Evaluation of the National Injury Prevention Plan: Priorities for 2001-2003 and National Injury Prevention Plan: Priorities for 2001-2003 Implementation Plan

**Report to the Strategic Injury Prevention Partnership by
The Centre for Accident Research & Road Safety - Queensland**

ACKNOWLEDGEMENTS

TABLE OF CONTENTS

LIST OF TABLES

FOREWORD

National Injury Prevention Plans are sets of principles that underpin and guide activities; documents that outline intentions; and statements of action taken to define relationships that facilitate the reduction of injury-related harm[1]. The critical role of evaluation in the ongoing development of policy is recognised in the commissioning of this evaluation of the *National Injury Prevention Plan 2001-2003*[2] as part of the process of developing its replacement, the *National Injury Prevention Plan – 2004 Onwards*[3]. The Strategic Injury Prevention Partnership (SIPP) is currently undertaking a multifaceted review of injury policy at the national and jurisdictional level and is pleased to be able to include the results of this report in its overall consideration of the relevant issues. We would like to thank the Australian Government for its key role in commissioning this report and commend the excellent work of the research team involved. We hope this document will increase the level of critical discussion of injury prevention policy that takes place in the public domain and invite you all to continue to provide your input through SIPP to this important aspect of Australia's health.

Rod McClure
Chair
Strategic Injury Prevention Partnership

---

[1] Foster M, Mitchell R, McClure R. Injury Prevention Policy. *In: The Scientific basis of injury prevention and control* McClure RJ, Stevenson M, McEvoy S. (Eds) IP Communications, Sydney, 2004

[2] Strategic Injury Prevention Partnership. *National Injury Prevention Plan 2001-2003*

[3] Strategic Injury Prevention Partnership. *National Injury Prevention Plan – 2004 Onwards*.

EXECUTIVE SUMMARY

Background and data issues
- This evaluation examines the *National Injury Prevention Plan: Priorities for 2001-2003* and the *National Injury Prevention Plan: Priorities for 2001-2003 Implementation Plan* which are jointly referred to as the Plan.
- The Evaluation focussed on a number of issues. These were:
    - the process of development of the Plan and the Implementation Plan in terms of context, history, opportunities and barriers
    - the strengths and weaknesses of the Plan
    - the extent to which the three aims of the Plan were met
    - the impact the Plan had on the area of injury prevention
    - stakeholder satisfaction with aspects of the Plan including its planning, development and implementation
- Critical analysis of relevant documents and a modified Delphi process were used to carry out the Evaluation
    - The Delphi process drew on the expert opinions of key people from government, research, non-government and practitioner areas of injury prevention, in association with the Strategic Injury Prevention Partnership (SIPP).
    - Three rounds of the Delphi were conducted. The first round consisted of in-depth telephone interviews to determine the major themes (n = 23). The second round allowed participants to reflect on responses to the first round and was conducted by email and telephone (n = 23). The third round was an email survey asking for responses to key themes emerging from the previous rounds (n = 30). Round 3 also assessed participants' perceptions of the extent to which the aims of the Plan had been achieved and stakeholder satisfaction with the Plan.

Findings from the Delphi Survey
- Context and history of the Plan
    - Generally participants described the development of the Plan as a lengthy and difficult process
    - The resulting National Injury Prevention Plan did not necessarily have high levels of commitment from all the parties needed to ensure successful implementation.
    - The Plan succeeded in identifying four Priority Areas for immediate action in injury prevention and in specifying a number of strategies that might be adopted to progress these areas.
- Strengths and weaknesses of the Plan
    - Strengths were identified as
        - evidence based on injury research /statistics and proven or promising interventions
        - promotion of consideration of the way that injury prevention resources are allocated
        - Plan's existence had a positive impact on the profile of injury prevention
    - Weaknesses were:
        - The Plan was confined to the injury concerns of the health sector alone
        - Ineffective consultation process
        - Lack of resources provided for implementation

- Participant perceptions of the extent to which the aims of the Plan were met
  - Generally participants did not think any of the aims of the Plan had been achieved more than moderately well.
  - The first aim of the Plan, "To focus national effort towards four priority issues" and part of the third aim, "To promote evidence-based sustainable injury prevention interventions to the health sector", were the two highest rated aims (mean rating 4.8 on 10 point scale)
- Impact of the Plan on the area of injury prevention
  - This Evaluation was unable to make any meaningful comment about the impact of the Plan on injury prevention due to lack of appropriate information. This is discussed in Sections 4.1 and 4.2.
- Stakeholder satisfaction
  - 62% of participants rated their satisfaction with The Plan itself at moderate or above.
  - A large number of participants were dissatisfied with the planning of the Plan. Overall, 85% of participants rated the planning as moderately satisfying at best
  - Almost all participants were dissatisfied with the implementation of the Plan with 96% rating implementation at moderately satisfying or less. Moreover, a large minority of participants (29%) indicated they were "not at all" satisfied or only slightly more satisfied than this with the implementation.
- Success of the Plan was hindered by a number of critical issues:
  - Lack of adequate resources
  - Poor engagement of key injury prevention groups
  - Confinement of the focus of the Plan to those areas of injury prevention over which health departments have influence
  - Lack of appropriate performance indicators or measures with which to gauge progress
- Conclusions
  - A key issue in the development and implementation of the Plan was the lack of identification of resources for specific strategies within the Plan. It is difficult to disentangle issues of lack of commitment to the Plan from issues related to lack of resources. Future planning would benefit from discussions relating to the resource issues and how to resolve them
  - An overall strategy for injury prevention needs to take account of the key areas of injury even where the health department has little influence. Future planning should identify who is going to be responsible for those areas (and how the health department can support and encourage those groups) even if the health plan only specifies actions within health.
  - Engagement of key stakeholders is a key issue for future planning. Explicit statements should be incorporated into future Plans systematically identifying who the stakeholders are and why they have been included as well as which groups have not been included and the reasons for not including them. An effective method(s) of engaging key stakeholders should be designed as part of the planning process.
  - Future planning needs to establish a way of measuring the extent and reach of programs that are put into place
  - A systematic utilisation of a framework such as the *Guidelines for Improving National Public Health Strategies Development and Coordination* (NPHP, 1999) might assist in development of future Plans.

1.0   INTRODUCTION

The Evaluation Team, consisting of members from The Centre for Accident Research and Road Safety and the University of Queensland, undertook a process evaluation of the *National Injury Prevention Plan: Priorities for 2001-2003* and the *National Injury Prevention Plan: Priorities for 2001-2003 Implementation Plan* (referred to jointly as the Plan below) between April and August 2004.

This Evaluation consisted of a critical analysis of relevant documentation and a modified Delphi process in order to address the following:
- The history and context of the development of the Plan
- The strengths and weaknesses of the Plan
- The opportunities presented by the Plan and the barriers to its implementation
- The extent to which the aims of the Plan had been met
- Noting the impact of the Plan on the injury prevention area
- The issues related to performance indicators in the four Priority Areas of the Plan in the context of the time frame for the Plan
- Performance and process indicators in each of the four Priority Areas of the Plan
- Stakeholder satisfaction with the Plan

1.1   Background to the *National Injury Prevention Plan: Priorities for 2001-2003*.

Injury prevention and control has been a National Health Priority Area since 1986. The lifetime cost of injury to Australia is estimated as $13,305 million per year including direct costs of treatment and the indirect costs to the individual, families, industry and society (Moller & Cantwell, 1999). It is the fourth leading cause of death in Australia, accounting for 6 per cent of all deaths or the deaths of more than 7,000 people each year (NIPAC, 1999). Injury is the seventh leading cause of loss of healthy years of life (Mathers, Voss & Stevenson, 1999) and results in more than 400,000 hospitalisations annually (NIPAC, 1999). In 2003, Access Economics estimated that there was still $1.3 trillion of potential health gains to be made from reducing intentional and unintentional injuries (Access Economics, 2003).

In 1997, the National Injury Prevention Advisory Council (NIPAC) was formed to provide advice to the Department of Health and Aged Care on ways to reduce the incidence and severity of injury. As part of this function, NIPAC commissioned research into proven and promising injury prevention strategies as well as identification of injury areas in which further evidence was needed (Moller & Cantwell, 1999; NIPAC, 1999). Based on the results of this research, NIPAC prepared the *National Injury Prevention Plan: Priorities for 2001-2003* (the Plan). The Plan was intended as a broad framework for national activity in areas identified as both 1) high priority for immediate action and 2) where the health sector could and should take a leading role (SIPP, 2001).

The National Public Health Partnership Group, a sub-committee of the Australian Health Ministers' Advisory Council (AHMAC), established the Strategic Injury Prevention Partnership (SIPP) in August 2000 with the role of providing a forum for leadership on injury prevention in Australia. SIPP was also charged with implementation of the *National Injury Prevention Plan: Priorities for 2001-2003*. Accordingly, SIPP prepared an implementation plan for the Plan, entitled the *National Injury Prevention Plan: Priorities for 2001-2003 Implementation Plan* (Implementation Plan) which was released in 2001. The Implementation Plan sets out the key work areas, strategies and tasks for each of the four

Priority Areas identified in the Plan. Key players and potential partners from other sectors are also identified.

The National Injury Prevention Plan 2001-2003

The goal of the *National Injury Prevention Plan: Priorities for 2001-2003* was to:

> "reduce the incidence and impact of injuries on the health and well-being of the Australian population in the four priority areas for immediate action" (DHAC, p. 4)

The Plan focussed on four specific Priority Areas in order to achieve greatest progress. It represented a broad framework for national activity in the Priority Areas where the health sector could and should take a leading role. These areas were: Falls in Older People; Falls in Children; Drowning and Near Drowning; and Poisoning in Children. The Priority Areas were selected on the basis of the following criteria: the existence of proven or promising interventions; interventions were able to be implemented; and where the leadership required was clearly the responsibility of the health sector.

The aims of the Plan were to:
- Focus national injury prevention efforts towards four priority issues;
- Strengthen national infrastructure to improve knowledge of injury and to implement injury prevention activities; and
- Promote evidence-based, sustainable injury prevention interventions to the health system, other sectors and the broad community.

Within the Plan, the available evidence regarding the size of the health problem in terms of mortality, morbidity and direct costs to the health care system for each Priority Area is presented along with a review (where available) of proven and promising interventions. The Plan lists strategies for promotion of best practice and research and surveillance for each Priority Area.

The Plan also identifies key stakeholders at government, community and professional level along with their roles and responsibilities in relation to the area of injury prevention. For government, the Plan outlines strategies that could be used to progress injury prevention at each level.

The *National Injury Prevention Plan 2001-2003* in the International Context

As in many other countries, Australia responded to the WHO's *Global Strategy for Health for All by the Year 2000* (WHO, 1981) by setting national health goals in specific areas. In Australia, these included injury.

In 1988, injury prevention and reduction was identified as one of five priority health areas for action in the *Health for All Australians* report from the Second International Conference on Health Promotion held in Adelaide (The Health Targets and Implementation Committee, 1988). The Plan represented an attempt to provide a framework through which to coordinate national action in injury prevention.

In 2003, the WHO discussion on developing national policies on violence and injury prevention highlighted the aims of such planning and policy documents. These included: to raise awareness about the magnitude of the injury problem; determine principles of action; provide a framework for action; define institutional responsibilities; and engage a variety of partners. Policies are distinguished by their greater focus on underlying principles and

priorities for action whereas action plans pay more specific attention to activities, implementation and resources required, timelines and responsibilities. In its final structure as two documents (the Plan and the associated Implementation Plan), the Plan attempts to address both of these levels.

1.2 The Brief for this Evaluation

The brief for this evaluation was:

> To provide the Commonwealth Department of Health and Aging with an evaluation of the *National Injury Prevention Plan: Priorities for 2001-2003* and the *National Injury Prevention Plan Priorities for 2001-2003 Implementation Plan*. The Evaluation took place at the national level although some conclusions relate to one of the four particular Priority Areas (Falls in Older People, Falls in Children, Drowning and Near Drowning, and Poisoning among Children), jurisdictions or states.

The agreed methodology was a critical analysis together with a modified Delphi process (described further below).

The purposes of the evaluation were:

- to document the process of development of the 2001-2003 Plan and the Implementation Plan in terms of context, history, opportunities and barriers.

- to summarise the strengths and highlight the weaknesses of the Plan so that future plans can benefit from lessons provided by the 2001-2003 Plan and planning process.

- to assess the extent to which the 3 aims of the Plan have been met.

- to note what impact the Plan has had on the area of injury prevention.

The target audience for the evaluation is the Strategic Injury Prevention Partnership (SIPP) and key stakeholders. The Evaluation provides a reporting mechanism through SIPP to the National Public Health Partnership (NPHP), the Australian Health Ministers' Advisory Council (AHMAC) and the Australian Health Ministers Council (AHMC).

The Evaluation Framework

The evaluation framework included the following elements:
- discussion on an outcome evaluation of whether the aims of the Plan were achieved;
- a process evaluation to measure the development and implementation of the Plan;
- a discussion on the issues relating to performance indicators for each of the 4 priority areas given the time frame of the Plan;
- performance indicators for the infrastructure and the programs;
- discussion on the numbers, geographic spread and scope of injury prevention projects / programs for the priority areas;
- any relevant existing evaluations in any of the 4 priority areas;
- a measurement of stakeholder satisfaction with the Plan; and
- selected performance and process indicators in each of the 4 priority areas.

2.0   METHOD

After detailed discussions between the Evaluation Team, the SIPP Evaluation Sub-Committee and SIPP members in Sydney in March 2004, it was agreed that the evaluation would consist of a critical analysis of relevant documents and a modified Delphi Process in order to address the areas of interest outlined above. Each of these methods is described in greater detail below.

2.1   The Delphi Process

Originally formulated during the 1950s by the Rand Corporation as a way of using expert opinion to help in defense problems, Delphi is a method where expert opinion is used to deal with a complex problem. It is particularly suitable where the information environment is uncertain and the methods of calculating risk too cumbersome and expensive to be feasible (Linstone & Turoff, 2002).

Essentially, Delphi is a process whereby informed individuals can work together using their areas of expertise in order to construct a group consensus about how a particular problem can viewed or approached, a solution constructed or new insights generated. It is particularly appropriate where there are high levels of uncertainty, where the best source of information is that of expert opinion.

The process itself usually consists of assembling a group or panel of willing participants who have recognised expertise, and providing them with the parameters of a problem. The panel is then asked to respond to particular issues, usually by email or post.

The monitor or facilitator of the Delphi structures 'rounds' of the process where a compilation of the information produced in response to the questions is shared with the panel. The panel then digests this and the next round is a response to the feedback as well as specific questions. Panellists are encouraged to elaborate on areas of disagreement. Rounds continue until saturation or stability of the consensus. Typically, 3-4 rounds are used. A voting procedure can be used to converge the consensus in situations where prioritising is a primary feature eg. in deciding which interventions/programmes to funds.

Advantages in using Delphi in the evaluation of the Plan

- Allows for the geographical dispersion of the panel members.

- Is sensitive to the different levels of political power and any factional impediments.

- Brings together expertise in disparate disciplines which have an interest and stake in the outcome.

- Cost effective in obtaining input from members.

- Deals with the uncertainty constraints in the injury prevention area.

- Engages those who are most likely to be affected by the outcome and therefore increases later commitment to the measures that are suggested.

2.2   Participants

For this Delphi process, experts in the areas of injury prevention administration, practice, research and policy development were deemed to be the relevant groups from which to invite people to participate. The size of the Panel for the Delphi was set at a maximum of 25 members in order to allow sufficient representation from each of the areas of expertise as well as from the different jurisdictions.

After discussion with SIPP, it was decided that participants would be drawn from two sources. The first source was the current and past members of the Strategic Injury Prevention Partnership (SIPP). The second source was a list of 33 other Australian experts in the injury prevention field. This list was compiled by SIPP.

SIPP members were asked to contact the experts that they had nominated and seek their participation in the evaluation. Once this had been done, CARRS-Q drafted a background letter that explained the purpose of the evaluation and invited experts to participate. This letter was distributed during March 2004 on SIPP letterhead through the Chair of SIPP, Associate Professor Rod McClure, to those experts who had indicated a willingness to take part.

CARRS-Q sent a second letter to potential participants explaining the Delphi process of the evaluation and what would be involved in participating. This letter also explained that a selection of people would be contacted for the first round interviews, with everyone else invited to contribute to the third (final) round.

Based on maximising representation of the various injury prevention areas (research, practice, policy administration, non-government and so on) sixteen potential participants were selected from the experts list. A further thirteen people from the SIPP membership were also selected for the first round of the Delphi process. Each of these people was contacted by telephone to see if they would participate and if so, to set an appointment for a telephone interview. A total of twenty-three people agreed to be interviewed. Interviews were carried out during April and early May 2004.

2.3   Procedure

After consultation with the Evaluation Sub-Committee of SIPP, the Delphi process for this evaluation was designed with three rounds. Rounds 1 and 2 were designed to uncover the key issues in the development and implementation of the Plan. Round 3 summarised these and was designed to assess the extent of consensus in relation to each of the key issues. Procedures for each round are described separately below.

