

*Preventing Accidental Injury –
Priorities for Action*
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Report to the Chief Medical Officer
from
The Accidental Injury Task Force



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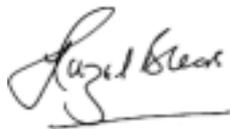
Foreword

When someone gets injured, they tend to accept the injury as one of those distressing but unfortunate events that can happen to anyone. The very word ‘accident’ implies something unplanned or unforeseen, as though there was nothing anyone could do to prevent it. But that is not true. Much unintended injury can be avoided. We know what causes it, we know how to prevent it, and we can prevent it. In this sense, ‘we’ means everyone: every individual can take sensible steps to avoid injuring themselves. At the same time, every professional and every agency involved in promoting safety can stress that safety is not accidental – it is often simple and common sense.

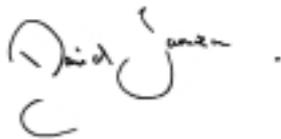
A number of key programmes are already being driven forward across Government to improve safety at home, safety at work, and safety on the roads. These are vital, life-saving programmes. They have already begun to achieve encouraging results, for example in reducing road casualties and fire deaths. But to achieve sustained reductions will need more concerted effort. Not by any one agency or profession, but by a wide variety of different professions and agencies working together and focusing their collective efforts where they are needed most.

But co-ordination also needs a lead. In working together to promote the health and welfare of children and older people, the national health service and local authorities are well placed to take the initiative in preventing unintentional injury, and in focusing preventive efforts on those in the lowest social groups who often suffer most from injuries.

As Government Ministers responsible for programmes to prevent unintentional injuries, we welcome this report, with its particular emphasis on co-ordinated, cross-boundary working. As the report of an expert, cross-sectoral Task Force, it should be of value to all those involved in helping protect people from unintentional injuries of any kind.



Hazel Blears MP Parliamentary Under-Secretary of State for Public Health (DoH)



David Jamieson (DfT)



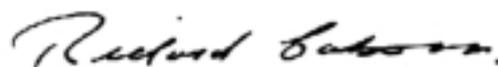
Christopher Leslie MP (ODPM)



Melanie Johnson MP (DTI)



The Rt Hon Nick Brown MP (DWP)



Richard Caborn MP Minister of State for Sports (DCMS)

Introduction

Every year 10,000 people die from accidental injury. It is the leading cause of death among children aged 0–14 years. In addition, there are many millions of non-fatal accidents each year. Around 2.8 million of them occur in the home, many caused by falls, others by fires. Over 300,000 people are hurt in road traffic accidents, 5% of them children. In these ways accidental injury takes a heavy toll of society, particularly children and older people. And it strikes hardest at the most disadvantaged.

Over half a million accidents result in admission to hospital for treatment. Treating injury costs the NHS a staggering £2 billion a year and the consequences simply of injuries received at home cost society £25 billion a year. So it is not surprising that in its 1999 White Paper *Saving Lives: Our Healthier Nation* this Government made injury prevention a priority. The difficulty is that for preventive action to be effective it must be co-ordinated across a range of agencies and, within Government, given priority by several different Departments.

The Accidental Injury Task Force was established to provide the basis for that cross-Government action and to identify from the available evidence those steps which would have the greatest impact in preventing injury.

This report by the Task Force offers us a practical way forward, drawing on the research literature from around the world. It suggests that for relatively modest investment good progress can be made quickly towards the achievement of the 2010 target delivered in *Saving Lives*. The benefits, in terms of deaths and illness which will be averted, will be immediate and the gains to society very great.

I am pleased to welcome this report.



Sir Liam Donaldson Chief Medical Officer

Executive Summary

Introduction

- 1 The White Paper *Saving Lives, Our Healthier Nation* set national targets to reduce the rates of death and serious injury from accidents by 2010. It also announced that a Task Force would be set up to advise on how these targets should be achieved.
- 2 The Task Force began work in November 2000. It included leading experts on accidents from academia, the NHS, local government, the police, the voluntary sector, and Government departments.
- 3 The Terms of Reference of the Task Force were: *To advise the Chief Medical Officer on:*
 - (a) *The most important priorities for immediate action in order to meet the targets;*
 - (b) *The development of an implementation plan, consulting with other stakeholders as necessary;*
 - (c) *Whether the necessary delivery structures are in place to take forward the implementation plan;*
 - (d) *How progress on the implementation plan should be monitored; and*
 - (e) *How to develop and publicise a more united approach to accident prevention across Government and the NHS.*
- 4 At an early stage, the Task Force discussed whether it should extend its remit to non-accidental injury. It decided against doing so, since that would bring in much broader issues such as suicide and criminal injury which would deflect the Task Force from its main concern with accidental injury.
- 5 The Task Force set up three working groups of experts to advise it on injuries in children and young adults, on injuries in older people, and on measuring and monitoring accidental injury. Reports from these three groups are published separately.
- 6 Some 150 local managers, accident prevention specialists, and practitioners were invited to conferences in March and October 2001. Those invited were drawn from a broad spectrum of government, academic and non-Government organisations. The conferences discussed examples of good practice developed by individual health and local authorities, and fire brigades. Facilitated workshops at both conferences yielded many comments which have been discussed by the Task Force.

Developments in Health Policy Since Our Healthier Nation

- 7 The White Paper was published in July 1999. It was followed a year later by *The NHS Plan*, which focussed priorities on improving cancer, CHD, and mental health, and paid particular attention to the needs of children and older people.
- 8 *Shifting the Balance of Power* and a major speech in January 2002 by the Secretary of State for Health, announced that NHS front line staff would be given greater responsibility and autonomy. In future healthcare would be delivered by a range of organisations working within a framework of standards set by Government. This central framework providing for flexible local delivery is similar to the approach being used in local government following the Urban White Paper.
- 9 The report takes account of these developments.

Burden of Accidental Injury

- 10 The following figures illustrate the scale of the problem, and the scope for improvement:
 - Injury is the leading cause of child death in England and Wales. In the period 1998–2000 in England, 1003 children aged 0–14 years died as a result of accidental injury.
 - Falls (62%), road traffic accidents (12%), fire (3%) and suffocation (3%) cause the largest number of fatal injuries in older people.
 - There were 320,283 road accident casualties in Great Britain in 2000, of whom 16,184 were child pedestrians (0–15yrs), and 5,832 were older pedestrians (60yrs and above).
 - There were some 4,000 accidental deaths in the home in 1999. Half were adults of working age (15–64yrs).
- 11 The burden of accidental death and injury is disproportionately heavy on the most disadvantaged in society.
 - Residential fire deaths for children are 15 times greater for children in social class V compared to those in social class I.
 - Child pedestrian deaths are 5 times greater.
- 12 The cost to individuals, to the NHS, and to society of these deaths and injuries is considerable.
 - The estimated cost to the NHS in England of injury in 2000–1 (including poisoning and intentional injury) is £2.2bn.
 - The estimated value of preventing road traffic accidents in Great Britain in 2000 was £12.2bn.
 - The cost to society of home accidents in the UK was estimated in 1996 as £25bn pa.

Priorities for Action

- 13 In common with current NHS and Government initiatives the Task Force agreed to adopt two population groups for priority attention. These are children and young adults, and older people. The Task Force identified examples of inequality within these two population groups. Examples of inequality within other groups, for example the working age population, were also considered.
- 14 The working groups set up to address these two population priorities sifted the evidence to identify the approaches to intervention that were well tried or most promising, while offering the potential to achieve the biggest reductions in accidental deaths and injuries.
- 15 The burden of injury is greatest in: falls by older people, road accidents, and dwelling fires, in that order. In headline terms, the intervention areas which have the scope to make the biggest impact in the short-term are as follows:

Priority Areas	Headline Interventions
Falls at or near home	<ol style="list-style-type: none"> 1 Referral of individuals to a falls prevention programme 2 Targeted exercise programmes for falls prevention 3 Prevention and treatment of osteoporosis 4 Home safety checks*
Road accidents	<ol style="list-style-type: none"> 1 20mph speed limits in areas of higher pedestrian activity 2 Local child pedestrian training schemes and safe travel plans 3 Systematic road safety intervention in inner city areas 4 Advice and assessment programmes for elderly car drivers
Dwelling fires	<ol style="list-style-type: none"> 1 Installation of smoke alarms by fire brigades 2 Home fire risk assessments, safety checks and escape plans* 3 Target deprived groups, particularly children and older people in privately rented and temporary accommodation, and households in which people smoke
Play and recreation	<ol style="list-style-type: none"> 1 Increase number of children undertaking cycle training and wearing cycle helmets 2 Produce guidelines for safety in children's sports 3 Strengthen risk and safety education in schools

* scope to combine the two.

- 16 Department for Transport, Department of Trade and Industry, Health and Safety Executive and Office of the Deputy Prime Minister (ODPM) have initiatives in these areas. **The Task Force recommends that these headline interventions form the core of local implementation plans.** This core will give focus and clarity to the current somewhat fragmented approach. The report gives examples of leading interventions in these areas and goes on to identify the interventions which it believes should take priority in future.
- 17 These interventions should be targeted in particular at areas of health inequality. And the report identifies other interventions that can be built around this core where there is scope locally to take action on them.

Longer Term Priorities

- 18 For the longer term, the report identifies the following priority areas:

Priority Areas	Headline Interventions
Young car drivers & passengers	<ol style="list-style-type: none"> 1 Better speed management including use of safety cameras at accident sites 2 Improve training and hazard perception skills 3 Increase use of rear seat safety belts
Sports injuries	<ol style="list-style-type: none"> 1 Creation of a sports injury database
Injuries at work	<ol style="list-style-type: none"> 1 Focus on industries most at risk of falls 2 Disseminate lessons learned
Home & Leisure injuries	<ol style="list-style-type: none"> 1 Information campaigns on DIY and garden safety 2 Good practice initiatives

Framework for Delivery

- 19 In keeping with the principle of devolved responsibility, the Task Force concluded that its responsibility lay primarily in providing a framework for delivery, rather than attempting to prescribe detailed plans for delivery. The following conclusions sketch out the main features of that framework.
- 20 In its 2001 report *Injury Prevention*, The BMA recommended that a new agency should be created to co-ordinate accidental injury prevention (AIP) at a national level (BMA 2001). However, the Task Force concluded that this would be difficult to justify in the light of current Government policy to devolve work to lower levels.
- 21 The Task Force recognised that it will not be possible to deliver national targets on reducing accidents unless there is a more integrated approach to accident prevention, coupled with a strong lead at every level. The Task Force therefore concluded that **the development and promulgation of a more united approach across Government and the NHS should be a priority.**
- 22 Given that accidental injuries affect the health of many, and have a considerable impact on the NHS, the Task Force concluded that **the Department of Health is ideally placed to co-ordinate the delivery of cross-Government action.**
- 23 Since Regional Directors of Public Health will shortly be located in Government Offices of the Regions, **the Task Force recommended that Regional Directors of Public Health should lead on co-ordinating the delivery of accidental injury prevention, following the strategies recommended in this report.**
- 24 The Task Force considered that Public Health Observatories, together with their counterparts in local government, should play a key role in the surveillance of accidental injury.

- 25 **The Task Force concluded that local authorities, primary care trusts and other local organisations should come together through Local Strategic Partnerships (LSPs) to deliver AIP.** As part of their health improvement and modernisation responsibilities, **local directors of public health should work through LSPs to co-ordinate delivery of AIP** at the local level.
- 26 The means used to deliver local AIP will vary from place to place. However, the evidence submitted to the Task Force led it believe that delivery is more likely to be achieved where it is made the task of an identifiable individual working to a local implementation plan.

General Principles

- 27 The Task Force identified a number of principles that must underscore successful implementation.
- 28 Specific steps to help deliver local implementation will include:
- using data collected to a common format to show where action is needed most;
 - adapting key interventions to specific local needs where they have the greatest impact;
 - developing and disseminating good practice to show what can be done;
 - showing how these interventions can help deliver other programmes and meet targets elsewhere (e.g. Health Inequalities, Sure Start, etc);
 - involving **all** stakeholders in producing a local action plan;
 - developing a well trained workforce with capacity to undertake injury prevention work;
 - recruiting high-level support;
 - recruiting support from the voluntary sector;
 - identifying sources of additional funding; and
 - identifying indicators to monitor performance.

Delivery Structures

- 29 The development of an implementation plan will include a more detailed assessment of delivery structures. However, the above recommendations suggest that the structures required for immediate implementation will include:
- Regional Directors of Public Health working in Government Offices of the Regions;
 - Regional Public Health Observatories;
 - the Director of Public Health in each Primary Care Trust;
 - the Local Strategic Partnership in each community; and
 - a named individual to deliver plans.

- 30 For the initial momentum to be maintained in the medium to long-term, a stronger infrastructure needs to be created that will be capable of achieving further, sustained reductions. The Task Force believes that this can be done by improving the infrastructure for delivery, and in particular:
- the adoption of a common minimum dataset;
 - the use of a central website with a gateway to give access to injury data at national, regional and local level across all sectors;
 - the dissemination of examples of good practice;
 - structured training for professionals whose duties will include AIP; and
 - increasing our skills and knowledge base to fill the gaps.

