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# Accidental injury: a neglected area within Primary Care Groups and Trusts?

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## Abstract

**Our objective was to assess accidental injury prevention activity within Primary Care Groups/Trusts (PCG/Ts), and current knowledge and attitudes towards accidental injuries and their prevention amongst PCG/T board members. We used a cross-sectional postal questionnaire survey design. Participants were board members of 51 PCG/Ts in Trent. The main outcome measures were prioritization of accidental injury prevention and factors influencing prioritization, perceptions of the accidental injury rates in the population served by the PCG/T, accidental injury prevention activity undertaken by the PCG/T, attitudes towards accidental injury prevention and towards the PCG/Ts involvement in accidental injury prevention, knowledge of accidental injury mortality, and beliefs in the effectiveness of interventions. Many (66%) PCG/T board members see accident prevention as the least important of the priority areas in the Government's health strategy for England. Half the PCG/Ts (49%) had formally discussed accidents at a PCG/T meeting, 34% had taken action and 29% had written an accident prevention strategy. The median number of agencies PCG/Ts were working with on accident prevention was 2. GPs held less positive attitudes about accident prevention than other board members ($Z = -10.01$, $P < 0.001$), but had a greater knowledge about injury mortality ($Z = -3.92$, $P < 0.001$). Health promotion leads had more positive attitudes towards accident prevention than other board members ($Z = -3.70$, $P < 0.001$). There were misconceptions amongst health promotion leads about the effectiveness of some accident prevention interventions. We conclude that there is little evidence of prioritization of accidents as an area for health improvement. Although some PCG/Ts are undertaking accidental injury prevention, a minority have demonstrated strategic planning with respect to accident prevention or collaboration with a wide range of agencies. Accident prevention and the PCG/Ts role within this are not viewed positively by all board members. Gaps in knowledge about accidents and their prevention are apparent. PCG/Ts will need help and support to fully develop their potential in preventing accidental injuries.**

## Introduction

As part of the UK Governments' reform of the NHS, 481 Primary Care Groups (PCGs) were established across England in 1999, each serving a population of around 100 000 people (Bojke *et al.*, 2001). Since then mergers of PCGs have led to Primary Care Trusts (PCTs), serving much larger populations (Wilkin *et al.*, 2001a). The Governments health strategy for England, *Saving Lives: Our Healthier Nation*, identified PCG/Ts as responsible for improving the health of local communities. Health authorities were charged with developing health improvement programmes to

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address national priorities, and PCG/Ts with planning and resourcing their implementation (Department of Health, 1999). More recently, the role of PCTs in community development, health promotion, and working in partnership with Local Authorities and other partners to improve the health of their communities has been outlined (Department of Health, 2001b). The roles and responsibilities of PCTs are rapidly changing (Wilkin *et al.*, 2001b). Not only are they responsible for prevention, but with the abolition of health authorities this is extending to commissioning primary and secondary care services, which will include the treatment of injury and rehabilitation, and care of those disabled by injury (Department of Health, 2001c). Paying for both prevention and treatment may highlight the importance of injury prevention to PCTs, and act as an incentive to increase preventive activity.

Four national priorities have been identified in 'Saving Lives: Our Healthier Nation': heart disease and stroke, cancer, mental health, and accidents. Accidents were chosen as a priority because more than one person dies every hour from accidents in England, treating injuries costs the NHS approximately £1.2 billion each year, and they are the greatest single threat to life for children and young people (Department of Health, 1999). The target set within the strategy is to reduce death rates from accidents by a fifth and serious injury rates by a 10th by 2010. Despite the importance of preventing accidental injuries, and the developing role of PCTs in commissioning both treatment and preventive care, little is known about their activity in this area (Wilkin *et al.*, 2001a).

