Annex D** – the sign-in sheets completed at the focus groups; and
- **Annex E** – equalities monitoring data for the individuals participating in the fieldwork.
- **Annex F** – a summary of the written feedback received from two practitioners in Newcastle (supplementary information not included in the main body of the report; see chapter 2, page 5 for more information on this)

2 METHODOLOGY

This chapter describes the study aims and the methodology used to carry out our fieldwork and analysis, including:

- the key fieldwork questions;
- our approach to sampling and recruitment; and
- the techniques used for carrying out the fieldwork consultation and analysis.

2.1 Aims and questions for the fieldwork

The aim of the fieldwork was as follows:

To examine the relevance, usability, acceptability, and implementability of the draft NICE recommendations on the prevention of unintentional injury among under 15s in the home.

We therefore developed the following fieldwork questions to examine 'evidence into practice', focusing on the following key issues of importance to NICE:

- particular issues or barriers (e.g. the nature of partnerships between organisations, management and funding issues, or training needs) that would help or hinder the effective implementation of the draft guidance by different parts of the target audience;
- factors that might facilitate the uptake of the recommendations on the prevention of unintentional injury among under 15s in the home, and help to overcome barriers to effective implementation;
- the extent to which the draft recommendations impact on, and have the potential to improve, current professional practice and service provision;
- the likely impact on reducing accidents and unintentional injury among under 15s in the home, and its fit with other relevant policy initiatives, e.g. on the development of a home safety adviser role and DCSF funded campaigns on child safety;
- the relative priority of, and the emphasis that ought to be given to, each of the draft recommendations;
- practitioner views on whether the draft recommendations are clearly worded, and how their wording could be improved;
- perceptions of NICE's involvement in this policy area, if appropriate to the audience under consideration; and
- any additional evidence or advice that ought to be taken into account in the final guidance.

Throughout the fieldwork we asked practitioners for examples that illustrated current (and good) practice in preventing unintentional injury among under 15s in the home. In chapters 3 to 6 of this report we have drawn on these examples to show how practitioners might work with the final recommendations.

The fieldwork methodology was designed by GHK and Noble Denton in conjunction with the NICE CPHE team, in order to conform to the CPHE methods manual.

The discussion guide used with practitioners in this fieldwork can be seen at **Annex A**.

2.2 Sampling

2.2.1 Key principles and achieved sample

A sampling frame for the fieldwork was developed in order to give a robust picture of how diverse professional groups, working in different settings, were likely to respond to the draft guidance. This was developed as part of our preparatory work.

The **fieldwork was carried out within nine local authority areas (one in each Government Office region)**, selected in order to take account of:

- different local authority types (county, unitary, metropolitan and London boroughs);
- rural and urban settings; and
- socio-economic characteristics of the population (including ethnicity and multiple deprivation).

While the overall sample included relatively wealthy local authority areas, the **sample was weighted towards those areas with relatively high degrees of deprivation**, in order to reflect the incidence of unintentional childhood injuries in the home. We also found during the course of the fieldwork that many of the more deprived local authority areas were participating in the **DCSF-funded 'Safe at Home' scheme**, which is provided by RoSPA[2] in conjunction with local authorities, and were able to bring their experience of implementing this scheme when giving their feedback.

The fieldwork took place in the following nine local authority areas (Government Office Region is given in brackets):

- Nottinghamshire (East Midlands);
- Luton (East of England);
- Lambeth (London);
- Middlesbrough (North East);
- Stockport (North West);
- Hampshire (South East);
- Plymouth (South West);
- Birmingham (West Midlands); and
- Leeds (Yorkshire and the Humber).

The aim of working within particular local authority areas was to examine how the draft NICE guidance will impact on partnership work in each, as we were aware that responsibility for preventing accidents in the home lies between many different types of practitioner and agencies (health services, local authority, police and fire services, housing associations, etc.).

A list of target local authority areas for the sample was drawn up shortly after the award of contract, in order to maximise the time available for recruitment and to book time in busy professionals' calendars. Alongside this, matched reserve areas were also identified. In a number of cases where practitioners in the 'first choice' local authority did not wish to take part, practitioners in the matched reserve were invited to take part in a focus group.

At the end of the consultation period, we achieved a **final sample of 65 practitioners across England, consulted through nine focus groups and one face to face, in-depth interview**. We aimed to conduct one focus group with approximately 8 participants for the fieldwork in each of the nine local authority areas (giving a total of 72 practitioners). In spite

[2] The Royal Society for the Prevention of Accidents

of invitations going out to approximately 200 practitioners, attendance at the focus groups varied from 2 to 11 practitioners in each.

While the achieved sample was composed of participants with a wide range of professional backgrounds, the low attendance in some areas meant that we implemented contingency plans to recruit more practitioners, in order to try and ensure an appropriate geographical balance. This resulted in an individual face-to-face interview taking place in Birmingham; as well as taking written feedback from two practitioners in a tenth local authority area (Newcastle-upon-Tyne). The two practitioners from Newcastle have not been included in the participant count or the overall analysis, as their feedback was not facilitated in the same way; and to include their comments would lead to an analysis based on inconsistent material. However, their comments reflected much of what was said by the practitioners who had attended focus groups or interviews. For reference, a summary of their comments is included at **Annex F**.

We believe that the **varied levels of attendance reflected the fragmented nature of responsibility in different localities for the prevention of unintentional injury in the home**, a point that was emphasised by several focus group participants (described in more detail in chapter 3 of this report).

Finally, it should also be noted that in some cases, practitioners responsible for accident prevention worked across local authority boundaries. For instance, in Nottinghamshire some roles covered both the county of Nottinghamshire (a two-tier local authority) and the city of Nottingham (a unitary local authority).

2.2.2 Composition of the local focus groups

The nine focus groups were composed of a wide range of local practitioners, employed by a variety of local agencies. Both specialists in unintentional injury or accident prevention, and practitioners with a broader remit for the welfare of children aged 0-15, were recruited. Practitioners also occupied roles at different levels in their respective organisations, and included:

- heads of community safety (in the police, fire service or local authority);
- heads of children's services;
- service managers in children's services, including those with a remit for disability;
- home safety managers, including those with a responsibility for implementing local home safety equipment schemes such as 'Safe at Home';
- social workers, including those responsible for fostering and adoption;
- children's centre managers;
- health visitor service managers and frontline health visitors;
- school health service managers and school nurses;
- public health practitioners;
- local child death review panel managers;
- family support workers;
- housing association managers;
- information or data managers with experience of working on local data on accidents;
- police officers, including senior officers; and
- fire service staff, including those with a remit for community safety or education.

At each focus group, practitioners were asked to identify the term that best described their employer. Of the total sample of 65 participants:

- 30 practitioners worked for local authorities, mostly in children's services;
- 24 practitioners worked for NHS organisations, mostly in primary care;
- 5 practitioners worked for police or fire services; and
- 6 practitioners worked for other organisations, including voluntary and community sector organisations.

Practitioners were also asked about their main responsibilities (they could give more than one answer), which showed that:

- 23 practitioners considered themselves to be responsible for the prevention of unintentional injury or accidents;
- 32 practitioners considered themselves to have a specialist role in relation to children, e.g. safeguarding, fostering and adoption, or youth work;
- 22 practitioners stated that one of their main roles was health promotion; and
- 17 practitioners stated that they had a role in primary care.

Tables 2.1 and 2.2 below give details of the numbers of practitioners that participated in each local authority area, their employers, and their stated responsibilities.

Table 2.1 Achieved sample, by location and employer

	Nottinghamshire	Luton	Lambeth	Middlesbrough	Stockport	Hampshire	Plymouth	Birmingham	Leeds	TOTAL
Total number of practitioners	**11**	**8**	**7**	**11**	**6**	**10**	**3**	**3**[3]	**6**	**65**
of which were employed by:										
Local authority – Children's Services	1	6	4	6	3	1	0	2	0	**23**
Local authority – Other	2	0	0	1	0	3	0	0	1	**7**
NHS – Primary care	5	2	1	1	3	4	1	0	4	**21**
NHS – Secondary / acute care	2	0	1	0	0	0	0	0	0	**3**
Police service	0	0	0	1	0	0	1	0	0	**2**
Fire service	1	0	0	0	0	1	0	1	0	**3**
Voluntary and Community Sector	0	0	1	2	0	0	1	0	1	**5**
Other	0	0	0	0	0	1	0	0	0	**1**

[3] Two participants attended a focus group; an in-depth interview was carried out with a third individual.

Table 2.2 Main responsibilities of practitioners recruited (participants could give more than one answer)

	Nottinghamshire	Luton	Lambeth	Middlesbrough	Stockport	Hampshire	Plymouth	Birmingham	Leeds	TOTAL
Accident prevention	8	4	3	0	2	1	1	1	3	23
Children's services	6	6	5	5	2	4	1	2	1	32
Emergency care	0	2	0	0	0	0	0	0	0	2
Primary care	3	3	1	1	1	4	1	0	3	17
Health promotion or public health	8	3	1	1	2	4	1	0	2	22
Housing and care homes	0	0	0	0	0	1	0	0	0	1
Workforce development	1	2	1	1	2	0	0	0	0	7
Community or outreach work	6	3	1	0	1	2	1	1	0	15
None of the above	0	0	1	2	0	0	1	1	0	5

2.3 Recruitment

2.3.1 Methods for recruitment and engagement

Recruitment was carried out using a purposive sampling process, designed to recruit a diverse group of participants who could give useful feedback.