Conclusion

- 31 The Task Force has identified where efforts should be focused in future, and how they can have maximum impact through better planning, co-ordination and leadership. It has set out an agenda for delivering real reductions in accidental injury which result in deaths and serious injuries, and has identified proven practical measures that can be applied now.

1

Introduction

1.1 The Accidental Injury Task Force

Saving Lives, Our Healthier Nation set national targets to reduce death rates from accidents by at least one fifth and the rate of serious injury by at least one tenth by 2010; and announced that a Task Force would be set up to advise on how to achieve these targets.

The Task Force began work in November 2000. It included leading experts and representatives from academia, the NHS, local government, the police, the voluntary sector, and Government departments. Membership of the Task Force is given at Appendix 1.

The terms of reference of the Task Force were: *To advise the Chief Medical Officer on*

- *the most important priorities for action in order to meet the targets;*
- *the development of an implementation plan, consulting with other stakeholders as necessary;*
- *whether the necessary delivery structures are in place to take forward the implementation plan;*
- *how progress on the implementation plan should be monitored; and*
- *how to develop and publicise a more united approach to accident prevention across Government and the NHS.*

Within its terms of reference, the Task Force concentrated first on prevention and casualty reduction (rather than treatment); on possibilities for reducing health inequalities; and on immediate actions to make greater use of proven or promising interventions.

At an early stage, the Task Force discussed whether it should extend its remit to non-accidental injury. It decided against doing so, since that would bring in much broader issues such as suicide and criminal injury which would deflect the Task Force from its main concern with accidental injury.

The aim of the Task Force was to complete its investigation by the end of 2001 and report to the CMO as soon as possible thereafter. It set up three expert working groups to advise it: on Children and Young Adults, on Older People, and on Measuring and Monitoring Injury. Their terms of reference are also at Appendix 1. These Working Groups first met in April and gave the Task Force initial advice in June. Reports from these three groups are published separately.

Some 150 local managers and accident prevention specialists were invited to conferences in March and October. Those invited were drawn from a broad spectrum of government, academic and non-Government organisations. The conferences discussed examples of good practice developed by individual health and local authorities and fire brigades. Facilitated workshops at both conferences yielded many comments which have been discussed by the Task Force.

1.2 Developments in Health Policy Since *Our Healthier Nation*

The White Paper was published in July 1999. It was followed a year later by *The NHS Plan*, which focussed priorities on improving cancer, CHD, and mental health, and paid particular attention to the needs of children and older people.

Shifting the Balance of Power: Securing Delivery was published in January 2002 and announced that NHS front-line staff would be given greater authority to deliver services to meet local needs. The Secretary of State for Health reinforced this in a speech on 15 January 2002, and announced that healthcare would in future be delivered by a range of organisations working within a national framework of standards. The Department's role, by comparison, would be to set the strategic direction for health and give account of performance to Parliament. This central framework providing for flexible local delivery is similar to the approach being used in local government following the Urban White Paper.

The report takes account of these developments.

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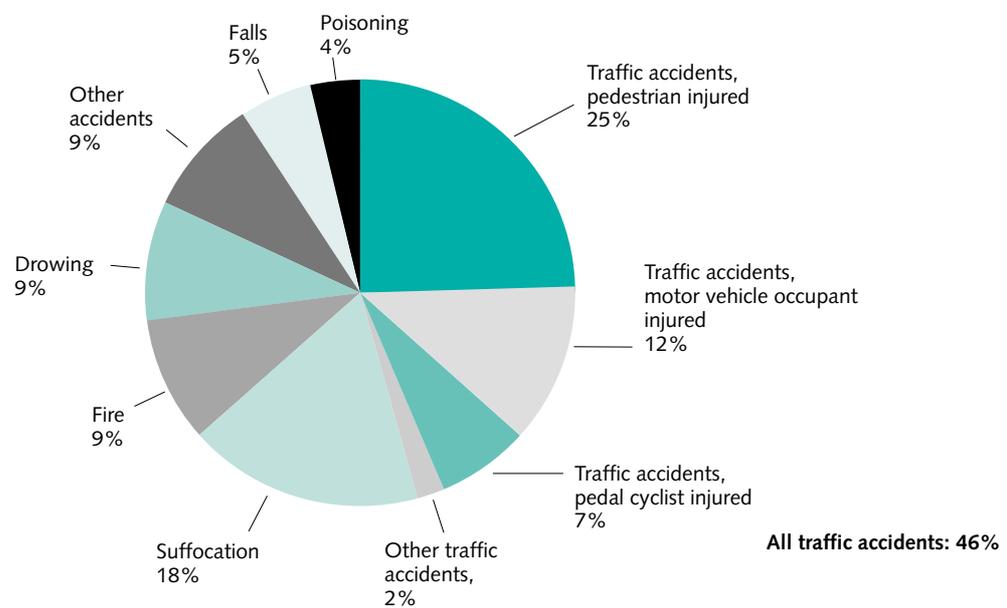
The Burden of Injury and its Consequences

2.1 The size of the problem

The following figures highlight the scale of the problem and the scope for improvement:

- Injury is the leading cause of death in children in England and Wales, as in all industrialised countries. It is also the major cause of ill health and disability.
- In the period 1998–2000 in England, 1003 children aged 0–14 years died as a result of accidental injury. Boys are twice as likely to die as a result of injuries: These differences are greatest for older children. The ratio of hospital admissions for injury for boys to girls is 3:2.

Accidental injury deaths by external cause category, persons, ages 0–14, England, 2000 (SOURCE: ONS)

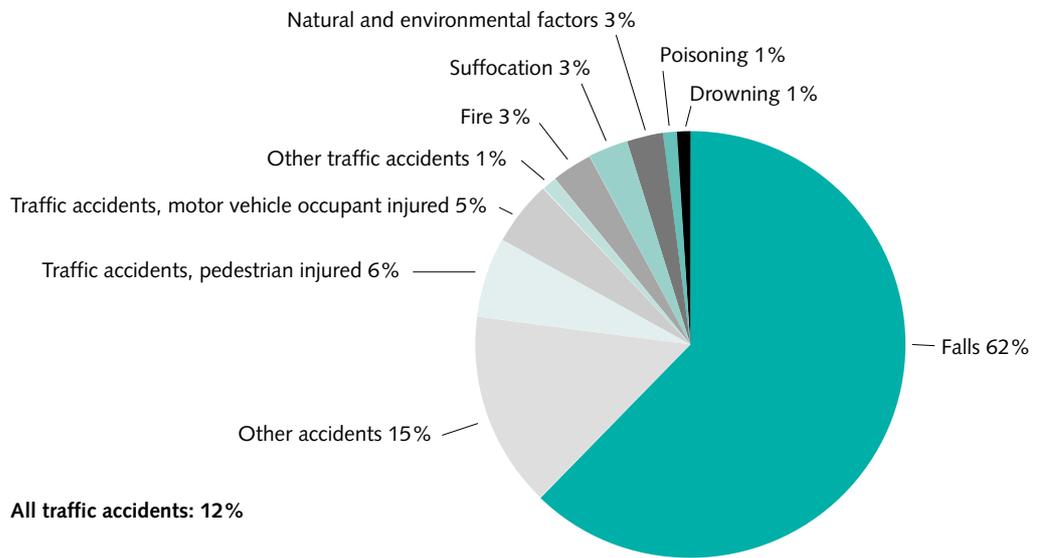


- Over 50% of all accidental injury deaths occur in people aged 65 and over. The age-specific death and admission rates increase ‘exponentially’ with increasing age for women over 55 and men over 65.

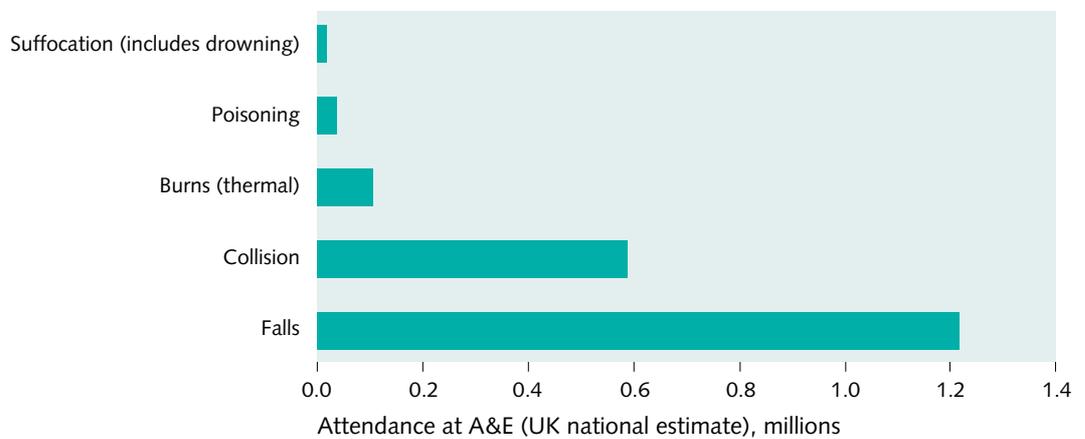
- Falls (62%), road traffic accidents (12%), fire & flames (3%) and suffocation (3%) are the causes of the largest number of fatal injuries in older people.
- There were 320,283 road accident casualties in Great Britain in 2000, of whom 16,184 were child pedestrians (0–15 yrs) and 5832 were older pedestrians (60yrs and over).
- 3,409 people died as a result of a road accident. Of these, 107 were child pedestrians and a further 366 were older pedestrians.
- There were 56,700 accidental dwelling fires attended by fire brigades in the UK in 2000, resulting in 396 deaths and 12,000 injuries. Almost half the deaths occurred in people aged 65 and over.

Accidental injury deaths by external cause category, persons, ages 65+, England, 2000

(SOURCE: ONS)



Attendance at A&E due to non-fatal accidents in the home, 1999, UK national estimates

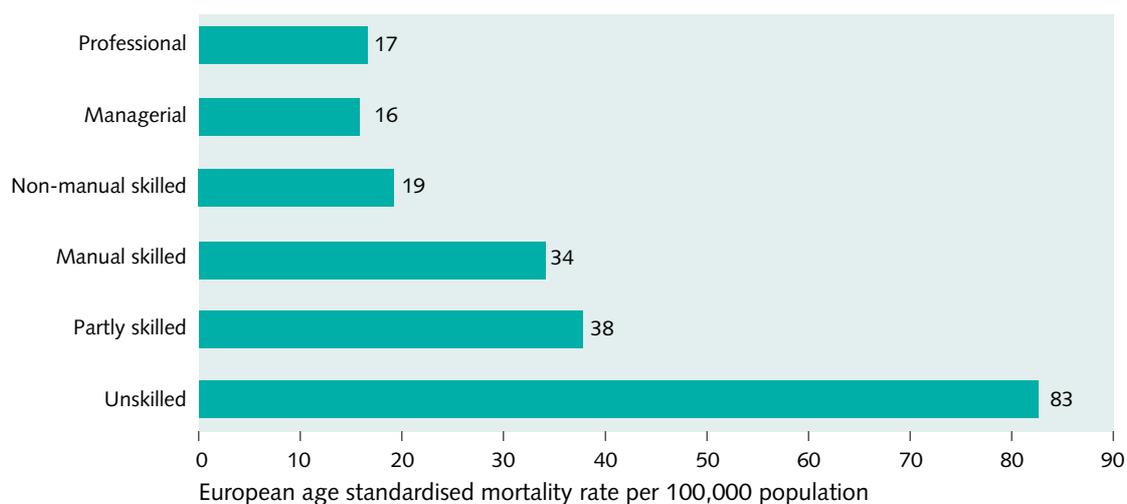


SOURCE: HOME AND FIRE ACCIDENT SURVEILLANCE SYSTEM (HFAS)

- There were some 4,000 accidental deaths in the home in 1999. Half were adults of working age (15–64 years) who make up two thirds of the UK population in contrast to older people who account for 47% of deaths and 16% of the population.
- Non-fatal accidents in the home or at leisure resulted in 5.93 million A&E attendances in the UK in 1999. Those involving an inpatient stay of four or more days account for approximately 200,000 accident victims (over 3% of total accidents).
- For leisure accidents, 66% are in the 15–44 age range, over 80% involve falls or collisions, 50% involve sport, and males outnumber females by more than 3 to 1.
- Every year about 800,000 people are injured playing sport. In young adults these injuries result in up to 4 million days off work and school and approximately 0.4 million attendances at A & E each year.

Since the Saving Lives White Paper, the Government has also announced targets for reducing health inequalities. These inequalities can be measured by gradients in injury or deaths according to age, sex, ethnicity, social class, and geographic location:

Mortality rates from injury and poisoning in children (ages 0–15) by social class of father, England and Wales, 1989–92



SOURCE: I ROBERTS AND C POWER (1996), BMJ VOL 31.3; FROM ONS DATA

- The social class gradient for injuries is steeper than any other cause of death in childhood. The injury death rate for children from unskilled families is five times that of children from professional families.
- Residential fire death rates for children are 15 times greater for children in social class V compared to those in social class I; for pedestrian deaths the rate is five to one. The gap between rich and poor children's deaths from injury widened between 1981 and 1991
- The manual occupations are most at risk of injury with risk reducing to very low levels in the non-manual and professional occupations. Manual workers make up 42% of the workforce but account for 72% of reportable injuries.