We are currently undertaking a randomized controlled trial to determine the effect of providing accidental injury information to PCG/Ts on their preventive activity. The data presented here form the baseline assessment for this trial, whose results will be presented at a later date. The aim of this paper is to describe accidental injury prevention activity within PCG/Ts, and knowledge and attitudes towards accidental injuries and their prevention amongst PCG/T board members.

## Methods

A cross-sectional survey was undertaken of all board members of the 51 PCG/Ts in Trent in April 2000. Approval for the study was obtained from the Multi-Centre Research Ethics Committee and all Local Research Ethics Committees in Trent.

### Questionnaire development and piloting

We developed a longer and shorter version of the study questionnaire. The longer version was sent to the person most responsible for health promotion (the health promotion lead) in each PCG/T. It contained questions on prioritization of accidental injury prevention, and factors influencing the prioritization, perceptions of accidental injury rates in the population served by the PCG/T, accidental injury prevention activity undertaken by the PCG/T, attitudes towards accidental injury prevention and towards the PCG/Ts involvement in it, knowledge of accidental injury mortality, perceptions of the effectiveness of interventions, professional group, and duration of membership of the PCG/T. A shorter version was designed for other board members. This was identical, but excluded questions on preventive activity undertaken by the PCG/T, perceptions of injury rates and the effectiveness of interventions. The questionnaire was piloted on members of PCG/Ts in the West Midlands region.

### Questionnaire administration

Fifty-one health promotion lead and 618 other board member questionnaires were sent by post in April 2000. One reminder was sent to non-responders. A telephone follow-up of non-responding health promotion leads ($n = 5$) was undertaken to determine whether the PCG/T had an injury prevention strategy as this was the primary outcome measure for the subsequent randomized controlled trial. The results presented here relate only to returned questionnaires.

### Data entry and analysis

Data were entered into a Microsoft Access database. A random 1:10 sample of questionnaires was

double entered, and discrepancies with the original data were identified and corrected. Data were analysed using SPSS version 10 and STATA version 5. The difference between proportions and 99% confidence intervals have been calculated. Continuous data were not normally distributed so have been analysed using Mann–Whitney *U*-tests and Spearman's correlation coefficients. In view of the large number of statistical tests undertaken, a *P* value of 0.01 has been taken as significant for all analyses.

### Computation of scores

Scores were created for attitudes towards accidental injury prevention (the questions included in the score are shown in Table III) and for knowledge of accidental injury epidemiology. For the attitude score, the responses to 11 attitudinal questions (five-point Likert scales from 1 to 5) were combined. Each question was coded so that a high score indicated a positive attitude towards injury prevention. Respondents with missing values for any attitudinal statement were excluded from the analysis (33 of 478, 6.9%). Item analysis was undertaken including examination of the distribution of each item, calculation of inter-item correlations, item-total correlations and Cronbach's α. All 11 items were included in the score, which had a Cronbach's α of 0.81. The maximum obtainable score was 55 the minimum was 11.

A knowledge score was computed by summing the responses to the three questions concerning the most common mechanism of injury death in childhood (0–15 years), young adulthood (16–24 years) and older people (75 years and over). Questions were coded as '1' if correct and '0' if incorrect or missing. The score represents the number of correct answers.

## Results

### Characteristics of responders

A total of 478 responses were received (71%). Forty-six of the 51 PCG/Ts returned a health promotion lead questionnaire (90%). However, eight of these (19%, eight of 43) were completed by people who did not consider themselves to be the person most responsible for health promotion in the PCG/T. The professional group of responders is shown in Table I. Most respondents (87%, 396 of 457) had been members of the PCG/T for more than 1 year. Those completing the health promotion lead questionnaire were newer members of the PCG/T [32% (14 of 44) up to 1 year versus 11% (47 of 413) for other board members, difference = 21%, 99% CI 2–39%].

