Reducing unintentional injuries in and around the home among children under five years
About Public Health England

Public Health England’s mission is to protect and improve the nation’s health and to address inequalities through working with national and local government, the NHS, industry and the voluntary and community sector. PHE is an operationally autonomous executive agency of the Department of Health.

Public Health England
133-155 Waterloo Road
Wellington House
London SE1 8UG
Tel: 020 7654 8000
www.gov.uk/phe
Twitter: @PHE_uk
Facebook: www.facebook.com/PublicHealthEngland

Prepared by: PHE worked with the Child Accident Prevention Trust, assisted by the Royal Society for the Prevention of Accidents, to prepare this report. The report was produced with the support and input from the Association of Directors of Public Health.

For queries relating to this document, please contact: Eustace.DeSousa@phe.gov.uk

© Crown copyright 2014
You may re-use this information (excluding logos) free of charge in any format or medium, under the terms of the Open Government Licence v2.0. To view this licence, visit OGL or email psi@nationalarchives.gsi.gov.uk. Where we have identified any third party copyright information you will need to obtain permission from the copyright holders concerned.

Published June 2014
PHE publications gateway number: 2014150

This document is available in other formats on request.
Contents

About Public Health England 2
Contents 3
Executive summary 4
Introduction 6
Key findings from the five-year study 7
Costs: the economic case for prevention 12
Key prevention opportunities 14
Four-step plan for local authorities and partnerships 18
  Step one: where are we now? 18
  Step two: where do we want to get to? 18
  Step three: how are we going to get there? 18
  Step four: how will we know when we have got there? 19
Key data to use 20
Case studies 21
Resources 21
Methodology 24
References 25
Executive summary

Unintentional injuries in and around the home are a leading cause of preventable death for children under five years and are a major cause of ill health and serious disability. Our analysis of the most recently available five years of data shows that each year approximately 60 children and young people died, 450,000 attended accident and emergency (A&E) and 40,000 were admitted to hospital as an emergency.

This document sets out three action areas for local authorities and their partners that will reduce the numbers of children injured and killed. It also describes four steps local partnerships can take to build robust injury prevention strategies.

This approach is informed by the evidence base and a new analysis of data, which we are making available alongside this report. It builds on what local authorities are already doing to keep children safer and healthier.

The Chief Medical Officer has made a powerful economic case for preventing unintentional injuries. This report highlights the need for more information about the wider costs and benefits of injury prevention. This will help local areas prioritise investments and is an issue which PHE will work on with leading experts and organisations. Injury prevention can be low cost and there is a tremendous return for young children in terms of preventable years of life lost and disability adjusted life years.

The paper identifies unintentional injuries as a major health inequality. There is a persistent social gradient for unintentional injuries and inequalities have widened. Our analysis shows that the emergency hospital admission rate for unintentional injuries among the under-fives is 45% higher for children from the most deprived areas compared with children from the least deprived, and previous research indicates that for some injury types this inequality may be much larger.

Health inequalities can be tackled via antipoverty strategies, by targeting deprived areas, and engaging with local communities and families via proportionate universalism as advocated in the Marmot review of health inequalities in England.

Research has shown what works in preventing unintentional injuries and the National Institute for Health and Care Excellence (NICE) has produced evidence-based guidelines.

There are three key action areas.

1. Providing leadership and mobilising existing services prevents injuries

Directors of public health and directors of children’s services, together with local children’s trust boards/children’s partnership boards and health and wellbeing boards (HWBs), are in an ideal position to provide strategic leadership for injury prevention through focused planning and commissioning.

Preventing unintentional injuries does not require major new investment; much can be achieved by mobilising existing services, building on strengths and developing capacity.

Broader partnership working across the public, private and voluntary and community (VCS) sectors is essential, bringing together a very wide range of services from diverse settings including health, education, social care, housing and homelessness and fire and rescue.

Good co-ordination adds value and enables more to be achieved than organisations working in isolation. NICE PH29 makes recommendations on how to do this.