The recruitment process was carried out as follows:

- an initial contact was made with a key point of contact in the local authority (an officer responsible for children's safety in the home in Children's Services or the Local Safeguarding Children's Board, where the responsibility for the prevention of unintentional injuries usually lies);
- the research team introduced the study to each of these key contacts, asked for their support in identifying appropriate contacts among the professional groups outlined in the draft guidance, and asked for assistance in hosting a focus group on their premises (in some cases, there was a local partnership on unintentional injury that could be contacted); and
- invitations to a focus group were then sent out to all the potential participants identified.

Informed consent was obtained from each participant once they had agreed to take part (an example consent letter can be seen at **Annex B**). Shortly before the fieldwork took place, the draft recommendations were sent to all participants to read, along with a short pre-read task comprising a series of key questions designed to help structure their thoughts prior to attending (**Annex C**).

Those participants who did not return their consent forms were given the opportunity to complete them at the focus group or interview. At this point, participants were also asked to complete a sign in sheet and an ethnicity / disability status monitoring form (**Annex E**).

2.4 Methods used for the fieldwork

Focus groups were the main method used for the fieldwork – with a discussion guide (**Annex A**) being used to structure the discussions. Discussions were facilitated rather than led; it was important that fieldwork participants made their own conclusions (with as little prompting as possible) on what in their view was good or bad about the draft recommendations, and where the gaps lay.

Focus groups **were attended by one lead researcher and one scribe** to make fieldwork notes; as well as being digitally recorded to ensure the accuracy of quotes, although they were not transcribed. Where possible, CPHE team members observed fieldwork sessions to hear participants' views first hand. At the start of each focus group, the lead researcher explained the principles of anonymity for the participants.

After each focus group, participants were sent a summary sheet containing the main points of feedback, so that they could verify their feedback and highlight any inaccuracies in the researchers' understanding of their comments.

Where in-depth interviews took place, the same discussion guide and process was used to structure the conversation around the draft recommendations.

2.5 Data analysis

Once fieldwork notes were completed, data analysis took place using a content analysis approach, including the iterative use and immediate analysis of field notes throughout the fieldwork period. Using the main fieldwork questions, the researchers identified core themes emerging from the data, defining concepts, creating typologies, providing explanations and finding associations between the views of different participants. These were inserted into a grid.

Regular briefing and debriefing sessions took place during the fieldwork process to ensure that the analysis was carried out in a robust manner.

3 RESPONSES TO THE RECOMMENDATIONS AS A WHOLE

This chapter examines participants' responses to the NICE recommendations on preventing unintentional injuries in the home among under 15s as a whole. It also examines all the cross-cutting aspects of the responses to the draft recommendations, including specific barriers and facilitators to implementation.

Subsequent chapters then examine the responses of relevance to the specific individual recommendations. For clarity, we have reproduced each of the draft recommendations that we consulted on at the start of each subsequent chapter.

Throughout the report, we have used the following terms to give an indication of the weight of evidence given by practitioners.

'**The vast majority of practitioners thought that**…' means that over 80% of the population referred to in the statement agreed with the particular view expressed. This constitutes very strong evidence in favour of a particular view.

'**Most practitioners thought that**…' means that over 50% of the population referred to agreed with the particular view expressed. This constitutes strong evidence in favour of a particular view.

'**Some practitioners thought that**…' means that a significant minority (5 or more people) of the total population across all the focus groups referred to agreed with the particular view expressed. While this may constitute a minority view, such evidence could be taken into account when read alongside the other evidence provided by practitioners.

Where appropriate, we also refer to staff from different sectors collectively. For example, we refer to local practitioners with a particular specialism in unintentional injury prevention as "home safety practitioners".

The findings of the fieldwork are illustrated by quotes from participants, as well as examples of practice described by participants.

3.1 Findings

3.1.1 Practitioners broadly welcomed the recommendations, and thought that they could have a positive impact on commissioners

The vast majority of practitioners thought that **the draft recommendations were a welcome and timely intervention** to raise awareness of the importance of unintentional injury to children in the home as an important public health issue. In particular, those practitioners that had heard of NICE thought that as the recommendations came from a trusted and recognised source of guidance, they would be helpful in making the case to commissioners for more resources and priority to be given to preventing unintentional injury in the home, an area that was thought by almost all practitioners to have been a relatively low priority in recent years (see 3.1.2 below).

> *"If the ultimate aim is to supply and install free home safety equipment to families who are identified as at need, whatever criteria, I think we'd all support that as a mechanism to reduce injuries"*
>
> *Healthier Communities Service Officer*

Most practitioners agreed that unintentional injuries were a major cause of children attending A&E and minor injury units, and that any proven actions to reduce such attendances would save money and so ought to be of interest to commissioners:

> *"It will be a money-saver, ultimately – commissioners may have a receptive air"*
>
> *Acute Children's Services Support Manager*

However the vast majority of practitioners expressed a number of common reservations about how straightforward the draft recommendations would be to implement. **Several**

important barriers were described, including a lack of funding, political sensitivities, and a general lack of leadership, that would need to be overcome. These concerns led some practitioners to describe the draft recommendations as "idealistic", although almost all of them thought the general principles underlying the recommendations were sound.

"In years to come, if this is implemented, and it prevents even one child death, it will be a very positive outcome… but I don't think it will be easy to get to that place"

Child Death Overview Process Manager

3.1.2 Practitioners thought that the prevention of unintentional injury is a low priority for local services, and that there was a lack of leadership and ownership

Throughout all the focus groups and interviews, a common theme emerged around the low priority given both locally and nationally to reducing unintentional injury among under 15s in the home, and home safety in general, although some practitioners felt that this was starting to change in their areas. We also found that across the different fieldwork areas there was **no consistent central ownership for preventing unintentional injuries in the home**.

This was a sentiment reflected by the vast majority of practitioners with an interest in the field of unintentional injury prevention, who often stated that **the lack of specific national targets** (the national Public Service Agreement on improving children and young people's safety was felt by some to prioritise injuries on the roads and deliberate harm) and **local area agreement (LAA) targets meant that injuries in the home were given a low priority**.

"Home safety, it's on a lot of people's agendas but it doesn't get the priority because a lot of other things take priority and it falls right down to the bottom"

Home Safety Manager, voluntary and community sector

Where specific multi-agency forums tasked with reducing unintentional injury in the home were identified, some practitioners said that they were poorly attended or did not command the authority with key agencies to make meaningful changes such as those outlined in the draft recommendations. Although local children's safeguarding boards or Children's Trusts were usually the accountable bodies for unintentional injury in the home, most practitioners did not think that this was a priority for them in practice.

Locally, many practitioners thought that ownership and leadership among agencies for the prevention of injury in the home was fragmented. In some areas, police, fire, local authority and NHS services were aware of each other's actions in relation to preventing unintentional injury in the home; however, in other areas, practitioners said that they had limited knowledge of the actions that partner agencies were taking or how those partners were targeting their home safety interventions. Some practitioners stated that unlike injuries on the road to children, which are perceived to have a higher priority and which local authorities have a statutory responsibility to reduce; the responsibility for unintentional injuries in the home had moved between different Government departments in recent years. While local authorities are obliged to employ a road safety officer, none of the local areas we visited were aware of a similar post for home safety in their localities – meaning that reducing unintentional injuries in the home was just among many responsibilities that local practitioners had to take on. **Most practitioners wanted to see the recommendations give clear direction on the need for dedicated leadership for taking action.** The response of one public health specialist was typical:

"I'm not sure that child accident prevention has been given a particularly high priority. I think it's rising but there has been a lack of strategic drivers and it falls between lots of different stools sometimes... I think the fact that NICE is doing all these evidence reviews is helpful… I've got child accident prevention within my portfolio of responsibilities, providing leadership. But in practice I'm not sure I do

provide particularly good leadership because of lack of time... it's something that is sort of tagged on to my work as a specialist area. I think that's an issue for us, is that we haven't got much sort of dedicated capacity around childhood accidents and I think until recently it's not been a particularly high priority."

Public Health Specialist, PCT

Some practitioners also thought that a lack of data that could be used to measure the scale of the problem locally, or evidence the outcomes of local interventions, was a reason for the low priority given to unintentional injury in the home. For instance, **practitioners stated that there is very little data currently collected (and shared) about the causes of unintentional injuries to children in the home**, unless there is thought to be a 'safeguarding' issue; equally, clinicians may never come into contact with many injuries or 'near misses' that happen in the home (see chapter 4).

In addition, some practitioners thought that tackling unintentional injury in a high-profile, targeted intervention would be perceived badly by the public, and local elected members might be reluctant to support actions that could be seen as stigmatising or overly intrusive (see chapter 6). Again, this was seen to be barrier that was particular to the home space, as an 'unregulated' environment.

3.1.3 Practitioners thought that the lack of resources was a critical barrier to implementing the recommendations fully

Related to the lack of priority given to preventing unintentional injury to children in the home, the vast majority of practitioners thought **a lack of resources** would be a critical barrier to implementing the draft recommendations in full. **This covers not only funding, but also the lack of time / staffing in local services, and lack of skills** to carry out meaningful risk assessments or identify households that might benefit from home safety equipment.

"What we need is the resources and coming together in order for this to be pushed forward.... budgets are being cut back"

Social Worker

"I don't think practitioners or the local authorities have that manpower in order to be doing what is recommended here."

Social Worker

Practitioners' views on the implementability of the draft recommendations were often coloured by how costly an action was thought to be, and while some elements of them (e.g. identifying barriers and risk factors to creating a safe home or establishing partnerships) were thought to be achievable, other aspects (e.g. establishing a shared database that could identify specific households at risk, or install and maintain large volumes of home safety equipment) were felt to be more costly and less achievable.