### Prioritization of accidents and accident prevention activity

Two-thirds (66%, 283 of 431) ranked accidents as the least important of the four priority areas. Eighty-four percent (362 of 431) ranked heart disease and stroke as most important, 48% ranked cancer as second most important (206 of 431), and 42% ranked mental health as third most important (181 of 431). Based on the health promotion lead questionnaire, 49% of PCG/Ts (20 of 41) had formally discussed accidents at a PCG/T meeting, 46% (19 of 41) had agreed to take action and 34% (14 of 41) had taken action. Twenty percent (eight of 41) had agreed to discuss accidents at a later date and 29% (12 of 41) had written a strategy for accident prevention. Seventy-six percent (357 of 473) said their PCG/T would need help developing an accident prevention strategy.

Overall, 57% (264 of 464) of board members said their PCG/T was involved in accident prevention in some capacity. Of these, 80% (207 of 258) said their PCG/T was involved in child accident prevention, 26% (68 of 258) in accident prevention for young people and 74% (190 of 258) in accident prevention with older people. Twenty-nine percent (13 of 45) of those completing health promotion lead questionnaires said their PCG/T was not involved in any accident prevention work. The remaining 33 provided details of the agencies their PCG/T was working with and these are shown in Table II.

#### *Comparisons between GPs and other PCG/T members*

Prioritizing accidents as least important did not differ by professional group [70% (158 of 226)

**Table I.** *Professional group of respondents (%) [missing values]*

| Professional group | Health promotion member questionnaire [3] | All board member questionnaire [3] | Total |
|---|---|---|---|
| GP | 12 (27.9) | 235 (54.8) | 247 (52.3) |
| Nursing | 9 (20.9) | 69 (16.1) | 78 (16.5) |
| Social services | 1 (2.3) | 29 (6.8) | 30 (6.4) |
| Lay person | 1 (2.3) | 30 (7.0) | 31 (6.6) |
| Health authority | 6 (14.0) | 26 (6.1) | 32 (6.8) |
| Public health | 7 (16.3) | 8 (1.9) | 15 (3.2) |
| Practice manager | 0 | 5 (1.2) | 5 (1.1) |
| Other | 7 (16.3) | 27 (6.3) | 34 (7.2) |

**Table II.** *Agencies with which PCGs are working on accident prevention (%)*

| Agency | Working with agency for | | |
|---|---|---|---|
| | Child accident prevention | Accident prevention in young people | Accident prevention in older people |
| Fire and rescue service | 6 (18.2) | 2 (6.1) | 8 (24.2) |
| Road safety | 14 (42.4) | 9 (27.3) | 5 (15.2) |
| Community nursing | 30 (90.9) | 11 (33.3) | 25 (75.8) |
| A & E Department | 8 (24.2) | 3 (9.1) | 9 (27.3) |
| Local authority | 22 (66.7) | 14 (42.4) | 23 (69.7) |

The median number of agencies PCG/Ts were working with for child accident prevention was 2 (IQR 1.5–3.0), for accident prevention with young people was 1 (IQR 0–2) and for older people was 2 (IQR 1–3).

GPs versus 62% (124 of 201) other board members; difference = 8%, 99% CI –4 to 20%]. GPs choice of priority areas was more likely to be influenced by the availability of effective preventive interventions than other board members [78% (192 of 246) versus 60% (134 of 224); difference = 18%, 99% CI 8–29%], by availability of effective treatment interventions [73% (179 of 246) versus 45%(101 of 224); difference =28%, 99% CI 16% to 39%] and less influenced by particular problems in their PCG/T area [56% (138 of 245) versus 71% (158 of 224); difference= –14%, 99% CI –26 to –3%].

### *Comparison between those completing a health promotion lead questionnaire and other board members*

Prioritizing accidents as least important did not differ between those completing a health promotion lead questionnaire and other board members [67% (28 of 42) versus 66% (255 of 389); difference = 1%, 99% CI –19 to 21%]. Other board members were more likely to be influenced by the availability of effective preventive interventions when prioritizing the 'Our Healthier Nation' areas than those completing the health promotion lead questionnaire [71% (307 of 430) versus 50% (23 of 46); difference = 21%, 99% CI 2–41%).