In reporting the analysis of the separate rounds, we have given more attention to Round 3 as the final and summary round. The detailed findings from Rounds 1 and 2 are reported in Appendix 1 and 2 respectively.

Round 1 of the Delphi process.

The aim of the first round was to determine the key issues associated with development of the Plan and its implementation. Round 1 consisted of individual, in-depth interviews. These were conducted by telephone, except for one interview which was held in person by request. All interviews were audio taped, with verbal consent. Participants were informed that the interviewer was using a speaker phone to allow recording onto a hand-held tape recorder.

They were advised that their comments would be held in confidence, with all data being reported anonymously and that any quotes used would be de-identified. They were advised that they could stop the recording at any stage. All participants agreed to the recordings.

The interview questions were open-ended and focussed on the participant's experience of the development of the *National Injury Prevention Plan: Priorities for 2001-2003* as well as issues that participants saw as important to understanding the impact of the Plan or the area of injury prevention in general. These are given below.

> "Could you start by telling me what you think the key issues were in the development of the National Injury Prevention Plan or the Implementation Plan?"

> "How well do you think the Plan has been translated at the policy and action level in your jurisdiction (or jurisdictions you know about)?"

> "What, if anything do you think could or should be done differently for the next Plan?"

Probe questions were also asked in some interviews in order to clarify or elaborate points raised by participants. Interviews finished by asking participants whether they had any other comments to make or questions that they thought they should have been asked and hadn't been. Interviews lasted between 20 and 50 minutes, with most lasting 30 minutes.

Round 2 of the Delphi process.

This round was designed to allow participants to review all the issues raised in the first round and elaborate on, or clarify, points where necessary.

Each participant was sent two documents by email. The first of these was the Round 2 Delphi Process, which participants were asked to respond to by email, phone or conventional post. This document listed the key points raised in the interviews in relation to the strengths, weaknesses, opportunities and barriers associated with the development of the NIPP 2001-2003, as well as the suggestions for the development of the next Plan. Participants were asked to read the list and clarify anything which was unclear or add anything which they had thought of since the interviews.

The second document for Round 2 was a complete summary of all themes from the interviews in the first round. It was not necessary for participants to read this document in order to respond to Round 2, though they were encouraged to provide any clarification or feedback that they thought important.

Those participants who elected to respond by telephone (13/23) were interviewed a second time during June 2004. These interviews varied greatly in length, with the shortest lasting 10 minutes while the longest ones were about 60 minutes. The interviewer made notes about clarifications offered by participants and the statements summarising these were checked for wording and accuracy with participants prior to the end of each interview (see Appendix 2).

Altogether, 8 responses to Round 2 were received by email, 2 responses by conventional post (with one of these also being interviewed by phone) and the remaining 13 were telephone responses.

Round 3 of the Delphi process.

Round 3 was designed as the final process in the Delphi. It allowed participants to review the summary of the first two rounds. This round was also concerned with gauging the extent of consensus in relation to the main themes and issues emerging in the previous two rounds.

The questionnaire for Round 3 consisted of 8 separate sections 6 of which corresponded to the main themes or issues emerging from Rounds 1 and 2. These themes were: input and engagement; the four Priority Areas; Ownership and implementation of the Plan; Resource allocation; Outcomes/measures/targets; Looking forward. The remaining 2 sections addressed whether participants thought the aims of the Plan had been achieved and their satisfaction, as stakeholders, with aspects of the Plan (see Appendix 3).

Each section was comprised of several items that were derived from the sub-themes and issues raised by participants and appeared in the form of statements (for example, "From a health department perspective, the four Priority Areas were the best choices"). Participants indicated the extent to which they agreed or disagreed with each statement (see Appendix 3). For sections 1-5 and section 7, the scales were 5-point Likert-like scales SA= Strongly Agree to SD= Strongly Disagree. Section 6 asked participants about the extent o which they thought the aims of the Plan had been achieved and used a 10-point scale (1="not at all" to 10 = "completely") with an extra point of 0 = "Don't know". Section 8 used the same 10-point scale to obtain participants' estimations of their level of satisfaction with aspects of the Plan.

Round 3 questionnaires were sent by email to all of the Round 2 participants in early July 2004. A further 17 designated experts who had not participated in Rounds 1 and 2 were also contacted and invited to participate in Round 3, making a total of 40 potential participants for the final round. Responses were requested within a 10 day period. A further reminder email was sent on the eleventh day to those people who had not yet sent a response and follow-up phone calls were made on the thirteenth day. A total of 21 of the 23 participants (91%) from the first two rounds completed Round 3. Nine of the 17 additional experts responded (52%) making a total of 30 responses and an overall response rate of 75% to Round 3.

3.0   FINDINGS of the DELPHI PROCESS

This section summarises the qualitative data from the first two rounds of the Delphi process and the quantitative analysis of the final round.

Though normally a Delphi process strives for consensus from the second round, the range of opinions expressed in this Evaluation Delphi has been retained in the paragraphs and tables that follow partly because some minority views were held strongly even if not widely and in many cases represented views of key stakeholders outside government or the health sector as well as inside it. Since the views and satisfaction of stakeholders was a key area of interest in this Evaluation, there seemed little to gain from removing the diversity expressed in earlier rounds. The final round provided an opportunity to gauge the extent of consensus around each main issue.

3.1   Themes emerging from Round 1

As mentioned previously, interviews for Round 1 were open-ended and resulted in rich information about the key areas of interest. Full details of participants' comments and the findings can be seen in Appendix 1.

There were six main themes or issues that were extracted from Round 1 interviews. These are summarised below.

The development of the Plan

Generally participants described the development of the Plan as a lengthy and difficult process that resulted in a National Injury Prevention Plan that did not necessarily have high levels of commitment from all the parties needed to ensure successful implementation. However, the Plan had succeeded in identifying four Priority Areas for immediate action in injury prevention and in specifying a number of strategies that might be adopted to progress these areas.

The strengths of the Plan

The main strengths of the Plan were given as 1) its basis on current research evidence, 2) its promotion of thinking about the way that injury prevention resources are allocated and 3) that the Plan's existence had some positive impact on the profile of injury prevention.

The weaknesses of the Plan

There were three main weaknesses in the Plan. Firstly, the concerns of the Plan were seen as being limited to the health sector alone, though concern about injury prevention is intersectoral. The second weakness was that the consultation process used to engage key non-health groups had not done this successfully. The third weakness was perceived as the lack of resourcing at both Commonwealth and State/Territory level for the strategies and actions suggested in the Plan.

Opportunities presented by the Plan

The main opportunity identified by participants was that of having a national policy in injury prevention which might raise the profile of injury prevention in general and allow some progress to be made in critical areas. There was also an opportunity, through working on the Plan, for jurisdictions to work together more closely and achieve some leverage of their activities as a result.

Barriers to implementation of the Plan

Two key barriers to implementation were identified. These were 1) the lack of engagement of key groups with an interest in injury prevention and 2) the lack of resourcing of the Plan.

Suggestions for the development of the next Plan

Suggestions for improvement to the development of the next Plan were many and often addressed the shortcomings identified as barriers or weaknesses. Thus the main concerns were with achieving effective engagement and resourcing as well as ensuring greater collaboration amongst groups concerned with injury prevention (see Appendix 1).

3.2 Themes emerging from Round 2

Round 2 of the Delphi was intended to ensure that the findings of Round 1 were accurate and complete and to allow participants to reflect on the findings from Round 1. Round 2 consisted of six sections corresponding to the areas of interest of the research and main issues that emerged during Round 1. They were: Background and context; Strengths; Weaknesses; Opportunities; Barriers; What should be done for the next NIPP. Each section listed the main sub-themes extracted from Round 1 with space for comments. Participants were asked to read through the document and clarify anything they thought was unclear (see Appendix 1). They were also encouraged to add anything that seemed important. Round 2 was distributed by email and respondents were asked to respond either by email or through a follow-up phone call.

Responses from Round 2 were also analysed by extracting the main themes. Six themes resulted: 1) Input and engagement; 2) The four Priority Areas; 3) Ownership and implementation of the Plan; 4) Resource allocation; 5) Outcomes/measures/targets and 6) Looking forward. The complete responses can be seen in Appendix 2.

3.3 Results of Round 3

Round 3 was aimed at gauging how much agreement or otherwise there was with the key issues that arose in Rounds 1 and 2. Sections in Round 3 corresponded to the issues from Round 2 (above) and appeared as sections 1-5 and section 7. In Round 3 we were also interested in finding out about the extent to which participants thought the aims of the Plan had been achieved (section 6) and their level of satisfaction with aspects of the Plan (section 8). Participants were encouraged to make other comments for each section if they wished. Appendix 3 contains a copy of the Round 3 questionnaire.

Analysis of Round 3 was conducted using SPSS v12 (SPSS, 2004) as well as theme analysis of qualitative comments. Results are reported below under the headings used for each section of the Round 3 questionnaire. These results also include the main points raised by participants in Rounds 1 and 2. This is in order to elucidate or elaborate the meanings of particular themes or issues.

Section 1: Input and Engagement

One theme running through both Rounds 1 and 2 is that many participants thought the consultation process in developing and implementing the Plan was not wide enough and did not engage non-health groups sufficiently well. Participants who were drawn from practitioner areas or NGOs were particularly concerned that their interests had not been represented and that the resulting Plan therefore had reduced relevance to them and others like them. Though the following quote is rather lengthy, it expresses the various concerns that were raised:

> Other National Plans (eg Mental Health; Cardiovascular) allow non-health bodies like ours to see where they fit in the overall picture. The way the IP Plan is written we can't do that…People who were part of injury prevention networking across Australia (such as in occupational health, farm safety, water safety, indigenous health etc.) but who were not part of the health system were not included. So properly the Plan was a National Health Department Injury Prevention Plan rather than a National Plan. We see ourselves as part of health but we are not in a health department. The Plan only picks up things which are the domain of people within the health departments, which was not what other National Priority Areas Plans did….Because the Plan excludes so many of the people who are involved in injury, even if everything that was in the Plan gets done, we will only have improved injury a little instead of a lot.

In the Round 3 questionnaire there were five items in Section 1 which asked about participants' views on the representation of different groups in the development of the Plan (Table 1).

The first 3 items referred to historical material and as such, a large proportion of participants indicated that they were "Unsure" in response. We interpreted this to mean that participants did not want to give an opinion on something about which they felt they had little knowledge and indeed, some of the qualitative responses to this section stated this. For these 3 items responses are calculated after removal of the "Unsure" responses.

Though a very high proportion of participants (90%) responded "Agree" or Strongly Agree" to whether NIPAC had provided adequate representation of the interests of experts in the process of developing the Plan (item 1.1), opinion was divided over whether this was the case for practitioners and community bodies (item 1.2) with the majority (60%) disagreeing.

For item 1.3, a large majority (88%) agreed that the process of changing from NIPAC to SIPP had led to disengagement of key non-health groups.

Items 1.4 and 1.5 were directed towards future Plans and did not create the same level of "Unsure" response. There was almost universal agreement (93%) with the statement that "Future National Injury Prevention Plans should ensure engagement of all key stakeholders throughout the development and implementation process" suggesting that this is a key issue for future Plans.

Opinion was divided on item 1.5. While a majority agreed (59%) that "effective implementation of future Plans requires an executive body comprised of key stakeholders…", 21% of participants disagreed and a further 6 people (21%) were unsure. Qualitative responses suggested that the wording of the statement made this item difficult for participants to know what was meant by "executive body" and whether this was purely administrative or was advisory instead.

Table 1:   Stakeholder input into, and engagement with, the Plan. (Responses to items in Round 3)

Section 1: Input and Engagement	Frequency of response					n
	Strongly Disagree	Disagree	Unsure	Agree	Strongly Agree	
1.1 The membership of NIPAC ensured adequate representation of expert and independent injury prevention people/bodies in the development of the Plan.	0	2	9	15	3	29
1.2 The membership of NIPAC ensured adequate representation of practitioner and community interests in development of the Plan.	0	12	9	7	1	29
1.3 The transfer of responsibility for the Plan and its implementation from NIPAC to SIPP disengaged some key non-health groups.	0	2	12	11	4	29
1.4 Future National Injury Prevention Plans should ensure engagement of all key injury stakeholders throughout the development and implementation process.	0	1	1	10	17	29
1.5 Effective implementation of future Plans requires an executive body comprised of key stakeholders on which SIPP is represented.	0	6	6	10	7	29

Section 2: The four Priority Areas

Section 2 was the longest section with 11 items related to the four Priority Areas. This was because a theme that emerged early in the evaluation process was that many people disagreed either with the process of selection of the four Priority Areas or with the injury areas that had been chosen. Round 3 statements in this section were intended to try to tease out the finer aspects of the issues raised in relation to the four Priority Areas as well as to examine the extent of consensus.

During Round 1 it appeared that the contention about the four Priority Areas was about the evidence leading to identification of the areas and the degree of importance that these represented in the different jurisdictions. However, Round 2 responses indicated that most participants saw the evidence on which the Priority Areas had been selected as sound, and perceived two areas, Falls in Older People and Falls in Children, as being high priorities in all jurisdictions. The real issue seemed to be more about the confinement of the selection of the four areas to those which the health sector might be reasonably expected to have an impact. Participants commented that this led to the exclusion of injury issues with high impact but over which health had little influence, as illustrated here:

> I was on NIPAC [because of my specialist background]….It was not very satisfying work because injury [in my area of interest] was seen as the responsibility of another section of government….any truly comprehensive national plan must include all aspects of injury not just focus on those aspects that are under the control of health at a national or State level

A consequence of this restriction was that many people working in the area of injury would have been unable to recognise their own work within the Plan and would have perceived it as of little relevance to them. Some participants saw this as actively disengaging important groups in injury prevention and leading to a low level of support for the Plan in non-health organisations. One participant commented in this way:

> The fact that the 4 areas were health ones meant that all the burden fell on health. Health bears the burden of all injury even if it is not the primary agent in prevention. The Plan would have had more relevance to a wider group of implementers if it had been broader. Health jurisdictions may have given it higher priority. It wouldn't have disengaged people the way that it did

Clearly this picks up some of the points that were raised in the previous section relating to participants' concern with the necessity to ensure effective engagement of key groups.

Round 3 responses to Section 2 are displayed in Table 2. The highest level of agreement was for item 2.3 where 90% agreed that Falls in Older People had high relevance to a wide group of injury workers. This statement also drew a high proportion of "Strongly Agree" responses (35%) suggesting that participants felt strongly about the relevance of Falls in Older People to injury workers. Somewhat surprisingly, given the distinction drawn by participants in earlier rounds between this Priority Area and the others, two-thirds of participants (67%) saw the other 3 Priority Areas as having high relevance to a wide range of workers (item 2.4).

Items 2.1 and 2.9 generated high levels of agreement, with 80% and 77% respectively. Thus participants agreed that the focus on four Priority Areas was an appropriate strategy in a first-time Plan. Moreover, affirmative responses to item 2.9, "It is desirable for future Plans to focus on a limited number (4-8) of key injury areas/issues in order to make progress" suggest that this approach is seen as one worthy of continuing.

Responses to item 2.5 show a large proportion (43%) of participants have indicated that they are "Unsure" whether the other 3 Priority Areas reflected the highest priorities within the jurisdictions. Unsureness here may be lack of information. Only those participants in administrative positions may have been aware of which injury areas were the highest priorities at a jurisdictional level. Removing these "Unsure" responses leads to 76% agreement with this item, suggesting that those participants in a position to know regarded the Priority Areas (with the exception of Falls in Older People) as not reflective of the highest injury priorities at a jurisdictional level.

Table 2:   The four Priority Areas of the Plan. (Responses to items in Round 3).

Section 2: The Four Priority Areas	Frequency of response					n
	Strongly Disagree	Disagree	Unsure	Agree	Strongly Agree	
2.1 The focus in the Plan on four Priority Areas was an appropriate strategic approach for a first-time National Injury Prevention Plan.	0	5	1	17	7	30
2.2 The specific Priority Areas identified in the Plan did not reflect the areas of highest injury burden according to the evidence available at the time	1	7	5	14	3	30
2.3 Falls in Older People as a Priority Area in the Plan had high relevance to a wide group of injury prevention workers and professionals	0	1	2	16	10	29
2.4 The other three Priority Areas had high relevance to a wide group of injury prevention workers and professionals	0	6	4	18	2	30
2.5 The four Priority Areas (with the exception of Falls in Older People) did not reflect the highest injury priorities in most jurisdictions	0	4	13	11	2	30
2.6 From a health department perspective, the four Priority Areas were the best choices.	1	7	15	5	2	30
2.7 The Plan provided a basis for local plans and programs for Falls in Older People	0	6	7	15	1	29
2.8 The Plan provided a basis for local plans and programs in the other 3 Priority Areas.	0	9	8	10	3	30
2.9 It is desirable for future Plans to focus on a limited number (4-8) of key injury areas/issues in order to make progress	0	6	1	17	6	30
2.10 Future Plans should choose priorities according to the evidence of greatest burden/cost	2	6	3	16	3	30
2.11 Future Plans should be recognised and written as Health Department Injury Prevention Plans rather than National Injury Prevention Plans	5	10	5	5	4	29

Similarly, item 2.6 also indicates that a large number of participants (50%) were unsure about the views of the various health departments towards the four Priority Areas. Again, this may reflect a lack of information. Removing the "Unsure" responses from this item however, reveals an almost even split in opinion suggesting that this is an area of division at jurisdictional health department level.