"The problem is because there's so many problems with each of the recommendations that people might say, well yes that would be a really good idea but we can't do that. We don't have the funding to do that. Yeah, very nice but then put it to one side"

Fire Service Community Fire Safety advisor

Some practitioners took the view that they were aware of the local postcode areas where the risk or incidence of unintentional injury to children was highest, and that spending more money on establishing a system that would be able to track the interventions and risks at a specific household level would be better spent on delivering more safety equipment, or educational interventions.

"We know what causes them [injuries in the home], we know what will prevent them, we don't need a database, what we need is the equipment, someone to install it, and the mechanisms for that to happen"

Head of Children's Services

In particular, most practitioners interpreted recommendation 3 as calling for a separate home safety service that was linked into the different local agencies (or thought that this was the only realistic way to achieve the outcomes that recommendation 3 proposed). While they thought that this was a laudable idea, such a service was considered to be costly to establish (see chapter 6) and this was an important barrier to overcome.

3.1.4 Practitioners wanted the draft recommendations to acknowledge that there were different issues and needs for children aged under 5, and older children

The vast majority of practitioners thought that one of the key issues that was not covered or acknowledged explicitly by the draft recommendations were the different interventions that might be required, as well as the barriers and facilitators to implementation, for children of different ages.

"Although looking at under 15s is important, [the recommendations need to] be able to discriminate locally using your intelligence of the nuances that occur between the under 5s and the older age group"

Public Health Registrar

For example, **children under 5 are seen at home by a range of different services**, such as health visitors – which are a statutory and universal service. In some of the focus group areas, health visitors already carry out a limited risk assessment for home safety and refer onto services that can provide a comprehensive risk assessment and home safety advice or equipment where required. **Most practitioners thought that the issues raised by the recommendations around trust, engagement and feasibility are different for the under 5s compared to the over 5s**. Health visitors are a universal service that are generally seen as trusted, and could have a role in relation to improving home safety as the draft recommendations suggest; although there are no similar 'home visiting' services (as outlined in recommendation 1) for older children unless those children have a disability. For instance, social services may carry out home visits in households with older children, but such visits will be as a result of other problems in the household being brought to their attention, and the dynamics that would permit a discussion of home safety are different. The following comment illustrates how many practitioners thought the general tone of the recommendations was more suited to (and more feasible to realise with) services in contact with the younger age group:

"[It's] relatively easy to identify households under 5s as they have more contact with universal services like Health Visitors"

Head of Children's Centre

Agencies / groups that practitioners thought would be central to effective interventions to prevent unintentional injury to children under 5 included: local children's centres and Sure Start programmes; childminders; as well as health visitors and community midwives. For households with children over 5: school nursing services; parent support advisers (PSAs) or parent liaison officers attached to schools; environmental health; social workers were all highlighted as possible agencies that might have a role in carrying out home visits as part of implementing the recommendations. Some practitioners stated that occupational therapy and services for disabled children would visit children of all ages at home, as well as voluntary and community sector organisations.

In addition, **most practitioners thought that different interventions might be more effective with older children**. For instance, while smoke alarms are universally recommended; other equipment such as stair gates are only appropriate and relevant for

toddlers (depending on their age and development, as well as the presence of older children). In contrast, most practitioners felt that where households had older children only, the type of accidents that occurred were different and there was a limited amount that could be done in relation to equipment; they often felt it was better to prioritise education. For instance, children can convey home safety and risk reduction messages to their parents or carers, contributing to a safer home environment.

"A risk to a toddler is a very different risk to that of a child of 12-13, so how's it [the interventions proposed] going to be sustained over that age span of that child?"

Child Death Overview Process Manager

3.1.5 Practitioners wanted to see a greater emphasis on educational interventions that go alongside the installation of home safety equipment

Alongside the examples of barriers to creating a safe home given throughout the draft recommendations, **parental understanding was thought by the vast majority of practitioners to be a major barrier** to the effectiveness of home safety equipment and home safety advice / risk assessments.

"[the biggest risk factors for unintentional injuries among children are] parental understanding and income."

Children's Centre Manager

The vast majority of practitioners thought that the planning and delivery of educational interventions ought to have had a higher profile throughout the draft recommendations, as they thought that they were inseparable from overcoming barriers to the uptake and installation of home safety equipment and risk assessments in households (even though the scope of the recommendations was clearly explained).

"Education is first and foremost"

Head of Children's Services

"There needs to be stronger recommendations on the education side... because it isn't just about the installation of safety equipment and that's how these recommendations read"

Home Safety Manager, voluntary and community sector

Practitioners pointed to education /training with three groups: professionals, parents and carers, and children themselves.

"NICE say education isn't something that we're looking at, at the moment, but it really is a really important part of it because it isn't just education of the children, it's education for their carers as well"

Fire Service Education Advisor Community Fire Safety

Some practitioners suggested that the final recommendations could 'signpost' where current or future NICE guidance might cover evidence-based practice in respect of the educational aspects of preventing unintentional injury to children.

3.1.6 Practitioners were welcoming of the ideas in the draft recommendations on data sharing, but raised a number of issues connected with data gathering and sharing

Most practitioners thought that the focus in the draft recommendations on data sharing between agencies was positive.

"I think it would be an enormous advantage to all services at all levels if all data collected by different services and different agencies was put together"

Service Manager, Children and Families

"A local database that was accessible by anyone working with families would be useful"

Children's Centre manager

However, practitioner views on the feasibility of the various measures called for in the draft recommendations varied. The vast majority raised a number of different concerns related to data gathering and sharing, which are discussed in more detail in the following chapters of this fieldwork report. In general, most practitioners interpreted the recommendations as calling for two distinct types of data gathering / databases: one related to the collection of information about households at risk (recommendations 1 and 2) to target interventions; and one related to recording delivery, tracking and follow-up of households that had received an intervention (recommendation 3).

3.1.7 Most practitioners questioned the scope of the recommendations and the logic of separating out gardens and outdoor spaces

Most practitioners were unsure as to why garden spaces were not covered by scope of the draft recommendations, as the practitioners and systems required to deal with improving practice in those areas would be the same. Some practitioners also questioned whether a focus on households might be to the detriment of improving wider living spaces:

"There is a wider question – that no green areas in social housing leads to more accidents inside – there is a wider concern in the home and outside, for example if doors open onto a main road with no garden gate"

Housing manager

"Large numbers of accidents at home, as we would recognise 'at home', are in and around [gardens and outbuildings]"

Local RoSPA representative

3.1.8 Not all practitioners found the layout of the recommendations to be entirely clear

Throughout the fieldwork consultation, it was clear that **some practitioners did not find the layout of the recommendations to be entirely clear**. A number of practitioners queried why each recommendation did not give a detailed list of agencies that should take action (as in recommendation 2); some practitioners thought that not all the target audience would understand terms such as 'local strategic partnerships'.

In addition, two groups of practitioners made the comment that 'window locks' are more usually referred to as 'window guards'.

It should also be noted that while some practitioners preferred the term 'accidents', the use of 'unintentional injury' was widely understood and used by the majority of practitioners that were consulted.

3.1.9 There are important gaps in the coverage of 'who should take action' throughout the draft recommendations

Practitioners identified other gaps throughout the draft recommendations in the target audience for 'who should take action' (mostly of relevance to recommendation 2, but also throughout). The most commonly mentioned groups were:

- environmental health services;
- voluntary and community sector organisations;
- schools and parent support advisers (PSAs);
- Accident and Emergency departments.

"I think schools and the third sector applies right through for all the recommendations"

Senior Children's Centre Co-ordinator

"It doesn't say how to engage with children, young people and families. The voluntary and faith organisations are missing"

Health visitor

It should be noticed that in some cases, practitioners made comments about the lack of coverage of certain groups without fully understanding the intended 'flow' of the recommendations from beginning to end.

3.2 Discussion

The draft recommendations as a whole were welcomed and were thought by most practitioners to be addressing a neglected area of public health, where ownership is currently fragmented and which is generally considered to be a low priority.

In this context, most practitioners felt that parts of the recommendations were unrealistic and carried large cost and other resource implications, in particular those sections relating to data gathering and sharing.

The recommendations as a whole may benefit from greater clarity or detail in respect of educational interventions that can accompany the installation and supply of safety equipment and risk assessments; differences between interventions aimed at households with children under and over 5 years; the order in which agencies are listed in 'who should take action?' (perhaps a comprehensive list could be given at the start of the recommendations); and the relationship with any future recommendations on unintentional injury to children in outdoor spaces.

4 RECOMMENDATION ONE

Recommendation 1 Identifying and prioritising households at greatest risk

Who is the target population?

Children and young people aged under 15 years at greatest risk of an unintentional injury, their parents and carers.

Who should take action?

Local strategic partnerships (LSPs), children and young people's strategic partnerships (where they are not part of the LSP), local safeguarding children boards (LSCBs) and children's trusts.

What action should they take?

- Use local information to identify and prioritise households where children and young people aged under 15 are at greatest risk of unintentional injury. Factors could include overcrowding, a low income and a lack of appropriately installed safety equipment. The data could come from surveys and needs assessments and existing datasets (such as hospital episode statistics). Or data could be gathered as part of routine practice (for example, during home visits by community practitioners).
- Consider establishing or using an existing database to share information on high-risk households with other statutory agencies. For example, social workers, GPs and health visitors could identify overcrowded dwellings and notify others via a database accessible to all statutory organisations.