- Men have a 20% higher relative risk of all workplace injury not explained by job characteristics than do women. 98% of workplace fatalities are to men. Young men (16–24) have a higher risk of workplace injury than older workers but have a lower risk of fatal injury.

Addressing these inequalities poses a special challenge to target our efforts and work in different ways to have an impact on these disadvantaged groups.

2.2 Impact on individuals, families and society

An obvious consequence of an accident is the physical injury sustained or, in the worst case, death. This has impacts far beyond the physical healing. The individual suffering non-fatal but serious injury, is likely to be off work or school for days, weeks, or even months; some people never return to work. Even for those members of society too old or too young to be at work or school there is need for extra help from friends and family to care for the injured person. In the more severe cases there is lasting disability that requires long term care, sometimes requiring specially adapted homes, vehicles or work places.

The World Health Organisation estimated that, globally, injuries are responsible for one in six years lived with disability and there is evidence that the disabilities are becoming more serious.

Long after the physical hurt has healed there are often psychological long term effects; these are an important and often hidden impact of accidents, leading to loss of confidence, disturbed sleep and appetite, often restricting quality of life.

2.3 Cost to the NHS, individuals and society

The cost to the NHS of treating people who have been injured in accidents is considerable. There are A&E costs, inpatient and subsequent outpatient costs, not to mention the costs of rehabilitation of people who have suffered some form of disability, no matter how slight. A recent Department of Health estimate puts the cost of to the NHS of treating accidental injury and poisoning at £2.2bn per annum. This does not include rehabilitation costs, which are likely to be considerable.

Each year DTLR (now DfT) publishes its Highways Economics Note No. 1, *The valuation of the benefits of prevention of road accidents* (DTLR 2001a). The published figures are the cost-benefit values and represent the benefits that could be obtained by the prevention of road accidents. The method of valuation has been based since 1993 on a consistent willingness to pay approach. It includes all aspect of valuation of casualties including the human cost (pain grief and suffering) and loss of output due to injury, and medical and ambulance costs associated with road traffic injuries. This methodology and broad values have been adopted by the following Government Departments in their valuation of the benefits of preventing injury.

In 2000 there were 233,729 **road traffic accidents** in Great Britain involving injury to at least one person with the estimated value of preventing these being £12,170 million at 2000 prices and values (DTLR 2001b).

The cost to society of **home accidents** in the UK is estimated to be £25,000 million annually (Hopkin and Simpson 1996). During 1999, 3,974 people died as a result of an accident in the home. There were estimated to be 2.8 million accidents in the home and a further 3.1 million leisure accidents (which includes sport), (DTI 2001).

A recent research study (Weiner 2001) estimated that the cost of **dwelling fires** to the economy of England and Wales in 1999 to be £1700 million. Deaths and injuries accounted for £750 million worth of that figure. In contrast the cost of death and injuries in commercial buildings is estimated to be £50 million.

The HSE estimates, using the total loss approach, that the costs to individual workers of **workplace injuries and ill-health** due to reduced income and additional expenditure is £7,000 million. The cost to employers is estimated to be between £3,300 and £6,500 million. The total costs to society as a whole, including pain, grief and suffering, and the individual and employer costs, is between £14,500 and £18,100 million (2.1–2.2% of GDP). These figures are based on 1995/6 prices with net present value costs in future years included (HSE 1999).

As different methods and base years have been used in calculating these figures they cannot be aggregated to give a total value of preventing injuries using 1999 figures. They are presented here to give an overview of the magnitude of the problem in resource, human and social costs and values.

3

Overview of Priorities for Action

3.1 Immediate Priority Areas

Using available data on the distribution and setting of injuries, the Task Force identified the following priority areas for most urgent attention. The criteria used to identify these priorities included: that they are a substantial burden of injury, they represent areas where marked social disadvantage was apparent, and that some evidence-based interventions were available. For each priority area some evidence-based interventions were identified.

Priority area = ***

Marked social disadvantage = +

	Children	Older People
Pedestrians	*** +	**
Fires and thermal injuries	*** +	**
Falls and fractures		***
Car occupants		**
Play and recreation (e.g. cycling & swimming)	**	

3.2 Young and older pedestrians

3.2.1 Objective

To reduce the number of accidental deaths and serious non-fatal casualties resulting from pedestrian injuries to:

- children aged 0–15 years
- older people aged 60 years and older.

Pedestrian injuries were selected as a priority in these two population groups: 25% of children's accidental injury deaths and 6% of those to older people. There are steep social gradients (5:1) for childhood pedestrian deaths. Older pedestrians are as much at risk of injury when crossing the road as are 10–15 year old males (Ward *et al* 1994).

3.2.2 Proven and promising interventions

Progress has been made in reducing the number of children and older pedestrians killed or seriously injured. There has been a 20% reduction in deaths for each of the groups compared with the 1994–98 baseline (133 to 107 for children aged 0–15 years and 471 to 366 for older people aged 60 and over). Numbers of serious injuries have reduced by 23 and 22 % respectively (DTLR 2001b).

There is a strong link between vehicle speed and the risk of collisions with pedestrians and to the severity of the injury sustained. If a car hits a pedestrian, the likelihood of the person being killed rises dramatically as speed increases. By reducing vehicle speeds, packages of urban safety measures, including traffic calming and traffic management, have reduced injuries to vulnerable pedestrians. An evaluation of the impact of 20 mph zones showed a 61% reduction in total injuries and a 70% reduction in child pedestrian injuries. Accidents were reduced by about 6% for each 1 mph reduction in vehicle speed. Public compliance with such schemes is good but can be increased by public consultation.

A potential for casualty reduction can be achieved through improved pedestrian facilities, including priority walking routes and improved crossing facilities located where pedestrians need them. Examples are given the *Road Safety Good Practice Guide* (DTLR 2001c).

Following a successful initiative in a Glasgow housing estate that had an exceptionally high child pedestrian accident rate, DTLR, with the co-operation of their school teachers, has launched a programme to train groups of 5–6 year-old children pedestrian skills at the roadside. It is focussing on children in deprived areas and has been pump-primed with funding of £10 million over 3 years, after which voluntary groups such as local Parent-Teacher Associations would be encouraged to take it up. Thirty eight successful bids were announced in September 2001.

The Injury Minimisation Programme for Schools (IMPS) also takes groups of children out of the classroom to teach them safety skills (not only on the roads) using interactive videos and visits to an A&E department to raise awareness of injury risks. The scheme has been shown to raise knowledge of how to administer first aid and the correct procedure to make a call to the emergency services. IMPS is currently being piloted in several deprived areas. There may be scope for this scheme to collaborate with the DTLR scheme to achieve wider coverage.

Links to National Strategies and Programmes

- *Saving Lives: Our Healthier Nation* (Department of Health 1999).
- *Tomorrow's Roads – Safer for Everyone*. The Government's road safety strategy and casualty reduction targets for 2010. (DETR 2000a).
 - 10 year strategy to reduce road traffic casualties (baseline 1994–98)
 - Reduce the number of people killed or seriously injured in road accidents by 40%
 - Reduce the number of children killed or seriously injured by 50%

- Reduce the slight casualty rate by 10%, expressed as the number of people slightly injured per 100 million vehicle kilometres

Social inclusion strategies

Deprived areas have relatively poor road safety records. Safer roads can help to build stronger communities.

Encouraging walking: advice to local authorities. (DETR 2000b) aims to make walking safer, easier and more convenient.

Key Stakeholders

Department for Transport (DfT), Department for Education and Skills (DfES), Local Highway Authorities, Police Forces, Road user associations, Individual road users.

3.2.3 New initiatives

A cross-Departmental School Travel Advisory Group (STAG) was set up, and guidelines have been issued jointly with DTLR, DfES and DH on Safe Travel to School which are designed to reduce the use of cars while improving the safety of children on their journeys to school. This focus on increased but safe physical activity for children also helps deliver some of the objectives of the NHS National Service Framework for Coronary Heart Disease (Department of Health 2001a).

Local authorities are now required to prepare Local Transport Plans, which must include strategies for school travel and arrangements for working with individual schools to develop comprehensive school travel plans. Authorities are encouraged to include an integrated strategy for reducing car use and improving children's safety on the journey to school, together with separate targets for modal shift. Some of the Travel Plan co-ordinators work with workplaces as well as schools.

Other DfT/Home Office road safety initiatives are aimed at drivers. They include the extension of self-funding safety cameras to all parts of the country. The use of cameras on a pilot basis demonstrated their effectiveness in reducing fatal and serious casualties by 47% at camera sites. Another initiative is a consultation paper on measures to improve the instruction of new drivers, *Introducing a more structured approach to driving* (DTLR 2002). HSE are also studying trends in work-related car accidents. These developments are aimed at improving safe driving, which should also contribute to reducing accidents to pedestrians struck by a car.

Traffic calmed 20mph zones have been effective in reducing child pedestrian injuries in residential areas. DfT are therefore encouraging and funding the introduction of more of these zones. DfT also support the extension of Home Zones where the speed of traffic is reduced to walking pace to improve amenity of residential roads. They also allow children to be more independently mobile on streets in their own locality. This is expected to have positive effects on children's road safety.

The Government has announced five towns that have successfully bid for a share of £5m over two years to improve the safety of high streets which have a disproportionate

number of pedestrian casualties, especially those involving older people. Two of the areas are in inner cities.

The DfT encourages Local Highway Authorities to use best practice in road safety when developing and implementing their Local Transport Plans.

Examples of collaboration and good practice

Hertfordshire County Council was among one of the first to introduce the concept of a 'Walking Bus' around 1997. It can best be described as a mobile patrol where the patrol walks along a designated route with the objective of providing an adult presence to keep an eye on children to enhance their safety and person security as they walk to school. It encourages less use of the car for short trips, it enables children to get more exercise and learn pedestrian skills, and it promotes conversation between children. Often the children's school bags are carried on a trolley. *Road Safety Good Practice Guide (DTLR 2001c)*.

3.2.4 Next steps

The most successful strategies and programmes that improve the safety of children and older people as pedestrians combine elements of environmental change, education and enforcement (or regulation). Future initiatives designed to reduce the number of pedestrians injured will use, or develop further, good practice based on cost-effective interventions that have been properly evaluated.

- Encourage the extension of current traffic calming and speed restriction initiatives (especially 20 mph speed limits) in residential areas across the whole country, giving priority to deprived urban areas.
- Develop and introduce road safety measures such as traffic calming and better use of road space for pedestrians on high streets where there are many pedestrian injuries. It is on high streets where many injuries occur to older people.
- Develop with local authorities and schools, child pedestrian training schemes using local volunteers. These schemes would be specially targeted on deprived areas.
- Promote improvement in pedestrian facilities in areas with heavy traffic flows, again with priority to deprived urban areas.
- Demonstrate how significant investment, together with integrated network and safety management can benefit deprived communities through the implementation of an inner city demonstration project.

What may be possible in the medium/long-term?

In the medium/longer term, work will be focused on the Road Safety Strategy's recommendations for action to achieve the Government's target for a 50% reduction in the number of children killed or seriously injured in road accidents, together with a 40% reduction in all road deaths and serious injuries. Action will include:

- Capitalise on the potential of pedestrian skills training in reducing injury rates.
- Encouraging more parents to become involved in the safety of their children on the roads through *One Step Ahead* for new parents and new resources for children's transition from primary to secondary school.

3.2.5 Gaps in our knowledge

- improvements in pedestrian friendly car fronts to protect children and older people;
- further speed modification measures for roads and vehicles to protect pedestrians;
- community-based injury prevention programmes need to be evaluated;
- different approaches need to be included: child-to-child, use of incentives to change behaviour, tailored health education materials, benefits of programmes;
- research is required to inform how evidence can best be turned into practice to improve safety for both the young and the old;
- studies targeting professionals and policy makers are required; and
- comparative designs are necessary that employ the same research design in different countries.

3.3 Dwelling fires involving children and older people

3.3.1 Objective

To reduce the number of accidental deaths and serious non-fatal casualties from dwelling fires in:

- children aged 0–14 years
- older adults aged 65 years and older

Fires were selected as a priority in these two population groups: fire and flames cause 9% of accidental injury deaths in children and 3% in older people. There are very steep social gradients (15 to 1) for childhood deaths.

Links to National Strategies and Programmes

- *Saving Lives: Our Healthier Nation* (Department of Health 1999).
- *Safe as Houses. The Report of the Community Fire Safety Task Force.* (1997).

As a result of its recommendations the Home Office launched a five year strategy to reduce accidental deaths in the home from fire by 20% of the five year average to 1998 by March 2004.

Key Stakeholders

Office of the Deputy Prime Minister (was formerly the Home Office, then Department of Transport, Local Government and the Regions (DTLR)), National Community Fire Safety Centre, Local fire brigades – Community Fire Safety Units, Department of Trade and Industry Consumer Safety Unit, NHS Acute trusts (A&E, burns unit staff), Local Authorities (especially Housing, and Environmental Health).