## Perceptions of injury rates

Almost two-thirds of those completing a health promotion lead questionnaire thought the injury rates in their PCG/T were the same as or higher than the national average for children (66%, 29 of 44), for young people (64%, 28 of 44) and for older people (61%, 27/44). Perceptions of injury rates did not appear to be related to accidental injury prevention activity. Those perceiving their PCG/T injury rate to be the same as or higher than the national average for any age group were not more likely to belong to a PCG/T that had formally

discussed accident prevention at a board meeting [57% (13 of 23) versus 31% (five of 16); difference = 25%, 99% CI –15 to 65%], agreed to take action on accident prevention [57% (13 of 23) versus 25% (four of 16); difference = 32%, 99% CI –7 to 70%], had taken action [44% (10 of 23) versus 13% (two of 16); difference = 31%, 99% CI –3 to 65%], agreed to discuss at a later date [22% (five of 23) versus 19% (three of 16); difference = 3%, 99% CI –31 to 36%] or had written an accident prevention strategy [30% (seven of 23) versus 25% (four of 16); difference = 5%, 99% CI –32 to 43%].

## Attitudes towards injury prevention and knowledge of injury mortality

The responses to the attitude questions are shown in Table III. Although the majority believe most accidents are preventable and that accident strategies can save money, they have more divided views about whether the PCG/T can be effective in reducing accidents. In addition, they tend to see the responsibility for accident prevention lying with individuals or parents, or with other agencies.

Knowledge of how injury deaths occur was poor for deaths in childhood (29% correct, 140 of 478), better for deaths in young people (50% correct, 241 of 478) and best for deaths amongst older people (74% correct, 352 of 478). The median number of correct answers was 2 [interquartile (IQR) range 1–2]. There was no correlation between knowledge and attitude scores ($r_s$ = –0.06, $P$ = 0.20).

### *Comparisons between GPs and other PCG/T members*

Table IV illustrates that GPs hold more negative views about accident prevention than other board members for nine of the 11 statements. The median attitude score was higher for other board members than GPs [39 (IQR 36–43) versus 33 (IQR 28–37) $Z$ = –10.01, $P < 0.001$]. Knowledge was better amongst GPs than other board members [median correct answers 2 (IQR 1–2) versus 1 (IQR 1–2) Z = –3.92, $P < 0.001$].

**Table III.** *Attitudes towards injury prevention amongst respondents (%) [missing values]*

| Statement | Strongly agree | Agree | Unsure | Disagree | Strongly disagree |
|---|---|---|---|---|---|
| Accident prevention is predominantly the responsibility of the individual or parent [4] | 73 (15.4) | 273 (57.6) | 10 (2.1) | 105 (22.2) | 13 (2.7) |
| Most accidents are preventable [3] | 89 (18.7) | 337 (70.9) | 16 (3.4) | 32 (6.7) | 1 (0.2) |
| I believe PCGs can be effective in preventing accidents [3] | 21 (4.4) | 252 (53.1) | 86 (18.1) | 96 (20.3) | 20 (4.2) |
| Other agencies have greater responsibility for accident prevention than the PCG [9] | 68 (14.5) | 224 (47.8) | 57 (12.2) | 110 (23.0) | 10 (2.1) |
| The NHS should concentrate on treating injuries effectively whilst other agencies concentrate on preventing accidents [2] | 32 (6.7) | 126 (26.5) | 26 (5.5) | 233 (48.9) | 59 (12.4) |
| Our PCG will probably increase current spending on accident prevention [7] | 1 (0.2) | 117 (24.8) | 191 (40.6) | 135 (28.7) | 27 (5.7) |
| Accident prevention strategies can save money by reducing the number of accidents that need treatment [5] | 116 (24.5) | 304 (64.3) | 31 (6.6) | 20 (4.2) | 2 (0.4) |
| PCGs should fund safety equipment for those on low incomes [6] | 20 (4.2) | 105 (22.2) | 116 (24.6) | 163 (34.5) | 68 (14.4) |
| National and regional agencies are better placed than local ones to educate the public about accident prevention [3] | 43 (9.1) | 135 (28.4) | 60 (12.6) | 194 (40.8) | 43 (9.1) |
| PCGs should be involved in lobbying or campaigning on local safety issues [3] | 38 (8.0) | 263 (55.4) | 67 (14.1) | 87 (4.2) | 20 (4.2) |
| It is important for our PCG to collect data on accidents [4] | 81 (17.1) | 268 (56.5) | 50 (10.5) | 60 (12.7) | 15 (3.2) |