2. The early years workforce needs support and training to enable it to strengthen its central role in helping to reduce unintentional injuries

Health visitors lead and support delivery of the Healthy Child Programme (HCP), which has injury prevention at its core, and children’s centres are key partners. Further opportunities will arise when public health commissioning responsibilities for under-fives transfer from NHS England to local authorities in October 2015. Staff training to further develop confidence and competence in this area is important. With appropriate training and supervision, voluntary and community organisations will also be able to focus more explicitly on injury prevention in their work with families.

3. Focusing on five kinds of injuries for the under-fives makes sense

There is a strong argument to focus on tackling the leading, preventable causes of death and serious long-term harm. Our analysis of national data identifies that five injury types could be prioritised: choking, suffocation and strangulation; falls; poisoning; burns and scalds; and drowning.

Local injury and other data will provide important local context, but the national data on deaths and injuries provides a powerful call to action.
Introduction

Unintentional injuries in and around home are a major cause of death and disability among children under five years in England. An average of 62 children died each year between 2008 and 2012. These injuries result in an estimated 452,200 visits to A&E departments and approximately 40,000 emergency hospital admissions among children of this age each year. In England home-related injuries account for 8% of deaths of the children aged 1 to 4 years.

The majority of these injuries are preventable. This document explains the scale and nature of the problem, including the frequencies and rates of deaths and injuries, and the significance of deprivation. It also covers the costs to families and health and social care services and presents the priorities for action, highlighting the main risks to children and the ways that local authorities and their partners can achieve change, building on what they do currently.

The most obvious reason for reducing these injuries is the benefits to children and their families. The personal costs of an injury can be devastating. For example, a toddler’s severe bathwater scald will require years of painful skin grafts. A fall at home can result in permanent brain damage. The injuries can have major effects on education, employment, emotional wellbeing and family relationships.

There are also high financial costs. The short-term average healthcare cost of an individual injury (all types) is £2,494 and the wider costs of a serious home accident for a child aged 0 to 4 years has been estimated at £33,200.

But there are also significant costs to local authorities and to society as a whole. For example, a traumatic brain injury (TBI) to a child under five from a serious fall may result in acquired disabilities which lead to high education and social care costs as well as loss of earnings to families and benefit costs to the state. The approximate lifetime costs for a three-year-old child who suffers a severe TBI is £4.89m.

Injury reductions can be achieved at low cost. Local authorities can strengthen their existing work by prioritising the issue and mobilising existing programmes and services through leadership, co-ordination and training. NICE guidance PH29 and PH30 (2010) and the evidence update (NICE, 2013) offer a valuable framework for shaping the work.

---

Office for National Statistics. Crown copyright reserved.
Hospital Episode Statistics (HES). Copyright © 2014. Re-used with the permission of The Health and Social Care Information Centre. All rights reserved.
Key findings from the five-year study

We conducted a study of mortality and hospital admission data over a five-year period to identify key trends which will help inform prioritisation of injury prevention interventions. Headline findings are presented in this chapter, and the full analysis can be found in the slides available at www.chimat.org.uk/earlyyears/injuries.

Between 2008 and 2012, 311 children aged under five years died from unintentional injuries compared with 199 aged 5 to 14 years. The mortality rate for unintentional injuries among children aged 0 to 4 years over this period was 1.90 per 100,000 population, whereas the rate for children aged 5 to 14 years was 0.66 per 100,000.

Unintentional injuries in and around the home are a leading preventable cause of death for children under five years and accounted for 8% of all deaths of all children aged 1 to 4 years between 2008 and 2012.

Between 2008-09 and 2012-13 there were approximately 40,000 emergency hospital admissions each year for under-fives following unintentional injuries.

Because children under five years account for a disproportionately high number of deaths and a large number of hospital admissions, local authorities may want to treat this group as a priority for action within wider unintentional injury prevention strategies.

To support this work it is necessary to first understand the sorts of injuries young children experience and why, and second to be clear on which injuries cause most hospital admissions and which cause most deaths.