4.1 Findings

4.1.1 Recommendation 1 was mostly considered to be a good idea in principle, but very difficult to implement fully

Practitioners agreed with the underlying principles of recommendation 1, but they thought that it would be difficult to implement the recommendation fully. This was largely because of concerns about the extent to which greater data sharing down to the household level was feasible or desirable (see below).

Some of the feedback given below relates to both recommendations 1 and 2.

4.1.2 There were differences of opinion amongst practitioners as to whether targeting individual households was appropriate and necessary

Practitioners had differing views on whether it was appropriate to target individual households at high risk (recommendation 1 and 2). Partly, this was because data sharing in relation to risks in a particular street, estate or postcode area is subject to different rules in relation to data about specific households (see first bullet, recommendation 2).

Sharing information about risk factors at an area level was largely felt by practitioners to be desirable and possible in future; some practitioners felt that this knowledge was already available in their local area. However, collecting information from home visits about risk factors, sharing this with other agencies for the purpose of targeting specific households, and keeping a record of interventions received (as opposed to using the information to contribute to area-level intelligence on risks; or simply generating a referral that was not recorded 'centrally') was felt by some practitioners to be **overly intrusive or stigmatising. In addition, given that householders would need to give their consent to such individual-level data sharing, some practitioners felt this might jeopardise trusted relationships with particular agencies**.

"This would need to be done with family knowledge – most want help but some would feel like you are interfering"

Community nurse, PCT

"We [the fire service] are well liked and well respected within the community. So where we have a home that perhaps is overcrowded and they wouldn't let any other agencies in, certainly wouldn't let the police in, you know, really reluctant to let a health visitor in because the fire service are going in there and we're telling them that we're going in there just for their safety and that's why we are going in there, for their safety – so that there isn't a fire, so that no one is injured. If they then think that we're going to pass on all that information to goodness knows who then that could – might – potentially cause us some difficulties"

Fire Service Education Advisor Community Fire Safety

"It would be a departure to target specific households. We know which neighbourhoods have most presentation at casualty. This takes it further"

Police superintendent

In addition, **some practitioners felt that such a step would require unjustifiable time and expense**, and preferred to focus on target groups and areas rather than particular households.

"I think there is a generic way of looking at these things so that you don't have to collect data on specific households. We know the demographics, we know where the problems are likely to be caused. Low income, etc. etc. So because we're aware of that these are areas, target groups that we should be getting to as opposed to almost picking on individual households"

Fire Service Education Advisor Community Fire Safety

Some practitioners pointed to the difficulties encountered by current and previous data-sharing initiatives such as Contact Point, and were uncertain as to the feasibility of sharing information via a database, or the extent to which a new database of this type should be a priority for implementation within the draft recommendations.

"Having the same systems where migration of information can happen would be best practice. However, there are probably more than 15 systems in the council which do not talk to each other, even though they share the same department"

Service Manager, Children and Families

"There's the big issues about... data protection in terms of the database and sharing of information, which seems an impossible thing to overcome"

Head of Children's Services

However, some practitioners thought that better community engagement (along the lines suggested in recommendation 2) might be a way to facilitate trust in local communities (see chapter 5).

4.1.3 Practitioners doubted whether it was possible to collect data of sufficient quality in one place, in order to target those households at highest risk

Practitioners also doubted whether the information currently collected was of sufficient quality to enable the targeting of specific households. This is of relevance to recommendations 1 and 2. In many local areas where focus groups were carried out, referral systems are in place where unintentional injuries related to household safety are identified: for instance, it appears to be common practice that A&E departments will make health visitors aware of injuries to under 5s that present there. However, most practitioners stated that detailed data on the causes of unintentional injury was not usually kept by A&E;

nor was it always thought that the A&E setting was the best opportunity to ask questions about this.

"Accidents and Emergency Admissions database is the first place that referrals may come from, but this is not kept in a database per se."

Acute Children's Services Support Manager

"The A&E datasets aren't really designed to support this kind of work at all, so we don't know where the injury occurred on most occasions or, you know, what the nature of that accident was. It's not recorded or coded. All the clinical codes that relate to payment are covered because they cost money but not so with the kind of causation... we don't know a broken nose from an assault from a broken nose from someone falling on their face."

NHS Information manager

In addition, **some practitioners also stated that different sources of data tell you about different aspects of risk, but do not give the complete picture**. Some of them emphasised that A&E data always occurs after the injury (it is a 'lagging indicator') while there is also a need for data on risk factors that could potentially cause injuries ('leading indicators').

Furthermore, practitioners stated that data collected by different organisations is always collected in different forms. While this can be analysed to give a high-level picture of risks that are present in a certain locality, it is difficult to make systems 'talk' to each other. **Some practitioners wanted the recommendations to emphasise the importance of standard forms for the collection of information**:

"You've have to have a standard template because everybody would collect it differently and then how would you record it?"

Head of Community Safety (Fire Service)

In recent years many of the local areas were starting to implement the Common Assessment Framework (CAF) for children's services across a range of agencies; however practitioners said that these were not filled in consistently and that additional training would be required to ensure that all practitioners used it to highlight risks to children from a lack of safety equipment in the home. One local area had developed a 'trigger tool' which was used by a number of practitioners to do a similar task with older people, and were thinking of extending its use to children.

Accessing data was also an issue for most practitioners; some thought that the draft recommendation ought to state that a particular agency ought to lead on collecting the data at a strategic level. It was thought that substantial, longer-term changes in working practice would be required.

"There needs to be a community base, at the moment with A&E information it is reactive. Health visitors and GPs may not share information"

Designated Nurse for safeguarding children

"Finding where it's [data] is sat is a task in itself. If you don't know the right person to ask or the right question to ask you don't necessarily get that magic key"

Children's Centre manager

"Any kind of information sharing, and this goes through all the recommendations really, requires a change in working practice as well"

NHS Information manager

Most practitioners also stated that **households are rarely 'static'** and that information about households or overcrowding could get of date too quickly for it to be of use for targeting individual households.

"In housing we aim to have a profile on housing, but what we have can be out of date. We have a standard questionnaire about numbers in the house but some won't tell you – ones who are not honest are a worry, for example if someone has come out of prison"

Housing manager

Finally, one group of practitioners felt that for households where information is patchy (such as rural households) relying on limited sources of data might result in these households being missed:

"From a local authority point of view we look at the wards whereas public health is on a household basis – like [my colleague] said, households tend to be in pockets of deprivation. There are also a group of households which are rural that get missed'

Local authority manager

4.1.4 Some practitioners wanted to see greater detail on what constituted a 'high-risk' home

Some practitioners wanted to see greater detail on the definition of a 'high-risk' home in recommendation 1, with criteria for what 'high-risk' might be:

"What constitutes a high risk home? It would need some clear parameters and definitions wouldn't it"

Head of Children's Services

Some other practitioners were concerned that focusing too much on homes considered at 'high-risk' might detract from a whole population approach (such as wider education and home safety campaigns), or could result in missing a group of people who might still need help but who do not meet the usual criteria for 'high-risk'.

"There is a danger in focusing on the most at risk children when we are all at risk of an unintentional injury. Could undermine that whole population approach... we are all at risk of home based injury"

Public health registrar

"There is that group of families where they're not on any benefit because they have got an earner, but they are still struggling to keep their head above water... there's still a risk there because spending on safety equipment is quite a big investment"

Home Safety Manager (voluntary and community sector)

4.2 Discussion

While the intentions of recommendation 1 were welcomed, there are many (and differing) concerns among practitioners about data gathering and sharing. Practitioners identified several barriers to effective data sharing, particularly if this includes the sharing of information on specific households, which:

- might be perceived as overly intrusive or stigmatising;
- might lead to trusted relationships being put at risk;
- would be prohibitively expensive; and
- would require long-term changes in working practices.

Practitioners felt that the sharing of data to target particular groups or areas at high risk was more feasible, but also identified a number of barriers, including inconsistent methods for collecting and recording data and the difficulties of consolidating data from several sources to give a coherent picture. Most practitioners thought that although there were limitations to their current knowledge, the recommendation was not practical to achieve in its entirety.

Some practitioners also wanted recommendation 1 to give greater detail about, and provide a definition of what constituted ‘high-risk’ households.

5 RECOMMENDATION TWO

Recommendation 2 Establishing partnerships

Who is the target population?

Children and young people aged under 15 years at greatest risk of an unintentional injury, their parents and carers.

Who should take action?

- PCT strategic planners and child health leads.
- Fire and rescue services.
- Housing associations.
- Local authorities: leads for children's services, environmental health, accident prevention and home safety and housing.
- Children's trusts.
- Sure Start and Children's Centres.
- Others with a remit to prevent unintentional injury in the home.

What action should they take?

Establish local partnerships with relevant statutory and voluntary organisations (including those involved in lifestyle and other heath initiatives) to:

- Identify and collect data on specific households where children and young people aged under 15 are at greatest risk of an unintentional injury.
- Identify barriers to creating a safe home (for example, cultural norms, issues of trust or lack of control over the home environment).
- Get the community involved (as outlined in NICE public health guidance 9 'Community engagement' www.nice.org.uk/PH9). For example, use local 'community champions' to promote home safety interventions and help practitioners gain the trust of householders.
- Develop and deliver interventions, in line with recommendation 3.

5.1 Findings

5.1.1 Practitioners thought that recommendation 2 was relevant but many wanted to see existing partnerships reinvigorated

The vast majority of practitioners thought that a recommendation on operational partnerships and their role was useful and relevant to their work on preventing unintentional injury to children in the home.