The factors that put older people at risk include physical disabilities, psychiatric illness, impaired vision and sense of smell, and living on lower incomes or in rented accommodation.

The factors that contribute to risk of injury from fires for children are living in single parent family households, or living in rented or temporary accommodation

3.3.2 Proven and promising interventions

There is evidence that smoke alarm programmes can achieve reductions in residential house fires and in injuries from fire and flames. A smoke alarm programme in Oklahoma City, USA targeted inner city areas with a high risk of fires and achieved a significant level of injury reduction (Mallonee *et al* 1996). Recent research conducted in London by the Institute of Child Health (DiGuseppi *et al* 1999) indicated that simply giving smoke alarms to people is not effective. As a result, Fire Brigades are being encouraged to install the alarms on behalf of those at risk of fire.

One of the most important risk factors for death in the event of a house fire is the absence of a smoke alarm. Living in privately rented accommodation was the strongest predictor of the absence of a smoke alarm. Ownership of smoke alarms is not the only factor: where they are positioned and whether they function is of great importance. Reports from fire brigades show that in over half the cases where a battery-operated smoke alarm did not operate in a fire, the battery had been removed. In addition to alarms with a one-year life battery, devices with a 10 year sealed unit battery are available.

Encouraging householders to carry out home fire safety checks, which include ensuring internal doors are closed at night, taking care with smoking materials and cooking appliances are promising interventions to be encouraged. Reducing smoking would have the added public health benefit of reducing house fires.

Cigarette lighters and matches pose a special risk to children. In the United States, Canada and Australia there are requirements that all lighters are child resistant. DTI through standard PREN13869 is pushing for similar standards to be adopted in the European Union. On matches, safety labels have been introduced to warn consumers. Reduction in the amount of toxic smoke produced in a fire has been achieved through a ban of the most hazardous grades of foam in furniture. Deaths have fallen from 51 per 1000 fires in 1988 to 34 in 1991, stabilising at 40 subsequently. There is evidence from an observational study that the replacement of electric blankets over 10 years old would prevent fires.

For particularly vulnerable groups in society, targeted residential sprinkler installation is a promising intervention. The cost of installing residential sprinklers has been estimated by industry to be around £1,500 per household, although conditions such as local water pressure and the number of rooms in the house can have a marked effect upon the price of installation.

3.3.3 New initiatives

The report of the Community Fire Safety Task Force (1997), *Safe as Houses*, led the Government to signal a shift in emphasis in the fire service from fire suppression to fire prevention. The fire service was given a target to reduce accidental fire related deaths in the home in England and Wales by 20% from the 1994–99. Progress to date has been good with the 2000/2001 figures showing a 19% reduction from the 1994–99 average (308 compared with 379).

The National Community Fire Safety Centre was established in 1998 to lead and co-ordinate fire prevention programmes at the national level. The Centre has an ongoing series of programmes including national safety campaigns and local fire safety education. The Centre has a budget of £6m pa.

The current main initiatives include the installation of smoke alarms, including their installation in deprived communities, and the use of fire brigades and others to visit people's homes and check them for fire safety risks. In the last 12 months Ministers have launched integrated media, promotional and community-based campaigns on buying and installing smoke alarms and highlighting the importance of fire action plans.

Smoking cessation programmes will also contribute to a reduction in dwelling fires. This initiative is the responsibility of the NHS through the Primary Care Trusts.

DTI is working to encourage the phasing out of furniture that does not comply with fire safety regulations, and is working with industry to improve the safe use of candles in the home.

3.3.4 Next steps

- continue a programme of media campaigns and community partnership action, focussed on areas of high risk, emphasising the need for kitchen fire safety, and for the use and correct maintenance of smoke alarms;
- encourage fire brigades to install smoke alarms in homes – not just give them away;
- encourage the systematic identification of families at risk of house fires by health visitors and their referral to a local fire brigade;
- encourage the phasing out of furniture which does not comply with fire safety regulations; and
- work with industry to improve the safe use of candles.

What may be possible in the medium/long-term

In the longer-term, if additional resources can be secured, we hope to:

- encourage more fire brigades to convert existing operational fire stations into community fire stations, as a resource to the local community;
- extend the adoption of Home Fire Risk Assessments; and
- pilot and evaluate the installation of sprinklers in multiple occupation houses where there is a higher risk of fire.

Promote best practice by:

- increased integration of planning at a local level between the fire service, local authority and health authority, particularly in relation to targeting specific at-risk communities;
- monitor the ownership of correctly functioning smoke detectors at a local level;
- campaigns and points of sales advice on smoke alarms and their correct location;
- programmes specifically to target more deprived groups, particularly children and older people in privately rented accommodation and temporary accommodation, and households in which people smoke;
- programmes to install and maintain efficient and acceptable devices;
- smoke alarms provided as part of equipment loan scheme;
- audit and advice by health visitors on house visits;
- link with positive parenting and grand-parenting programmes to promote safety awareness about house fires and escape plans in case of fire;
- respond to the special needs of households with members with disabilities; and
- programmes to reduce the number of electric blankets used that are over 10 years old.

Examples of collaboration among key stakeholders

Housing Estate Initiative – Cheshire Fire Service has joined forces with local and private housing authorities, and started addressing home fire safety and arson incidents. Through meetings with residents and young people, the aim has been to empower residents to make their communities safer. Both adults and children have engaged in safety initiatives, and undertaken activities to improve the fire safety of their homes and those of their neighbours. The initiatives have increased people's awareness of fire, increased smoke alarm ownership, and encouraged fire planning.

In Hull Health Action Zone the Fire Service has given basic fire safety training to midwives, who carry out a basic fire safety check on their first post-natal home visit to new mothers. This initiative is now being extended throughout the East Riding of Yorkshire.

In partnership with the Powys Alliance for Health, the DTI has supported via its Home Safety Modernisation Fund, a project to test and replace electric blankets and provide general safety advice to over 65s.

3.3.5 Gaps in our knowledge

- identify the level and monitor the ownership of correctly functioning smoke alarms at a local level in different population groups;
- evaluate the use of escape plans and how these can be delivered;
- improve knowledge of effectiveness of local and national campaigns in increasing smoke alarm/sprinkler uptake in high risk dwellings; and
- improve flame retardant fabrics for use in fashionable clothing for older and younger people.

3.4 Injuries to older people from falls and fractures

3.4.1 Objective

To reduce the occurrence of falls and fracture in older people.

Target populations include older people who seek medical attention for a fall, repeat fallers, older people discharged from hospital, those living in institutions or who are housebound, people experiencing gait or balance problems, and people with previous fragility fracture or major risk factors for osteoporosis. 62% of accidental injury deaths in older people are caused by falls.

Links to national strategies and programmes

- *Saving Lives: Our Healthier Nation*. (Department of Health 1999).
- National Service Framework for Older People (Department of Health 2001b).
- NHS Plan (Department of Health 2000).

Key Stakeholders

DTI Consumer Safety Unit, Primary Care Groups/Trusts and other Primary Care services, NHS Hospital Trusts (A&E, Health Care of Older People, Rheumatology); Local Authorities, and Housing Associations.

3.4.2 Proven and promising interventions

Strategies for prevention include reducing the risk of falls, strengthening bones, and reducing the energy of impact. A number of guidelines and reviews have been produced that summarise and interpret the evidence:

- multifaceted assessment and intervention to prevent falls (AGS *et al* 2001);
- prevention and treatment of osteoporosis (RCP 2000);
- targeted exercise programmes (Skelton and Dinan 1999); and
- rehabilitative services for older people who have fallen (Simpson 1999).

These approaches are in broad agreement with that presented in the NSF – for Older People.

Additionally, hip protectors are interventions that have been shown to reduce hip fracture occurrence amongst selected populations of frail older people.

3.4.3 New initiatives

Standard Six of the NHS National Service Framework for Older People (NSF) (Department of Health 2001b) requires the NHS to work in partnership with councils to take action to prevent falls and reduce fractures and other injuries. It requires actions in several categories:

- *A community approach* which involves keeping streets and pavements clear and in good repair, making homes safer, and educating older people on how to avoid risk in the home, e.g. utilising resources through DTI's *Slips, Trips and Broken Hips* campaign (DTI 1999).
- *An individual approach* to preventing falls injury by identifying those most at risk of falling and fracturing and referring them to appropriate programmes using a dedicated falls service.

The NHS National Service Framework for Coronary Heart Disease (Department of Health 2001a) also encourages physical activity, although it is not aimed specifically at elderly people. The interests of both NSFs come together in the Older People and Physical Activity Working Group, chaired by DCMS. This cross-Government Group advises the Inter-Ministerial Group on Older People.

A project to improve the mobility of very elderly people is being sponsored by DH and run by the Public Health Department at Merton, Sutton and Wandsworth Health Authority. This is currently being evaluated along with other schemes, with a view to providing good practice guidance for the NHS. The NSF for Older People requires local health care providers to include by April 2004 the development of a local falls prevention service in Health Improvement and Modernisation Plans.

As part of its Revitalising Health and Safety strategy, the Health and Safety Commission has selected slips and trips as a priority programme for attention by local authority enforcement. The elderly are particularly at risk, not least because the consequences can be more severe.

3.4.4 Next steps

- Implementation of a service for assessment of older people who attend A&E with a fall and intervention in those who are at high risk of future falls.
- Inclusion of prevention of osteoporotic fractures in local HIMP's and identification of lead clinicians in primary and secondary care to develop local osteoporosis programmes with the formation of a dedicated multidisciplinary group.
- Equity of access nationally to DXA scans at rate of 1000 per 100,000 population to support selective case finding in the management of osteoporosis.
- Promotion of exercise intervention; increase the role of PCTs in partnership with Local Authorities in exercise promotion, referral for exercise to professionals (physiotherapists and related) who have been trained in exercise aimed at falls and fracture prevention.

What may be possible in the medium to longer term

Full implementation of the falls prevention guidelines that includes the development of a falls service.

- full implementation of the National Osteoporosis Society primary care strategy in falls and osteoporosis;

- full implementation of the exercise referral toolkit; and
- develop a joint approach to home safety checks/audits, which include the public space around the home such as the pavement and the road.

The implementation of medium/long-term interventions requires resources, a trained work force, facilitation of interdisciplinary and multi-agency working, adaptation of national and multinational guidelines to the local situation, including the development of locally agreed referral pathways and management plans. Each of the above includes elements of awareness raising and behaviour change, modification of the environment, and health and social service assessment, treatment and rehabilitation.

Through the DTI *Slips, Trips...* campaign (DTI 1999) messages are being incorporated into the basic training of some professionals. For example, Centre for Sheltered Housing Studies module for housing managers *The role of scheme managers in falls prevention* and EXTEND curriculum for exercise teachers trained to give classes to older people in community and special settings. Messages are also being incorporated into on-going professional development of a number of key professionals, for example, pharmacists *Encouraging Safe Activity in Older People* pack and the planned briefing sheet on foot health and falls for members of the Society of Chiropractors and Podiatrists.

3.4.5 Gaps in our knowledge

- develop validated multiple risk assessment tools/instruments to identify those at risk of falling and modifiable risk factors amongst high-risk individuals;
- gather more multidisciplinary information in respect of why people fall in relation to the environment, sports participation, health, medication effects, illicit drugs and alcohol;
- investigate trends in accident mortality rates and to examine why these rates have not continued their previous decline;
- systematically examine the causal network of falls and falls injury;
- update review work relating to community-wide interventions to reduce falls;
- identify which subgroups may be at risk from falls and implement prevention strategies;
- identify which risk factors are modifiable, which will reduce fall rates and what effective and feasible methods can modify risk factors;
- examine effectiveness of falls prevention programmes in institutions such as hospitals and nursing homes;
- examine how falls can be prevented in individuals with cognitive impairment and dementia; to examine the relationship between impaired vision and falls, and to identify how modified footwear may reduce falls;
- examine interventions shown to be effective overseas in UK settings;
- examine the role of hip protectors in preventing fractures and long term trends in hip fracture incidence;

- examine why individuals may resist acceptance of environmental modifications and other falls injury prevention programmes;
- in line with research recommendations in relation to accidental injury in children, more research is needed to inform how evidence relating to older people can best be turned into practice; and
- a joint research project is being undertaken by the Health and Safety Laboratory (an HSE agency) and the Building Research Establishment on stair design and its relationship to falls to inform future strategies.

3.5 Injuries to older car occupants

3.5.1 Objective

To reduce death and serious accidental injury amongst older car occupants.

Amongst people aged 60 years and over, 2905 were killed or seriously injured while driving or as a passenger in a car (DTLR 2001). Older people are much more vulnerable to injury in the event of a collision and do not recover as quickly. Those over 75 years are three times more likely to die than 20 year olds and those over 80 are up to six times more likely to die.

Older drivers find it more difficult to drive at night, on fast roads and in complex traffic conditions. It is important for older people's independent mobility that they are able to drive to undertake their daily business without causing undue risk to themselves or others. Injuries to vehicle occupants led to 5% of accidental injury deaths in older people.