Unintentional injuries for the under-fives tend to happen in and around the home. They are linked to a number of factors including:

- child development
- the physical environment in the home
- the knowledge and behaviour of parents and other carers (including literacy)
- overcrowding or homelessness
- the availability of safety equipment
- new consumer products in the home

---

Office for National Statistics. Crown copyright reserved.
Office for National Statistics. Crown copyright reserved.
HES. Copyright © 2014. Re-used with the permission of The Health and Social Care Information Centre. All rights reserved.
Reducing unintentional injuries in and around the home among children under five years

Accident types have different profiles – some are often fatal, such as choking and strangulation and drowning. Others, such as burns and scalds, result in hospitalisation and sometimes serious long-term acquired disability, but rarely death.

Figure 1 shows the causes of emergency hospital admissions and deaths for the under-fives following unintentional injuries over the five-year period 2008-09 to 2012-13 with the number for each.

Figure 1. The main causes of emergency hospital admissions and deaths for under-fives following unintentional injuries in and around the home, ONS, England, Crown Copyright
Choosing priorities

The injury and mortality data in figure 1 indicates that local authorities could prioritise the reduction of five causes of unintentional injuries among the under-fives. This grouping includes the most severe and preventable\(^9\) injuries, including those that result in high death rates and the largest number of emergency hospital admissions. Each has its own profile and characteristics:

1. Choking, suffocation and strangulation

These injuries result in the highest number of deaths for the under-fives (138).\(^h\) There are three main groups:

- **Inhalation of food and vomit** – a leading cause of deaths. There are low numbers of admissions but these are much longer than average. The injuries primarily affect children under the age of two
- **Hanging and strangulation** – results in low numbers of hospital admissions but unfortunately a high number of deaths. In England there were at least 28 deaths to the under-fives between 2008 and 2012. Blind cords are a major hazard
- **Suffocation in bed** – 37 children died from this cause in England over the five-year period

2. Falls

Injuries from falls lead to the most injury-related admissions for under-fives (93,315). They are also the third most common cause of death for this age group (24). Even a fall from a high chair can have serious consequences including brain damage. There are four broad groups:

- **Falls from furniture** lead to the bulk of hospital admissions but few deaths. They result in average lengths of emergency admissions
- **Falls on and from stairs and steps** continue to be a leading cause of hospital admissions for the under-fives. Deaths are very rare
- **Falls while being carried** have resulted in five deaths in the past five years. These injuries primarily affect children under the age of one
- **Falls from/out of buildings**, such as from windows or balconies, have also led to five deaths in the past five years

\(^9\) Although unintentional injuries caused by children being struck by objects (bumps) and people/animals (collisions and dog bites) are important and result in high numbers of hospital admissions, most are harder to prevent than the injury types we have prioritised.

\(^h\) The numbers for the different accident types in this section all relate to the five-year periods covered in Figure 1.
3. Poisoning

The two main risks are medicines and household chemicals. These injuries lead to very high numbers of short hospital admissions but, thankfully, very few deaths. However, these admissions are on the increase. They peak when the child is one year of age for household chemicals and two for medicines.

- medicines are the cause of over 70% of poisoning admissions
- household chemicals account for nearly 20% of the admissions

4. Burns and scalds

The fourth highest cause of hospital admissions for under-fives – but deaths are rare (3). In total, 12% of burns and scalds admissions are for more than three days compared with an average of 5% for all unintentional injuries. These injuries are expensive to treat and serious burns and scalds are disfiguring and disabling for young children. They come from five main sources:

- scalds from hot drinks lead to moderate numbers of admissions, though with longer than average hospitalisations. Admissions peak for children aged one year
- contact with hot household appliances cover a range of hazards. In recent years the number of children being treated for burns from hair straighteners has doubled. They now account for up to one in ten burns injuries to children\(^{17}\)
- contact with other hot fluids, including water heated on a stove remains a serious hazard
- burns from hot heating appliances, including radiators and pipes
- bath water scalds lead to relatively low numbers of admissions. Deaths are rare but the injuries can be severe. They peak when children are about a year old. They result in a higher proportion of long hospital stays: 21% of admissions are for over three days. Bath water scalds are very expensive injuries to treat