> *"In terms of getting the message out that there needs to be that joined up approach, it's useful"*
>
> *Public Health registrar*

In particular, many practitioners thought that the recognition of the importance of housing associations was important:

> *"The housing associations and city council holds information – there was a gap in a serious case review recently where housing were missed out. It came about the housing issue was major"*
>
> *Nurse, PCT*

Most practitioners were already members of local partnerships, although they made the point that partnership meetings were often poorly attended or their members were unable to effect change to the degree that they would wish. In these cases practitioners thought that **the recommendation could do more to reinvigorate existing partnerships**, and that recommendation 2 ought not to imply the creation of new partnership arrangements. The main barrier to implementing recommendation 2 was the low priority given to the prevention of unintentional injury in the home.

"The partnerships are already there – we just need to make this a priority"

Housing manager

"I think the concept of a local partnership is good, certainly the concept of community involvement is good, I think the second point about, identify barriers to creating a safe home, I honestly think that is something we can do fairly easily"

Healthier Communities Service Officer

5.1.2 Practitioners broadly agreed with the need for community engagement, but wanted to see more detail on best practice

The vast majority of practitioners were also **glad that the recommendation emphasised the importance of community involvement**. This was thought to be particularly important, if the interventions outlined in draft recommendation 3 were not to be perceived as 'singling out' parents and carers who were unable to keep a safe home. Good quality community engagement – from local information campaigns to the use of 'community champions' as suggested by draft recommendation 2, could play a part in gaining the trust of householders:

"If they're involved with services at the moment, there could be some concerns that this could be misconstrued as 'something else they're doing wrong' so this would mean it needs a really strong communication strategy, that community champion to reassure them… I wouldn't want to be on what I might see as a 'I've got an unsafe house database' but I would like to be in a 'they are helping me with my new born baby in all these aspects database'"

Early Years Workforce Development Manager

Most practitioners were able to give examples of local initiatives where the use of community workers, voluntary and community sector agencies, or schools had been able to help to communicate home safety messages. In particular many schools now feature parent support advisers (PSAs), whose role it is to engage with disadvantaged parents to offer support and advice:

"I think schools also have a part to play. They have parents coming in as well as children and they get to know home situations, what's happening, sometimes they've got the home liaison staff to go in, they've got the links there as well"

Education welfare officer

"Our Safer Start worker... was a local resident in that community and I think that really helped to build up trust around families being able to engage and access the service"

Locality Manager, Health Visiting and School Nursing

Practitioners also highlighted issues to do with engaging private landlords, who are as responsible for home safety as their tenants, and community workers might also be a way to spread home safety messages and inform them of their responsibilities:

"Landlords will not accept a lot of the safety issues as being their responsibility"

Community Nursery Nurse

However, some practitioners also wanted to see recommendation 2 give greater detail on who 'community champions' might be, although they recognised that the recommendation signposted another piece of NICE guidance to cover this.

5.2 Discussion

Many of the concerns and barriers identified by practitioners for recommendation 2 were in common with those identified in the other two draft recommendations – for example, issues of data sharing, the need to counter stigmatisation of particular groups and households, and the low priority of work on the prevention of unintentional injury to children in the home.

Practitioners nevertheless thought that the emphasis on partnerships was helpful, although they wanted the recommendation to make it clear that making best use of existing partnerships could be just as effective as establishing new ones.

The focus on community engagement as part of the broader drive to reassure households that services are supporting them, and pass on home safety education messages across a wide cross-section of people was also thought to be helpful, although some practitioners wanted more detail as to what exactly this might involve.

6 RECOMMENDATION THREE

Recommendation 3 Delivery

Who is the target population?

Children and young people aged under 15 years at greatest risk of an unintentional injury, their parents and carers.

Who should take action?

Local partnerships with responsibility for delivery (see recommendation 2).

What action should they take?

- Offer home risk assessments to the households identified and prioritised in recommendations 1 and 2. Where appropriate, supply and install suitable, high quality home safety equipment.
- Ensure the assessment, supply and installation of equipment are 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)
  - cultural and religious beliefs
  - whether or not English is the first language
  - levels of literacy
  - the control people have over their home environment (for example, tenants of social and private landlords, women in traditional, patriarchal families and those living with extended families may not have the authority to agree to an installation)
  - the household's perception of, and degree of trust in, authority.
- Ensure follow-up advice and information is given in person, by phone or letter. This should emphasise the need to be vigilant about home safety, outline why safety equipment has been installed – and the danger of disabling it.
- Keep records of households that have been given safety advice or equipment to prevent duplication. (It may be possible to use an existing local database.) Ensure they are accessible to all those with a direct or indirect responsibility for preventing unintentional injuries in the home.
- Use these records to identify when maintenance and follow-up is required, to feed into strategic planning and to prioritise future interventions (see recommendation 1).
- Ensure homes where safety equipment has been installed are re-visited to see if it is still appropriate and functional. Homes should also be checked to determine whether there are any new requirements (for example, this may be due to changes in the building itself or the family). Home safety messages should be reinforced.
- Encourage all practitioners who visit families and carers with children and young people aged under 15 to provide home safety advice and, where necessary, conduct a home risk assessment. If possible, they should supply and install home safety equipment. If they do not have the appropriate skills or equipment, they should refer the household to services that can carry out these tasks.

6.1 Findings

6.1.1 Practitioners thought that recommendation 3 contained a lot of useful information on delivery, but that much of it was unrealistic to implement

Practitioners thought that the recommendation on delivery was the most specific of the three recommendations, and that the recommendation largely illustrated what best practice would look like. However, they also thought that much of it was unrealistic to implement,

and expressed concerns about whether certain aspects of the recommendations were feasible.

> *"It [Recommendation 3] is the best one... it's proactive, it gives you space to monitor and follow up, you can chase people up if it's not happening, I think the only thing that's missing is a time period, processes, that sort of thing really so you can get the ball rolling more effectively"*
>
> *Social Worker*

> *"What is described is the ideal. The ideal is to ensure a standard of safety in each home, and this is one way of achieving it. The big question is, is it achievable?"*
>
> *Service Manager, Children and Families*

In particular, **most practitioners were confused about who would be legally responsible for maintenance and the implications of this in relation to liability**; they were also concerned that by largely omitting references to education, **the recommendation could be seen to be taking away personal responsibility from people** to look after installed safety equipment in their own home (an issue that many practitioners had encountered in implementing current and previous equipment supply schemes), and which might result in people taking less individual responsibility for their own safety.

6.1.2 Most practitioners thought that the recommendations implied the need for a new, dedicated service for home safety in order to implement recommendation 3 effectively

The vast majority of practitioners, whilst recognising that all those visiting homes could have a role in promoting home safety and identifying risk as suggested by recommendation 3, thought that for the desired outcomes to be achieved **a separate service would be needed to carry out risk assessments and install home safety equipment**.

There were a number of reasons for this. Firstly, professionals such as health visitors do not have the time to examine home safety in detail during visits, although they can pick up on issues and make referrals (as they were already doing in some local areas, including those participating in the 'Safe at Home' scheme). Secondly, it was thought that the draft recommendation did not take sufficient account of the different skill sets required for:

- assessing risk in relation to home safety;
- installing equipment in the house; and
- providing follow-up and reassessing risk so that maintenance, where needed, could be arranged.

Some practitioners also raised additional concerns that no matter how highly trained any service provider might be, a 'one size fits all' approach was not desirable and, as the second bullet of recommendation 3 suggests, specialists would still be required to examine the need for equipment in the case of, for example, disabled children.

Such a service would need to be sufficiently funded:

> *"If this is the expectation, will it be underpinned with funding, as it's almost creating a new service rather than an add-on to an existing service"*
>
> *Service Manager, Children and Families*

6.1.3 Practitioners thought that recommendation 3 did not take additional practitioner training to conduct risk assessments into account

The vast majority of practitioners did not think the expectation that all practitioners would undertake sufficiently comprehensive risk assessments leading to the installation of home safety equipment was realistic. They thought that it would be **better for a wider group of**

professionals to be able to identify families that might benefit from additional help, and then refer or signpost them on to a service that could carry out a more comprehensive risk assessment, as assessing risk is a different skill set.

> *"The first thing that strikes me is, is one person in a position to do a complete risk assessment"*
>
> *Early Years Workforce Development Manager*

> *"I don't think you'll ever get to a point where every professional is doing a risk assessment other than enough to say whether there needs to be a referral. If that's what it [the recommendation] means then it's achievable"*
>
> *Police superintendent*

However, most practitioners were also against a 'tick-box' approach to identifying risk, and emphasised that training would still be necessary.

6.1.4 Practitioners broadly agreed with the factors to be taken into account when installing equipment in the second bullet, but disability was missing

Most practitioners agreed with the broad list of factors in the second bullet of draft recommendation 3 to be considered in assessing, supplying and installing safety equipment for individual households. Whilst recognising that the list was not exhaustive, **most practitioners thought that disability was a very important factor that ought to be included**. Some practitioners also queried whether 'developmental age' ought to include both physical and mental aspects of development, in order to make this statement clearer.