**Table IV.** *Comparisons of attitudes towards injury prevention between GPs, health promotion leads and other board members [missing values]*

| Statement | Median (IQR) attitude score for GPs | Median (IQR) attitude score other board members | *Z* score and *P* value for GPs versus other board members | Median (IQR) attitude score for health promotion leads | Median (IQR) attitude score for other board members | *Z* score and *P* value for health promotion leads versus other board members |
|---|---|---|---|---|---|---|
| Accident prevention is predominantly the responsibility of the individual or parent | 2 (2, 2) [1] | 2 (2, 4) [3] | –7.56<br>$P < 0.001$ | 2 (2, 4) [1] | 2 (2, 3) [3] | –1.50<br>$P = 0.13$ |
| Most accidents are preventable | 2 (2, 2) | 2 (2, 2) [3] | –1.50<br>$P = 0.14$ | 2 (1, 2) | 2 (2, 2) [3] | –2.32<br>$P = 0.02$ |
| I believe PCGs can be effective in preventing accidents | 3 (2, 4) [2] | 2 (2, 2) [1] | –8.31<br>$P < 0.001$ | 2 (2, 2) | 2 (2, 4) [3] | –4.26<br>$P < 0.001$ |
| Other agencies have greater responsibility for accident prevention than the PCG | 2 (2, 2) [2] | 3 (2, 4) [6] | –7.20<br>$P < 0.001$ | 2 (2, 4) [2] | 2 (2, 3) [7] | –1.71<br>$P = 0.09$ |
| The NHS should concentrate on treating injuries effectively whilst other agencies concentrate on preventing accidents | 3 (2, 4) | 4 (4, 4) [1] | –7.43<br>$P < 0.001$ | 4 (4, 5) | 4 (2, 4) [2] | –4.66<br>$P < 0.001$ |
| Our PCG will probably increase current spending on accident prevention | 3 (2, 4) [3] | 3 (3, 4) [4] | –1.88<br>$P = 0.06$ | 3 (2, 3) [2] | 3 (3, 4) [5] | 2.50<br>$P = 0.01$ |
| Accident prevention strategies can save money by reducing the number of accidents that need treatment | 2 (2, 2) [3] | 2 (1, 2) [1] | –5.79<br>$P < 0.001$ | 2 (1, 2) [1] | 2 (2, 2) [4] | –1.15<br>$P = 0.25$ |
| PCGs should fund safety equipment for those on low incomes | 4 (3, 4) [4] | 3 (2, 4) [2] | –6.45<br>$P < 0.001$ | 3 (2, 4) | 4 (2, 4) [6] | 2.79<br>$P = 0.005$ |
| National and regional agencies are better placed than local ones to educate the public about preventing accidents | 2 (2, 4) [2] | 4 (3, 4) [1] | –7.05<br>$P < 0.001$ | 4 (3, 4) | 3 (2, 4) [3] | –1.90<br>$P = 0.06$ |
| PCGs should be involved in lobbying or campaigning on local safety issues | 2 (2, 4) [3] | 2 (2, 3) | –4.56<br>$P < 0.001$ | 2 (2, 3) | 2 (2, 3) [3] | –1.35<br>$P = 0.18$ |
| It is important for our PCG to collect data on accidents | 2 (2, 3) [4] | 2 (2, 2) | –6.13<br>$P < 0.001$ | 2 (2, 2) | 2 (2, 3) [4] | –1.81<br>$P = 0.07$ |

A low score indicates agreement with the statement. Minimum score = 1, maximum score = 5.