5. Drowning

The lethal nature of drowning (62 deaths) means the rate of deaths is very high in comparison to emergency hospital admissions (8 admissions for every death). For the under-fives the main risk is the bath, although the circumstances of a third of deaths caused by drowning and submersion are unspecified.
Other hazards

Although five principal causes of unintentional injuries have been prioritised, other causes should not be ignored. For example, exposure to smoke, fire and flames results in a high proportion of deaths among the under-fives in and around the home, but a relatively low level of emergency hospital admissions. Furthermore, hazards change, especially as new products such as hair straighteners or liquid detergent capsules emerge, and as children grow up. Concerns have been raised about harm caused by swallowing powerful button batteries and more recently the dangers of nicotine poisoning from electronic cigarettes.

Data issues

There are weaknesses in the data available, with the cause of hospital admissions unknown for nearly 9% of hospital admissions for this age group. Also, little is known nationally about unintentional injuries that do not result in hospital admissions but are treated in other health care settings or at home.

There are geographic differences in the rates of unintentional injuries between (and within) local authorities.

The national data, gathered over a five-year period, provides key information for local authorities and should help shape priorities.

Local knowledge will supplement this picture, including information from child death overview panels and serious case reviews but because these numbers are likely to be very small it is important not to base priorities on local data alone.

Links with deprivation and gender

There is a persistent social gradient for unintentional injuries and inequalities have widened. Children of never-employed or long-term unemployed parents are 13 times more likely to die from an unintentional injury than children whose parents are employed in higher managerial and professional occupations.

Our own analysis shows that the emergency hospital admission rate for unintentional injuries among the under-fives is 45% higher for children from the most deprived areas compared with children from the least deprived. Emergency hospital admissions among the most deprived children under five in 2012-13 were close to 1,400 per 100,000. For the least deprived children the rates were under 1,000 per 100,000.

---

1 HES. Copyright © 2014. Re-used with the permission of The Health and Social Care Information Centre. All rights reserved.
Previous research indicates that for some injury types this inequality may be much larger.\textsuperscript{24} For example, children living in the most disadvantaged areas have a 50% higher risk of being burned, scalded or poisoned resulting in primary or secondary care attendance than those in the most advantaged areas.\textsuperscript{25} Boys have higher rates of death and hospital admissions. Between 2008-09 and 2012-13 55% of admissions were for boys and 45% for girls.\textsuperscript{j} For deaths, the difference by sex is similar: 60:40.\textsuperscript{k}

Costs: the economic case for prevention

Calculating the costs of unintentional injuries and making the economic case for prevention is a complex process. The Chief Medical Officer’s report identifies barriers that can limit action but also presents a powerful economic case for injury prevention.\textsuperscript{26}

Above all, the personal costs of an injury can be devastating with significant lasting physical and emotional effects which impact on learning, employment opportunities and family relationships. For example, a toddler’s severe bathwater scald can require painful skin grafts into early adulthood which disrupt schooling and add to family stress.\textsuperscript{13}

The financial costs are also high. The short-term average healthcare cost of an individual injury (all types) is £2,494\textsuperscript{27} and the wider costs of a serious home accident for a child aged 0 to 4 has been estimated at £33,200.\textsuperscript{28}

But while NHS costs tend to be highlighted, there are significant costs to local authorities and to society as a whole. For example, a traumatic brain injury (TBI) to a child under five from a serious fall may result in acquired disabilities which lead to high education and social care costs. The lifetime costs for a three-year-old child who suffers a severe TBI totals £4.89m and are summarised in table 1.