Though agreement with item 2.10, "Future Plans should choose priorities according to the evidence of greatest burden/cost" reached 63% a number of participants made comments that preventability was an essential criterion for selection, suggesting that consensus would have been much stronger had preventability been included. There were also comments referring to the availability of effective interventions in making these sorts of choices.

The highest level of *disagreement* was for item 2.11 at 52%, indicating that most participants would prefer to maintain the Plan as a National Plan rather than confining it to health departments. However, opinion was spread over the spectrum of responses suggesting that participants had strong views on this issue and that consensus might be difficult to obtain.

Section 3: Ownership and implementation of the Plan

Because of the issues already discussed above, in Rounds 1 and 2 many participants commented that the Plan had not really been owned by anyone. Poor ownership was seen as part of the reason for poor implementation of the Plan, particularly outside the health sector. As with the previous section, during Round 3 we were interested in trying to tease out some of the finer points that emerged in the earlier rounds in relation to this issue. Results are displayed in Table 3.

Item 3.3, "Because Falls in Older People was a high injury priority in most jurisdictions it was more likely to be adopted" attracted the highest level of agreement for this section, with 80% of participants agreeing. A somewhat smaller proportion (67%) agreed that the other 3 Priority Areas were less likely to be adopted because they were not the highest injury priorities in most jurisdictions (item 3.4).

A moderately high proportion (70%) of participants thought that the opportunities for jurisdictions to collaborate had not been realised in the development and implementation of the Plan (item 3.6).

At first inspection, agreement with item 3.1, ownership of the Plan by the jurisdictions appears to have reached only 57%. However there were a high number of "Unsure" responses to this item. Here again, it may be that participants simply didn't feel in a position to comment on jurisdictional matters outside their own spheres of work. Removing these unsure responses results in a very high level of agreement with this item (90%), suggesting that jurisdictions see themselves as not having taken ownership of the Plan very well.

The disengagement of non-health groups referred to earlier is reflected in responses to item 3.2, ownership of the Plan by groups other than health ones. Almost half of the participants disagreed that ownership by these groups had been high. For this item too there was a high number "unsure" responses, which, if removed strengthen the level of disagreement to 63%.

Opinion was spread across the range of responses for item 3.5, with only 47% agreeing that the Plan had resulted in a higher profile for injury prevention. The high level of "unsure" responses is worth noting here too. It may be that a sizeable sub-group of participants is unaware of any impact of the Plan. For this item, removal of "unsure" responses results in an increase in agreement with the statement that "the Plan increased the profile of injury prevention in Australia" to 67%.

Table 3: **Level of ownership of the Plan and its implementation. (Responses to items in Round 3)**

Section 3: Ownership and Implementation of the Plan	Frequency of response					n
	Strongly Disagree	Disagree	Unsure	Agree	Strongly Agree	
3.1 Ownership of the Plan by the jurisdictions was poor.	0	2	11	13	4	30
3.2 Ownership of the Plan by other key injury prevention organisations (eg researchers, industry groups, non-government organisations etc.) was high.	3	11	8	6	2	30
3.3 Because Falls in Older People was a high injury priority in most jurisdictions, this area of the Plan was more likely to be adopted.	0	2	4	21	3	30
3.4 Because the other 3 Priority Areas were not the highest injury priorities in some jurisdictions, these areas of the Plan were less likely to be adopted.	1	4	5	19	1	30
3.5 The Plan increased the profile of injury prevention in Australia.	1	6	9	12	2	30
3.6 The opportunities for jurisdictions to work together as a result of the Plan were largely unrealised.	0	3	6	20	1	30

Section 4: Resource allocation

Lack of resourcing was identified early in the evaluation process as a major barrier to the implementation of the Plan and a source of frustration for many participants. In Rounds 1 and 2 several participants highlighted the fact that injury as a health area has a huge impact and cost on the health system yet attracts fewer resources than other health areas with arguably less impact (for instance, infectious disease). The area of Falls in Older People was identified as an exception to this in that funding had already been dedicated to it from the Commonwealth National Falls Prevention for Older People Initiative. This meant that most jurisdictions had implemented some initiatives in this Priority Area during the 2001-2003 timeframe of the Plan.

This concern with resource allocation was reflected in response rates to this section in Round 3: consensus levels to items here were the highest in the whole survey (see Table 4). There was no disagreement with items 4.1, 4.2 and 4.7 and only 1 person disagreed with item 4.6. These results suggest that participants saw the issue of resource allocation in essentially the same way. There was also much more of a tendency for people to indicate "Strongly Agree" for these items than for any others in the survey, indicating stronger levels of feeling about the issue of resources than for other issues.

Table 4: Resource allocation for the Plan. (Responses to items Round 3)

Section 4: Resource allocation	Frequency of response					n
	Strongly Disagree	Disagree	Unsure	Agree	Strongly Agree	
4.1 The Plan was under-resourced at Commonwealth level.	0	0	4	15	11	30
4.2 The Plan was under-resourced at State/Territory level.	0	0	5	15	10	30
4.3 Funding dedicated to Falls in Older People meant implementation by the jurisdictions was high for that priority area.	1	2	11	14	2	30
4.4 Resource allocation was a key reason for limited implementation in the other 3 Priority Areas.	1	2	10	12	5	30
4.5 The Plan encouraged critical thinking about the allocation of injury prevention resources in most jurisdictions.	1	10	9	9	1	30
4.6 Development of future Plans should incorporate a discussion of how the Commonwealth will resource them.	0	1	2	15	12	30
4.7 Development of future Plans should incorporate a discussion of how the States and Territories will resource them.	0	0	3	14	13	30

The overwhelming majority saw the Plan as under-resourced at both Commonwealth and State/Territory level (items 4.1, 4.2). Participants' high levels of agreement with items 4.6 and 4.7 suggest that they may see discussion of these issues at the development stage as a potential way to redress this.

Section 5: Outcomes, measures and targets in the Plan

In Round 1 some participants had indicated a concern with the nature of the outcomes and targets expressed in the Plan and the issue of demonstrating progress against any stated goals. A number of people made reference to the desire for a Plan of this kind to act as a source of inspiration for injury prevention workers at all levels. They saw this as something that could be accomplished through setting targets and goals so that, though they are unlikely to be achieved outright, attempting to achieve them was feasible and would progress the area of injury prevention. At the same time, those participants who had expressed this desire were mindful that when such aspirational targets and goals are written into a National Plan that they can easily be misinterpreted as hard and fast outcomes to be delivered by some person or group, making those who agree to 'sign-off' on such documents reluctant to do so. They were anxious that a clear acknowledgement be made that the aspirational goals and targets not be viewed or treated in this way.

A second, and related, concern expressed by participants in the earlier rounds was with the extent to which the Plan ought to have contained measurable or deliverable goals, targets or outcomes. Some participants noted that the lack of baseline measures in the Plan made it hard

to see whether progress had been made. Others noted that process or indicator measures could have been useful in assessing progress and that these might have been written into the Plan.

The following quotes illustrate the points made in the paragraphs above:

> We need to have aspirations to aim for [within the Plan] but with well defined indicators that are not confused with operational targets
> and
> The trick here is to set clear distinguishable aspirational targets from the operational ones and to set them so that can meet both inspiration and progress towards measurement
> and
> There is a need to set stretch targets to get people passionate (but these need to be underpinned by evidence). Accountabilities should be process ones that if in place will achieve the goal (based on known evidence). Also need to really commit to the accountabilities

Section 5 of Round 3 aimed to quantify the above views of the Plan.

As can be seen in responses to item 5.1 (Table 5), a majority of participants (67%) agreed that the Plan had not incorporated aspirational goals. An even larger proportion (80%) acknowledged the lack of hard targets within the Plan (item 5.2).

Table 5:   Outcomes, measures and targets contained in the Plan. (Responses to items in Round 3)

Section 5: Outcomes, measures and targets in the Plan	Frequency of response					n
	Strongly Disagree	Disagree	Unsure	Agree	Strongly Agree	
5.1 The Plan did not incorporate aspirational goals.	0	4	6	18	2	30
5.2 The Plan did not include hard targets against which to measure progress.	0	2	4	21	3	30
5.3 Some baseline measures are needed for future Plans so that progress can be assessed.	0	0	2	21	7	30

The overwhelming majority of participants (93%) agreed with the statement "Some baseline measures are needed for future Plans so that progress can be assessed" (item 5.3). While agreement on this point is very strong, it should not be taken to mean that this sort of measurement is the only one that participants are concerned with. From the qualitative comments on this issue in the previous rounds, participants see such measures as essential to measuring progress but also note the that they should not be the sole measures used to gauge progress or achievement. The following quote captures this sentiment:

> Although National data is available there is such a delay and it is so generic that it is impossible to use it to measure progress in local interventions. Whilst it is expected that the sum of local interventions will add up to make a difference at National level (if there are enough of them) it is not very useful…what we need…[are] some interim measures which do not rely on hospital data collections but which would demonstrate that the effort put into a program can be shown to make a difference.

Section 6: Achievement of the aims of the Plan

This section of Round 3 aimed at gauging the extent to which participants thought the various aims of the Plan had been achieved (see Table 6). A 10-point one scale was used with participants responding to the question "to what extent do you think this aim [of the Plan] was achieved?" by selecting a number ranging from 1 = "not at all" to 10 = "completely" or 0 = "Don't know". "Don't know" responses levels were low but have been removed in the calculation of the results reported below. Thus in the calculation of proportions and mean ratings for item 6.1, 6.2, 6.3 and 6.5, n = 28. For item 6.4, n = 29.

The first aim of the Plan was "To focus national effort towards four priority issues" (item 6.1). With a mean rating of 4.8 this was one of the two highest rated aims. However, though no one thought this aim had not been achieved at all, the large majority of participants (80%) indicated that they thought this aim had been only "moderately" (≤ 6) achieved at best, with one person thinking this aim had been completely achieved.

The second aim of the Plan was split into two items, 6.2 and 6.3 to separate the two aspects of infrastructure referred to in the aim. Again, most participants (80%) thought that the Plan had achieved its aim of strengthening infrastructure to improve knowledge of injury only moderately at best (item 6.2). Participants thought achievement of strengthening infrastructure to implement injury prevention activities (item 6.3) was slightly less successful than this, with 90% of participants rating this aim "moderately" or less (mean rating = 3.9).

Table 6: Participants' assessment of the extent o which the aims of the Plan had been achieved

Section 6: The Aims of the Plan: To what extent do you think the following aims of the Plan were achieved?	Frequency of response*											Mean**
	1	2	3	4	Moderately 5	6	7	8	9	10	Don't know 0	
6.1 To focus national injury prevention efforts towards four priority issues.	0	4	2	7	6	5	2	1	0	1	2	4.8
6.2 To strengthen national infrastructure to improve knowledge of injury.	2	5	2	7	4	4	2	2	0	0	2	4.2
6.3 To strengthen national infrastructure to implement injury prevention activities	3	5	2	6	8	3	1	0	0	0	2	3.9
6.4 To promote evidence-based sustainable injury prevention interventions to the health sector.	0	5	3	1	9	6	4	1	0	0	1	4.8
6.5 To promote evidence-based sustainable injury prevention interventions to non-health sectors and the broad community.	3	6	3	8	4	3	1	0	0	0	2	3.5

*Note that 1 = "not at all" and 10 = "completely"
**means have been calculated after removing "Don't know" responses from the totals for each item.

The third aim of the Plan was also separated into two items. Item 6.4 examined the extent to which participants thought the Plan had promoted evidence-based sustainable injury preventions to the health sector. This was the other highest rated aim, with a mean rating of

4.8. However, as with the first aim, 80% of participants still rated this aim as moderately achieved or less.

The final aspect of the third aim, promotion of evidence-based interventions to the non-health sectors, fared worst of all in this section, with 90% of participants rating achievement of this aim at "moderately" or less (mean rating = 3.5).

Section 7: Looking forward.

As reported above, Round 1 generated many and varied suggestions for the development of the next National Injury Prevention Plan (see Appendix 1). Most of these were included in the Round 2 questionnaire for participants to have an opportunity to comment (see Appendix 2 for complete comments). For Round 3 those suggestions that were related to the main themes included in this round (that is the section headings from Round 3) became the items for Section 7.

This section attracted the next highest levels of consensus (after Section 4). For three items, 7.1, 7.2 and 7.5, there was no disagreement (see Table 7).

Table 7: **Round 3 responses to participant suggestions to improve the development of future Plans.**

Section 7: Looking forward	Frequency of response					n
	Strongly Disagree	Disagree	Unsure	Agree	Strongly Agree	
7.1 Future Plans should focus on achieving high ownership by jurisdictions and other key stakeholders as a principal concern.	0	0	4	12	14	30
7.2 Future Plans should include a longer term strategy accompanied by a mid-term review.	0	0	1	15	14	30
7.3 Future Plans should incorporate aspirational goals that are not treated as hard targets.	0	6	6	13	5	30
7.4 The development of future Plans should include a separate workplan that has stretch targets or goals against which jurisdictions agree to report process measures.	0	3	2	19	6	30
7.5 The goals and targets set in future Plans should be achievable in the timeframe of the Plan.	0	0	4	20	6	30
7.6 Departmental research reports should be widely disseminated so that they can be taken into account in future Plans.	0	1	1	21	7	30
7.7 Future Plans should include mechanisms that encourage operational partnerships across jurisdictions.	0	2	0	18	10	30
7.8 Future Plans should clearly state (in marketing language) the benefits/advantages of implementing it.	1	1	0	22	6	30
7.9 I would like to see future injury Plans include an advocacy component.	1	2	5	15	7	30

Item 7.2 "Future Plans should include a longer term strategy accompanied by a mid-term review" had almost unanimous agreement (97%) with just one person unsure. In the earlier rounds this suggestion seemed to be related to a desire to keep the focus of the Plan relevant to those people and groups who would be implementing it.

The issue of engagement of stakeholders was presented in item 7.1. In Round 2, participants had highlighted the limitations placed on the Plan by its lack of representation of groups outside health. The general feeling of wishing to redress this is reflected in responses to item 7.1, where 87% of participants agreed with making engagement of key stakeholders a principal concern of future Plans.

The desire for greater levels of jurisdictional collaboration, first raised in Round 1, was reflected in the very high rate of agreement (93%) with the suggestion that future Plans incorporate mechanisms to encourage operational partnerships across jurisdictions (item 7.7). The same level of agreement (93%) was obtained for item 7.8, that "Future Plans should clearly state (in marketing terms) the benefits/advantages of implementing it".

Rounds 1 and 2 revealed a concern that the time period for the Plan should allow for impact from activities to be demonstrated. This was picked up in item 7.5, where the vast majority (87%) of participants agreed that goals and targets in future Plans should be achievable in the timeframe of the Plan.

Eighty-three percent of participants agreed with future Plans having a separate workplan with stretch targets and goals against which the jurisdictions would agree to report in process terms (item 7.4).

Almost all participants (93%) agreed with the statement that "Departmental reports should be widely disseminated so that they can be taken into account in future Plans".

Participants' comments during Rounds 1 and 2 had made reference to the importance of the political context of injury prevention within public health. Several participants had suggested that the Plan could somehow act in an advocacy role. Item 7.9 was designed to assess what extent of agreement there was with this sentiment. Results for this item indicate that, whilst 73% of participants agreed that they would like to see future Plans include an advocacy component, feelings about this were not as strong as for some of the other suggestions already described.

As reported previously, two thirds of participants agreed that the Plan did not have aspirational goals (item 5.1). However, only a moderate proportion (60%) thought that such goals should be incorporated in future Plans (item 7.3).

Section 8: Stakeholder satisfaction with aspects of the Plan and its development.

Section 8 examined participants' satisfaction with the development and implementation of the Plan (see Table 8). Items 8.1 and 8.2 referred to the planning and development of the Plan. For these two items, responses included a large proportion of "Don't know" responses (30% and 27% respectively). This reflects the fact that many of the people who participated in the evaluation were not involved in the process of planning and development of the Plan. These responses have been removed in the calculation of response rates and means for all items. Hence for item 8.1, n = 21 for item 8.2, n = 22, for item 8.3, n = 29 and for item 8.4, n = 28.

A large proportion of participants were dissatisfied with the planning of the Plan, with 30% rating their satisfaction at 4 or less and only 14% rating this aspect of the Plan 7 or better. Overall, 85% of participants rated the planning as moderately satisfying at best (item 8.1).

Table 8: **Stakeholder ratings of their levels of satisfaction with aspects of the Plan and its development**

Section 8: Stakeholder Satisfaction In regard to the National Injury Prevention Plan 2001-2003, how satisfied were you with the following?	Frequency of response*											Mean**
					moderately						Don't know	
	1	2	3	4	5	6	7	8	9	10	0	
8.1 Its planning?	1	2	1	5	5	4	1	0	2	0	9	4.9
8.2 Its development?	1	5	2	4	1	4	3	0	2	0	8	4.6
8.3 The Plan itself?	0	3	3	5	6	5	5	1	1	0	1	5.1
8.4 The implementation of the Plan?	3	5	4	6	4	5	1	0	0	0	2	3.8

* Note that 1 = "not at all" and 10 = "completely"
**means have been calculated after removing "Don't know" responses from the totals for each item.