**Table V.** *Perceived effectiveness of injury prevention interventions—number (%) of health promotion leads believing intervention to be effective or very effective [missing values]*

| Intervention | Believe intervention is effective or very effective (%) |
|---|---|
| Children | |
| cycle helmets [1] | 41 (91.1) |
| home safety advice [1] | 35 (77.8) |
| media campaigns [1] | 41 (91.1) |
| traffic calming | 28 (60.9) |
| low-cost safety equipment | 41 (89.1) |
| Young people | |
| smoke alarms | 36 (78.3) |
| visibility aids for cyclists | 41 (89.1) |
| road safety campaigns | 18 (39.1) |
| protective sports equipment/clothing | 35 (76.1) |
| regulations regarding protective sports equipment [1] | 29 (64.4) |
| Older people | |
| soft hip protectors | 24 (52.2) |
| calcium and vitamin D | 32 (69.6) |
| HRT | 26 (56.5) |
| review of medications [1] | 38 (84.4) |
| weight bearing exercise [1] | 41 (89.1) |

*Comparison between those completing a health promotion lead questionnaire and other board members*

There were fewer differences between health promotion leads and other board members in terms of the individual attitude questions (Table IV). The median attitude score was higher for health promotion leads than other board members [39 (IQR 36–43) versus 36 (IQR 31–40) $Z = -3.70$, $P < 0.001$]. There was no significant difference in median knowledge score between those completing the health promotion lead questionnaire and other board members [correct answers 1 (IQR 0–2) versus 2 (IQR 1–2), $Z = -1.72$ $P = 0.086$].

### Effectiveness of interventions

Perceptions of the effectiveness of interventions are shown in Table V. Media campaigns are seen as being more effective than traffic calming in preventing accidents to children. Road safety campaigns are seen as being the least effective of the interventions for preventing accidents to young people. Medication reviews and weight-bearing exercise are seen as being more effective than soft hip protectors for preventing accidents in older people.

## Discussion

### Strengths and weakness of our study

This is the first study to report on accidental injury prevention within PCG/Ts, and the knowledge and attitudes of PCG/T members towards accidental injuries and their prevention.

Our study covers all PCG/Ts in Trent, but it is possible that those elsewhere have made greater progress; however, the National Tracker Survey would suggest this is not the case (Wilkin *et al.*, 2001a). Although we achieved a high response rate to our survey, a non-response bias may have occurred whereby those responding were more interested in, and possibly more motivated to undertake, accidental injury prevention. This being the case, our findings may overestimate accidental injury prevention activity being undertaken within PCG/Ts, but this would not alter our conclusions. As our data were collected in April 2000, it must be remembered that PCG/Ts may have developed their activity in this area since then, especially in relation to falls and the National Service Framework (HSF) for Older People (Department of Health, 2001a).

The quantitative nature of our study has enabled us to gain a broad, rather than an in-depth picture of the accident prevention activity of PCG/Ts. However, we are currently undertaking a qualitative interview study with a sample of PCG/T members to further our understanding of the reasons behind the responses on the questionnaire and the results of this will be presented at a later date.

### Comparisons with previous work

There are no published studies on the role of PCG/Ts in accidental injury prevention with which to compare our work. The second National Tracker Survey (Wilkin *et al.*, 2001a), which looked at

PCG/T development as a whole, found most had developed an infrastructure for health improvement and had developed links with other agencies, but the extent of these collaborations was not clear. Accidents were not mentioned as a priority for health improvement (Gillam *et al.*, 2001; Wilkin *et al.*, 2001a) and few had implemented accident prevention activities, findings similar to our own (Wilkin *et al.*, 2001a). One-quarter had allocated some of their budget to accident prevention involving agencies beyond the NHS (Gillam *et al.*, 2001). More than half the PCG/Ts felt they needed help with needs assessment or with public health functions (Wilkin *et al.*, 2001a). Similarly we found three-quarters of PCG/Ts felt they needed help to develop an accident-prevention strategy.