\textsuperscript{j} HES. Copyright © 2014. Re-used with the permission of The Health and Social Care Information Centre. All rights reserved.
\textsuperscript{k} Office for National Statistics. Crown copyright reserved.
Table 1. Approximate lifetime medical, educational and social costs for a child who suffers a severe traumatic brain injury (TBI) at the age of three\textsuperscript{29,30}

<table>
<thead>
<tr>
<th>Cost category</th>
<th>Description</th>
<th>Lifetime cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical</td>
<td>Acute care (including paediatric intensive care unit and rehabilitation), outpatient appointments, community health services, general health problems, special equipment to aid mobility, communication and day-to-day activities.</td>
<td>£268,000</td>
</tr>
<tr>
<td>Educational</td>
<td>Additional cost of attending special educational needs (SEN) schools, transport to and from school, SEN statements</td>
<td>£238,000</td>
</tr>
<tr>
<td>Direct social costs</td>
<td>Social care assessments, direct payments for a home care worker, grants for home and vehicle adaptations, residential respite breaks, residential care from the age of 40.</td>
<td>£1.19m</td>
</tr>
<tr>
<td>Missed employment</td>
<td>Missed employment opportunities for the child and the mother who gives up work to be a full-time carer.</td>
<td>£1.73m</td>
</tr>
<tr>
<td>Cost to government in lost tax revenue</td>
<td>Lost income tax revenue for mother and child</td>
<td>£346,000</td>
</tr>
<tr>
<td>Cost to government in benefits</td>
<td>Transfer payments including Disability Living Allowance, Carers’ Allowance and child tax credits</td>
<td>£1.12m</td>
</tr>
<tr>
<td>Total cost of lifelong care and support</td>
<td></td>
<td>£4.89m</td>
</tr>
</tbody>
</table>

Although these injuries are relatively rare the information highlights the impact on local authority services. Other serious injuries such as severe bathwater scalds which incur individual lifetime medical costs of around £189,000, also generate significant economic costs\textsuperscript{31} but the social care costs are not well documented. This is an important gap.

NICE has provided estimates of the costs of implementing their guidance PH29 and PH30 together with a costing template.\textsuperscript{32,33}

\textsuperscript{1} The source only refers to one parent.
Key prevention opportunities

Providing leadership

The Health and Social Care Act (2012)\textsuperscript{34} gives local authorities responsibilities for improving health and reducing health inequalities.\textsuperscript{35} These include having a central role in delivering on the Public Health Outcomes Framework indicator 2.7 to reduce hospital admissions from unintentional and deliberate injuries for children and young people.\textsuperscript{36}

Public health commissioning responsibilities for children aged 0 to 5 years will transfer from NHS England to local authorities on 1 October 2015. This includes the under-fives Healthy Child Programme, the commissioning of health visiting services and the Family Nurse Partnership services. Funding for the under-fives responsibilities will sit within the overall “ring-fenced” public health budget within local authorities. The transfer marks the final part of the overall public health transfer and presents an opportunity for local authorities to transform services for under-fives including driving forward the more integrated, systems approach that is essential for reducing unintentional injuries.\textsuperscript{37}

Financial constraints mean that it is essential to focus resources where they will make the most impact. Preventing unintentional injuries among young children has significant long term benefits for individuals, families and society. As we have shown, it has a significant inequalities aspect as well.

Local children’s trust boards/children’s partnership boards and health and wellbeing boards are in an ideal position to provide strategic leadership and co-ordination under the direction of the director of public health and the director of children’s services.

Mobilising existing services and working in partnership

Recognising that existing programmes and services present the best opportunity to drive reductions in unintentional injuries among children can help unlock major opportunities in accident prevention.

For example, NICE public health guidance PH30 ‘Preventing unintentional injuries among the under-15s in the home’ recommendation five highlights the benefits of integrating home safety into professionals’ other visits and is consistent with the Making Every Contact Count (MECC) approach to reducing health inequalities.\textsuperscript{38} The key is mobilising these services and providing a strong lead to push injury prevention higher up the agenda of respective partners. NICE PH29 makes wider recommendations for how to co-ordinate unintentional injury prevention activities.
Health visitors lead and support delivery of universal injury prevention work for infants and young children through the Healthy Child Programme and children’s centres share this aim and are key partners. The Early Years Foundation Stage (EYFS) progress checks at age two provide the opportunity for an integrated health and education review with parents. Additional opportunities will emerge for collaborative working locally when the commissioning arrangements for child health change (see above).