Similarly, the development of the Plan (item 8.2) was not very satisfying for participants as stakeholders (mean = 4.6). Here 55% of participants rated their satisfaction with development of the Plan as less than moderate, while a further 23% were moderately satisfied with this aspect of the Plan, giving a total of 78% moderately satisfied at best. Twenty-three percent indicated that they were more than moderately satisfied with the Plan's development.

The Plan itself fared best in the ratings in this section, with 62% of participants rating their satisfaction at moderate or above (item 8.3).

Satisfaction with the implementation of the Plan was rated most the negatively with 29% of participants indicating they were "not at all" satisfied or only slightly more satisfied than this. Only one person rated the implementation of the Plan as better than moderately satisfying. Overall, an overwhelming majority of participants (96%) were moderately satisfied or less with the Plan's implementation.

4.0   SUMMARY of the FINDINGS

4.1   Outcomes from the aims of the Plan

Given that this Evaluation has been based on information provided under the terms of the Tender and in accordance with the Plan itself, we are unable to carry out an outcome evaluation. To do so, we would require some baseline measures regarded as good indicators for progress on the Plan. As discussed in Section 4.4 and 4.5 below, baseline measures and performance indicators were never agreed on for this Plan. The Evaluation has thus been prepared using critical analysis of relevant documents and expert opinion in the form of a modified Delphi survey.

4.2   The spread and scope of injury prevention projects/programs for the Priority Areas

As with the outcome evaluation, this Evaluation process is unable to comment on the numbers, geographic spread or scope of injury prevention activities due to insufficient information. However, one point worth raising is that participants in the Delphi process made a clear distinction between the level of projects/programs in the Falls in Older People Priority Area and the other three areas. Activity in Falls in Older People was regarded as being greater and at a more advanced level than for any of the other three areas. One explanation participants offered for this was that the Commonwealth National Falls Prevention for Older People Initiative had led to dedicated funding that had increased falls research activity and the implementation of falls prevention interventions in most jurisdictions. Participants also indicated throughout the Evaluation that Falls in Older People was by far the most expensive direct injury cost to the health system and was thus a high priority everywhere regardless of funding.

4.3   The development and implementation of the Plan: findings from the Delphi process

Rounds 1 and 2 of the Delphi process gathered information on the history and story of the development of the Plan and its implementation. NIPAC's work laid the ground for the selection of the 4 Priority Areas and identified the need for performance indicators that were sensitive to the interests of injury prevention issues. SIPP undertook the creation of the implementation plan and the development of the performance indicators.

Though the Plan was based on the best injury research data and evidence available at the time, adoption of the suggestions and strategies within it was not as wide as might be expected. Several reasons can be advanced for this. Firstly, a high degree of acrimony was generated between the Commonwealth and the other members of NIPAC in the process of identifying the Priority Areas. This subsequently led to a level of non-cooperation that hindered the ownership and adoption of the Plan by key groups.

Secondly, the demise of NIPAC and creation of SIPP meant that most non-health groups and bodies were no longer represented in the development process of the Plan. Subsequent consultation did not effectively engage these groups with the result that many had little input or relationship with the Plan. Ultimately, the Plan was written with the intention of being relevant to a wide group of injury prevention workers, who, because much of their work had been defined as not within the scope of the health sector, could not see how they fitted with the Plan and therefore had little reason to adopt its suggestions or attempt to use it in any way.

Thirdly, the implementation of the Plan was severely hampered by the lack of funding at all levels of government. Only Falls in Older People received significant financial resources, and this was not necessarily as a result of commitment to the Plan. In the absence of incentives to do otherwise, jurisdictions continued to follow their own injury prevention priorities and plans, which for some did not include all of the four Priority Areas of the Plan.

4.4 Issues relating to performance indicators for each of the four Priority Areas given the time frame of the Plan

The Plan identified objectives and outcomes for each Priority Area while the Implementation Plan suggested strategies and actions to address these. The Plan makes reference to the intention to develop specific indicators in each Priority Area.

In 2001, members of the Strategic Injury Prevention Partnership met to discuss and develop performance indicators for the Priority Areas. In considering existing indicators provided by the National Health Priority Area Injury Indicators, shortcomings in the usefulness and feasibility of some of these indicators was noted. These shortcomings included the very general nature of the data, the time lag to receive information, ongoing relevance and the capacity of the various jurisdictions to collect and report them. The need for development of additional indicators specifically for the Plan which were capable of taking risk, quality and process into account was also noted.

Though the existence of NHPA indicators was seen as useful, and the revision of these indicators was expected to form the basis of performance indicators for the Plan, no set of specific indicators was ever identified or adopted. Similarly, while possible sources of data for baseline and progress measures of any indicators were identified in the discussion referred to above, the Implementation Plan does not contain details of any proposed data sources or data collection methods, nor are there any specific targets based on these.

For any indicators, difficulties that may be associated with their development include the degree to which data is available, cost-effective to obtain, and related to the outcomes of interest. These difficulties were highlighted in the discussions to develop indicators. However, progress is virtually impossible to gauge without some form of indicator and the identification of meaningful (if ambitious) targets. Indeed this issue was raised by participants in the qualitative and quantitative portions of this evaluation. Participants agreed that the intention to measure progress had not been translated into concrete methods for doing so. Therefore it seems imperative that the next Plan address the issue of measuring progress early in the development process and aim to include agreed indicators.

Recommendation: That SIPP discuss and develop a minimum number of agreed indicators to measure progress in each of the identified Priority Areas of the next Plan.

Agreed indicators should be relevant to the three-year timeframe of the next Plan. This means that measures of the extent and reach of programs are likely to be as relevant as impact and outcome measures.

4.5   Performance Indicators for infrastructure and programs

Part 3 of the *Guidelines for the Development of National Public Health Strategies* (NPHP, 1999) suggests a number of questions be asked in relation to the key applied elements of a public health strategy such as the policy framework and the infrastructure requirements that underpin it. Below, the Plan is discussed in relation to the relevant questions about infrastructure requirements. Specifically these are 1) information and surveillance needs and 2) the program evaluation needs.

Infrastructure Requirements

Information and surveillance

In their workshop addressing the evaluation of the Plan and the development of performance indicators for it, SIPP members discussed possible sources of data and information systems. As already noted, the existing National Health Priority Area Injury Indicators which were based on AIHW hospital morbidity and ABS mortality data were under review by NISU at the time of the discussion. SIPP members acknowledged these indicators as useful to development of indicators for the Plan but recognised that the short time frame of the Plan meant that other indicators more appropriate to measuring progress over this time would need to be developed. No existing data sources were found that would be able to provide information on some of the dimensions of interest (for example, reach, quality and cost of interventions). However, existing sources of information and data, such as the national Computer Assisted Telephone Interviews and the ABS Health and Wellbeing survey were identified as potentially useful if injury specific question sets could be included.

Having laid this ground work it appears that progress came to a halt. It would seem appropriate to revive this process prior to the next Plan.

> *Recommendation*: That SIPP determine a minimum set of outcomes from the next Plan and recommence investigating appropriate indicators for these. As part of this, appropriate existing data sources capable of providing information on dimensions of interest should be identified. In the absence of existing data sources, SIPP members and relevant experts from key stakeholder groups should discuss feasible methods of obtaining data for indicators.

Program Evaluation

The issues under this heading are closely connected to those of performance indicators. Any programs which are intended to act on the strategies suggested should have measurable outcomes associated with them (either in terms of changes in data or in terms of agreed proxy indicators) as well as provision for monitoring and evaluation.

While some information about individual programs, particularly in the area of Falls in Older People, was provided for the Evaluation, there is insufficient information to comment to any real extent on this aspect of the Plan or the Implementation Plan. However, the Plan was initially based on information regarding effective and feasible interventions and only proven or promising interventions were included in the strategies and best practice detailed in the Plan.

> *Recommendation:* That SIPP revisit the issue of performance indicators and determine a minimum set of proxy indicators for the outcomes anticipated from the next Plan. These should then tie in with the data sources from the previous recommendation.

4.6   Existing evaluations in the four Priority Areas

Evaluation of *The Australian National Water Safety Plan* was the only evaluation that we became aware of during this Evaluation. This is summarised below.

Evaluation of the Australian National Water Safety Plan 1998-2003 (Franklin, 2003)

The National Water Safety Plan (NWSP): *Fostering cooperation and commitment in the fight against drowning* was developed by the Australian Water Safety Council (AWSC), 1998, to provide a coordinated approach to water safety. This was in response to an increase in the number of drowning deaths on Australian beaches in 1997 and in recognition of drowning as the third highest cause of accidental death in this country (AWSC, 1998). Agencies at all levels of government, as well as not-for-profit and commercial organisations associated with water safety, were involved in development of the strategy.

The evaluation of the NWSP aimed to identify trends in drowning between 1998-2002, establish whether the NWSP had prioritised the water safety issues of 1998, and examine whether communication and sharing of ideas within the water safety community increased during the period of the NWSP. In addition, the evaluation was to determine whether water safety standards had been established, particularly at a national level, during the period of the NWSP and whether commitment to support existing expertise, programs and resources had been maintained or improved (Franklin, 2003).

The evaluation was carried out during 2003 using several different methods (Franklin, 2003) including: review of the water safety peer-reviewed and "grey" literature, analysis of drowning-deaths statistics, key informant interviews, and survey questionnaire (distributed by conventional mail, email and linked to the Australian Water Safety Council website on http://www.watersafety.com.au/evaluation_NWSP.htm).

There were nine main findings in the report from the evaluation of the NWSP. These were:
- drowning rate declined after the introduction of the NWSP, particularly during the summer months, though 0-4 year olds still over represented in the statistics
- the NWSP identified and prioritised the water safety issues of 1998
- the NWSP improved communication within the water safety community
- there was some identification of, and improvement in, organisational linkages to reduce duplication of effort
- the NWSP had a positive effect on applying water safety standards across the country
- there is commitment to support, bolster and improve expertise, programs and resources in water safety
- level of resources increased after the introduction of the NWSP
- the NWSP was a successful document overall and increased the level of water safety activity

The report of the evaluation made a number of recommendations for improving the subsequent National Water Safety Plan, including recommendations for the scope and content of the next plan, and suggestions related to increasing public awareness of the NWSP (see Franklin, 2003).

There were also recommendations for the Australian Water Safety Council. These included suggestions related to the composition of the AWSC and suggestions related to improving its activities.

Though there have been evaluations of specific programs (eg. in the Falls in Older People Priority Area) these have occurred at the local level and so are not included here.

4.7   Stakeholder satisfaction with the Plan

Stakeholder participation
NIPAC's work in developing the Plan meant that some key stakeholder groups were included in the process. The findings from the Delphi process for this evaluation suggest that participants regarded the consultation and engagement processes as a source of many of the weaknesses in the subsequent Plan and a reason for its poor implementation. Though a large number of stakeholders and key bodies are identified in the Plan itself, Delphi participants commented on the inconsistency and ineffectiveness of the consultation that was carried out and several participants stressed that engagement of key groups was never actually secured. One reason for this may lie in the lack of articulation of clear mechanisms and processes, together with who will take responsibility for them, to achieve effective engagement in either the Plan or the Implementation Plan.

As identified by many participants in the Delphi process, the development of the next Plan should focus on this specifically in order to ensure that effective stakeholder engagement occurs.

> *Recommendation:* That developers of the next Plan identify a minimum set of key stakeholders and discuss and design an effective process to engage these groups in the development of the next Plan. This process may have sub-processes within it that address different methods of engaging groups with different characteristics (eg research, NGO, practitioner bodies, professional bodies etc.)

Objectives
The Plan set out three primary objectives in the form of the aims of the Plan. These centred on focussing national injury prevention efforts towards the four Priorities, strengthening infrastructure and promoting evidence-based sustainable injury prevention interventions. These are clear and are pitched appropriately at the national level. Greater clarity might be obtained by separating out the targets of the more complex aims so that those people implementing the next Plan can see more clearly those aims relevant to their own efforts.

Principles
In terms of best practice in public health strategy development, the guiding principles for strategies should be clearly stated. The Introduction to the Plan sets out the rationale for developing a National Plan in the injury area and states the approach that was adopted in deciding the priorities. The criteria used to select the four Priority Areas are clearly stated and important areas not included in the priorities are also identified.

Outcomes
In accordance with the guidelines referred to above, the Plan clearly stated an overall health outcome to reduce the incidence and impact of injuries for all four of the Priority Areas. More numerous and detailed outcomes were specified for each of the four Priority Areas.

Roles and responsibilities
The Plan clearly identified several groups of stakeholders in injury prevention and the kinds of contributions their activities make to the area. Appendix 1 of the Plan detailed particular organisations with special interests and roles. The roles of Government departments at

Commonwealth, State/Territory and local level were detailed in the body of the Plan, where the need for collaboration between such bodies in facilitating effective implementation of Plan was highlighted.

Key players and potential partners capable of implementing the Plan were identified within the Plan and the Implementation Plan. The Implementation Plan gave considerable space to detailing actions for achieving progress on each strategy associated with the Priority Areas. Though the Plan made reference to activities being undertaken by those sectors and jurisdictions best placed to do so, responsibility for oversight of implementation was assigned to SIPP.

Target Groups
Specific sub-groups of the population were identified for targeting for interventions in relation to each of the four Priority Areas of the Plan.

Partners
Potential partners for collaboration towards achieving the aims of the Plan were identified in both the Plan and the Implementation Plan. Many of these were within the government sector and the Plan referred to the strengthening of such partnerships through collaboration.

An aspect of best practice in relation to partners is to ensure relevant steps are taken to engender support from them on policy development as well as program delivery and input into activities and interventions. As already discussed, NIPAC, as a body with representatives from government and non-government organisations, provided one avenue for input from some partners. Consultation with interested parties was another method undertaken to try to engage partners. However, as highlighted above, participants commented fairly consistently that collaborations and partnerships across and between sectors were nowhere near as extensive as needed or as had been envisaged or desired when the Plan was written. Some participants focussed on this aspect when thinking of improvements for the next Plan, suggesting that fostering and supporting partnerships was critical to succeeding in the implementation of any National Plan.

> ***Recommendation:*** That SIPP and any partners to the development of the next Plan design and establish mechanisms within the Plan for fostering and supporting operational partnerships between jurisdictions and across sectors. These partnerships should set themselves specific objectives in relation to the Plan with appropriate activity, process or outcome indicators and reporting mechanisms.

Findings from Round 3 of the Delphi process
Overall findings from Section 8 of Round 3 of the Delphi process demonstrated high levels of stakeholder dissatisfaction with the planning, development and implementation aspects of the Plan (see Table 8). The Plan itself was the most highly rated aspect with a mean satisfaction rating of 5.1. However, it should be noted that only 62% of participants rated their satisfaction as moderate or better even for this aspect of the Plan. Of all the aspects of the Plan, satisfaction with the implementation of the Plan was rated most the negatively. Almost all participants (96%) indicated they were moderately satisfied or less with the Plan's implementation and 29% of participants indicated they were "not at all" satisfied or only slightly more satisfied than this.

As indicated in the findings of the earlier rounds of the Delphi, a large part of this dissatisfaction was generated by the process of developing the Plan, the restrictions placed on the selection of the Priority Areas, the poor resourcing for the Plan, the lack of engagement of

key injury prevention groups and the low levels of commitment to implementing the Plan in most jurisdictions.

4.8 Extent to which the aims of the Plan were achieved

In this Evaluation, one of the aims of Round 3 of the Delphi process was to assess expert opinion of whether the aims of the Plan had been achieved.

As reported in Section 3.3, the results of Round 3 indicated that generally participants did not think any of the aims had been achieved to a large extent. Only one person rated any of the aims as completely achieved (see Table 6) and all aims received mean ratings below 5 ("moderately" achieved) on the 10-point scale that was used. Notable here is that, for each aim, 80% or more of the participants in this evaluation rated the aim as "moderately" achieved or less. Thus a huge majority of the expert opinion sought through this Evaluation considered the aims of the Plan were under achieved.

Of the five aims resulting from disaggregating the aims of the Plan (see Table 6), participants rated the first aim and part of the third aim the most highly (mean rating = 4.8 on a 10 point scale). For the first aim, "To focus national effort towards four priority issues", 60% of participants' ratings fell between 4 and 6 (where 1 = "not at all" achieved to 10 = "completely" achieved), indicating that they thought this aim had been moderately achieved. Similarly for part of the third aim, "To promote evidence-based sustainable injury prevention interventions to the health sector" 53% of participants saw this aim as moderately achieved.

4.9 Conclusions

The *National Injury Prevention Plan: Priorities for 2001-2003* set out to achieve a great deal, including the coordination of national effort in injury prevention towards the four Priority Areas identified in the Plan.

From the critical analysis of available documents and the modified Delphi process carried out for this Evaluation several issues emerged as critical to the success or otherwise of the Plan.