Links to national strategies and programmes

Tomorrow's Roads: Safer for Everyone The Government's road safety strategy and casualty reduction targets for 2010. (DETR 2000a).

Key stakeholders

DfT; Highways Agency; Local Authorities, Police, Vehicle designers and manufacturers

3.5.2 Proven and promising interventions

Increased protection afforded by newer model cars, safer roads resulting from new road construction, local safety measures and anti-drink driving measures have all contributed to a reduction in the number of older people killed or injured. The use of seat belts, presence of air-bags, and side impact protection are all likely to be effective for the older car occupants.

3.5.3 New initiatives

The number of drivers and passengers aged 60–69 years killed or seriously injured has declined by 13% from the 1994–98 average of 1462 to 1276 in 2000. Those killed or seriously injured in the 70–79 age group has fallen by 9% (1188 to 1084) and for the over 80s the figure has gone down by just over 5% (577 to 545) (DTLR 2001b). The population of older people has increased.

The most important effects of ageing for older travellers are the increased fragility that occurs with age; reduced visual acuity especially at night; and reduced physical mobility especially of the neck, which affects their ability to look right, left and to the rear.

Key interventions include:

- With ageing, spinal joints can become stiff and regular spinal exercise can promote looser spinal joints and improve rear observation when driving (Taylor 1995).
- 15 Mobility Centres across the UK which work as a collective Forum in using cognitive and physical assessment to advise older drivers on their physical and mental capacity to deal with the complexities of driving.

3.5.4 Next steps

To reinforce what is already being done, we propose to:

- promote more vigorously regular eye tests both for acuity and glaucoma; and
- encourage Local Highway Authorities to target advice and assessment initiatives in areas of high numbers of elderly car drivers.

What may be possible in the medium/long-term

For the future, it may be possible that:

- Local Highway Authorities will be encouraged to develop road safety and speed management strategies, enforced by the police, that take more account of the needs of older drivers on both urban and rural roads. *The elderly driver could be used as the normative driver to whom the traffic environment should be adapted* (Rumar 1986). *Any changes in the traffic environment designed to ameliorate the problems of elderly drivers will also be of benefit to younger drivers* (Holland 2001).
- To reduce reliance on the car through the planning process and implementation of traffic management schemes that include provision of adequate public transport with buses designed for the mobility impaired, together with good concessionary fares for older people.

3.5.5 Gaps in our knowledge

The issues surrounding design and use of vehicles are led by the European Union who are seeking ways to make cars safer for their occupants. We need to seek ways of providing more information about safety features for older drivers and encouraging them to purchase the most appropriate cars for their needs as they get older.

3.6 Injuries to children from play and recreation

3.6.1 Objectives

To reduce deaths and injuries to children associated with play, sports, and recreation through the provision of safer places to play, safer cycling and improved water safety awareness.

Children's participation in sports and recreational activities like cycling and swimming is actively encouraged, both to improve general health and fitness, and to help social development. But this increased activity can also increase the risk of injury.

To reflect the incidence of accidental injury deaths from cycling and drowning in children, cycling injuries and drowning were selected as priorities. Sports injuries cause fewer deaths but account for many hospital admissions and A&E attendances.

Links to national strategies and programmes

Tomorrow's Roads: Safer for Everyone The Government's road safety strategy and casualty reduction targets for 2010. (DETR 2000a).

Saving Lives: Our Healthier Nation (Department of Health 1999)

Key stakeholders

DfT, Local Authorities, Police, RoSPA, HSE, DfES, DTI

3.6.2 Proven and promising interventions

Slowing traffic in areas where there are children about is an important part of helping children keep safe when at play, especially on foot and on bicycles. In this context the 20mph zone is an intervention which has been demonstrated to be effective in reducing the number of child casualties. Homes Zones are interventions that are increasingly being promoted as ways of changing use of residential streets.

Regulations to exclude certain products from the market or require, say, safer packaging where they have been proven to cause significant numbers of accidents or represent unreasonable risks are effective but must be viewed as a last resort. Likewise voluntary agreements on, for example, labelling can prevent accidents by informing consumer behaviour.

The Adventure Activities Licensing Scheme provides an inspection system to check the safety standards of over 900 providers of adventure activities to young people. The scheme was put in place after the Lyme Bay disaster in which four teenagers lost their lives while kayaking in the sea. It covers the four most hazardous categories of activity – caving, climbing, watersports and trekking. The inspectors aim to ensure that providers meet not only the basic standards of safety but put in place continuous improvement mechanisms.

The Football Association has led a campaign to highlight safety issues involved with using goalposts in grassroots football following the deaths of 9 children, in accidents involving goalposts during recent years. The main theme of the campaign urges everyone involved with football to recognise the potential dangers of using goalposts and to undertake the necessary checks and precautions. The campaign is supported by the Department for Education and Skills, the Football Association, the Department for Culture, Media and Sport, the Health and Safety Executive, and the British Standards Institute.

3.6.3 New initiatives

- cycle training for about a third of children aged 9–10 years. The most effective courses last several weeks and include practical road skills;
- programmes to encourage the wearing of cycle helmets and conspicuity aids;
- programmes to encourage safe travel to school, including cycling;
- the provision of engineering measures such as cycle lanes and speed controls;
- publicity campaigns focusing on specific safety issues around the home and garden; and
- safety education guidance.

The Safety Education Sub Group of the PSHE Advisory Group has drafted Safety Education Guidance for schools – an area of the curriculum where there was no authoritative guidance available. The introduction of the PSHE framework in 1999, which includes the theme of developing a safe, healthy lifestyle together with the National Healthy School Standard, with safety as one of the 8 themes, presented an opportunity to draft this guidance. The Guidance draws on the expertise of representatives from many different agencies – a good example of multi agency working – and DfES Ministers consider that it will be a useful tool to schools. The guidance will be publicised in *Spectrum*, the magazine for schools, and it will be available from the DfES website.

- The assessment and management of risk through adventure programmes – ‘Summer Activities for 16 Year Olds’ – Pilot

DfES have run the Summer Activities for 16 year olds pilot programme during 2000 and 2001. Its basis is adventure activities during the summer and one of its outcomes has been to teach young people the transferable skills of being able to recognise the necessity of risk assessment and risk management if they and their fellows are not to be overcome by natural hazards.

Additionally, risk education can take place anywhere in the curriculum and this has been recognised by the AITF working group.

3.6.4 Next steps

- increase the number of children receiving the most effective cycle training courses;
- target cycle helmet campaigns on more deprived communities;
- target safe travel to school programmes on more deprived communities; and
- improve the co-ordination of data on drownings.

What may be possible in the medium/long-term

- once wearing rates have increased, legislation could be considered to reinforce the use of cycle helmets – further efforts are currently needed to promote helmet wearing;
- strengthen risk and safety education in the school curriculum;
- produce guidelines for safety in sports in which children are involved; and
- introduce training for teachers and others who supervise children on school trips involving water.

3.6.5 Gaps in our knowledge

- more studies are needed in the areas of sports and leisure injuries, drownings, falls, child agricultural injuries and community first aid;
- community-based injury prevention programmes need to be evaluated;
- different approaches need to be included: child-to-child, use of incentives to change behaviour, tailored health education materials, benefits of programmes;
- research is required to inform how evidence can best be turned into practice; and
- environmental risks in schools, sports and leisure environments.

4

Longer-Term Priority Areas

Other priorities identified by the Task Force for longer term action are:

Priority area = ***

Marked social disadvantage = +

	Young Adults (especially males)	Working age Adults
Drivers and passengers	***	
Sports	**	
At work		**
At home & leisure		**

4.1 Injuries to young drivers and passengers

4.1.1 Objectives

To reduce the burden of death and injury in young adults by targeting young drivers and other young vehicle occupants.

This is a priority group not only because of the large burden caused by death and injury in young people in terms of disability or quality adjusted life years lost, but also because it is the only group in the population in which little progress in reducing accidental death rates has been made for some years. Injuries to vehicle occupants in traffic accidents lead to about 40% of accidental injury deaths in people aged 15–24.

Links to national strategies and programmes

Tomorrow's Roads: Safer for Everyone The Government's road safety strategy and casualty reduction targets for 2010. (DETR 2000a).

Saving Lives: Our Healthier Nation (Department of Health 1999)

Key stakeholders

DfT Local Authorities, Police, RoSPA

4.1.2 Proven and promising interventions

Newly qualified drivers, the majority of whom are also young drivers, are at particularly high risk after passing the driving test. As many as one in five new drivers has an accident in the first year, and whereas 17–21 year olds represent only about 7 percent of all license holders, they make up 13 percent of drivers involved in injury accidents. The reasons for their higher risk include deficits in driving skills, but also poor attitude and behaviour that can lead to unnecessary exposure to danger. Young drivers have more accidents in the evenings and early mornings and a high proportion of these are single vehicle accidents. Research shows that speed is a more significant factor in young drivers accidents than for older drivers.

There is strong evidence that safety cameras located at accident sites can reduce the numbers of people killed or seriously injured. A recent study estimates the average reduction to be 47% at camera sites. There is also further evidence that among the high speeders and accident involved are young drivers, especially on rural roads. Police enforcement activity, whether on the road or remotely through the use of cameras, is making a contribution to the reduction in the number of young people killed or seriously injured. Traffic management and road safety initiatives improve safety of drivers of all ages but those which discourage overtaking and excessive speeds on approaches to bends and junctions are likely to be effective at reducing injuries to younger drivers who are vulnerable at these locations.

4.1.3 New initiatives

DfT leads a comprehensive Road Safety Strategy aimed at all age groups. A few examples of measures being introduced are:

- vehicle engineering measures to make car interiors safer, e.g. using air bags;
- enforcement of rear-seat belt wearing;
- drink-driving campaigns;
- drugs and driving; and
- the Police and LHAs are working together to target excess and inappropriate speed choice by young drivers.

4.1.4 Next steps

- continue the enforcement of rear-seat belt wearing;
- develop a voluntary logbook scheme for drivers;
- education has an important role to play. Speed is now a key element of novice training for car drivers and motorcyclists; and
- improve the quality of training for all drivers by continuing to improve the driving test. This will help to ensure that drivers are equipped with the right skills and the right attitude to drive safely and responsibly.

A test of hazard perception ability is being developed, which will form part of the learner driver theory test from October 2002. The test will measure how quickly the

learner driver detects that a hazard is starting to develop, and good scanning and anticipation will be required to achieve a high score in the test. The associated training will also focus on the need for safe speeds and appropriate separation distances, in order that the driver will be able to respond to hazards in good time. It is hoped that this measure will affect speed choice by alerting new drivers to the potential for hazards in the traffic environment.

What may be possible in the medium/long-term

- Develop and implement speed management strategies that will encourage drivers to choose safer speeds, which use road signs and markings to give better guidance on appropriate speeds at bends, and which discourage unsafe overtaking.

4.1.5 Gaps in our knowledge

- There is an urgent need to update our knowledge of accidental injury in respect of 15 to 24 year olds and further studies are required in respect of 12 to 14 year olds.
- More information is needed about the possible links between alcohol and illicit drug use and accidental injury in adolescents and young adults.

4.2 Sports injuries to young adults

4.2.1 Objectives

To reduce the burden of death and injury in young people aged 15–24 by targeting adults playing sports who sustain 50% of all sports and recreational injuries. Although the incidence of serious longer-term injuries is relatively small, there is a case for targeting these groups because of the burden they impose on society.

Following the severe injury to boxer Michael Watson in 1991, there was a widespread call to review medical and safety standards for participants in high-risk sports. While much has been done since then to improve standards (particularly within boxing), there remains a general view that provision of guidelines and immediate medical care at sporting events is extremely uneven and often inadequate.

Links to national strategies and programmes

Saving Lives: Our Healthier Nation (Department of Health 1999).

Key stakeholders

DfT, Local Authorities, RoSPA, HSE, DfES, DTI, Department for Culture, Media and Sport (DCMS), sports associations and sports clubs.

4.2.2 Proven and promising interventions

At present no central database on sports injuries exists. However, the National Sports Medicine Institute is working with UK Sport and Sport England to examine the feasibility of a national sports injury database. The development of such a database could enable a more detailed analysis of the situation by targeting specific sports, activities or injuries to assess the extent of the problem and help identify successful interventions. Preventive measures could then be initiated and the effect of those measures could be monitored through further analysis.

4.2.3 New initiatives

A working group on Improving Safety and Medical Provision in UK Sport has finalised its report on the establishment of a UK Advisory and Accreditation Service for Safety in Sport.

Further work is being undertaken by UK Sport to provide a detailed analysis of the scale of the problem within and across sports in the UK and to consider options for change.

4.2.4 Next steps

What may be possible in the medium/longer term

It may be possible in the longer term to have guidelines and standards set for safety in each sport.

4.2.5 Gaps in our knowledge

- developing better sports protection equipment for general public; and
- obtaining further evidence from National Governing bodies on current levels of safety and medical provision in sport and on the scale of the problem within and across sports in the UK.

4.3 Injuries at work

4.3.1 Objectives

To reduce the unacceptable suffering and costs caused by work related injury to workers and to members of the public where they are affected by work activities.