Preventing unintentional injuries for the under-fives is an aim of targeted interventions such as the Family Nurse Partnership programme as well as of widely used parenting programmes such as The Incredible Years. The work also supports the wider aims of the Troubled Families Programme and family intervention services and projects. For some families, unintentional injuries are a result of neglect which is an important aspect of child protection work.

Broader partnership working across the public, private and voluntary and community (VCS) sectors is essential, bringing together other services such as early years providers including child-minders, GPs, midwives, Home-Start, social housing including housing associations, fire and rescue, care and repair, and safety equipment suppliers.

A&E departments and minor injury units also play an important role as they are able to advise families about future prevention when they see an injured child.

With key agencies on board, other more focused initiatives such as home safety equipment schemes will have a better chance of being implemented effectively when staff are clear how they operate and have had appropriate training.

**Focusing on what works and addressing inequalities**

Health inequalities can be tackled via antipoverty strategies and by targeting deprived areas. This will include engaging with local communities and families via proportionate universalism as advocated in the Marmot review of health inequalities in England.

An important resource to guide local planning is NICE PH30, which has five recommendations. They include prioritising households at greatest risk; working in partnership; co-ordinating delivery; ensuring families with children at high risk of injury are provided with home safety assessments and advice and referred to safety equipment schemes; and integrating home safety into other home visits. NICE PH29 makes wider recommendations for how to co-ordinate unintentional injury prevention activities to help achieve the commitments set out in local plans.

Interventions to prevent unintentional injuries have traditionally been considered in terms of the “three Es”: education, enforcement and engineering. This schema is
enhanced with a fourth “E” – empowerment, with the different strands operating well together.

Existing services are currently promoting these approaches and with stronger leadership could be enabled to do so more systematically. For example, education is crucial for policy makers and professionals as well as for parents and carers. Understanding the significance of unintentional injuries and being aware of the interventions that are most effective will enable those in positions of authority to discharge their responsibilities effectively and to make best use of resources.

Health visitor provision is expanding and transforming, and health visitors, together with GPs, practice nurses and are ideally placed to help identify households at greatest risk as well as provide advice about future prevention following minor injuries. Clinical commissioning groups (CCGs) are important strategic partners. Health visitors should have appropriate training that will enable them to identify home safety behaviours, make well-informed decisions and offer appropriate advice. The Family Nurse Partnership is playing an important role with vulnerable families and has evidence of addressing accident prevention issues with its families. There is scope to continue to learn from this effective intervention.

Children’s centres are well placed to provide information and support to families around child accident prevention through educational input at centres and family outreach work. Training for staff to further develop confidence and competence in this area is important. With appropriate training and supervision, voluntary and community organisations such as Home-Start are also able to support vulnerable families on injury prevention as part of customised user-led services given the trusting relationships they develop.

Educative approaches are often the best ways of addressing issues with parents such as safe sleeping, scalds from hot drinks and the danger of drowning in a bath. When accident prevention is embedded in existing services there is potential to get across messages from a trusted source. For example, such as when a breastfeeding support volunteer explains about the dangers of holding a hot drink when feeding a baby.

Education has an important role in tandem with engineering approaches such as the use of home safety equipment. It can be very difficult for low-income families to afford to make their homes safer. Research shows that providing safety education and free or low-cost safety equipment (engineering) is effective in improving home safety and can reduce inequalities in some home safety practices.

Equally, child-resistant packaging (engineering) alone will not prevent an inquisitive child from swallowing medicines or household chemicals. Appreciating the importance
of storing the products safety out of reach, and child supervision, is most likely to be achieved through parental education.

Bath water scalds can be severe injuries. Thermostatic mixing valves (TMVs), which reduce the temperature of bathwater to safe levels, are an effective engineering solution to this problem. But initiatives to make the products available to vulnerable families need to reach those who will benefit most in a way that is not stigmatising. Therefore education for professionals on how to do this is essential for achieving take up, as well as for families on the benefits of the offer. 58

Enforcement through trading standards and environmental health involves the use of standards, regulations or legislation to enforce safer behaviour, safer environments or safer products to reduce the risk of injury.