The first of these issues is that injury prevention is a multi-sector concern that must be treated as such. Development of the Plan required the engagement of key partners from each of the relevant sectors (eg research, government policy, health administration, injury prevention practice, non-government etc.). Experts consulted during the Delphi process highlighted the fact that this engagement with a wide range of these sectors was never sufficiently secured and indeed, some key groups were disengaged during the phase when NIPAC was disbanded and SIPP was formed. Development of future Plans can benefit from this experience by ensuring an effective process for engaging a minimum number of these key groups in the planning and development process. This might ensure greater levels of commitment by these groups to the implementation process.

The second issue is that of resources for the implementation of the Plan and future Plans. A lack of adequate resources dedicated to each Priority Area identified in the Plan contributed considerably to a lack of activity generally in terms of implementing the Plan. While funding realities may mean that there will never be very much money for injury prevention, a serious commitment to implementing the Plan can only achieve results if the issue of funding is addressed. Implementation will require incentives for it to occur. Some of these incentives

may be non-financial, however, at least some must be attached to real monetary gains for altering priorities at a jurisdictional level.

The third issue concerns measurement of progress. No easy way of measuring the activity in the four Priority Areas as a result of the Plan was ever identified or agreed to. Future planning needs to find an accessible and acceptable way of measuring the extent and reach of programs that are actually put into place.

The fourth issue relates to jurisdictional collaborations. Many participants saw the Plan as an opportunity for jurisdictions to work together and leverage their resources. However this opportunity was largely missed in the timeframe of the Plan. It seems that more recently a start has been made on getting jurisdictional collaborations established. Here again, incentives may assist jurisdictions and other groups to work together across and within sectors. Developers of future Plans could seriously consider designing such incentives into the workplan aspect of the Plan itself.

Finally, it was clear from the results of the third round of the Delphi that participants felt that restricting the Plan to a focus primarily on health department concerns had reduced its relevance to many people working in the injury prevention field. However, the majority still wanted a national focus to future Plans. They rejected the idea of writing future Plans as health department-only ones. This suggests that stakeholders are still hopeful of a national approach and see this as the appropriate direction for progress in the area. The development of future Plans needs to take this into account. Specifically, the focus of the Plan on injury areas that are confined to the scope of health departments results in restricting the applicability of the Plan to the work of only a narrow section of people who are involved in injury prevention. While it is difficult for a Commonwealth department to influence those whom it does not directly employ or fund, this is a critical task that can and should be attempted.

5.0   References

Access Economics. (2003) *Exceptional Returns: the value of investing in Health R &D in Australia.* Canberra: Australian Society for Medical Research.

Australian Water Safety Council. (1998) *The National Water Safety Plan: Fostering cooperation and commitment in the fight against drowning.* Sydney: AWSC.

Commonwealth Department of Health and Aged Care. (2001) *National Injury Prevention Plan: Priorities for 2001-2003*. Canberra: Department of Health and Aged Care.

Commonwealth Department of Health and Aging. (2002) *Directions of the National Health Priority Area Initiative*. Canberra: National Health Priority Action Council.

Franklin, R. C. (2003) *Evaluation of the National Water Safety Plan 1998-2003*. Sydney: Australian Water Safety Council.

Linstone H. & Turoff, M. (2002) Introduction. In Linstone, H. & Turoff, M. (Eds), *The Delphi Method*, on-line version of 1975 edition of the book. http://www.is.njit.edu/pubs/delphibook/ch1.html; accessed 25/2/04.

Mathers, C., Vos, T. & Stevenson, C. (1999) *The Burden of Disease & Injury in Australia.* Canberra: AIHW.

Moller, J. & Cantwell, G. (1999) *Paradigm Shift: Injury-from problem to solution.* Australia: NHMRC

National Health Performance Committee. (2001) *National Health Performance Framework Report*. Brisbane: Queensland Health.

National Injury Prevention Advisory Council (NIPAC). (1999) *Directions in Injury Prevention: Report 2 Injury Prevention Interventions—Good buys for the next decade.* Canberra: Dept of Health and Aged Care.

Strategic Injury Prevention Partnership (SIPP). (2001) National Injury Prevention Plan Priorities for 2001-2003: Working paper on evaluation and performance indicators for the Plan. Unpublished working paper and report of a workshop, 2001.

SPSS. (2004) Statistical Package for the Social Sciences (version 12). Chicago: SPSS

The Health Targets and Implementation (Health for All) Committee. (1988) *Health for All Australians*. Report to the Australian Health Ministers' Advisory Council and the Australian Health Ministers' Conference. Canberra: Australian Government Publishing Service.

World Health Organization (WHO). (1981) *Global Strategy for Health for All by the Year 2000*. Switzerland: WHO.

Appendix 1:   Themes emerging from the Round 1 Interviews

List of Tables

RESCINDED

Appendix 1:   Themes emerging from the Round 1 Interviews

This appendix gives the complete results for the first round of the Delphi process used in the Evaluation of the *National Injury Prevention Plan: Priorities for 2001-2003*. Findings have been summarised under the headings that emerged from the theme-analysis of the interview transcripts.

The Themes

Perceptions of the development of the National Injury Prevention Plan: Priorities for 2001-2003 and the Implementation Plan.

Many of the points raised in relation to the development and implementation of the NIPP related to the difficulties of the process. Initially, NIPAC was formed specifically to provide high-level independent advice on injury prevention to the Commonwealth Department of Health and Aged Care and to Health Ministers. NIPAC consisted of injury prevention representatives from each State and Territory and people from independent organisations with special interest, expertise or research involvement in injury prevention. Originally members of NIPAC participated with the belief that they should be advocates about injury prevention at senior governmental level and because they hoped to demonstrate that national investment in the area would help save lives and money. For some, NIPAC was their third Commonwealth-initiated involvement in national planning focussing on injury prevention.

In order to provide an evidence base for subsequent decisions, background research was commissioned and existing research was used, resulting in a description of the size of the injury problem, information about effective interventions and a list of candidate areas for national action. NIPAC arranged to devote a one-day meeting to discussing these candidate areas and the way to proceed.

However, in the background, relationships between the Commonwealth representatives on NIPAC and the other members were souring. A change in sympathies within the Commonwealth led to a growing discrepancy between the role NIPAC saw for itself as an injury prevention advocate and the Commonwealth's view of its role. At the same time, NIPAC was seeking firm commitment from the Commonwealth regarding support for, and action on, its pending suggestions. To address this, the Commonwealth agreed to attend the one-day meeting and offered to provide support and funding for action providing NIPAC met specified constraints. These were that no more than 3 or 4 areas for immediate action could be identified as Priority Areas and those areas had to fall clearly within the scope of Health sector responsibility. They were also required to make their decision by the end of the day.

Everyone who recalled this process saw it as less than ideal. Apart from the pressure to make the decision within the single-day time frame, the redefining of the scope of interest from a broad evidence-based one to a much narrower one delineated by the parameters of the Health sector was felt to run against the reasons people had been involved in the process in the first place. This insistence on meeting these conditions was seen as an abuse of power: two people referred to feeling "bullied", another to "strong-arm tactics" and another to "administrative fiat". Reluctantly, NIPAC agreed to the conditions and used a group-consensus ranking process during the meeting to determine the top four areas from those that met the constraints. However, the process aggravated the already strained relationships between the Commonwealth and the other NIPAC members.

The ranking process resulted in Falls in Older People and Falls in Children being clearly identified as first and second ranks. The other areas for inclusion were less clear-cut and

negotiation of these resulted in selection of Drowning and Near Drowning for the third area and Poisoning in Children for the fourth area. Though drowning and near drowning was not completely within the control of the Health sector (one of the selection criteria), inclusion of this area had seemed worthwhile within the frame of the other criteria used. Also, the actions/interventions that were being suggested were of a more minor nature and were perceived as having large anticipated impact. The last area became a choice between adolescent injury and childhood poisoning. Poisoning was eventually chosen because it was an area that was argued to be easily and strongly influenced by the Commonwealth through legislation and control over therapeutic substances and their packaging (a factor identified as critical in poisoning of 0-4 year olds).

However, Commonwealth funding was eventually only provided to the Priority Area of Falls in Older People. Moreover, there was a perception that this funding was provided as a result of the Commonwealth National Falls Prevention for Older People Initiative rather than any commitments made to the NIPP.

Very soon after the critical meeting to decide the Priority Areas, NIPAC was disbanded. This left the Plan without an implementing body or an implementation plan. In response to this, SIPP was formed and became the body responsible for writing the Implementation Plan for the 2001-2003 Plan and for ensuring action on the suggestions with it.

The creation of SIPP had the advantage that the members were in positions that allowed them to back their decisions with jurisdictional commitment of funding. There was an expectation that the Plan would lead to the separate jurisdictions supporting its implementation through local funds. At Federal level, in the area of Falls in Older People at least, the reasoning for this was that States and Territories would be the financial beneficiaries from any investments they made in preventive interventions in Falls in Older People. This was because the Commonwealth had agreed not to reduce Medicare funding in the event of reduced demand. However, the four Priority Areas did not necessarily accord with the highest injury prevention priorities in every jurisdiction. Without extra funding to encourage changes in these local priorities, and given the acrimony that had developed in personal relationships described above, jurisdictions responded by continuing to pursue and support jurisdictional priorities while trying to incorporate the national Priorities where this could be done without sacrificing local concerns.

There is also a general perception among participants in the Evaluation that the *National Injury Prevention Plan: Priorities for 2001-2003* and *Implementation Plan* process suffered from a lack of broad consultation with interested bodies and experts who might have influence or knowledge in the injury area or who might be expected to be intimately involved in implementation at the practice level. In the early days of NIPAC there had been a wide involvement of sectors such as research, government, non-government and community organisations. With the demise of NIPAC and the creation of SIPP, the Commonwealth had undertaken to engage bodies identified as having a national interest or involvement in injury prevention and left to the States and Territories the engagement of more local bodies. This was undertaken with varying degrees of effectiveness and some community and non-government groups and bodies felt excluded from a process they thought they had a legitimate interest in.

As a result of the tensions described above, and with exception of the Priority Area of Falls in Older People, there appears to have been poor uptake of the NIPP 2001-2003 except in Queensland, where all four areas were written into the *Health Outcomes Plan: Injury Prevention and Control 2000-2004*.

Perceived Strengths and Weaknesses of the Plan

Participant's views on the strengths and weaknesses of the Plan were summarised from the interview transcripts and Table A1 displays these. In the second round of the Delphi participants were asked to comment on the main themes that had been extracted from these lists or include any points that they had thought of subsequently. The results from the second round are discussed in the paragraphs which follow.

The strengths identified related to the influence of the Plan. Most participants saw the very existence of the Plan as having raised the profile of injury prevention, though some commented that this had been limited and others thought it was only true in the area of Falls in Older People.

Similarly, most participants thought the Plan had encouraged critical thinking about how resources for injury should be allocated. This was particularly evident in Queensland where the Priority Areas influenced the *Health Outcomes Plan* and thus the emphasis on resource allocation. Again, some participants thought that the Plan had really had little influence on resource allocation, particularly in areas where there were perceived to be few resources to begin with.

One strength that was agreed by all who commented on it was that the Plan had been based on sound evidence about injury at the time of its writing, though the selection of the areas to focus on was subject to the constraints referred to above.

There were three main perceived weaknesses in the Plan. The first of these was that the concerns of the Plan were limited to those of the health sector alone. This was perceived as reducing its relevance to many people working in the injury area and as excluding important injury issues in some jurisdictions. Moreover it was seen as alienating some potentially very useful collaborators in non-health sectors or amongst independent or community bodies. Participants in this Evaluation who were from such non-health groups reported that they had felt left out of the process and that the Plan and its subsequent implementation had suffered as a result.

A second weakness was the consultation process used in constructing the Plan. While consultation with interested groups was carried out, and in the initial stages, NIPAC membership meant many groups were represented, participants acknowledged that much wider as well as deeper consultation was desirable for a National Plan. In particular, participants referred to the need to include practitioners and professional bodies whose members deal with injury and its prevention daily as well as people who might have to action the Plan in some way and others who already work in specific priority areas (for example, the water safety area was mentioned in this respect).

The third weakness was the resourcing of the Plan. The intention of the Plan was to focus activity and resources towards the 4 Priority Areas. However, the Commonwealth provided funding only for Falls in Older People, and given that jurisdictions had different perceptions about their priorities for injury from those identified in the 4 Priority Areas, resources were not created or redirected at State and Territory level either. The exception to this was Queensland, where the 4 Priority Areas did guide the allocation of injury prevention resources.

Table A1.1:   Strengths and Weaknesses of the Plan (Delphi Process Round 1)

Strengths	Weaknesses
• provided good opportunity for having higher profile for injury prevention • Embodied high ideals for what could be achieved • based on evidence about injury prevalence and effectiveness of interventions • encouraged critical thinking about what areas resources for injury prevention should be put into • provided an opportunity to voice the view that there really ought to be more recognition of the need for expertise in injury prevention policy and plan writing • was a way to focus down on a few issues and try to make progress • provided an argument about need and evidence for jurisdictions to try to attract or increase funding for injury prevention activities • provided a basis for some jurisdictions in terms of their local plans and programs in particular Priority Areas (eg Falls in Older People; children's injury prevention) • allowed for identification of best practice in the Falls in Older People • identified potential partner organisations	• inadequate funding at both Federal and State/Territory level (except in Queensland) • no real provisions for discussing or working out how responsibility and funding might be arranged between Commonwealth and the States and Territories in order to solve the resourcing issue • restriction to health sector focus only made it difficult for the Plan to represent national issues in injury so not really a National Plan • Consultation process with people outside the health sector was not broad or deep enough • The Plan is too broad for a workplan and too narrow for a vision • poor resourcing resulted in poorer profile for injury prevention in some places • selection of the 4 Priority Areas was done in a way that excluded some critical and important injury issues • though Falls in Older people was relevant to all jurisdictions, the other 3 Priority Areas were not necessarily the highest priorities in all jurisdictions • ability to have an impact on all 4 of the Priority Areas not necessarily realistic for each jurisdiction • the Plan did not detail how to have an impact on any of the 4 Priority Areas • the restriction to the 4 Priority Areas narrowed the implied understanding of injury and injury prevention • was not written in outcomes orientated way so it became difficult to measure its success against such things • over-emphasis on GPs within the document • under recognition of the usefulness and influence of allied health practitioners

Perceived opportunities presented by the Plan and barriers to its implementation

Several opportunities presented by the National Injury Prevention Plan were identified from the Delphi process. Table A2 displays the opportunities and barriers that emerged from the Delphi interviews. Those themes that attracted greatest agreement are discussed below.

Primarily, participants saw the Plan as an opportunity to have a national policy in injury prevention. The opportunity to raise the profile and get recognition for injury prevention especially within government structures was also recognised. In addition to these, some saw the Plan as a way of developing a broader understanding at government level of what is required to prevent injury.

However participants commented that other opportunities had gone unrealised. One of these, more a consequence of creation of the Strategic Injury Prevention Partnership than the Plan, was for jurisdictions to work more closely with each other and collaborate on common problems or share resources. Most people thought this opportunity could be much better utilised than it had been.

Table A1.2: Opportunities presented by the Plan and the perceived barriers to its implementation (Delphi process Round 1)

Opportunities	Barriers
• to have a national policy in injury prevention • to take ambitious step in injury prevention • to promote recognition of injury prevention in governmental structures • for jurisdictions to work together on injury issues that affect all in a way that can utilise resources most effectively • for jurisdictions to learn from each other in terms of data, initiatives, outcomes, understanding of injury environment(s) • to make progress in a few areas, to get investment and good returns • for a broader understanding at government level, of what is required to prevent injury	• lack of resources at both Federal and State/Territory level • the need to act on the Plan wasn't packaged in a compelling way • insufficient direct links between the Plan and other related initiatives and actions (eg. The Commonwealth National Falls Prevention for Older People Initiative, the National Water Safety Plan) • perceived lack of political commitment at Commonwealth level to the hard issues • insufficient acknowledgement of or attention to the need to capitalise on political opportunities to increase the profile of injury prevention or funding for it • consultation process not inclusive enough so some organisations (especially non-health ones) felt disconnected from the process • lack of realisation of collaboration opportunities with non-government bodies or non-health sector partners • lack of expertise among people who are making decisions about injury prevention

The main barrier to implementation of the Plan was identified as the lack of funding at both Federal and jurisdictional level (with the exception of Queensland). For some participants, this lack of funding was interpreted as a lack of commitment to the Plan.

The process of consultation with interested parties outside the health sector was also seen as a major barrier to implementation. There were varied opinions on what level of consultation was appropriate, how much had actually occurred and whether consultation had managed to engage non-government and non-health groups. One illustration given was the lack of links between the Plan and the National Water Safety Plan 1998-2003 which was clearly directly relevant to the Priority Area of Drowning and Near Drowning. Overall the impression was that, while consultation had taken place, the principal aim of having interested groups 'on-board' with the plan had not been achieved.

Suggestions for development of the next Plan
Within the Round 1 interviews for the Delphi process, participants were asked for suggestions for development of the next Plan. The themes extracted from these interviews are summarised in Table A1.3.

