

Preventing unintentional injuries:

what does NICE guidance mean for primary care?

Unintentional injuries are the second most common cause of child death, accounting for one in seven deaths between the ages of 1 and 14 years.¹ These deaths represent just the tip of the iceberg. Every year, around 100 000 children are admitted to hospital² and 2 million attend emergency departments.³ How many seek treatment only from their GP is not known.

The impact of injuries on children, their families, and society can be considerable. The immediate effect of an injury is pain, followed by the psychological trauma of having to visit hospital, and loss of enjoyment of everyday activities such as play. But children can also be left disabled and disfigured, and lose education, potentially affecting the rest of their lives. Caring for an injured child can cause family breakdown and loss of employment, as well as having immediate economic consequences. Society has to bear the costs of treatment, rehabilitation, and long-term support.

Unintentional injuries are often thought of as accidents, but they are not random, unpredictable events as the term accident implies. We can identify children at risk of injuries and the injuries they are likely to suffer. Those from disadvantaged families are at greatest risk.⁴ Not surprisingly, the types of injuries experienced are strongly related to a child's stage of development. For example, the more active children become, the more likely they are to run and trip, and climb and fall; the exploratory stage of child development results in children putting objects in their mouth leading to choking and poisoning. Copying adult tasks, such as food preparation, can lead to lacerations and burns.

STRATEGIES TO PREVENT UNINTENTIONAL INJURIES

GPs and primary health care teams (PHCTs) have multiple opportunities to contribute to injury prevention and these are highlighted in three recently published guidance documents from the National Institute for Health and Clinical Excellence (NICE). The guidance contains recommendations for all those with a role to play in injury prevention, including commissioners and providers of health services, local authorities, their directorates and strategic partners.

The first guidance document, *Strategies to Prevent Unintentional Injuries among Children and Young People Aged Under 15*,

focuses on strategies, regulation, enforcement, surveillance, and workforce development in relation to unintentional injuries in the home, at play and leisure, and on the roads.⁵ It describes proven interventions to reduce unintentional injury and how they can be implemented by professionals and practitioners.

There are several elements of particular relevance to PHCTs. First, the importance of developing professional standards for injury prevention and incorporating these into professional skills development programmes. Commissioners (which include clinical commissioning groups [CCGs]) are recommended to provide access to education and training for everyone who works with children, young people, and families. This is particularly welcome as, despite four-fifths of all child injury deaths and hospital admissions being due to *unintentional* as opposed to intentional injuries,^{1,2} there are currently no requirements for PHCTs to undertake unintentional injury prevention training, unlike safeguarding, for which regular training updates are required for GPs and other members of the PHCT.

Second, the guidance emphasises the need to incorporate injury prevention within local strategies for health and wellbeing. It recommends that local areas appoint injury prevention coordinators to develop strategies, coordinate prevention activities, and act as a local source of information and expertise. PHCTs will need to work closely with these coordinators.

HOME SAFETY

Preventing Unintentional Injuries in the Home Among Children and Young People Aged Under 15 focuses on home safety assessments and providing home safety equipment.⁶ It is based on good evidence that GPs and PHCTs can effectively help parents to improve home safety.⁷ The guidance highlights the importance of using home visits and other contacts to identify households, especially in disadvantaged circumstances, where children are at greatest risk of injury. It is here that safety improvements can be made by providing home safety assessments and safety equipment, and by encouraging families to undertake their own home safety checks.⁸

Other opportunities for improving safety include Healthy Child Programme contacts

(the new baby review at 14 days, 6–8-week physical examination, and 2–2.5 year review), routine immunisations, and the 'teachable moments' provided by consultations following an injury. NICE also recommends that PHCTs are alerted about repeated emergency department or minor injury unit attendances so that families can be offered advice and a home safety assessment. To maximise efficient identification of families who may benefit from home safety assessments, sharing information about these families between agencies and practitioners is recommended.

ROAD SAFETY

The third piece of guidance focuses on road design and modification: *Preventing Unintentional Injuries Among Children and Young People Aged Under 15: Road Design and Modification*.⁹ While most of the responsibility for implementing interventions rests with the highway authority and their partners, there is a role for PHCTs and CCGs to work with partners in order to advocate for promoting and enforcing speed reduction, especially in disadvantaged and rural areas.

HOW DOES THIS SUITE OF GUIDANCE RELATE TO CCGs?

There will be significant pressure to provide access to high quality local health care within tight financial limits. Understanding the costs associated with childhood injuries is therefore critical. In a typical CCG with a population of 100 000, there will be approximately 3300 emergency department visits and 200 hospital admissions for child injuries. NICE calculates these costs amount to around £475 000 per CCG per year.¹⁰ This does not take account of costs from using primary care services and of rarer severe injuries, such as head injuries, burns, or scalds, which can cost significantly more. The good news is that NICE estimates the guidance only needs to result in an 11% reduction in injuries to offset the cost of implementation.¹⁰

Recent guidance from the Royal College of General Practitioners on commissioning urgent and emergency care states that 'Prevention of an acute avoidable episode is as important as service provision to address it', but contains little detail on what CCGs can do to prevent injuries.¹¹ Effective injury prevention is best achieved through

interagency partnerships and collaborations. CCGs will need to work closely with directors of public health (DPHs) based within local authorities. DPHs can help CCGs assess population level needs and costs associated with injuries, critically appraise injury prevention initiatives, and advise on the evidence base for effective prevention. Such information is vital for Joint Strategic Needs Assessments which will form the basis of commissioning plans for Health and Wellbeing boards. DPHs can facilitate partnerships between healthcare commissioners and providers, housing, transport, play and leisure, early years and education directorates, as well as with external agencies, such as the emergency response services. All need to contribute to achieve the recommendations made in the suite of NICE guidance.

In many areas, such collaborations currently exist within Safety Partnerships and, where possible, these need to be maintained throughout this period of change. DPHs will also be crucial in raising the profile of injury prevention within local authorities, which are to be held responsible for delivering local injury prevention. Thus CCGs, which will be paying the NHS costs for injuries, will need to work closely with local authorities to ensure effective injury prevention is delivered. NICE guidance specifically for Overview and Scrutiny Committees can help to prioritise injury prevention and increase the likelihood of inclusion in local strategic plans.¹²

GP's ENGAGEMENT IN INJURY PREVENTION

What isn't mentioned in the NICE guidance is that perhaps, particularly as GPs, we need to see child injury prevention as part of our role. We have taken falls prevention for older people on board, and this new NICE guidance reminds us we need to do the same for child injury prevention. What is being asked of us is not that different from what we already do. We write to housing departments requesting re-housing or improvements on the grounds of ill-health; why not do the same for child safety? We visit older people at home who have fallen, explore reasons for the fall and refer to falls assessment teams. If we noticed a family did not have a smoke alarm how many of us would mention it? Perhaps we don't know this increases the risk of death in a house fire 2-3 fold¹³ and that the Fire and Rescue Service will provide free home fire safety checks and may fit smoke alarms?¹⁴ Or maybe we don't think it's our place to discuss smoke alarms?

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Thirty years ago, it was argued that GPs ignored smoking because they felt unable to influence it,¹⁵ and look how successful we are now at helping people stop smoking. How many more children need to die or be disabled before we implement effective injury prevention? By putting effective interventions into practice GPs and the PHCT can help to reduce the unacceptable toll of childhood injuries.



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