Approaches that empower parents and carers can embed home safety behaviours. For example, policies developed by parents at children’s centres on where hot drinks can be consumed safely are more likely to be adopted from other parents than policies created by staff alone. 59
Four-step plan for local authorities and partnerships

There are several steps that can be taken to prevent unintentional injuries in and around the home. These steps can be co-ordinated by existing bodies such as health and wellbeing boards, local safeguarding children’s boards or by specific unintentional injury prevention groups. This approach will also serve as a simple tool to help local authorities review existing plans.

Step one: where are we now?

- audit the child injury prevention activities/potential of existing services and programmes locally (local authority, NHS, VCS)
- ensure that the joint strategic needs assessment (JSNA) includes information about unintentional injuries
- refer to national data and the five priority areas in this guide – they provide a powerful call to action. Use reviews and local data to supplement this information
- explore ways of tackling data weaknesses including seeking PHE help
- identify neighbourhoods that might benefit from a targeted approach
- identify current resource levels (human, financial, “other”) and gaps

Step two: where do we want to get to?

- agree on underpinning values and reasons for home safety for the under-fives
- identify national and local policy drivers such as the joint health and wellbeing strategy, the child poverty strategy and the public health outcomes framework
- set out the local ambition to reduce injuries and prioritise vulnerable groups, comparing local performance with statistical neighbours for example

Step three: how are we going to get there?

- ensure that a senior manager is designated lead for child injury prevention, and that the development of a local strategy is directed by an appropriate board such as the health and wellbeing board
- review evidence-based guidelines and recommendations, for example NICE guidelines PH29 and PH30
- embed prevention work into existing services and programmes and into commissioning
- ensure there are effective arrangements in place for co-ordinating injury prevention activities – refer to NICE PH29
• agree a programme of activities based on evidence of effectiveness. If effective action is already taking place on a particular issue, or within one geographical area, coverage can then be extended
• prioritise the development of action plans for those most directly in touch with the most vulnerable, led by the services themselves
• identify resources needed and secure funds
• ensure that staff have appropriate knowledge and skills
• use a range of methods to ensure effective communication about initiatives
• develop and put in place evaluation and monitoring arrangements, including key performance indicators (KPIs)

Step four: how will we know when we have got there?

• monitor and evaluate. Monitor how the programme is running and evaluate the eventual outcomes, in terms of changes in measures such as injuries, safety practices, inequalities, knowledge and processes
• consider the effect of the programme on wider areas of health and wellbeing. Look for unintended consequences
**Key data to use**

Public Health England has several resources that can give local authorities a snapshot of local priorities and benchmark this against other areas. The Child and Maternal Health Intelligence Network ([www.chimat.org.uk](http://www.chimat.org.uk)) can provide data and evidence on the health and wellbeing of children and young people. The PHE data and knowledge gateway ([datagateway.phe.org.uk](http://datagateway.phe.org.uk)) contains information on a wide range of public health issues, including health inequalities and unintentional injury.

Unintentional injury reports for local authorities can be found at [www.chimat.org.uk/earlyyears/injuries](http://www.chimat.org.uk/earlyyears/injuries).

Admissions data for local hospitals, which forms the basis of the national HES database, is routinely collected and some hospitals have facilities to collect A&E data that can inform prevention activities. All fire and rescue services collect and collate data on the incidents that they attend. Other local data that can allow in-depth study of the topic may be available from child death overview panels (CDOPs) and coroners, although the numbers of cases will be small.

The causes of accidental deaths in England and Wales, broken down into age groups, are published annually by the Office for National Statistics.

National data on severe injuries is analysed by the Trauma Audit and Research Network ([TARN, www.tarn.ac.uk](http://www.tarn.ac.uk)) and the UK National Burn Injury Database holds detailed information from burns units ([NBID, ibidb.org/nbid](http://ibidb.org/nbid)).

In any needs assessment or intervention, the views of children and local residents can further enable local authorities to identify the best approaches to preventing injury. Many local organisations use Child Safety Week, which takes place in June each year to engage with mothers, fathers and children of all ages (including the under-fives) in activities that promote injury prevention.