As can be seen in Table A1.3, participants were concerned with addressing the perceived barriers to implementation identified earlier. Hence, issues of engagement and representation of stakeholders, securing action on the Plan's initiatives, raising the injury prevention profile and the nature of the goals of the Plan appeared in participant's comments.

There were also comments that related to the structure of the next Plan, with some participants suggesting that the duration should be somewhat longer and others that there should be a shorter duration for the Implementation Plan to allow revisions based on progress.

**Table A1.3:   Suggestions for the next National Injury Prevention Plan
(Round 1 of the Delphi process)**

- Broadening of the models and thinking about injury and injury prevention

- More consultation and engagement of stakeholders drawn from a wider range of groups and sectors that have an interest in or an influence on injury or injury prevention eg researchers, community groups, non-government organisations as well as those in government who influence environments in which injury occurs (councils etc) or who have key interests in specific population groups affected by injury (eg industry groups); those who deal with treatment eg surgeons, GPs, allied health professionals etc.

- More relating of the Plan to those people and departments who can take action on it with specific identification of the injury types relevant to specific departments/groups

- Greater ownership and commitment by everyone involved

- Involvement of non-government groups in planning and problem solving process

- Broader way of thinking about the way injury prevention should be promoted and advanced. Particularly seen as necessary at the political level in order to have injury clearly recognised as preventible

- Exploration of ways to achieve early progress without big dollar investments

- Approach of making injury prevention higher profile through more strategic means so that then can attract funding

- Clear identification of lead agencies in each State and Territory for specific actions. Coupled with this is the need to outline the responsibilities for each State and Territory.

- Plan must give room for jurisdictions to make decisions about how to allocate resources that are in accord with State/Territory priorities

- Plan must be non-prescriptive about injury prevention priorities in jurisdictions

- Definition of injury and injury prevention needs to be broad enough that workers in the area can see their work represented and might find the Plan useful as a result.

- Embody aims and goals jurisdictions are willing/able to report against within the document

- Set aspirational goals that are clearly distinguished from operational or deliverable goals

- Set some hard targets for injury reduction. Take some measures so there can be assessment of what's effective and how much is being gained as well as what's preventing progress

- Updating of evidence bases to take account of new data about effective interventions (eg. in the Falls in Older People area)

- Provision for checking the progress of the Plan regularly (about every 2 years) and keeping it current by modifying it

- Time period needs to be more realistic in terms of the perceived outcomes/aims of the Plan (no point in setting 3 years for things which may take decades to demonstrate a result)

- Recognition within the Plan of the dual aims of improving population health and addressing the social inequities that lead to disproportionate representation of some groups (eg non-English speaking; indigenous; lower-socio-economic; culturally diverse) in injury

- Specific addition of a cross-cutting issue related to safe design to pick up injuries that are product-related

- Build in evaluation process that is budgeted for from the start (will need to establish some baseline data as well)

Appendix 2: Round 2 of the Delphi-process questionnaire and responses to it

List of Tables

Appendix 2:   Round 2 of the Delphi-process questionnaire and responses to it

Below, a copy of the instructions and response form for Round 2 is given. Participants' responses are listed in the right hand columns for each section. It should be borne in mind when reading this material that though the number of people agreeing or disagreeing with each sub-theme has been given, participants were not asked to indicate whether they agreed or not with each item. Of the 23 participants who responded to Round 2, only 12 responded in this way, and not all 12 did so to every item. It is very likely that response numbers would have differed if the instructions had asked for this kind of response (see Round 3 for the extent of agreement/disagreement). Therefore these figures require caution in their interpretation. Readers interested in the extent of consensus with the sentiments raised in this round will find these addressed in findings from Round 3 (see Section 3.3 above).

RESCINDED

Round 2 Delphi Process

For Round 1 of the Delphi Process, 23 semi-structured interviews with key people in the injury prevention field were conducted and theme analysed. All interviews were audio taped and lasted between 20 and 45 minutes.

In the pages which follow, our summary of the major themes and points raised in relation to the NIPP 2001-2003 strengths, weaknesses, opportunities and barriers are given as well as the suggestions that were made for development of the next Plan. A more detailed list of the themes is attached, which includes all themes that emerged. We encourage you to take the time to read through this document to get a better understanding of the range of issues raised.

The Task for this round

For this part of the Delphi process, we are trying to find out if we have captured all the issues that you think were important.

We ask you to:

- read through the following pages and see if those points that you raised have been represented accurately. That is, have we understood what you were trying to convey?

- use the column on the right to expand on any points that you would like to clarify.

- feel free to include any thoughts that you may have had since the interviews or as a result of seeing issues raised by other participants in the right hand column.

At this stage of the Delphi process there is no implication that consensus has been reached on any particular point. Indeed, you will notice that some points raised are contradictory to others. The third round of the process will be focussed more on achieving consensus.

1. Background and context issues that affected the NIPP

Table A2.1: Sub-themes for background and context to the Plan and participant responses to them.

The sub-themes (derived from Round 1 analysis)	The responses to statements on the left hand side
A strength of the NIPP development process was the expert and independent input (from NIPAC)	Agree x 11 However it did not have bottom up ownership Input to the Plan was wider than NIPAC. The strength came from the consultation
The background documents for development of the NIPP (*Paradigm shift* and *Directions in Injury Prevention Report 2*) provided solid evidence about injury incidence, effectiveness of interventions and research needs for the future	Agree x 10 Strongly agree x 1 Probably true x 1 However document was jargony and difficult to interpret Probably not true as these documents not reinforced in the Plan 1 person commented that the documents were prepared under time and budget constraints so good within those limits Include "and severity" after injury incidence
The 4 Priority Areas selected were not as strongly evidence-based as they should have been	Disagree x 8 Agree x 1 in Falls area only Main point of disagreement is that evidence base **was** clear and strong. However, the rationale used to decide which areas to include was not agreed on by all participants In particular, road, workplace and adolescent injury should have been included on the basis of the evidence of injury burden but weren't. They were defined out of the process. Main explanation was because health sector was not lead agency so not able to make an impact in the short term/immediate future on it Purporting to write a National Plan but not really sitting across the areas that needed to have included. There is a question about whether a health sector has the authority to write a plan for the whole country. Instead it could accept that it is writing a Health response to injury prevention. This ties into the implementation: if you don't have clear process then you don't know that you can't do some things. However, [if you do know] you can try to implement things outside own area by encouraging others Fact that the 4 areas were health ones meant that all the burden fell on health. Health bears the burden of all injury even if not the primary agent in prevention. The Plan would have had more relevance to a wider group of implementers if it had been broader. Health jurisdictions may have given it higher priority. Wouldn't have disengaged people the way that it did
The 4 Priority Areas represented "best bang for the buck"	Agree x 7 Disagree x 4 4 Priority Areas is missing huge areas of Injury Prevention which have lessons for preventing injury and death Yes within a health sector-only approach Yes for achievement of health sector plan Yes providing that accept the narrow context of health sector as defining boundary

The sub-themes (derived from Round 1 analysis)	The responses to statements on the left hand side
Ownership of the NIPP was poor	….by the jurisdiction Agree x 10
	May be true x 1
	NIPP was not owned by anyone
	Could have had better ownership/adoption outside health if had made more contact with interested groups/bodies
	Certainly agree with this, and it must be a focus of the next plan
	Didn't have a mechanism to sell the Plan and get feedback on it so didn't get everyone on board
	Process of moving from NIPAC to SIPP disenfranchised some people from the Plan
	Issue for the next Plan and it is important. Lessons can be learned from other areas eg new National Tobacco Strategy where extensive consultation was undertaken
Lack of relevance of the NIPP led to low levels of adoption by States and Territories	Policies on falls prevention were developed in 3 States so that was good
	NIPP was relevant to the States/Territories but was not what they were doing so there was poor adoption
	with the exception of Queensland. Qld Health wrote the Priority Areas into the state plans for resource allocation in Qld.
	Also in ACT in area of falls prevention we used SIPP guidelines as basis for the falls program
	there was little reporting against the Plan so this is evidence that it wasn't relevant
	we didn't do much with it because we didn't have the resources and had other commitments
	it was lack of leadership and resourcing rather than relevance. Only in the last 12 months has the leadership started to be taken up and hence getting more progress
	It is possible to have a Plan/Strategy which is comprehensive, delineates roles and responsibilities for Cwth and State. There is an advantage in identifying at early point the areas where there is strong consensus that greatest benefit to all states and Territories will eventuate. Arguably where Cwth should be encouraged to invest and where joint efforts should focus
The implementation process was constrained by lack of expert and independent input	Constrained more by lack of funding and resources
	funding and lack of involvement of key bodies who might be seen as expert
	and lack of focus within SIPP process itself
	SIPP was focussed only indirectly on the Plan. Wasn't a matter of saying here is where we are and here is where we need to be. So although a lot of work was progressed the links with Plan would have been more obvious with a tighter focus
	There is value in keeping SIPP intergovernmental but also having higher level overarching Expert Steering Committee which can draw in other sectors, key experts etc.

2.   Strengths of the NIPP 2001-2003

Table A2.2: Sub-themes to strengths of the Plan and participant responses to them.

The sub-themes	The responses
Existence of NIPP gave a higher national profile to injury prevention	Agree x 9 Disagree x 2 However, there is a stark contrast between Falls and other Priorities Albeit in a few areas rather than as holistic concept Higher state profile for injury prevention resulted in some states because of extra funding and attention secured through using NIPP as an argument Don't think profile has been raised Some progress is better than none
NIPP encouraged critical thinking about resource allocation	Agree x 7 Disagree x 4 NIPP only identified the issues not how to address them What resources???
NIPP based on solid evidence about injury	Agree x 2 Agree x 10 but only given the constraints listed above Yes for Falls only
NIPP began changing the perspective of the public health aspect of injury prevention- from generalist public health approach to one that is more specialised and targeted	Agree x 5 Disagree x 5 Weak disagree x 1 Lots disagreement with this- those who saw some truth in this saw the process of recognition of need for expertise/content knowledge as having started much earlier and Plan just contributes Disagree- it is a bit pie in the sky as IP is a minor academic area and the general concept of what is needed is more administrative than expert
NIPP provided a basis for local plans and programs in particular Priority Areas	Disagree x 6 Agree x 6 However was always filtered through the State Health Dept Unsuccessful in doing this in area of water safety Yes in Qld For falls area only in SA and ACT No it didn't and this should feature strongly in next Plan
	Add a new opportunity: NIPP has provided an opportunity for voicing the view that there really ought to be more recognition of the need for expertise in the process

3. Weaknesses of the NIPP 2001-2003

Table A2.3: Sub-themes of weaknesses of the Plan and participant responses to these.

The sub-themes	The responses

NIPP was created under assumptions about resourcing that did not eventuate	Agree x 12
	
	Disagree x 1
	    Never really determined who would resource it
	
	    No real assumption that C'wth would give up money
	    Funding is done at jurisdictional level so have to give room within the Plan for them to decide how to do this
	
	Point strongly taken

Poor resourcing led to the view that injury prevention was not high on anyone's agenda	Agree x 7 Disagree x 4 Or poor resourcing was due to low priority Was more how the matters get dealt at policy level at Cwth and State levels Not true in Qld Also no attempt to engage the implementing groups that were providing the resources Disagree-people do take injury seriously but Injury Prevention needs to demonstrate that it can make a difference Disagree this is only one point of view This is the perception, however this is changing eg NSW has recently announced $8.5 million for falls prevention

The NIPP was developed by a different group (NIPAC) from the one expected to oversee its implementation (SIPP) which reduced the level of ownership by jurisdictions	Agree x 3
	
	Disagree x 2
	
	Strongly disagree x 1
	
	Disagreement centred on—
	    The reasons for reduced ownership lie in the politics instead
	
	    Exclusion of non-health parties created disconnection and reduced ownership
	
	    Meaning of implementation was not understood
	
	Strongly disagree-I thought the process was relatively seamless
	Governance and advisory issues are very important issue and needs to be addressed

Consultation process in the development of the NIPP did not include the people who might have to action it	Strongly agree x 2 Agree x 9 Disagree x 2 Needs to be emphasised in next version. Consultation phase needs to be a separate project in its own right and adequately resourced and in some instances was superficial eg Water Safety not black and white-some consultation did occur but not as inclusive as it could have been There wasn't any effective consultation with practitioners on the choice of the 4 Priority Areas and would have made sense to include them, especially when it came to the implementation plan

The sub-themes	The responses
	Agree that practitioners need to be consulted
	People doing the doing need to be involved
	Raises question of what should be the consultation process for next plan
Demographic and geographic differences amongst States and Territories made the 4 Priority Areas approach less likely to be adopted	Agree x 2
	Disagree x 7
	Nonsense
	Older falls and Children's falls were relevant to all jurisdictions
	Not true for Falls
	However they were narrow areas so they were relevant to fewer people
	Disagree-instead not all 4 areas were of equal importance or high importance but created some conflict within some jurisdictions because of the expectation from interest groups that each area would be given equal attention at local/jurisdictional level
	Disagree all 4 important everywhere
There was an unclear understanding of whether the final document was meant to be a vision statement or a workplan	Strongly agree x 1
	Agree x 6
	Disagree x 4
	Was meant to be a workplan according to document itself
	It was clearly a vision statement and also a guideline towards a workplan
	Some people very much wanted a vision or aspirational document but also wanted to have a way of evaluating and measuring outcomes. The tricky thing is not to get the two confused and land up with aspirational goals being treated as management targets that are reported against
	the Plan was somewhere in between
	This can occur-need to distinguish clearly and explicitly between strategy documentation and Action Plan—a common fault in public health
The perspective of injury and injury prevention presented by the NIPP was too narrow	Strongly agree x 7
	Agree x 9
	Disagree x 4
	Other National Plans (eg Mental Health; Cardiovascular) allow non-health bodies like ours to see where they fit in the overall picture. The way the IP Plan is written we can't do that…People who were part of injury prevention networking across Australia (such as in occupational health, farm safety, water safety, indigenous health) but who were not part of the health system were not included. So properly the Plan was a National Health Department Injury Prevention Plan rather than a National Plan. We see ourselves as part of health but we are not in a health department. The Plan only picks up things which are the domain of people within the health departments, which was not what other National Priority Areas Plans did….Because the Plan excludes so many of the people who are involved in injury, even if everything that was in the Plan gets done, we will only have improved injury a little instead of a lot.
	Focus of NIPP still excludes areas of injury that need to be included and as such fragments the area of injury prevention and excludes valuable partners

The sub-themes	The responses
	It was necessarily (and reluctantly) narrow in order to ensure implementation would occur
It was difficult to measure the success of the NIPP because it was not written in an outcomes orientated way	Agree x 6

Disagree x 2

Probably true x 2

Difficulty with this is more in terms of attributing how much observed change is actually due to the NIPP

Trick here is to set clear distinguishable aspirational targets from the operational ones and to set them so that can meet both inspiration and progress towards measurement

NIPAC to SIPP transition ensured this would be difficult |

4. Opportunities presented by the NIPP 2001-2003

Table A2.4: Sub-themes for opportunities presented by the Plan and participant responses to them.

The sub-themes	The responses
NIPP was an opportunity to have national policy in injury prevention	Agree x 13 Was action plan to begin and demonstrate what could be achieved. However was contingent upon agreeing to the health sector focus and select areas Only realised as a health dept not National level Plan
NIPP was an opportunity to get recognition of injury prevention in governmental structures	Agree x 13 In health structures at least Especially since captured at NPHP level
NIPP represented an opportunity to make progress in selected areas by focussing resources	Agree x 11 Disagree x 1 To some extent But no supporting resources Flawed argument-narrow focus doesn't necessarily lead to money (and indeed didn't in case of NIPP)
NIPP was an opportunity for jurisdictions to work together and to learn from each other	Agree x 6 Was opportunity but think it hasn't happened in practice (or not much) x 10 Distinguish between SIPP (which creates opportunities) and NIPP which is a document Independent groups very much want to be included eg Aust Water Safety Council Could have used this better
NIPP has provided an opportunity for a broader understanding (at government level) of what is required to prevent injury	Agree x 8 Disagree x 1 Doubt this is true x 2 Only has done this (if at all) in health 1 x More applicable to local level than to national level of recognition 1 x not fully realised

5.   Barriers to implementation of the NIPP 2001-2003

Table A2.5: Sub-themes to barriers to implementation of the Plan and participant responses to them.