In 2000/01 there were 292 fatal injuries to workers with the highest percentage in the construction industry (36%). Each year around 25 million working days are lost through work-related accidents and ill health.

The major occupational risk areas as measured by work related deaths are, quarrying stone at 10.4 fatal injuries per 100 000 workers, agriculture at 9 fatal injuries per 100 000 workers, extraction of oil and gas (8.9 per 100 000 workers) and construction (4.8 per 100 000 workers) for the period 1998/99–2000/1.

Workers in craft and related, plant and machinery, and personal protective services are most at risk with rates of reportable (major and over 3 day) injury greater than 2000 per 100 000 workers. They make up 31% of the workforce but account for 57% of reportable injuries. Rates reduce to lower levels (lower than 800 per 100 000 workers) in the professional, clerical, management and administrative occupations.

There are geographic variations, with the South East of England and London together making up 18% of all fatalities. However, there is probably the highest degree of construction work in the South East which contributes to this high rate. Yorkshire and the North East, Wales and the West come next, followed by the Home Counties – but the highest risk is in Scotland. Research has shown that risks of non-fatal injury reflect the mix of occupations and industries within regions.

Men have a 20% higher relative risk of all workplace injury (major, over three day, and less serious injuries) not explained by job characteristics than do women. This rises to 35% for reportable injuries (major and over three day). Some 98% of workplace fatalities are to men. Young men (16–24) have a higher risk of workplace injury than older workers but have a lower risk of fatal injury.

Links to national strategies and programmes

In the strategy **Revitalising Health and Safety** (DTLR & HSE 2000) the Health and Safety Commission has targets to be achieved by 2010. They are to:

- reduce by 10 per cent the incidence rate of fatal and major injury accidents (3000 fewer deaths and major injuries reported);
- reduce by 30 percent the number of working days lost per 100 000 workers from work related injury and ill-health; and
- reduce the incidence rate of cases of work related ill health by 20%.

It is intended to achieve 50% of the improvement by 2004.

The **Securing Health Together** (HSC 2000) strategy is the occupational health plank of the Revitalising Strategy. It aims to stop people being made ill by work and, if they are, to get them back to work quickly. A healthier workforce is seen as a key component in achieving reductions in inequalities, reducing costs to society and employers, and improving productivity. A framework of targets, evaluation, and national partnership working is in place with a commitment to the following outcomes:

- reducing work-related ill health to workers and the public;
- helping people who have been ill to return to work;
- improving work opportunities for people who are not in work thorough illness or disability;
- using the work environment to help people maintain their health.

Key Stakeholders

HSE, DH, DfT, businesses, trades unions, local authorities, consumer organisations.

4.3.2 Proven and promising interventions

The main interventions are current initiatives are:

- issuing guidance to industry;
- undertaking preventive inspections;
- education and training initiatives to highlight specific risks;
- investigation of serious incidents and feedback to industry of lessons learned; and
- promoting good practice through the Securing Health Together strategy.

4.3.3 New initiatives

The key new initiatives arise from the work to implement the Revitalising Health and Safety strategy. These include targeting resources on specific high risk sectors and establishing national targets for improvements. This includes consideration of measures that go beyond the scope of HSE's normal interventions and through the engagement of other government departments and stakeholders.

As part of its Revitalising Health and Safety strategy, the Health and Safety Commission has selected slips and trips as one of the priority programmes for attention. Slips and trips account for 33% of all major and 21% of minor injuries involving over three days absence from work. A total of 90% of major injuries result in fractures. These accidents occur mainly in the construction, health and social work and public administration sectors. Significant numbers also occur to the public, largely in the retail sector.

4.3.4 Next steps

HSC have identified a series of industry sectors and cross industry issues for specific attention following the publication of its Revitalising Health and Safety strategy:

- agriculture, including farm workers, self employed farmers and their families;
- construction, including the risk of falling from heights;
- workplace transport, including pedestrian injuries at the workplace and driving in the course of work;
- the health services sector;
- slips and trips;
- falls from heights;
- musculo skeletal disorders. There is anecdotal evidence that in some cases lower paid and manual workers may be at higher risk than their counterparts where they are performing manual operations; and
- stress, where the Whitehall II studies show that lower grade workers are more likely to suffer from stress related illness. This will be addressed as part of the priority programme.

Future interventions will be based on achieving the Revitalising Health and Safety targets, and the development of strategies to address the priority areas selected by HSC. Each strategy includes the following elements:

- *compliance*, to ensure that enforcement is targeted, proportionate, consistent and transparent, including changes to the legal framework;
- *developing the skills* of duty holders, workers and their representatives and enforcing authorities; and
- *continuous improvement*, including agreeing baselines against which future progress can be measured.

What may be possible in the medium/longer term

Other actions that are likely to take effect in the longer term include:

- improving the knowledge base through research, and dissemination to those who are in a position to control the risks; and
- ensuring that support mechanisms are in place to help those responsible for controlling risks to fulfil their duties.

4.3.5 Gaps in our knowledge

- risks to pedestrians in the industrial workforce (e.g. construction/industrial environments);
- safety techniques and risk management and their cross sectional relevance throughout injury prevention;
- further research is planned on causation and human or behavioural factors as contributors to accidents;
- means of communication of health and safety messages to businesses, especially smaller firms; and
- for each of the Revitalising priority programmes, research funds will be used to provide further evidence on interventions and the development of new measures to support advisory and enforcement functions.

4.4 Home and leisure injuries to working age adults

4.4.1 Objectives

To reduce the number of deaths and serious injuries occurring in adults of working age in the home and whilst undertaking leisure activities by targeting injuries from DIY, burns and scalds, garden safety, and carbon monoxide poisoning.

Adults of working age (15–64 years) accounted for 1977 (almost half) of the 3974 accidental deaths in the home in 1999. (This age group accounts for about two-thirds of the UK population in contrast to older people who account for 47% of deaths and 16% of the population). Rates are over twice as high for males compared with females in the 15–44 years age group and nearly twice as high for males aged 45–64 years. The highest rate of deaths in the 15–44 years age group is for drug poisonings, whilst for the next group it is falls.

DTI have estimated that 2.88 million (49% of the total) non-fatal accidents in the home or at leisure involved 15–64 year-olds in 1999. The most serious of these accidents (involving an inpatient stay of three or more days) account for approximately 37,500 accident victims in the 15–64 age group. This group accounts for around a quarter of these more serious accidents.

For the most serious home accidents, the 45–64s accounts for over 60%, and almost 80% of these involve falls, with females outnumbering males by roughly 2 to 1 in the 55–64 age range. For leisure accidents, 66% are in the 15–44 age range, over 80% involve falls or collisions, 50% involve sport, and males outnumber females by more than 3 to 1.

Some initial research by DTI has shown associations between higher accident rates and areas with higher proportions of lower average income/lower social class. These associations were particularly marked for the under-15s, but weak for 15–64s, and not at all evident for those over 65.

Links to national strategies and programmes

Saving Lives: Our Healthier Nation (Department of Health 1999)

Key stakeholders

HSE, Local Authorities, DTI, RoSPA

4.4.2 Proven and promising interventions

The majority of home and leisure accidents involving products are attributable to misuse. The DTI's approach therefore has been to target areas where accidents are rising or have already reached a significant level, and to work with industry and within government to seek to change consumer behaviour. The DTI has run publicity and information campaigns and utilised various forms of below the line marketing techniques on subjects such as garden and DIY safety, carbon monoxide poisoning and fireworks.

In addition the DTI has conducted research with the aim of encouraging manufacturers and designers to produce products that are safer and more inclusive. The DTI has issued a series of anthropometric data publications to establish reference data on strength of different groups of the population.

4.4.3 New initiatives

DTI-funded campaigns targeting these particular hazards

- support for the Royal Society for the Prevention of Accidents to raise awareness of risks; and
- a DTI modernisation fund to support local interventions and identify good practice in home safety.

4.4.4 Next steps

What may be possible in the medium/longer term

Possibilities for the future include:

- collect and disseminate evidence of good practice in home safety and produce guidelines;
- continue awareness campaigns to influence consumer behaviour. We know that injuries involving products are predominately due to misuse and that sustained awareness campaigns can influence consumer behaviour;
- work with industry, producers and retailers to improve product safety and provide information on safe use; and
- work with industry on regulations, voluntary agreements and other means to tackle specific safety issues, e.g. heating systems, packaging, and candles.

4.4.5 Gaps in our knowledge

- ergonomic design factors of stairs;
- home environment solutions in relation to falls, scalds, poisoning (e.g. enhanced lighting, hot water temperatures and safety containers, respectively);
- a better understanding of the effectiveness of safety campaigning and/or publicity in providing information and changing consumer behaviour; and
- improving provision of safety use information to public and manufacturing populations.

5

Framework for Delivery

The Task Force concluded that its responsibilities lay in providing a framework for delivery, rather than attempting to be prescriptive about detailed plans for delivery. The following conclusions sketch out the main features of that framework.

In its report on *Injury Prevention*, the BMA recommended that a new agency should be created to co-ordinate accidental injury prevention (AIP) at a national level (BMA 2001). However, the Task Force concludes that this would be difficult to justify in the light of current Government policy to devolve work to lower levels.

5.1 Immediate Priorities

The Task Force recognised that it will not be possible to deliver national targets on reducing accidents unless there is a more integrated approach to accident prevention, coupled with a strong lead at every level. The Task Force therefore concluded that the development and publication of a more united approach across Government and the NHS should be a priority.

Given that accidental injuries affect the health of many, and have a considerable impact on the NHS, the Task Force concluded that the Department of Health is ideally placed to steer the delivery of cross-Government action.

Since Regional Directors of Public Health will shortly be located in Government Offices of the Regions, the Task Force recommended that Regional Directors of Public Health should lead on co-ordinating the delivery of accidental injury prevention at regional level.

The Task Force considered that Public Health Observatories, together with their counterparts in local government, should play a key role in the surveillance of accidental injury.

The Task Force concluded that local authorities, primary care trusts and other local organisations should come together through Local Strategic Partnerships (LSPs) to deliver AIP. As part of their health improvement and modernisation responsibilities, local directors of public health should work through LSPs to co-ordinate delivery of AIP at local level.

The means used to deliver local AIP will vary from place to place. However, the evidence given the Task Force led it to believe that delivery is more likely to be achieved where it is made the task of an identifiable individual working to a local implementation plan.

5.1.1 Principles for Implementation

The Task Force identified a number of principles that must underscore successful implementation.

Specific steps to help create local implementation would include:

- using focused data to show where action is needed most;
- adapting key interventions to specific local needs where they have the greatest impact;
- developing and disseminating good practice to show what can be done;
- showing how these interventions can help deliver other programmes and meet targets elsewhere (eg Health Inequalities, Sure Start, etc);
- involving **all** stakeholders in producing a local action plan;
- developing a well trained workforce with capacity to undertake injury prevention work;
- recruiting high-level support;
- recruiting support from the voluntary sector;
- identifying sources of additional funding; and
- identifying indicators to monitor performance.

The development of an implementation plan will include a more detailed assessment of delivery structures. However, the above recommendations suggest that the structures required for immediate implementation will include:

- Directors of Public Health working in Government Offices of the Regions;
- Regional Public Health Observatories;
- a Public Health Director in Primary Care Trusts;
- a Local Strategic Partnership in each community; and
- a named individual to deliver plans.

5.1.2 Monitoring and Evaluation

Some mechanisms for monitoring delivery are already in place. Local Transport Plans are already monitored by DfT, and a number of local Public Service Agreements already include road safety initiatives. Health Improvement and Modernisation Programmes and National Service Frameworks will be monitored by Special Health Authorities. Death rates from accidents are already an NHS performance indicator.

A complete list of existing indicators is being compiled, and will be made available on request to those who monitor performance nationally, regionally and locally.

5.2 Longer-term actions to improve the infrastructure

The Task Force recognised that it will be difficult to achieve significant, sustained reductions in accidental injuries unless work is done, over time, to improve the supporting infrastructure. There needs to be a fully trained workforce, working to set priorities in a system which has good mechanisms for monitoring progress towards achieving these priorities in a cost-effective way. This all needs to be underpinned by research which is essential for strengthening what we know and identifying the gaps in our knowledge which need to be filled.

The Task force has considered the issues of infrastructure through:

- better data and injury surveillance;
- a well trained workforce with capacity to undertake injury prevention work;
- a research infrastructure and capacity to undertake and disseminate multi-disciplinary research to the highest international standards, especially on reducing inequalities and on cost-effective interventions.

Each will be addressed in turn.

5.3 Data and surveillance

The Task Force recognised that collection and dissemination of data is vitally important in the monitoring and evaluation of injury prevention programmes, and assists with the targeting of resources and activity to those identified with the greatest need. The analysis, interpretation and reporting of reliable data are essential elements in the prevention of accidents and subsequent injury.

Routine data sources rarely include measures different inequality dimensions such as social group. This could hinder monitoring the effect of interventions on social group or ethnicity.