The work elected members undertake with local residents (for example, ward surgeries) can also provide an important level of qualitative information.
Case studies

The Child Accident Prevention Trust’s (CAPT) Making the Link website features several case studies of different local authorities’ accident prevention strategies and activities.
www.makingthelink.net/case-studies

The Royal Society for the Prevention of Accidents’ (RoSPA) website has a specific section on home safety including case studies.
www.rospa.com/childsafety/inthehome

Resources

Public Health England (PHE)
Public Health Outcomes Framework data tool
www.phoutcomes.info

Local authority public health teams wishing to access aggregated HES analysis are encouraged to use their local PHE knowledge and intelligence team via
PHE.enquiries@gov.uk

PHE data resources:
www.chimat.org.uk/earlyyears/injuries

British Medical Association (BMA)
Injury Prevention (2001)
bmaopac.hosted.exlibrisgroup.com/exlibris/aleph/a21_1/apache_media/SY4CLTVKRE41T4TIH6PER95NXF8BLF.pdf

Growing up in the UK (2013)
bma.org.uk/working-for-change/improving-and-protecting-health/child-health/growing-up-in-the-uk

The Chief Medical Officer
Annual Report of the Chief Medical Officer 2012
Child Accident Prevention Trust (CAPT)
CAPT has two main websites. The Making the Link site contains information for senior staff and commissioners. The main site is designed for parents, carers and frontline staff.
www.makingthelink.net
www.capt.org.uk

Department of Health (DH)
Giving all children a healthy start in life

Department for Education (DfE)
Children’s services
www.gov.uk/childrens-services

Local Government Association (LGA)
The LGA works with local authorities, including lead members for children's services to deliver better health and wellbeing outcomes for children and young people.
www.local.gov.uk/childrens-health

National Institute for Health and Care Excellence (NICE)
guidance.nice.org.uk/PH29

PH30: Preventing unintentional injuries in the home among children and young people aged under 15 (2010)
guidance.nice.org.uk/PH30

guidance.nice.org.uk/nicemedia/live/13274/51694/51694.pdf

guidance.nice.org.uk/nicemedia/live/13274/51694/51694.pdf

Preventing unintentional injuries among the under-15s. The key facts for local councillors: making the case for investment (2011) LGID.
www.guidance.nice.org.uk/PH30/Factsheet
Strategies to prevent unintentional injuries among children and young people aged under 15: Evidence Update (2013)

Royal Society for the Prevention of Accidents (RoSPA)
RoSPA’s website includes specific sections on home safety and child accidents.
www.rospa.com

Delivering accident prevention at local level in the new public health system (2013)
www.rospa.com/about/currentcampaigns/publichealth/delivering-accident-prevention.aspx

University of Nottingham
Keeping children safe at home research programme
A programme identifying effective ways of passing on advice to parents on preventing accidents via children’s centres.
www.nottingham.ac.uk/research/groups/injuryresearch/projects/kcs/index.aspx

World Health Organization (WHO)

www.who.int/violence_injury_prevention/child/injury/world_report/Cover_and_front_matter.pdf?ua=1


Injuries and inequities: guidance for addressing inequities in unintentional injuries (2014)
Methodology

A study of the last five years of HES and mortality statistics for England was carried out to identify key issues.

HES data is collected over financial years, with the five-year study period being 2008/09 to 2012/13. The mortality data studied covered the calendar years 2008 to 2012 inclusive. The analysis excluded transport-related admissions and deaths. The initial analysis covered children and young people aged 0-25 years, but the main focus was on children under the age of five. Further information about the methodology of the analysis and the results can be found at www.chimat.org.uk/earlyyears/injuries.
References

Reducing unintentional injuries in and around the home among children under five years

26 Davies SC. 2013. op cit.
37 NICE 29. 2010. op cit.
42 Department for Education. Statutory Framework for the Early Years Foundation Stage. Setting the standards for learning, development and care for children from birth to five. 2014.
55 Kenkre J and Young E. Building resilience: volunteer support for families with complex circumstances and needs. 2013.