The sub-themes	The responses
Because of the breadth of the injury area, NIPP as a national planning mechanism was overambitious	1 x agree 1 x disagree-should have been able to do much of what was in the Plan 1 x disagree-there were only 4 areas 1 x disagree 4 areas was about right and no progress is not the same as overambitious 2 x Too narrow for vision but too broad for workplan with so few resources 1 x because of narrow health sector focus was underambitious 6 x Ambitious but not overambitious Hasn't really addressed injury as most of the solutions lie outside health and so health should be engaging those bodies who can act to reduce injury Only overambitious for level of resources Distillation of the 4 areas was important IP did not have a high profile
There was insufficient resourcing from the Federal government to support the Plan	Agree x 10 Agree strongly x 3 Probably x 1 Disagree x 1 in area of Older Falls there was good funding Also insufficient commitment Wasn't packaged in a way that was compelling Even falls funding was not result of NIPP so much as a result of the Falls in Older People Initiative. Had there been similar strategies for the other areas might have got more result Plan would have benefited from being directly linked to Nat Falls Init
There was insufficient funding from State/Territory governments to support the Plan	Agree x 10 Agree strongly x 3 Probably x 1 Disagree x 2 Injury doesn't have much money anyway Also insufficient commitment However, very slow increase in funding as evidence builds for what is effective and this is appropriate Funding has come at later stage for Falls in Older People so it is happening
Funding for the injury area tends to be on basis of high profile rather than importance or impact	Agree x 7 Partial agreement x 1 Disagree x 3 Not really important x 1

The sub-themes	The responses
	It is our job to get govt to make injury higher profile
	But so what? Same as everywhere else
	Disagree high profile is result of demonstrating impact
	Not relevant to this evaluation
	However can take longer view and prepare for opportunities that arise in this way and capitalise on them
	This could be used to create high profile for some of the areas
	Agree but the question is how do we use the evidence to move the high profile to the correct areas.
	Sometimes forced to respond to things that are not of high impact because of their emotional impact
	Role of SIPP could be to make issues high profile
Much of the injury area is sensitive to the vagaries of politics	Not relevant to this evaluation
	Agree x 8
	This is the job-we must engage with politics
	However no different from any other area/issue
	Inevitable
	Need to capitalise on it
	Exacerbated by the lack of core funding to create core infrastructure that might protect against politics or allow negotiation of political process
There was a lack of inclusion and consultation with people outside the health sector	Agree x 12
	Agreed strongly x 1
	Need engagement of key bodies/people from the outset so that get ownership.
	Need to pay greater attention to this in future
	This is particularly evidenced in Water Safety where the NIPP showed no link to the National Water Safety Plan 1998-2003. At the end of the period of this plan, drownings had decreased by 16%. Much of the success of this plan was attributed to effective education
	Add a new barrier: An important barrier is that many of the people who are making decisions about injury prevention don't have detailed expertise in the area
	Add a new barrier: There was a lack of will for State/Territories to work together and with the Commonwealth

6.   What should be done for the next NIPP?

Table A2.6: Participant suggestions for the next Plan (from Round 1) and responses to them (in Round 2).

The suggestions	The responses
More consultation and engagement of stakeholders who are drawn from a wider range of groups and sectors that have an interest in or an influence on injury or injury prevention	Agreed x 12 NSW Falls is a good model of consultation process Need engagement of key bodies/people from the outset so that get ownership Devise appropriate mechanisms and resource adequately States/Territories need to take responsibility for this Should be with industry groups who work on programs that address NIPP priority Areas eg Aust Water Safety Council Need to get appropriate sign off As long as clear that talking about health sector Plan as SIPP doesn't have a mandate to develop intersectorial Plan even though this might be frustrating to other sectors
More relating of the NIPP to those people and departments who can take action on it	Agree x 12 Needs to be marketed May have implications for membership of SIPP Whole of govt approach and then can bring various sectors together
A more strategic approach to the political realities of public health funding	Agree x 11 Disagree x 1 Leadership and advocacy work hence the importance of an overarching steering group More preparedness to tap opportunities and focus on tactics eg enabling policy officers while also lobbying to take the longer view in education and behaviour change but funding doesn't happen at federal level but at local level Consultation process is important here Would require a steering group including members from outside health
Incorporate a broader definition of injury prevention than was used for NIPP 2001-2003	Strongly agree x 1 Agree x 6 Disagree x 3 Not sure x 1 There is value in a focussed effort on the areas associated with greatest burden Defn was not the problem but Plan didn't incorporate enough of what injury is defined to be As long as still clear whether taking all injury or only unintentional

The suggestions	The responses
More needs to be made of the impact of legislation in encouraging the adoption of best practice	Agree x 7
	Disagree x 6
	This approach is too specific-consider this issue along with whole range of others
	Small issue not necessary here
	But only one of many things that could be focussed on
	Need to understand that can't use the Plan to advocate for legislative change
	Really about education rather than legislation
	A bit simplistic
Clear identification of lead agencies in each State and Territory for specific actions and outlining the responsibilities for each State and Territory.	Agree x 12
	…And sector
	Need better liaison with existing agencies
	Can be facilitated by a good strategy which builds on consultation and is therefore relevant and has agreed areas of national focus
	Strongly support this one
	Not sure that Plan can do this but consultation process is important
A much more flexible document is required.	Strongly agree x 1
	Agree x 7
	Probably x 1
	Disagree x 3
	Not sure x 1-too much flexibility may imply ambiguity. OK if it is focussed as well as flexible
	Prescribed is good to gauge effect
	However, different criteria need to be applied to selection eg epidemiology and known interventions
	Where flexible means more applicable rather than changing often
	So allow different states, regions and localities to move on issues that are important to them
	If it is too "flexible" it may get lost for being too broad and unable to be understood or applied
	Rather, more action on the current document is required
	Difficult to have a single plan to cover 4 separate areas especially since there would be few people in Australia with expertise in all 4 so partnerships become more difficult to organise

The suggestions	The responses
Have aims and goals that jurisdictions are willing and able to report against within the document	Agree x 9
	Disagree x 4
	And sectors
	If this is possible
	Plan should challenge States/Territories rather than be what they are already doing
	Naïve to expect too much reporting unless crafted very carefully
	Can't be too prescriptive or won't get sign off from senior management
	Don't hold up the writing of a plan for this as unlikely to get sign off if can't sure can deliver on the targets
	Should integrate with State/Territory plans
Return to the emphasis on data and data collection and setting of hard targets for injury reduction.	Agree x 5
	Disagree x 5
	Partially agree x 3
	I don't think this should be the whole emphasis but it helps as an indicator of effect
	Should do this in terms of driving the whole planning not for data sake
	Needs to be program based as more data won't reduce injury
	Need to have this but not at expense of interventions and programs. Good surveillance & monitoring is an integral part; trend data is important. Targets ok if meaningful, accepted and realistic (matched with investment)
	Need to have aspirations to aim for but with well defined indicators that are not confused with operational targets
	Rather, follow through on some action in the Priority Areas first
	Across each state/territory
	Targets yes but not reports for reports sake. Need to be actions occurring to gain the targets
	As long as there is a balance rather than making reductions the only measure. Should also include health service delivery
	Will be too hard to measure reductions in time frame of Plan Not necessarily useful

The suggestions	The responses
Avoid targets that are unrealistic in the current funding climate	Agree x 7
	Disagree x 5
	No. Should challenge government and others
	Need to set stretch targets to get people passionate (but these need to be underpinned by evidence). Accountabilities should be process ones that if in place will achieve the goal (based on known evidence). Also need to really commit the accountabilities
	Avoid technically inept targets as well
	Targets are needed but need to do the aspirational stuff so that can set a direction and argue for funding as well
	but clearly describe unmet needs and issues for which there is inadequate or infrastructure resources
	Provide some challenges as this may capitalise on opportunities that cannot be foreseen
	(too defeatist) Don't be limited by funding climate. IP area needs to be making arguments for investment based on the clear evidence of cost and burden
Time period needs to be more realistic in terms of the perceived outcomes/aims of the NIPP (no point in setting 3 years for things which may take decades to demonstrate a result)	Agree x 8
	Disagree x 3
	True that get little change in a 3 year time span so if get something happening that is good. 5years is probably better
	Recommend 5 year strategy with mid-term review. Need to have action plan drawn from the strategy
	3 years is a realistic govt term
	Need to separate unintentional injury from intentional. Can expect to get good quick results from unintentional injury area (with exception of falls in older people) especially when using legislation and environmental changes eg seatbelts; pool fences. Behavioural change on the other hand is much harder to see result from.
	A better step might be to extend present document and to resource it and set some targets
	3 years without transfer is what leads to the reduced impetus rather than different time scale
	Good to get shorter term feedback too though
	Need to have timeframes so can get discussion going

The suggestions	The responses
Greater account needs to be taken of the more disadvantaged sections of the community eg lower socio-economic; Non-English speaking, culturally diverse, Aboriginal	Strongly agree x 1
	Agree x 6
	Disagree x 2
	Perhaps x 1
	However need to impact overall
	Always have two opposing views of equity vs breadth and have to find solutions that serve the needs of both groups
	Need both greatest good for greatest number approach and social justice focus on those who have high incidence of particular injuries
	Focus should be on gathering evidence in these areas first
	Not much emphasis in current or next Plans. Enough evidence to suggest that need to look more closely rather than ignoring these areas
	Disagree think there is work in lower SE and indigenous
Add another cross-cutting issue relating to unsafe product design	Agree x 4
	Disagree x 3
	Possibly x 2-need to consult on this further
	Too vague to be comparable to other issues such as rural and remote etc
	Increase safe design
	Yes but this area is even more difficult to get a result in
	and recognising the role of design-solutions or environmental considerations in preventing or alleviating injury risk eg protective equipment design such as machine guards, air bags, protective clothing
	Office of Fair Trading do a great job but need more "teeth"
	More relevant for children
	Not sure this is useful as too big an area
	Improvements in safe design could have huge impact on death rates (up to 50%). Need engineers and workplace safety people involved in design
Updating of evidence bases to take account of new data about effective interventions	Agree x 9
	Disagree x 2
	Add: …and education programs
	Especially in falls the data has changed enormously
	But get some results on board first
	Plus effective education programs
	Can dissipate resources easily trying to maintain data bases which may not be very useful. Better to insist that policies and programs take latest evidence into account. To this end, agencies should encourage reports to be re-written for scientific literature so that info gets out there to wider community

The suggestions	The responses
Provision for checking the progress of the NIPP more regularly and keeping it current by modifying it periodically	Agree x 10
	Disagree x 1
	Don't want to monitor outcomes but process measures such as whether specific actions are being incorporated or implemented
	Recommend mid-term review along with overarching advisory committee
	and having effective accountability mechanisms
	SIPP must be more systematic in ensuring this happens within SIPP and is directly linked to the Plan
	Disagree only makes more work and then too hard. 3 years is not long and don't think could do more than was done in that time
Alter the composition of SIPP to include independent organisations and other sector representatives	Agree x 10
	Disagree x 3
	But only a little for practical reasons
	Why? What would they add? What is SIPP's role? Would this be a conflict of interest if money is involved?
	Need a second body that is intersectoral of which SIPP is a part
	As long as is based on need and know why people are being included
	Probably but may also need another group besides SIPP And this group should sit at higher level and have broader membership
	Agree with independent orgs not sure about other sector reps
	Add:
	Evaluation processes need to be built in and budgeted for from the beginning. This will require some base-line data to be set or collected

Other comments that were added during Round 2:

Injury prevention could borrow from risk management area in that could incorporate an emphasis on systematic approaches to prevention eg screening for particular things as routine

Reasons to take up the Plan need to be marketed better to those who make the decisions

Plan needs to refer to convincing reasons why it should be taken up

Plan can be used to benefit IP generally. Careful thought about how to get the Plan to do this in each jurisdiction

Too much is expected of GPs who are already overworked and fatigued; at the same time, allied health is overlooked

Appendix 3:   Round 3 Questionnaire

RESCINDED

Round 3 Delphi Process

Throughout the items below, "the Plan" refers to the National Injury Prevention Plan 2001-2003.

Rounds 1 and 2 of the Delphi process have revealed that there are some variations between jurisdictions in terms of the way the Plan was used and the impact that it had on activities. Given this, we are seeking your response to the following items from a national perspective: that is, when you think about all the jurisdictions together, what is your opinion in relation to each statement? We have left space at the end of each section for you to include comments specific to your area of expertise or jurisdiction if you wish. Feel free to use this space to tell us anything else you think is of relevance or importance to the evaluation.

Similarly, the earlier rounds have identified that the opinions and experiences with the Priority Area of Falls in Older People are somewhat different from the other Priority Areas. Accordingly, some questions refer to this area separately from the other three Priority Areas.

For topic areas 1 to 5 below, please indicate your opinion by writing the relevant letter(s) in the space below each item.

1. Input and engagement

For each item the scale is as follows:

Strongly Agree *(SA)* Agree *(A)* Unsure *(U)* Disagree *(D)* Strongly Disagree *(SD)*

1.1   The membership of NIPAC ensured adequate representation of expert and
        independent injury prevention people/bodies in the development of the Plan.
Response:

1.2   The membership of NIPAC ensured adequate representation of practitioner and
        community interests in development of the Plan.
Response:

1.3   The transfer of responsibility for the Plan and its implementation from NIPAC to SIPP
        disengaged some key non-health groups.
Response:

1.4   Future National Injury Prevention Plans should ensure engagement of all key injury
        stakeholders throughout the development and implementation process.
Response:

1.5   Effective implementation of future Plans requires an executive body comprised of key
        stakeholders on which SIPP is represented.
Response:

Further comments:

2. The four Priority Areas

For each item the scale is as follows:

Strongly Agree *(SA)*   Agree *(A)*   Unsure *(U)*   Disagree *(D)*   Strongly Disagree *(SD)*

2.1   The focus in the Plan on four Priority Areas was an appropriate strategic approach for a first-time National Injury Prevention Plan.
Response:

2.2   The specific Priority Areas identified in the Plan did not reflect the areas of highest injury burden according to the evidence available at the time.
Response:

2.3   Falls in Older People as a Priority Area in the Plan had high relevance to a wide group of injury prevention workers and professionals.
Response:

2.4   The other three Priority Areas had high relevance to a wide group of injury prevention workers and professionals.
Response:

2.5   The four Priority Areas (with the exception of Falls in Older People) did not reflect the highest injury priorities in most jurisdictions.
Response:

2.6   From a health department perspective, the four Priority Areas were the best choices.
Response:

2.7   The Plan provided a basis for local plans and programs for Falls in Older People
Response:

2.8   The Plan provided a basis for local plans and programs in the other 3 Priority Areas.
Response:

2.9   It is desirable for future Plans to focus on a limited number (4-8) of key injury areas/issues in order to make progress.
Response:

2.10   Future Plans should choose priorities according to the evidence of greatest burden/cost.
Response:

2.11   Future Plans should be recognised and written as Health Department Injury Prevention Plans rather than National Injury Prevention Plans
Response:

Further comments:

3. Ownership and implementation of the Plan

For each item the scale is as follows:

Strongly Agree *(SA)* Agree *(A)* Unsure *(U)* Disagree *(D)* Strongly Disagree *(SD)*

3.1   Ownership of the Plan by the jurisdictions was poor.
Response:

3.2   Ownership of the Plan by other key injury prevention organisations (eg researchers, industry groups, non-government organisations etc.) was high.
Response:

3.3   Because Falls in Older People was a high injury priority in most jurisdictions, this area of the Plan was more likely to be adopted.
Response:

3.4   Because the other 3 Priority Areas were not the highest injury priorities in some jurisdictions, these areas of the Plan were less likely to be adopted.
Response:

3.5   The Plan increased the profile of injury prevention in Australia.
Response:

3.6   The opportunities for jurisdictions to work together as a result of the Plan were largely unrealised.
Response:

Further comments:

4. Resource allocation

For each item the scale is as follows:

Strongly Agree *(SA)*   Agree *(A)*   Unsure *(U)*   Disagree *(D)*   Strongly Disagree *(SD)*

4.1   The Plan was under-resourced at Commonwealth level.
Response:

4.2   The Plan was under-resourced at State/Territory level.
Response:

4.3   Funding dedicated to Falls in Older People meant implementation by the jurisdictions was high for that priority area.
Response:

4.4   Resource allocation was a key reason for limited implementation in the other 3 Priority Areas.
Response:

4.5   The Plan encouraged critical thinking about the allocation of injury prevention resources in most jurisdictions.
Response:

4.6   Development of future Plans should incorporate a discussion of how the Commonwealth will resource them.
Response:

4.7   Development of future Plans should incorporate a discussion of how the States and Territories will resource them.
Response:

Further comments:

5. Outcomes/measures/targets

For each item the scale is as follows:

Strongly Agree *(SA)*   Agree *(A)*   Unsure *(U)*   Disagree *(D)*   Strongly Disagree *(SD)*

5.1   The Plan did not incorporate aspirational goals.
Response:

5.2   The Plan did not include hard targets against which to measure progress.
Response:

5.3   Some baseline measures are needed for future Plans so that progress can be assessed.
Response:

Further comments:

6. The Aims of the Plan

For this topic area, please respond by writing the number (0-10) corresponding to your opinion of the extent of achievement using the following scale:

Not at all				*Moderately*					*Completely*
1	2	3	4	5	6	7	8	9	10

Don't Know = 0

The stated Aims of the National Injury Prevention Plan 2001-2003 were as follows:
(Items have been disaggregated for ease of interpretation)

6.1　　To focus national injury prevention efforts towards four priority issues.
To what extent do you think this aim was achieved?

Response:

6.2　　To strengthen national infrastructure to improve knowledge of injury.
To what extent do you think this aim was achieved?

Response:

6.3　　To strengthen national infrastructure to implement injury prevention activities.
To what extent do you think this aim was achieved?

Response:

6.4　　To promote evidence-based sustainable injury prevention interventions to the health sector.
To what extent do you think this aim was achieved?

Response:

6.5　　To promote evidence-based sustainable injury prevention interventions to non-health sectors and the broad community.
To what extent do you think this aim was achieved?