5.3.1 What may be possible in the medium to longer term

In the field of data and surveillance there are no quick fixes. However, the Task Force recognised the urgency of improving the situation and has recommended a number of measures to tackle these difficulties. There is a great deal of data already collected and the priority is to make better use of what is currently available. However imperfect the current system might be in terms of future information needs, the first step in improving it will be for practitioners to work together to use and share the data already available whilst a more optimal solution is being developed.

The recommendations that follow involve further work and will need to be prioritised and costed to develop a strategy for information on injury prevention.

Nationally collected data

Government and other agencies collect large amounts of information on a routine basis and it is stored in national databases where there are differences in collection techniques, definitions and database structure. The information collected is often not easy to share as few people have a comprehensive picture of what is available and fewer still have an in-depth understanding of all the databases involved which would allow a full picture of injury to be built up. Having said this, many databases have been built up over decades by Government Departments and refinements made to their data quality, scope and structure. This means that many data sources are fit for the purposes for which they were collected but are not easily capable of being brought together to provide a coherent picture for injury prevention purposes. However, whilst this is neither cost effective nor efficient in public policy terms there may well be major costs of change involved to individual data collectors and analysts if time series data were to be compromised or other changes were required. These need to be assessed.

- *Department of Health* – Hospital Episode Statistics (HES), The Health Survey for England, A&E data, and the Trauma Audit and Research Network (TARN)
- *Department for Transport* – road traffic accident statistics (STATS19)
- *Office of the Deputy Prime Minister* – fire statistics (for injuries) (FDR1)
- *Department of Trade & Industry* – Home and Leisure Accidents, Home Accident Surveillance System (HASS), Home Accident Deaths Database (HADD), and Leisure Accidents Surveillance System (LASS).
- *Health & Safety Executive* – Work Related Accidents (RIDDOR, Safety Statistics Bulletin);
- *Office for National Statistics* – Mortality Statistics: Injury and Poisoning; Morbidity Statistics from General Practice.

National data are fragmented and not always easy to compare because of different definitions and coding conventions used by different Government Departments and agencies. The levels of national data and indicators of injury occurrence are well developed but gaps and overlaps exist in the coverage of accidents and there is a lack of comparability in the collected information. Comparable indicators of severity of injury are not well developed with different definitions of severity being used by different data collectors. There is also a lack of centrally available data from health service sources such as A&E departments and general practices which have the potential to provide data on injuries resulting from all kinds of accidents.

Regional data hardly exists at this aggregate level, except in the road transport area where Government Offices for the Regions are well established and regional statistics published centrally. The growth of Public Health Observatories provides an opportunity to develop regional surveillance and databases on injury.

Adopting a core minimum data set

The following has been identified to comprise a core minimum data set:

accident characteristics:

- type of accident;
- accident location;
- geographical identifier for location;
- time of day, day of week, and accident date

personal characteristics of each person injured

- age;
- sex;
- area of residence.

Adoption of common standards for this core set of items is *critical* for facilitating greater linkage as these items (when commonly defined) should allow the identification of the same accident/same characteristics of people injured across the sources.

Local data are fragmented, there is a lack of accessibility, and total numbers of injuries, especially deaths, are too small to enable local injury prevention programmes to be developed for individual injury types. However, there are several local injury surveillance systems being set up around the country. This helps people responsible for local injury prevention work together with synergy to solve local problems as often they have similar underlying causes such as poor housing, lack of knowledge, skills and experience, or poor environmental design. Different administrative boundaries at the local area do not always coincide which makes it difficult to bring the data together at Local Authority or Primary Care Trust level.

National information lead for injury

It is not feasible in the short term to establish a national injury surveillance centre to bring together the core minimum dataset at the national level. However, there is a need for a single source at national level to provide information and analysis, to enable monitoring of progress, and to lead developments to improve accidental injury data. This might be developed in the medium term.

Injury surveillance at regional level through Public Health Observatories

The Task Force believes that injury surveillance would best be carried out at regional level. Public Health Observatories could play a leading role, but all parties would need to help to collate, disseminate and analyse data on injuries and their consequences. One major barrier to be overcome is the difference in administrative boundaries between Local and Health Authorities, and PCTs. However, pump-priming funds may be needed to help the PHOs develop new systems.

Injury surveillance at the local level

The Task Force also recommends encouraging the development of local surveillance systems on a consistent basis at PCT level. It would be possible to build on the work of others to establish common protocols for improved data collection and exploration of ways of making this available at local and regional level.

5.3.2 Improved collection of data

A key step to improving understanding of injury at a local level and to introducing more targeted interventions is to improve data on injury collected by A&E Departments and in General Practice. All nationally collected data should be collected according to the core minimum data set recommendations, already agreed by data collectors during the PHIS (Public Health Information Strategy, Department of Health 1996) consultation phase. This is gradually being implemented by Government Departments as new reviews of data and storage are undertaken. It is recognised that standardisation across databases is only likely to be achieved as an iterative process. However, we recommend that this is adopted across all data sources especially at inpatient level, and also where there is a shortage of usable information from A&E departments and at PCT level (including General Practice).

Injury surveillance and prevention work requires close to complete external cause of injury coding (E-coding). Currently E-coding of hospital inpatient data is far from complete. It is recommended that a new national data quality indicator is introduced that measures the proportion of inpatient injury admissions (i.e. whose principal diagnosis is an injury) that are E-coded. It is further recommended that this indicator be included amongst those for which the Hospital Trust is performance managed.

Essential additional information

Additional information as recommended by the PHIS and Monitoring and Measuring Injury Working Group (MMIWG), including accurate geo-coding of the location of the accident; circumstances or events leading to the accident; socio-economic, ethnicity and other factors; type of activity preceding the accident; nature and severity of injury; and consequences of injury, including level of disability and ability to work. It is recognised that different databases have been set up for different purposes and are more suited to collecting some data items than others.

Measuring trends in exposure-specific risks

It is recommended that, where possible and cost-effective, data collectors be encouraged to collect data on exposure to inform injury prevention work about changes in trends in exposure-specific risks. At the local and regional levels relevant data systems need to be developed for the recording of exposure data, as some is already collected, and to allow additional exposure information to be added as and when it becomes available.

Coroners database

The BMA report, *Injury Prevention*, recommends that data from coroners' inquest reports relating to injury should be compiled into an anonymised standardised national database. The MMIWG supports this recommendation and recognises the need for a more systematised data collection system arising out of the investigation of deaths due to injury.

A study is needed to test the feasibility of linking HES and other Government Department data to a dataset of deaths relating to injury.

A knowledge base

We further recommend the development of systems for recording information on the effectiveness of injury prevention interventions. (One such a system, called MOLASSES, already exists for road engineering interventions). Where possible age-specific coverage of such items as use of cycle helmets and smoke alarms should be included. More information could be collected at the primary care level by setting up an accident and patient register to monitor ongoing medical effects and social implications of disability.

Assess the burden of injury

The burden of injury should be assessed on the basis of its occurrence, longer term consequences, and its costs to individuals and society including the health sector. An accurate account should be created of the burden of injury using internationally recognised methods, including Disability Adjusted Life Years (DALYs). This would aid comparison with other major public health threats in England.

5.3.3 Data Integration

A central register of existing databases covering this area would enable better access to the data and would allow easier ability to combine datasets. The creation of a website with a gateway to give access to national and regional data in the first instance is recommended. The Health Development Agency could undertake this.

The needs of users should be reviewed on a regular basis to ensure that the data and their analyses fit their needs.

5.3.4 Improved infrastructure

Data Protection, disclosure and confidentiality are issues that need to be resolved at national, regional and local levels. The National Statistics Code of Practice is currently out for public consultation and a National Statistics Data confidentiality disclosure and access protocol is being developed. A protocol for data matching is also being developed. The MMIWG recommend that these issues are further investigated once the Code of Practice and protocols are published.

5.3.5 Gaps in our knowledge.

- Develop standard definitions which agencies collecting data relevant to accidental injury could work towards adopting.
- Develop an agreed definition of severity of injury that is independent of length of stay in hospital. Research and development are needed to identify practicable ways of capturing severity of injury on routinely collected data systems, assessing the impact on safety work of implementing such changes to current collection systems and evaluating the benefits of change. This to be done in consultation with the HES data quality and classifications advisers.
- A research study is required to identify the feasibility and cost-benefit of different ways of linking different data sets using additional pieces of data and also to establish what is sensible to collect in a standardised way from different data sources.
- Research and development are needed to identify practicable ways of capturing injury-related disability. This can often be done in primary care.
- Research and development should be carried out to develop robust all-cause non-fatal indicators of injury occurrence.
- Address the quality of databases and controlled trials of interventions and to ensure relevant data is identifiable.

5.4 Action to improve delivery through a well trained workforce

5.4.1 People

It has long been recognised that the training of professionals is an integral part of developing good practice in injury prevention (e.g. Laidman 1987, 1992, 1993). Training motivates the workforce and is critical for achieving injury reduction outcomes. Training of the public health workforce was also a feature of the Report of the Chief Medical Officer's Project to Strengthen the Public Health Function.

A review of injury prevention initiatives by Towner *et al* (1996) showed that there are very few activities in place that target training practitioners and even fewer for training policy makers. Where training has taken place significant benefits for injury prevention work have been found. For example Marsh and Kendrick's (1998) controlled assessment of a multidisciplinary training programme for health professionals showed an increase in knowledge, networking and involvement in selected types of accident prevention activities.

People are the cornerstone of injury prevention work at all levels but none more so than those working at the local or community level. A priority for action is to develop a skilled workforce to champion, co-ordinate and lead work on injury prevention.

5.4.2 Training available now

Training given to the public health workforce is likely to include unintentional injury prevention of a general nature. However, there is a need for training courses which address the subject in more depth. One course which does this was launched recently by the University of Newcastle and the Child Accident Prevention Trust (CAPT), with support from the Department of Health. This may help build a more focused training capacity in the health sector, while extending training to local authorities and voluntary agencies whose staff are engaged in injury prevention. However, this is only a foundation course, and participants are likely to need some follow-up training.

In addition:

- RoSPA supports a City and Guilds Home Safety Certificate for those involved in care and repair, home check type work, which requires no entry qualifications and assumes little background knowledge.
- Road safety training by local road safety officers and engineers and the Institution of Highways and Transportation paved the way for an NVQ in road safety. This has units relevant to the health sector and others working in injury prevention.
- The Road Safety Officers Association (LARSOA), have for many years been offering courses for their members and there is parallel training for road safety engineers in road accident prevention work.
- There are also some half-day and day training sessions and conferences run at national level and at regional level for injury prevention practitioners (often by government departments, CAPT or RoSPA) and local level training by injury prevention and health promotion practitioners for other workers in their locality. These tend to be occasional events that cover specific topical issues or are related to practical initiatives.

Injury prevention is the responsibility of many people, which means that a wide range of jobs and professional roles can and should include some aspect of unintentional injury prevention. Much of the existing training is industry specific and does not contribute sufficiently to the needs of multi-disciplinary and multi-agency working that is needed to broaden the base of accidental injury work.

In order to achieve the most effective outputs in practice it is important that all relevant disciplines and individuals have a common base line of information and understanding to underpin their joint working and initiatives.

Capacity building across the disciplines would encompass initial training and in-service education and updating. The potential market for training is large but the needs of each individual can vary considerably depending on their job, employer and work role at any one time. Any training must be flexible in order to achieve its goals.

Barriers to extending training to all those who might benefit include:

- money; i.e. only limited budgets to support individual training;
- a lack of recognition among many employers that training is cost-effective; and
- when filling vacancies a lack of demand by employers for people with suitable qualifications.

5.4.3 Gaps in our knowledge

- Research is needed to develop information, knowledge and skills to enhance multi-disciplinary and multi-agency working and to develop priorities for collaboration, particularly regarding the development and testing of interventions.
- The impact of safety training on various groups in various settings (e.g. home carers, road users, people in sports/leisure environments, workforces within work environments).

5.5 Research infrastructure to fill the gaps in our knowledge

5.5.1 The role of research and development

A key to redressing the balance of small amounts of injury research aimed at a large accidental injury problem is to develop an infrastructure that builds capacity to increase the level and quality of research into the cause, prevention, treatment and rehabilitation of accidental injury. There must be capacity to carry through any research agenda and such developments of capacity and capability must be sustainable (Ward and Christie 2000).

Funding is the key to unlock this work at all levels. Government has a lever to help build up multi-disciplinary units and to stimulate sustainable collaborations and networks through its funding streams and commissioning practice. The Research Councils could be encouraged to fund post-graduate fellowships in injury prevention in order to increase research capacity.

Such centres, collaborations and networks would be instrumental in:

- the development of the R&D workforce capacity to ensure a sufficient supply of senior researchers able to grapple with complex methods, work across boundaries and ensure difficult R&D designs are carried out on the ground;
- fostering better understanding among researchers in different disciplines of the variety of valid methodological approaches to answering research questions; and
- providing mechanisms for breaking down barriers to effective working by encouraging the building of multi-disciplinary teams who can share and develop research methods as well as share data and research findings.