There is a small amount of work assessing knowledge of accidents and attitudes towards their prevention amongst some of the groups of health professionals who comprise PCG/Ts. Several studies have found little evidence of widespread support by GPs for their involvement in accident prevention (Carter and Jones, 1993; Carter *et al.*, 1995; Kendrick *et al.*, 1995a). GPs have often had little training in accident prevention (Carter *et al.*, 1995; Kendrick *et al.*, 1995a), tend to favour individually based educational approaches to preventing accidents (Kendrick *et al.*, 1995a) and have little experience of multi-agency working (Kendrick *et al.*, 1995a), which may help explain their less positive views towards the prevention of accidental injuries. Health visitors and practice nurses hold more positive views (Kendrick *et al.*, 1995b; Marsh *et al.*, 1995) and in the case of health visitors there is evidence for a greater involvement in accident prevention activities (Carter *et al.*, 1992; Marsh *et al.*, 1995). Since GPs comprise more than half the members of PCG/Ts, it is unsurprising that accident prevention is not seen as a priority.

## Implications for accident prevention in PCG/Ts

There is little evidence of prioritization of accidents as an area for health improvement. Few PCG/Ts have demonstrated strategic planning with respect to accident prevention and most recognize they need help in developing a strategy. PCG/Ts already report a lack of support from Health Authorities for public health functions (Wilkin *et al.*, 2001a). The new role for public health within PCTs has great potential for improving health and reducing inequalities; however, the capacity of the newly appointed PCT Directors of Public Health and the new public health networks to deliver the support required by PCTs is at present unclear.

The development of knowledge and skills in injury prevention is important so that PCTs can benefit from the range of interventions that have been shown to reduce accidental injury and to be cost-effective (British Medical Association, 2001; Towner *et al.*, 2001). Most PCG/T members will have had little, if any, training in accident prevention (Carter *et al.*, 1995; Kendrick *et al.*, 1995a,b; Phalp, 1995), and this would be a good starting point to try and address these issues (Phalp, 1995; Towner, 1995; Marsh and Kendrick, 1998; Towner *et al.*, 1998).

Although some collaboration is occurring with other agencies, PCG/Ts are more likely to collaborate within, rather than without, the NHS. Multi-agency working requires time, an understanding of the roles and responsibilities of the agencies involved, commitment, shared goals, and a shared strategy for realizing those goals (Child Accident Prevention Trust, Department of Trade and Industry and Health Education Authority, 1991). It is a complex process, and one that will be more successful if there is continuity of membership, a funded coordinator, participants of appropriate seniority, skilled chairing and a supportive organizational culture (Towner *et al.*, 1998; Green, 2000). PCG/Ts are going to need help in developing and maintaining multi-agency working in accident prevention.

Even with training and improved support for accident prevention, PCG/Ts are experiencing a rapid rate of change over a short period of time, which demands time, resources, managerial and strategic capacity and energy from the organization, and diverts attention away from health improvement (Wilkin *et al.*, 2001a). National guidance

such as NSFs are likely to have a similar effect with PCG/Ts focussing on responding to the most recent guidance at the expense of other areas (Gillam *et al.*, 2001). The NSF for Older People may have some impact in terms of falls prevention and the forthcoming framework for children in terms of child accident prevention, but their impact will require evaluation.

Unfortunately, despite *Saving Lives: Our Healthier Nation*, it seems accidental injuries are, at present, a neglected area for preventive action within primary care organizations. PCG/Ts are going to need considerable help and support to fully develop their potential in preventing accidental injuries.

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