The vast majority of practitioners agreed that the reference to the control that people have over their home environment was very important, as well as the household's degree of trust in authority. Some practitioners wanted to highlight that it was the method of delivery that was important for some families, rather than a reluctance to install safety equipment, as the following comment illustrates:

> *"One of our schemes is in Bradford, and the majority of the people having the equipment, wanting the equipment are from Asian families. So there is no evidence that they are saying [they are not keen] – there might be difficulty with who visits the family, who initially does the check – but I was inundated with calls from families in Bradford because my name accidentally went in the local paper so they were ringing me up for the equipment, so I know they don't mind!"*
>
> *Home Safety Manager (voluntary and community sector)*

6.1.5 Practitioners mostly thought that widespread follow-up and tracking was unrealistic

Most practitioners thought that **comprehensive follow up along the lines suggested in draft recommendation 3 would be impractical** and also very expensive. This was because families and households change very quickly and are not 'static', and in some cases practitioners thought that it was better for the household and the service if families were educated to contact the service if their circumstances changed.

> *"It is difficult to find companies to bid to do installations (apart from the cost) as much of the time it is on an ad hoc basis. And also to take the responsibility to install that equipment"*
>
> *Head of Children's Centre*

While most services currently operating do keep records of which households have received equipment, one group of practitioners gave the example that in some cases equipment such as smoke alarms are given away for free at community events and so it may not be possible to know who is using which equipment.

6.1.6 Practitioners thought that revisiting homes and maintaining equipment created issues around intrusiveness, liability and eroding personal responsibility

While most practitioners agreed that the maintenance of equipment was very important for home safety, they thought that it was important that educational interventions also take place, and that households are made to take responsibility for looking after their equipment and making decisions about risk (e.g. when it might be appropriate to remove a stair gate).

> *"Even when it's installed, it's only as good as it's installed on the day"*
>
> *Manager, Fostering Service*

> *"Where we can develop models to enable people to realise that they themselves have got a problem in their households as opposed to a professional doing it, through developing some kind of counselling type enablement package, that would have a better impact"*
>
> *Public Health registrar*

In particular, **most practitioners wanted to read more guidance about who would be legally responsible for maintenance, and the implications of this in relation to liability**. Should equipment malfunction because of a householder's actions, is the installer responsible because there was an expectation that equipment would be regularly maintained? Such concerns about responsibility and liability often arose from practitioners' previous experiences of home safety equipment schemes, where free home safety equipment had ended up being resold. Practitioners that were currently implementing home safety schemes often 'loaned' out equipment (on the expectation that they would not get most of it back) or sold equipment for a reduced price, on the grounds that this would encourage householders to take more responsibility for the upkeep of their own safety equipment.

> *"This was a really big issue for us [when carrying out our Safer Start scheme] and was one of the reasons why we went down about either giving it away and then fitting it or we were selling it very low cost because then that gave the onus back to the parent"*
>
> *Locality Manager, Health Visiting and School Nursing*

6.2 Discussion

Recommendation 3 was thought by most practitioners to be useful, but some of the individual bullets within it were thought to be unrealistic.

Practitioners thought that specialised skills were required in order to carry out the high quality risk assessments and installation of safety equipment referred to in the recommendation; and that this could not be done by practitioners such as health visitors. A wider group of practitioners could instead be trained to make referrals to a separate home safety service.

Practitioners were also concerned that follow up and tracking would be less cost-effective than educating households in the correct use of their home safety equipment.

Finally, recommendation 3 raised many questions about services' liability for installed safety equipment, particularly if there is an expectation that the services will return at regular intervals to ensure that equipment is correctly maintained. Therefore practitioners wanted to read more guidance on this aspect of the recommendation.

7 CONCLUSIONS

7.1 Overview

This chapter provides the main conclusions drawn from the fieldwork consultation with practitioners, and discusses the barriers that will need to be overcome in finalising, clarifying and explaining the guidance to practitioners.

7.1.1 Practitioners were welcoming of the recommendations, but thought that they represented an ideal, some elements of which were currently unfeasible

The recommendations as a whole were welcomed by the vast majority of practitioners, who thought that they addressed a neglected public health issue. Many of them welcomed any central guidance that might help to address the seemingly low priority of unintentional injury prevention in the home among commissioners, and the fragmented ownership of the issue in many of the focus group areas.

However, the view that some parts of the recommendations were unrealistic was equally strongly held, particularly in relation to:

- targeting individual households and sharing data among local agencies about the risks in specific households (all recommendations);
- the feasibility of collecting data of sufficient quality (recommendations 1 and 2);
- the cost of providing what practitioners perceived to be a comprehensive home safety service (recommendation 3);
- all practitioners carrying out risk assessments of sufficient quality to identify specific items of safety equipment to be installed in households (recommendation 3);
- following up all households that had received home safety equipment was thought to be too costly (recommendation 3); and
- taking on responsibility for the ongoing maintenance of safety equipment raised concerns among practitioners as to whether agencies would be held liable for the failure of supplied equipment.

The following comment from one of the focus groups gives a good summary of most practitioners' thoughts on the recommendations as a whole:

> *"The actions are appropriate to achieve the reduction of accidents in the home. Local practitioners may not be in a position to know whether this is achievable. Locally it will present an enormous challenge on resources and capacity and will raise questions on accountability and liability which will have to be addressed in any guidance or recommendations which emerge… [Equally] there are all sorts of public heath laws which are greeted with cries of intrusion or capacity but are now established and have improved quality of life. If this is going to go anywhere, it will probably have positive outcomes but will probably come up against some rough buffers along the way"*
>
> *Service Manager – Children and Families*

7.1.2 Practitioners thought that lack of resources was a key issue

The vast majority of practitioners thought that a lack of resources was a critical barrier to fully implementing the draft recommendations. This reflected the lack of resources (or lack of joined-up services) for unintentional injury prevention in the home at the present time in many of the focus group areas.

Practitioners' views on the implementability of the draft recommendations were often coloured by how costly an action was thought to be, and while some elements (e.g. identifying barriers and risk factors to creating a safe home or establishing partnerships)

were thought to be achievable, others (e.g. establishing a shared database that could identify specific households at risk, or install and maintain large volumes of home safety equipment) were felt to be more costly and less achievable.

In particular, most practitioners interpreted recommendation 3 as a call for a separate home safety service that was linked into the different local agencies, or thought that this was the only realistic way to achieve the outcomes that recommendation 3 proposed. While they thought that this was a laudable idea, such a service was considered to be costly to establish.

7.1.3 Practitioners wanted the draft recommendations to acknowledge that there were different issues and needs for children aged under 5, and for older children

The vast majority of practitioners thought that one of the key issues not covered or acknowledged explicitly by the draft recommendations was that different interventions might be required, and different barriers and facilitators to implementation exist, for children of different ages. Most practitioners thought that different interventions might be more effective with older children.

For example, children under 5 are seen at home by a range of different services, such as health visitors – which are a statutory and universal service; but for older children the only regular visitors may be social services, who visit as a result of other problems in the household being brought to their attention. Agencies / groups that practitioners thought would be central to effective interventions to prevent unintentional injury to children under 5 included: local children's centres and Sure Start programmes; childminders; as well as health visitors and community midwives. For households with children over 5: school nursing services; parent support advisers (PSAs) or parent liaison officers attached to schools; environmental health; and social workers were all highlighted as possible agencies that might have a role in carrying out home visits as part of implementing the recommendations. Some practitioners stated that occupational therapy and services for disabled children would visit children of all ages at home, as well as voluntary and community sector organisations.

7.1.4 Practitioners wanted to see a greater emphasis on educational interventions that go alongside the installation of home safety equipment

In addition to the examples of barriers to creating a safe home given throughout the draft recommendations, parental understanding was also thought by the vast majority of practitioners to be a major barrier to the effectiveness of home safety equipment and home safety advice / risk assessments.

The vast majority of practitioners thought that the planning and delivery of educational interventions ought to have a higher profile throughout the recommendations, as they were considered inseparable from overcoming barriers to the uptake of risk assessments and the installation of home safety equipment in households (even though the scope of the recommendations was clearly explained). Practitioners pointed to education / training with three groups: professionals, parents and carers, and children themselves.

7.1.5 Overcoming the possible stigmatisation of particular households or communities was thought to be important

Most practitioners were concerned that if individual households were to be targeted, this needed to be introduced in a sensitive and 'universalising' way (e.g. accompanied by a local campaign on home safety). Practitioners were glad that recommendation 2 in particular emphasised the importance of community involvement. This was thought to be particularly important, if the interventions outlined in draft recommendation 3 were not to be perceived as 'singling out' parents and carers as being unable to keep a safe home. Good quality community engagement – from local information campaigns to the use of

'community champions' as suggested by draft recommendation 2 - could play a part in gaining the trust of householders.

Most practitioners were able to give examples of local initiatives where the use of community workers, voluntary and community sector agencies, or schools had been effective in helping to communicate home safety messages.

7.2 Implications for the implementation and dissemination process

When asked about potential barriers to disseminating the final guidance, the fragmented nature of responsibility at a local level was thought by practitioners to be a key barrier.

> *"Guidance is not always taken on board – you know you could, should but how do you filter [it] to the front line services – unless you get to front line staff it won't work. How do you get the message across to operational people – we are trying to find out how to engage with local operational staff – it comes down to leadership, and if the staff know who to relate to and where to go"*
>
> *Nurse, PCT*

Although the responsibility for unintentional injury to children in the focus group areas usually lay with local safeguarding children's boards, several other stakeholders were suggested as being equally important to target for dissemination activities:

- health and wellbeing boards / partnerships, where these existed in the local strategic partnership;
- children's centres;
- schools;
- environmental health leads;
- the voluntary and community sector; and
- young people's organisations.

Gaining the support of local authority elected members (for instance, through the local authority health scrutiny process) was also felt by some practitioners to be crucial, particularly where practitioners knew about recent negative media coverage.