Additionally, there is a general R&D role to provide:

- Training and guidance to the research community on how to disseminate its research so it can be translated into practice. This can be achieved through meetings, virtual networks, dedicated data bases of ongoing projects, and journals which recognise accidental injury as a total concept;

- Training to local professional people in research methods and in preparing research proposals. Setting up a research network to co-ordinate community and local activities in injury prevention would facilitate developing strategies for working together and mapping the injury problem across the community.

In conclusion, there are compelling reasons as to why it is important to reduce the burden of accidental injury. In Britain, ownership of the injury problem, its solutions and research is fragmented with some important injury types (drowning, sports injuries, poisonings) falling between the gaps. For this reason, there is a need for collaborative research across all types of accidental injury from causation right through to rehabilitation of the injured.

Central Government should lead on pro-active research into accidental injury prevention. Responsive programmes, whether Government or Research Council, do not tend to attract the kind of research necessary to develop sustainable collaborations. International experience from the USA, Australia, and New Zealand indicates that a step change in interest and work in these areas is achieved when Government does take the lead. In each of these countries the Department responsible for Public Health has provided this lead.

5.5.2 Dissemination of information

Dissemination of information is an important part of the duties of all researchers and Government Departments. Research needs to be put into practice. The first step is to make people aware of research findings relevant to their practice. The accessibility of research findings is a major issue across all R&D.

- Dissemination strategies need to be developed by the Department of Health and others at national, regional and local levels so that research results are accessible and relevant to those involved in injury prevention within Government Offices for the Regions and Local Strategic Partnerships. One way to achieve this is to ensure that support is given to more reviewing activity across the board of injury prevention and treatment, so that what research there is, can be made easily accessible to everyone who needs it.
- Dissemination is not just a matter of making people aware of the results of research. It is also about changing professional practice so that those directly or indirectly involved in injury prevention, treatment and care act upon this research evidence. Effective ways need to be developed of getting research into practice across this heterogeneous discipline. This is an important part of training and capacity building referred to in Section 5.2.
- International work in injury prevention and control was given a boost by the start of the series of World Conferences on Injury Prevention and Control. The work in injury prevention is well advanced in each of the countries that have so far hosted the World Conference. Support should be considered for hosting a conference in this series to support and give recognition to British initiatives (Ward and Christie 2000).

5.5.3 Reducing inequalities in injury occurrence and prevention

The HDA are preparing a paper on these issues for presentation to the Department of Health. Some of the main issues are outlined below. There is much we do not know and at this stage there are more questions than answers.

Inequalities

A systematic review that targets inequalities as the primary point of inquiry is required to examine the effectiveness of interventions across social groups. This will also more clearly identify gaps in primary research involving a range of social groups.

More research is needed to:

- identify where social gradients are steep, where they are not and where they can be levelled, and to identify how the inequalities are different for different accident types, geographical regions and ethnic groups;
- further explore access to injury prevention programmes and advice (such as provided as part of the child health surveillance programme) by social group, to examine reasons for differential access to injury prevention initiatives by different social groups, and to explore how inequalities in access can be reduced;
- examine trends in injury morbidity by social group over time, with respect to a range of injury mechanisms and a range of injury severity;
- examine the question of what is the differential risk of injury by social group and examine whether there are differences in post injury survival by social group;
- examine why interventions were or were not effective in different social groups;
- to gather input from individuals in deprived areas and from ethnic minorities to ascertain how goals and objectives might reflect their views;
- develop more meaningful measures of exposure to risk for injuries and to examine the relationship between exposure to risk/hazards, especially for injuries and social disadvantage; and
- to determine strategies for risk reduction, drawing on the experience of children, families, and of older people in deprived areas.

5.5.4 Other cross-cutting research needs of priority groups

In relation to the priority groups identified by the task force there are gaps in our knowledge in areas which cut across the priority groups and settings. Some of these are identified below. The most prominent of these are those of cost effectiveness, safety in rural areas, aspects of changing unsafe behaviours, and a better understanding of risk.

Cost effectiveness

More needs to be known about:

- nationally agreed consistency of costing standards and conventions, and costs over time of preventing accidents, treating injury, and for rehabilitation and care;

- robust procedures for evaluation analyses to aid decision makers to set priorities between competing alternatives within programmes of prevention, treatment and rehabilitation;
- robust procedures for cost-effectiveness assessment once programme and interventions have been introduced;
- the cost of implementing interventions shown to be effective overseas;
- there is a need to examine the cost effectiveness of interventions to reduce inequalities in **childhood injuries**, particularly injuries incurred in the home;
- the cost effectiveness of interventions for **older people**; and
- the cost effectiveness of prevention strategies recommended in the National Service Framework for Older People.

Rural Areas

Research relating to accidents incurred through sports injuries, drowning, falls, and in rural areas is not plentiful. Gaps relating to sports injuries, drowning and falls are incorporated within reports relating to children and older people.

More needs to be known about

- differences in accidental injury between rural and urban communities, and injury on farms to both children and the workforce;
- whether rural populations manage injury prevention differently from urban populations in the respect of their remoteness from emergency/care/treatment facilities; and
- research on rural areas should include data collection relating to inequalities and cost effectiveness.

Staying Healthy, Protecting Health and Reducing Risk

Staying healthy, protecting health and reducing risk are also identified as actions to reduce accidental injury in *Saving Lives: Our Healthier Nation*.

More research is required in respect of:

- individual differences in behaviour, including propensity to multiple risk;
- the effects of stress on injury liability;
- the links between social deviance, at risk populations and injury;
- the ways in which children are supervised and the effects on accidental injury (e.g. poisoning, drowning, traffic accidents, farm accidents);
- the effects on injury occurrence of impairment through alcohol, illicit drugs, fatigue, and medical conditions for all adults and in all settings;
- exposure to risk in the population by injury type and population group;
- research relating to staying healthy, protecting health and reducing risk should monitor inequalities and cost effectiveness.

6

Conclusions

There are compelling reasons as to why it is important to reduce the burden of accidental injury. In England, ownership of the injury problem and its solution is fragmented with some important injury types such as drowning and sports injuries falling between the gaps of responsibility. The prevention of accidental injury of all types is too fragmented. Government strategies are in place to address important aspects such as road, work, and fire safety but hitherto the NHS – which bears much of the burden of the consequences of injury – has not always played a central role in prevention.

To encourage more concerted action there is a need for better co-ordination of injury prevention programmes, data and surveillance, and workforce capacity building; locally, regionally, and nationally. Unless action is taken to give accidental injury prevention a higher profile and greater momentum, particularly in the NHS, the accidental injury targets in *Savings Lives, Our Healthier Nation* are unlikely to be met.

Injury costs the NHS £2.2bn per annum. Over 7,000 people annually die in accidents on the roads or in the home. Injury prevention ‘saves lives’ and reduces long term suffering from disability. Injury prevention offers real benefits to individuals, to society, and to the Government. But those benefits will only be realised by planning specific actions to achieve them over and above what is being done at the moment.

The wider health policy map has changed since *Our Healthier Nation* was published and set targets for reducing death rates from accidental injury. It is within this wider context that children and young adults, and older people have been chosen by the Task Force as priority populations for immediate action. The NHS of 2002 and beyond sees injury prevention as being central to achieving wider Government programmes such as social exclusion and health inequalities. It is also a natural partner for policies on smoking, alcohol and physical activity.

Injury prevention needs more direct linkage to larger programmes. It needs better co-ordination and clearer leadership at national and regional level. And it needs a more disciplined focus on the areas where the burden is greatest, using interventions that have been demonstrated to work.

To make this happen, accidental injury prevention needs a new lease of life with its own identity. In other countries, work in injury prevention and control has been given a boost by hosting one of the biennial series of World Conferences on Injury Prevention and Control. Support should be considered for hosting a conference in this series to support and give recognition to British initiatives, together with support

for a series of national conferences to develop research networks and methods to disseminate best practice.

In this report, the Task Force has identified where efforts should be focused in future, and how they can have maximum impact through better planning, co-ordination and leadership. It sets out an agenda for delivering real reductions in accidental deaths and serious injuries, identifying proven practical measures that can be applied now.

There are some quick wins to be made in reducing the numbers of people killed or seriously injured. However, long term commitment within a framework for action at all levels is necessary to bring about programmes that are sustainable over time. This report spells out the importance of the need for a lead at National level and the Task Force believes that the Department of Health is best placed to steer cross-Government action.

There should also be a lead in developing strategies and programmes for implementation at regional level. The Task Force saw this as a responsibility for Regional Directors of Public Health located in the Government Offices for the Regions. There is strong support for Public Health Observatories to take a leading role in injury surveillance at the regional level. However, pump-priming funds may be needed to help the PHOs develop new systems.

At local level the Task Force saw the responsibility for co-ordinating the development and implementation of local injury prevention programmes and initiatives lying with the Directors of Public Health and the PCTs in partnership with other agencies and authorities through Local Strategic Partnerships.

The initial momentum must be maintained in the medium to long-term, a stronger infrastructure needs to be created that will be capable of achieving further, sustained reductions. The Task Force has set out how it believes that this can be done.

7

Acknowledgements

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- Colin Cryer, University of Kent, who was rapporteur to the Older Peoples' Working Group,
- Elizabeth Towner, University of Newcastle upon Tyne, who was rapporteur to the Children's Working Group,
- John Howard and Jean McIntyre from the Royal Society for the Prevention of Accidents, and Carol Sherriff and Mike Hayes from the Child Accident Prevention Trust who gave a strategic overview of specialists in the voluntary sector.

During the course of the work of the Task Force, Roger Peal, Head of Road Safety Division, DTLR (now DfT), passed away. Roger will be remembered for his significant and lasting contribution to the cause of safety, and road safety in particular. The Task Force wishes to acknowledge Roger's valuable contribution to its work.

8

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The Task Force and its Working Groups

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Terms of reference of the working groups

Children and young adults, and older people:

Taking account of Saving Lives and other relevant initiatives, to advise the Accidental Injury Task Force by 25 June 2001 on:

- the most important priorities for action to reduce the burden of accidental injury among children and young adults/older people;
- how such action might reduce health inequalities;
- what further work might be undertaken after 25 June by the working group on:
 - medium-term actions requiring further information or development;
 - longer-term actions requiring further research;
 - the development of an implementation plan for immediate action;
 - delivery structures to take forward the implementation plan.

Measuring and monitoring injury

- identify what we need to measure and monitor now, and in the future, at national, regional, and local levels;
- identify what is available now nationally, regionally, and locally in terms of data and information, and identify the immediate gaps;
- identify the data and information needs for the medium to longer term for improving information systems, including definitions and data linkage;
- develop an implementation plan for the outcomes of the measuring and monitoring working group;
- develop a procedure for monitoring the overall implementation plan for children and young adults, older people, and data and evaluation at national, regional and local levels; and
- develop a protocol for assessing how other Government Department's existing targets are contributing towards achieving the DH target.

The first three of these were substantially complete by 25 June 2001, the fourth to sixth to be developed subsequently.

The Working Groups met twice in the period February to June and prepared comprehensive reports which form the basis of the priorities and recommendations for action contained within this report. The Working Groups on children and young people, and older people were able to draw on two recent systematic reviews (Towner *et al* 2001, Cryer 2001) which were supplemented by new reviews commissioned by the Health Development Agency. These excellent and up-to-date reports were authored by Towner *et al* on *What works in preventing unintentional injuries in children and young adolescents?* and Cryer on *What works to prevent accidental injury amongst older people?* A third systematic review on young adults (Coleman *et al* 1996) was called upon but this is not as up-to-date and leaves a gap in our knowledge that needs to be filled of what works for young adults.

At its June meeting the Task Force approved the priorities identified and requested a draft report be produced during July for consultation during August and September. On 12 October the consultation process culminated in a conference in London to draw in any further comments, review existing conclusions. The report was presented to the Chief Medical Officer in the Spring of 2002.

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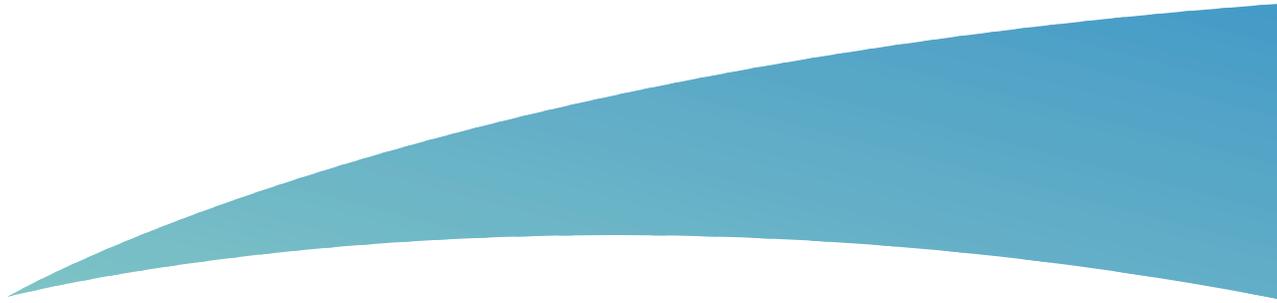
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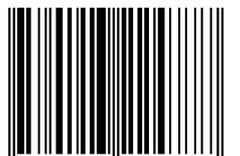
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