Response:

Further comments:

7. Looking Forward

For the items below, please use the following scale to indicate the extent to which you agree or disagree with the item:

Strongly Agree *(SA)*   Agree *(A)*   Unsure *(U)*   Disagree *(D)*   Strongly Disagree *(SD)*

7.1   Future Plans should focus on achieving high ownership by jurisdictions and other key stakeholders as a principal concern.
Response:

7.2   Future Plans should include a longer term strategy accompanied by a mid-term review.
Response:

7.3   Future Plans should incorporate aspirational goals that are not treated as hard targets.
Response:

7.4   The development of future Plans should include a separate workplan that has stretch targets or goals against which jurisdictions agree to report process measures.
Response:

7.5   The goals and targets set in future Plans should be achievable in the timeframe of the Plan.
Response:

7.6   Departmental research reports should be widely disseminated so that they can be taken into account in future Plans.
Response:

7.7   Future Plans should include mechanisms that encourage operational partnerships across jurisdictions.
Response:

7.8   Future Plans should clearly state (in marketing language) the benefits/advantages of implementing it.
Response:

7.9   I would like to see future injury Plans include an advocacy component.
Response:

Further comments:

8. Stakeholder satisfaction

Please use the scale below to indicate your level of satisfaction by writing in the corresponding number (0-9):

Not at all				*Moderately*					*Completely*
1	2	3	4	5	6	7	8	9	10

Don't Know = 0

In regard to the National Injury Prevention Plan 2001-2003, how satisfied were you with the following?

8.1   its planning?
Response:

8.2   its development?
Response:

8.3   the Plan itself?
Response:

8.4   the implementation of the Plan?
Response:

Is there anything else you would like to tell us?

Thanks you for your time and thought in this evaluation.
Regards
The Evaluation Team.

Appendix 4: Qualitative comments from Round 3 of the Delphi process

List of Tables

The following tables give verbatim comments from Round 3 of the Delphi process. These have been separated according to whether the participants were involved in all rounds or only the final one (Round 3). Some comments have been abbreviated slightly (and this is indicated with '…') or altered (indicated by [ ]) in order to remove information which might be identifying.

As can be seen below, participants raised essentially the same issues regardless of whether they had been included from the start of the Delphi or not.

Section 1: Input and Engagement

Table A4.1: Input and engagement (comments from participants in Round 3)

Comments from participants involved in all rounds	Comments from participants involved in Round 3 only
Qu 1.5 is not clear enough to be answered. What is meant by an executive body? Who are the stakeholders?	For this type of document there is never enough (if any) practitioner consultation.
Inclusion of AIPN or similar umbrella practitioner groups would have been advantageous [in the Plan]. Other practitioner groups were represented!	The way the Plan was written was predominantly for the health sector.
All the SIPP members are government employees and seem to be drawn from the 'policy maker' background only. I suspect their view is narrow and the opportunity for input and collaboration amongst policy makers, researchers and practitioners is lost.	Implementation of the 2001-2003 Plan appeared to be largely health driven. To be seen to reflect a comprehensive response to injury prevention, future National Injury Prevention Plans would need to include a wider constituent group.
Key public health groups were disengaged [from the consultation process] as well as non-health groups	Need to keep in mind who the future national Plans are being written for (that is- just for health? Or broader?).
Government is important so strong representation is required on a balanced executive body.	If wider groups are represented in the stakeholder group then the Plan should be named to ensure ownership of and commitment by the wider group.
Suggest another body could and should be formed to allow input from expert and independent injury prevention people/bodies. This group should be **strategic/advisory** rather than executive in my view.	Intention was there but no [name of state] State Plan eventuated!
[Executive body] depends on funding arrangements and executive support. However it is difficult to see how this body would operate given different politics within different jurisdictions.	
Membership [of NIPAC] was adequate of practitioner but not of community interests.	
Health cannot possibly lead a national plan on all aspects of risk management across all jurisdictions and relevant agencies—it is too broad. So the key relevant agencies should be health and NGOs with the understanding that the role is for health to negotiate with other agencies.	
SIPP or a subgroup of SIPP should be responsible for overseeing the implementation process.	

RESCINDED

Section 2: The 4 Priority Areas

Table A4.2: The 4 Priority Areas (comments from participants in Round 3)

Comments from participants involved in all rounds	Comments from participants involved in Round 3 only
Priorities should be chosen on the basis of other criteria in addition to burden/cost eg. Preventability	Plans should be based on the combination of both evidence of burden/cost and evidence of effective interventions.
Should also take into account the likely effectiveness of interventions ie "bang for the buck"	The key [with selecting Priorities] is to balance burden/cost with ability to prevent. There is no point in expending vast resources on something that either cannot be prevented or requires huge resources to do so. Having said that, information on cost-benefit/cost-effectiveness is not always available so the decision-making process then needs to fall back on what information is available and that has traditionally focussed on injury numbers and rates.
The PAs were chosen for a number of reasons including being doable to being strategic. One of the biggest problems I see is that there were not enough non-health organisations involved.	
In addition to burden and cost, the availability of evidence-based strategies should also be considered (if not available then this should inform research programs)	
Priorities should be chosen in consideration of burden but also according to preventability. If interventions are not known for an area/issue then we are unlikely to make any progress in actioning it. Therefore an evidence base is also needed.	
[Choice of PAs] Depends on ability to reduce burden ie if there is a problem that could be reduced easily but is not the greatest burden or cost, then this may be a better use of resources.	Road related injury, workplace injury suicide violence etc are other important injury prevention priorities however are being addresses nationally through other means and goes back to who the priority areas were for (ie health sector) and focus (unintentional injury).
Highest injury burden was not the only selection criteria [for choosing 4 PAs]. Ready implementation and likely effectiveness were equally important.	I would like to see both National and State data included.
Future Plans should provide a broader menu of priority areas with short and longer term goals and targets from which jurisdictions can make informed, potentially collaborative choices.	If wider groups are represented in the stakeholder group then the plan should be named to ensure ownership and commitment by the wider group.
[Future Plans] should prioritise according to greatest benefit achievable.	I think there is a big need for a NATIONAL approach to injury prevention but this must be structured in such a way that different states and local plans can be developed under the umbrella of this national approach, even to the point that local plans might quite appropriately have a focus on an area that is not specifically included in the national plan.
Health agencies cannot always focus on issues for which the highest burden is felt (eg road safety).	
The issue of what is to be contained in an injury prevention plan will always be contentious as there are many interest groups looking at a very small proportion of the injury burden who would like their area to be acknowledged to help obtain resources (usually financial) for their area. These interest groups need to be balanced against burden costs and the need to maintain a low injury rate.	
Future Plans should focus on strategic areas that are the highest injury priorities. However they should also take into account the evidence base for capacity for ameliorating injury risk. Where such evidence is not available, appropriate research should be encouraged as scoping work.	
If [the future plan is] only a health department Plan then how can intersectoral work be encouraged?	
The health department need a plan [too] and is remiss in not having one. A multi sector plan is needed as well.	
Other groups or agencies (public or private) may also produce so called "national plans"	
May get national plans but dubious whether 8 States or Territory Health Depts will come aboard.	

Section 3: Ownership and implementation of the Plan

Table A4.3: Ownership and implementation of the Plan (comments from participants in Round 3)

Comments from participants involved in all rounds	Comments from participants involved in Round 3 only
I think there are just not enough people on the ground to do everything	Difficult to know [whether ownership by the jurisdictions was poor] outside of my own jurisdiction
The problem was a general lack of interest/uptake. Alternative Priorities would probably have met with the same fate.	Some of the work of the Consumer Safety Unit related directly to the area of Falls in Children (baby walker, bunk bed and cot standards)
Ownership of the Plan by other key injury groups was higher than ownership by the jurisdictions	Progress in falls prevention in older people in Victoria has a high profile and is a priority for the Aged Care Branch. This is demonstrated by a recurrent allocation of $1.25 million. There is also $2 million allocated for falls and mobility clinics
Ownership by the health departments in the jurisdictions was poor and falls in the elderly received a lot resources helping it to be more accepted which did not happen in the other [priority] areas.	I am not sure I would ever have heard of the document [the Plan] had I not been on the standard injury prevention mailing lists and, let's face it, this info was not new to anyone on those lists.

Section 4: Resource allocation

Table A4.4: Resource allocation (comments from participants in Round 3)

Comments from participants involved in all rounds	Comments from participants involved in Round 3 only
There are limited resources at State level and there are just not enough people on the ground to be able to do everything. There were no additional resources from the Commonwealth or [my state] so the decision was made to just try to make a difference on one issue--falls.

I don't believe funding [for Falls] was high. However, given the funding available, especially in the last 2 years it has been well used by the Commonwealth. Despite this some jurisdictions have not made falls a high priority. They may have paid lip-service to it but outcomes and sustainable funding is still very limited.

Resourcing of a Plan is not something that government can put into a plan but what should be there is a justification for why the area should be funded and it would probably also be useful if some thinking had been undertaken on what level of resourcing would be required to achieve reduction in injury.

Funding dedicated to Falls in Older People was not high compared with other health conditions. Funding should be commensurate with the size and preventability of the problem.

Some allocation did occur for the other 3 Priority Areas in Qld but I am unsure about the other states.

Lack of evidence about what to do [was also a key reason for limited implementation of the Plan in the other 3 Priority areas] eg poisoning area.

Problem is Federation protecting-my-patch not how to achieve injury reduction. Is [funding] a C'wth or State matter? Answer-both. But will they bite the bullet? No. | Resource issues are fundamental if any future plan is to be effective. Since there are likely to be responsibilities at national and state and local level than resourcing at all these levels must be addressed.

Maybe Commonwealth funding [was] dedicated [to Falls] not necessarily jurisdictional funding.

Going back again to being clear about who the Plan is for, discussions [about how the Commonwealth will resource] need not necessarily target just Dept of Health and Aging either.

For implementation at a local level the resources were not there even for Falls in Older People. Major funding was allocated to the researchers but nothing to the workforce trying to implement strategies to address the problem. Looking at Area Health data, falls and the elderly is the major priority. The only way we could address the other 3 areas would be the creation of new positions….We hear about the multi millions of dollars available at both Commonwealth and State level but it is a rare thing for the average local injury prevention worker to be allocated even one cent of it.

The initial funding by the Commonwealth was an appropriate response but the infrastructure to plan the expenditure of the funds was inadequate. Resourcing at the State level for injuries other than falls among older people which have dedicated budgets has been modest but this reflects the State's focus on providing services as opposed to supporting preventive strategies. Future Plans should incorporate cross-jurisdictional collaboration/cooperation. Commonwealth resourcing should focus on areas of common interest-research, cost/benefit analysis, education and training using the current tertiary framework.

[Discussion of how States and Territories will resource the Plan] may be not just [confined] to health departments either.

While funding is an essential part of these plans so is the development of effective programs and resources to support those programs. The time taken to develop these means that separate time frames for program development and implementation within the community are necessary. |

Section 5: Outcomes/measures/targets

Table A4.5: Outcomes, measures and targets within the Plan (comments from participants in Round 3)

Comments from participants involved in all rounds	Comments from participants involved in Round 3 only
This is a hard one. Although national data is available there is such a delay and it is so generic that it is impossible to use it to measure progress in local interventions. Whilst it is expected that the sum of local interventions will add up to make a difference (if there are enough of them) it is not very useful. I hesitate to ask for hospital data as it is so expensive to collect a t A&E depts but it is what practitioners usually want because it would show if we are making a difference. What we need is someone clever to come up with some interim measures which do not rely of hospital data collections but which would show that the effort out in to a program can be shown to make a difference. Proxy indicators were possible. Base line measures should not be health outcome measures. Care needs to be taken to avoid setting unrealistic goals and (quantitative) targets unless we are equally clear about the investment thresholds required for impact….this has been done for the [US] Tobacco Control Program (see http://www.cdc.gov/tobacco/bestprac.htm) and there may be value in doing this for injury prevention perhaps focussing on a limited number (3-4) of key priorities. I'm not sure that in Falls prevention there was enough data at the time to set hard targets. Even now it is very difficult to measure the true falls rate in Australia. Therefore we need to be careful in how we define hard targets. The Plan could have been used as a starting point for SIPP Action Plans.	It would be difficult to set common targets but measures may be a possibility. The capacity of individual States/Territories to respond can vary according to their individual government's priority issues. Interim measures may be a possibility. I'm not convinced we need "aspirational goals" just manageable goals and the resources to achieve them would be more realistic. I don't like the use of targets but am very keen to see the explicit use of VALID baseline measures against which progress or the lack of it can be measured.

Section 6: The aims of the Plan

Table A4.6: The aims of the Plan (comments from participants in Round 3)

Comments from participants involved in all rounds	Comments from participants involved in Round 3 only
Falls prevention for older people is by far the most advanced area of injury prevention. This may be due to the fact that falls related injury in older people is the most frequent and the most costly, but also has the largest number of professional involvement	I am not convinced that the Plan had any important impact except to galvanise much of the injury community against it! However my impression is that its development and the circumstances surrounding this did serve to raise the profile of injury within the bureaucracy

Section 7: Looking Forward

Table A4.7: Looking forward (comments from participants in Round 3)

Comments from participants involved in all rounds	Comments from participants involved in Round 3 only
[Setting goals and targets for the timeframe of the Plan] may limit a plan as what is achievable today may underestimate what is achievable in 2 years time and is also related to resourcing.	Consumer safety would like to see future plans addressing product related injuries particularly in children.
[Goals and targets] may be subject to 'resources being available' if wait for this in all jurisdictions then there is a danger that no plan will ever be agreed.	Reporting against process measures is OK in theory but there will have to be careful attention paid to this as it may only serve to focus activity to pay lip service to the measures rather than concentrate on implementation of effective programs out of which come the evidence to be used for the process measures.
I would like to see future injury plans identifying differing strategies for researchers, practitioners and policy makers.	The consultation process should include injury prevention practitioners not just decision makers. There is no point in NSW health agreeing to report measures that cannot be achieved without the cooperation of the workforce.
Not sure what is meant by advocacy (I would support strategies for raising the awareness and understanding of the importance of injury prevention).	I don't think people should be afraid to set targets just in case they don't completely achieve them.
[Advocacy] can be difficult terrain for some governments to navigate. My advice would be **not** to include in such an explicit way but rather to frame it in terms of partnerships & engaging other sectors and experts. If a Strategic Advisory Committee were configured with appropriate terms of reference and membership it should be possible to achieve advocacy goals. Secretariat/support and travel for NGOs and Independent members should be allocated. Govt reps should pay their own way.	[Plan] should also include cost-benefit and cost-effectiveness information.
The Plan should be a strong statement of what is known and where we should be heading, not about advocacy as this will undermine the strength of the Plan. There are other groups that can advocate.	The people using the Plan do not need to be told the benefits and advantages of implementing it: we know the benefits and advantages. We just need to resources to enable us to do it. I also think we are pretty good at encouraging operational partnerships across jurisdictions.
Process measures are not sufficient. Impact measures (preferably true intermediate measures) and injury outcome measures are required. Some outcome measures will require a longer time-frame than the strategy but that is no reason to exclude them.	[Advocacy] is more the role of the professional associations like the PHA and AIPN
Advocacy should be included but care should be taken that it does not become the focus.	
People must feel they own the need for the changes they implement not have them authoritatively forced on them to comply. A delicate balance between freedom and public health [is needed].	
SIPP can only strive to influence progress towards outcomes and should not be held accountable for hard targets.	

Section 8: Stakeholder satisfaction
There were no additional comments in this section

Other Comments:
Some participants gave further comments in the section provided for this at the end of the questionnaire.

Table A4.8: Further comments from Round 3 participants.

Comments from participants involved in all rounds	Comments from participants involved in Round 3 only
Injury is not the only area battling for appropriate resource allocation—so one implication for successful negotiation is that where it is possible to look for common/shared efforts and link with other strategies (eg ALGS Population Health Plan for Aging, new National Physical Activity Strategy) that should be undertaken—mentioned explicitly as a principle for implementation. Work on health economic modelling and developing evidentiary basis for suggesting investment thresholds below which we will not see impact/returns on investment is a critical issue that needs to be addressed.	I am ….not seeing any direct benefits from the Plan at local government level [in the area of my work]. Also some of the community health centres in [my state] which have developed their own action plans in response to local issues have shown no interest in prevention of [the Priority Area injury I am working on] as their burden of disease data showed other health related issues as being of significantly higher prevalence. Evidence of intersectoral support for the Plan is missing and state and local jurisdictions have failed to implement the Plan as it was envisaged. Until governments move towards implementing and funding preventive health strategies it will be difficult to adequately respond to future demands to prevent injury. I would prefer to continue planning by Priority Areas rather than planning by target groups. The lack of a….State Plan has impacted not only on the responses here but has impacted significantly on implementation. At times we have felt like we are "in paralysis."…After numerous attempts to have a plan adopted/accepted, promises have been made but nothing has evolved from the initial draft. I was on NIPAC [because of my specialist background]….It was not very satisfying work because injury [in my area of interest] was seen as the responsibility of another section of government….any truly comprehensive national plan must include all aspects of injury not just focus on those aspects that are under the control of health at a national or State level.

75