In addition, the vast majority of practitioners thought that the lack of leadership at a local level was due to the lack of specific national targets and indicators for reducing unintentional injury to children in the home:

> *"They've got to 'badge' it on the back of some of the local and national indicators or the local priority targets for local authorities so having very specific statements which say 'this ties into this'... national indicators are critical [to implementation]"*
>
> *PH registrar*

7.3 Summary of suggested changes

This table consolidates the main changes suggested by practitioners to the text.

Recommendation	Suggested changes to the text
General comments	▪ Clear leadership and ownership of unintentional injury prevention to children in the home setting should be emphasised throughout the recommendations (e.g. dedicated home safety officers) ▪ Consider what ought to be a priority for implementation within the recommendations, given the cost and feasibility of implementing some elements

	▪ The recommendations ought to acknowledge that children under 5 and children over 5 are likely to need different interventions and make use of different services ▪ Consider giving greater emphasis to educational interventions (for parents and carers, children and practitioners) alongside risk assessment and the supply and installation of home safety equipment ▪ The guidance ought to show how the issues raised by practitioners in relation to data gathering and sharing might be resolved ▪ The layout / 'flow' of the recommendations was not entirely clear for all readers ▪ 'Window locks' should perhaps be changed to 'window guards'
Recommendation 1	▪ Consider clarifying whether targeting of individual households is necessary to achieve the desired outcome ▪ Consider giving more detail on what constitutes 'high-risk' ▪ Consider giving greater weight to the importance of maintaining trusted relationships when data sharing is proposed
Recommendation 2	▪ The recommendation ought to emphasise that this work can be done through existing as well as new partnerships ▪ More detail on best practice in community engagement may be needed, including more about the role that community champions or other community workers can play in building up trust and reducing potential stigmatisation of particular households
Recommendation 3	▪ The recommendation ought to clarify whether a separate home safety service is required in order to achieve the desired outcome ▪ The recommendation ought to acknowledge that frontline health (and other practitioners) would not be able to do more than refer to an appropriate service which would then carry out a full household risk assessment ▪ 'Disability' ought to be added to the factors listed in the second bullet ▪ The issues around agencies' liability need to be resolved and clarified in the recommendation, in relation to the ongoing maintenance of safety equipment ▪ The final guidance should be mindful of the cost of follow up and tracking (or explain how this might be done in a feasible way)

ANNEX A – FINAL DISCUSSION GUIDE

10 m	Introduction and admin
	Introduce GHK, the facilitator (and scribe). **Introduce NICE and why the focus group / interview is taking place:** - why the recommendations on prevention of unintentional injury in the home for under 15s are being produced. **Explain the focus on the supply and installation of home safety equipment and home risk assessments, and reducing unintentional injury among children and young people living in disadvantaged circumstances**. In these recommendations, education is considered when in conjunction with either supply/installation of equipment or home risk assessment. Legislation and strategies relating to prevention of unintentional injuries in the home, as well as the prevention of accidents in the external environment, will be covered in future sets of guidance. - why the audience's input is **important and valued** '*this is your opportunity to inform national recommendations on preventing unintentional injury among children and young people…*' , and how it helps in the development of the final recommendations. - explain if necessary how NICE's work links with the national PSA targets on prevention of fire-related deaths, improving health and well being and safety of young people, as well as public health more generally. - also be prepared to explain a little about the process by which the recommendations were developed and the evidence (explain if necessary that practitioners are being consulted on the recommendations only, rather than the whole draft guidance document – participants can also be referred to the NICE website. - explain that NICE wishes to **learn from practitioners'** experience and current good practice … '*we would like you to give examples throughout and draw our attention to any good practice that you feel that other practitioners could learn from… '* **Introduce consent and anonymity** - focus groups will be recorded for audit purposes - all views will be anonymised, neither individuals or their organisations will be named in the final report - **if a NICE representative is present**, introduce them as an observer who will not participate and who will respect confidentiality at all times

	Remind respondents that they must fill in the sign in sheet and give consent if they wish to take part (if they have not already done so) **Scribe to collect and bind all sheets** - offer respondents the opportunity to ask questions at any point **Ask whether participants have read draft recommendations** - If most have not, explain that each recommendation will be introduced to the group as the focus group progresses (ensure that copies of individual recommendations are on hand)
10 m	**Warm up**
	Respondents to introduce self, role and responsibilities Have you heard of NICE and what would you expect NICE's involvement in this area to achieve? **In relation to the following sections, ask respondents to think about examples when feeding back on the individual recommendations.**
15 m	**Recommendation 1 identifying and prioritising households at greatest risk**
	[Be prepared to start with a general question and follow up respondents' feedback throughout] **Will this recommendation help you in your efforts to prevent unintentional injury in the home for the under 15s?** Is this recommendation useful to you and colleagues in the services you work for? **Do you think that all the key issues in relation to identifying and prioritising households at greatest risk are covered?** Are there any local examples of factors (**point 1**) causing unintentional injury (in relation to home safety equipment) that have not been identified in the recommendations? **To what extent do you or statutory agencies currently have access to datasets and databases, or have shared systems containing data as outlined in point 2?** If databases are used already, what are they called and what do they include? How is the data used between organisations? **What impact might Recommendation 1 have on current or future services?** **What impact might Recommendation 1 have on planning policy, at local or higher levels?** **What factors might influence its implementation or effectiveness? Are there any barriers to implementing the recommendation**, e.g. identifying households at greatest risk of unintentional injury in the home? (E.g. availability of data, practicalities of data sharing etc) **How can these barriers be**

	overcome? **Who should take action on this recommendation? (prompt for views on whether the 'who should take action' list – in relation to strategic partnerships – is comprehensive)** **Is the recommendation easily understood and clearly worded?**
5 m	**Summarise and agree key points for recommendation 1 with respondents**
15 m	**Recommendation 2 Establishing partnerships**
	Will this recommendation help you in your efforts to prevent unintentional injury in the home for the under 15s? Is this recommendation useful to you and colleagues in the services you work for? **Do you think that all the key issues in relation to the actions that partnerships should take are covered?** **What partnerships between these agencies already exist and how do these differ from what the recommendations propose?** prompt as to how local barriers to creating a safe home might be identified (**point 1**). How can partnerships be improved, and will this recommendation influence existing and new partnerships? **How feasible is it to implement / set up the kind of partnerships described in recommendation 2?** **How are current interventions using community involvement or other methods to increase trust among particular groups?** Prompt for Community Champions or any similar schemes being delivered? **What impact might Recommendation 2 have on current or future services, and existing partnerships?** **What factors might influence its implementation or effectiveness? What barriers might influence how this recommendation is implemented? How can these barriers be overcome?** **Who should take action on this recommendation? (prompt for views on whether the 'who should take action' list is comprehensive)** **Is the recommendation easily understood and clearly worded?**
5 m	**Summarise and agree key points for recommendation 2 with respondents**
30 m	**Recommendation 3 Delivery**
	Will this recommendation help you in your efforts to prevent unintentional injury in the home for the under 15s? Is this recommendation useful to you and colleagues in the services you work for? **Discuss each of the points suggested in recommendation 3 in turn:**

	Focus on: **- the impact on the way that current services are delivered** **- how practical each point might be to implement, including <u>current practice</u>, the main <u>barriers</u> to implementing the recommendation, and <u>how these barriers might be overcome</u>** **To what extent are home risk assessments offered in the local authority areas? If so, how are these delivered? Have the interventions that you have employed locally been effective?** Why / why not? (prompt for local evidence). How is **follow-up advice** given? Do follow up visits take place and why / why not? **How is the delivery of home risk assessments and equipment tailored to households' specific needs** (prompt for the '**factors to take into account**' in recommendation 3) **Are records kept of households that have been given safety advice and equipment?** What follow-up maintenance is undertaken as a result? **How does this feed into local strategic planning and priorities?** **How can all practitioners be encouraged to give home safety advice, and where appropriate, carry out home risk assessments and install equipment?** **Do you think that all the key issues in relation to delivery of interventions on home safety for children and young people are covered?** **Are there any specific implications for <u>residential care homes</u> or social housing?** **Who should take action on this recommendation? (prompt for views on whether the 'who should take action' list is comprehensive)** **Is the recommendation easily understood and clearly worded?**
5 m	**Summarise and agree key points for recommendation 3 with respondents**
10 m	**General overview and sum-up**
	How relevant are these recommendations to your day to day practice? Why? **To what extent will these recommendations influence your practice or the practice of your organisation? Why?** **How practical is it to implement these recommendations overall?** Is it realistic to implement them – are you confident that they would work? **Are there any opportunities to embed these recommendations within local commissioning? What support do commissioners give to home safety improvement – and, what are the likely cost implications of**

	implementing these recommendations? **What areas of your current practice would need to change the most in order to implement these recommendations?** (Give examples) What do you think would be a useful way to incorporate this change in practice? **What are the biggest barriers likely to be? How can these be overcome?** **Do you think there are any gaps in the coverage of these recommendations?** What are they? **Are you aware of any duplication or overlap with any existing guidance** aimed at professionals that work in the prevention of unintentional injury in the home? (Prompt for links to national policy documents, other recommended interventions and educational programmes) **Are there any potential negative impacts of these recommendations? Why?** **Would you say that you have trust in these recommendations? Why?** Did anything surprise you in relation to the content of the guidance? **What could NICE do to raise awareness of the recommendations and communicate them to your professional group?** What communication channels (e.g. journals, bulletins) do you use in your area to alert staff on new practice/research/training opportunities? Do you have any more comments about the recommendations?
5 m	**Summarise and agree on general points arising from the entire focus group**
5 m	**Close and thank respondents for their time**
	Remind participants to **leave sign in sheets and consent forms behind** and make sure these are collected at the exit. **Scribe to collect and bind all sheets.** Ensure that the **event organiser is thanked** and that any expenses for catering are collected.

ANNEX B – CONSENT LETTER

GHK Consulting Ltd
67 Clerkenwell Road
EC1R 5BL
Tel: 020 7611 1100
Fax: 020 3368 6900
[insert researcher email]

[date]

Dear [insert name]

Re. NICE Fieldwork on the prevention of unintentional injuries among under 15's in the home

Consent to Participate in Research

[Insert location and address of focus group]

[Date and time of focus group / interview]

As part of the NICE fieldwork process, we are carrying out fieldwork in [insert name of region or LA area] in order to find out your views as a practitioner so that NICE's recommendations on the prevention of unintentional injuries among under 15's in the home are relevant, appropriate, useful, feasible and implementable. NICE is an independent organisation, created by central government, to be responsible for providing national guidance on promoting good health and preventing and treating ill health. The objective of NICE's public health guidance is to bring about social, economic, organisational, community and individual change to improve health and reduce inequalities in health. Consulting practitioners through fieldwork is an integral part of the process in which NICE guidance is produced.

The interview / focus group [delete as appropriate] will last no longer than [time], but you have the right to end early if it is inconvenient or talk for longer should you wish to.

If you agree to participate in the fieldwork, you will be asked to take part in an interview / focus group [delete as appropriate], which will be recorded by a digital recorder. The recordings will be handled in accordance with standard NICE fieldwork practice, and transcripts will be held securely and destroyed after five years, according to NICE procedures and requirements.

The final fieldwork report produced as a result of the analysis will be used by NICE to produce a final version of its recommendations to practitioners, and this report will be published on the NICE website.

Although GHK may quote you, all comments will be anonymised within the fieldwork report and no comments will be attributable to any individual. At the end of the focus group or interview, the facilitator will summarise the main themes that emerged, and also circulate them in an email, to give participants the opportunity to check these for accuracy. There is no obligation to comment at that stage unless you wish to raise

specific issues. **GHK will provide you with a copy of the draft NICE guidance at a date closer to the interview / focus group**.

If you have any questions regarding this research or your rights as a participant, you can contact Aidan Moss (Project Manager) at aidan.moss@ghkint.com or by telephone 020 7611 1100.

Your signature indicates that you have read and understood the information provided above, that you willingly agree to participate, that you understand your right to discontinue participation at any time, without being required to give a reason and without penalty, and that you have received a copy of this form.

Printed Name	
Signature	
Today's Date	
Organisation	
Phone	
Email	

Please fax or post this form to the address given above.

ANNEX C – PRIOR READING TASK

Please read through the draft recommendations attached. NICE are concerned about how useful, relevant and appropriate these recommendations are for a wide variety of professional groups, as well as the barriers that might prevent them from being implemented.

The following task will help you to structure your feedback. We would be grateful if you could complete this and bring it with you to the meeting.

Which of the recommendations do you think are most useful to you and why?
Do you think these recommendations will change the way that you or your organisation deliver services – in particular, thinking of safety equipment and home risk assessments? Why / why not?
Do you think that the recommendations are practical and realistic? Why / why not?
How possible do you think it would be to implement these recommendations? What would need to happen in order for the recommendations to be implemented successfully?

Do you think there are any gaps in these recommendations? What additions would make them more comprehensive?
Are you aware of any good practice in your local area on preventing unintentional injury in the home for children and young people, that you would like to draw to NICE's attention?

ANNEX D – SIGN IN SHEET

Sign in sheet – Preventing Unintentional Injury

Please fill in the following sheet in order that we can tell a little bit more about you:

Your name: _____

Your role: _____

Your organisation: _____

Email: _____

Q1. **Please tick the box that best describes your employer:**

Local authority / Council – Children's Services	
Local authority / Council – Other	
NHS – Primary care	
NHS – Secondary / acute care (e.g. A&E)	
Police service	
Fire service	
Voluntary and Community Sector	
University	
Other	

Q2. **Please tick any of the following boxes if the following responsibilities are a main part of your work:**

Accident prevention	
Children's services, including safeguarding, fostering, youth work etc.	
Emergency care	
Primary care e.g. community nursing or health visiting	
Health promotion, public health or epidemiology	
Housing and care homes	
Workforce development	
Community or outreach work with the public	
None of the above	

ANNEX E – EQUALITIES MONITORING FORM AND DATA

E1 Equalities Monitoring Form

What is your ethnic group?

White - British	
White – Any Other White background	
Mixed - White and Black Caribbean	
Mixed - White and Black African	
Mixed - White and Asian	
Mixed - Any Other Mixed background	
Black or Black British - Caribbean	
Black or Black British – African	
Black or Black British – Other Black background	
Asian or Asian British - Indian	
Asian or Asian British - Pakistani	
Asian or Asian British - Bangladeshi	
Asian or Asian British – Any Other Asian background	
Chinese or other ethnic group - Chinese	
Chinese or other ethnic group – Any Other ethnic group	

Do you consider yourself to have a disability?

Yes	
No	

E2 Equalities monitoring data for Fieldwork on Smoking Prevention in Schools

This table gives a breakdown of the participants' ethnic groups and disability status.

Ethnic group

White - British	51
White – Any Other White background	2
Mixed - White and Black Caribbean	2
Mixed - White and Black African	0
Mixed - White and Asian	0
Mixed - Any Other Mixed background	0
Black or Black British - Caribbean	3
Black or Black British – African	1
Black or Black British – Other Black background	0
Asian or Asian British - Indian	1
Asian or Asian British - Pakistani	0
Asian or Asian British - Bangladeshi	0
Asian or Asian British – Any Other Asian background	0
Chinese or other ethnic group - Chinese	0
Chinese or other ethnic group – Any Other ethnic group	0
Not known / Declined to answer	5
TOTAL	**65**

Disability status

Yes	2
No	55
Declined to answer	8
TOTAL	**65**

ANNEX F – WRITTEN FEEDBACK FROM NEWCASTLE PRACTITIONERS

This Annex summarises the written feedback from two practitioners in Newcastle, who could not take part in a focus group or interview. They filled in a 'pre-read' form in order to pass on their feedback on the draft recommendations. Although this feedback was not analysed with the rest of the feedback, it nevertheless reflects many of the findings in the main report.

Feedback was received from a representative of the local child accident prevention group (for under 5s) and the other from a nurse with responsibility for child protection.

Which of the recommendations do you think are most useful to you and why?
Delivery, by providing a focused piece of work that links with both early intervention and prevention and targeted support where unintentional injuries have occurred. The delivery agent may also be able to focus on the data provided by A&E to identified areas of work.
Do you think these recommendations will change the way that you or your organisation deliver services – in particular, thinking of safety equipment and home risk assessments? Why / why not?
Health Visitors carry out general risk assessments whenever they see a family and routinely discuss safety at the 6-9 month developmental contact – this includes recommending appropriate safety equipment within the home. The [local child accident prevention group] has tried to tackle accidents in the home using a variety of delivery methods. The Under 5's work in the main has been well covered. Safety Works have provided safety messages for school age children via the interactive safety centre. I could see this approach to be an opportunity to co-ordinate the work across the whole of the age range.
Do you think that the recommendations are practical and realistic? Why / why not?
Recommendation 3 ?who will undertake the follow-up/ maintenance inspections once the equipment is installed and who will be accountable for assessing and passing equipment as safe? There is a cost implication to providing the staff to identify and prioritise households and to provide access to the appropriate equipment. Health visitors currently have access to the households of all under 5's however, in Newcastle no-one visits the homes of children over 5 (to my knowledge).
How possible do you think it would be to implement these recommendations? What would need to happen in order for the recommendations to be implemented successfully?
?There could be breach of confidentiality/ information sharing issues to sharing information onto a multi-agency accessible database which identifies overcrowded/ high risk families. IT security for any database would need to be addressed and also who and how it could be accessed. One route may be to include the information on Contact Point. We would need to identify the key partners across the age group. Coordinate the delivery of services to avoid duplication and provide resources for extra staff

costs and equipment.

A named person identified to coordinate the delivery and disseminate the data in relation to accidents in the home.

Key partners in BME communities need to be identified to relay the relevant messages or take on specific pieces of work.

Do you think there are any gaps in these recommendations? What needs to be added to them to make them comprehensive?

? Training and funding issues

Named coordinator linked to the local safeguarding board.

Are you aware of any good practice in your local area on preventing unintentional injury in the home for children and young people, that you would like to draw to NICE's attention?

Newcastle run a safety equipment scheme which provides the following safety equipment for families in receipt of benefits:

- 2 x safety gates for a house/ 1 x safety gate for a flat
- 1 x fire guard
- 1 x smoke alarm
- 1 x on/off door stop
- Cupboard/ drawer locks for the kitchen

Safety Works has been remodelled and provides purpose built scenarios relating to home safety, the kitchen, the teenagers bedroom, the bathroom and the garden.

Any other comments?

Newcastle previously offered a family safety scheme which was linked to a children's centre. The project sent outreach workers into families' homes and gave advice about and access to safety equipment to reduce accidents in the home.

Newcastle also offer a home safety equipment scheme which is delivered via Your Homes Newcastle and comes via a health visitor referral. This scheme is funded by Your Homes and the PCT.

Sustaining funding for such interventions is a challenge.