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CHILD ACCIDENT PREVENTION STRATEGY

Children's and Young People Health and Wellbeing Group
Somerset County Council

CONTENTS

EXECUTIVE SUMMARY

Unintentional injury and death is defined as 'an injury or death occurring as a result of an unplanned and unexpected event which occurs at a specific time from an external cause'. However, despite being called accidents, these are not random, chance events. To a significant extent accidents are predictable and preventable through increased awareness, improvements in the environment and greater product and equipment safety. Accidents are also strongly related to deprivation and as such are both a major cause and symptom of inequality.

Key Local Statistics

Mortality

- There were fourteen children aged 0-14 who died in Somerset from an avoidable accident between 2006 and 2013

Morbidity

- In 2012/13 there were higher rates of children (aged 0-4 and 0-14) being admitted to hospital for unintentional and deliberate injuries than both the South West and England averages
- The rate of hospital admissions for accidents has been significantly higher for 0-4 year olds than for 5-14 year olds in every year between 2010 and 2013
- Accidents at home account for the greatest number of hospital admissions
- Admissions for falls are greater than for any other accident group

A&E attendances

- Over half of the attendances for 0-14 year olds have been coded as an Other Attendance or were unknown/uncoded
- A&E attendances for children aged 0-14 were lower in 2013 than in 2012
- Over two-thirds of all admissions for pedal cyclists and almost all for motorcyclists were of males aged 5-14
- The rate of attendances for children registered in the least deprived quintile is significantly lower than for all others.

Preventing unintentional injury is an important component of wider efforts to improve health. It is a complex area requiring a complex range of responses. This issue is not just the responsibility of any one organisation and the effectiveness of this strategy is therefore dependent on cross agency agreement and a commitment to action. In turn the strategy will provide a framework and an opportunity to develop a common understanding of accidental injury to children and related inequalities within Somerset.

1. INTRODUCTION

1.1 Unintentional injury and death is defined as 'an injury or death occurring as a result of an unplanned and unexpected event which occurs at a specific time from an external cause'.

1.2 Unintentional injury in and around the home are a major cause of death and disability for children under 5 in England. An average of 62 Children died each year between 2008-2012[i]. These injuries result in an estimated 452,200 visits to A&E departments[ii] and approximately 40,000 emergency hospital admissions among children of this age each year.

1.3 Injuries are the leading cause of death for children aged 1-4 and 15-19 and is a leading cause of death amongst children and young people aged 4 – 14, second only to cancer. Around 2 million children and young people visit UK Accident and Emergency Departments each year as a result of a non-fatal injury[iii].

Scope and definition

1.4 Despite being called accidents, these are not random, chance events. To a significant extent accidents are predictable and preventable through increased awareness, improvements in the environment and greater product and equipment safety. Accidents are also strongly related to deprivation and as such are both a major cause and symptom of inequality.

1.5 The Child Accident Prevention Trust (CAPT) highlight findings from the 'Accident Prevention Amongst Children Review', which found that partnership work is a major driver for success in reducing death and serious injury from preventable childhood accidents. They state that 'creative partnership projects that pool resources and share opportunities can make a difference at a local level'. These findings are also supported by the Department of Health report 'Better Safe Than Sorry'[iii], which found that 'partnerships are the key to the delivery of strategies aimed at preventing unintentional injury and require cooperation at local level'.

1.6 This strategy will:

- Raise the profile of accidental injury in children and young people (aged 14 and under) and highlight opportunities for prevention
- Highlight the extent and cost of accidental injury among children and young people nationally and in Somerset, indicating where inequalities exist
- Outline national and local priorities for action and relevant targets

- Provide recommendations for further action in order to reduce accidents in children and young people in Somerset, and to reduce inequalities

- Outline a Somerset model for future service delivery based on a partnership approach

Guiding principles

1.7 This strategy relates to unintentional injuries, which are often referred to 'accidents'. This is an event which results in an injury which was not deliberate and could have theoretically been avoided if the necessary intervention was in place. The following are the guiding principles upon which all actions are based:

- Take proportionate universalism approach, ensuring that interventions are made universally available but increased effort will be targeted to those most disadvantage, in line with the principles of Marmot[iv]

- To focus intention in the home for families with children 0-5, whilst not forgetting other groups

- To ensure prevention interventions are balanced with physical activity, learning and practicality

- To enable parents, children and young people to be informed to make robust risk assessment judgements, be aware of hazards and methods to avoid injury

- To ensure intervention are evidence based, effective and value for money

Aim

1.8 The effectiveness of this strategy is dependent on cross agency agreement and a commitment to action. In turn the strategy will provide a framework for action and an opportunity to develop a common understanding of accidental injury to children and related inequalities within Somerset. Through integration into the planning systems of the Local Safeguarding Board and Somerset Children's Trust, appropriate resources can then be allocated to tackle injuries amongst children on a knowledge led basis.

1.9 The aim of this strategy is to reduce accidental injuries in children and young people, to minimise inequalities and create safer environments for children.

Outcome measures

1.10 The following outcome measures will be used in the production of and evaluation of this strategy:

Public Health Outcomes Framework

- Hospital admissions caused by unintentional and deliberate injuries in children (aged 0-14)
- Hospital admissions caused by unintentional injuries in children (0-4)
- Hospital admissions caused by unintentional injuries in young people (15-24)

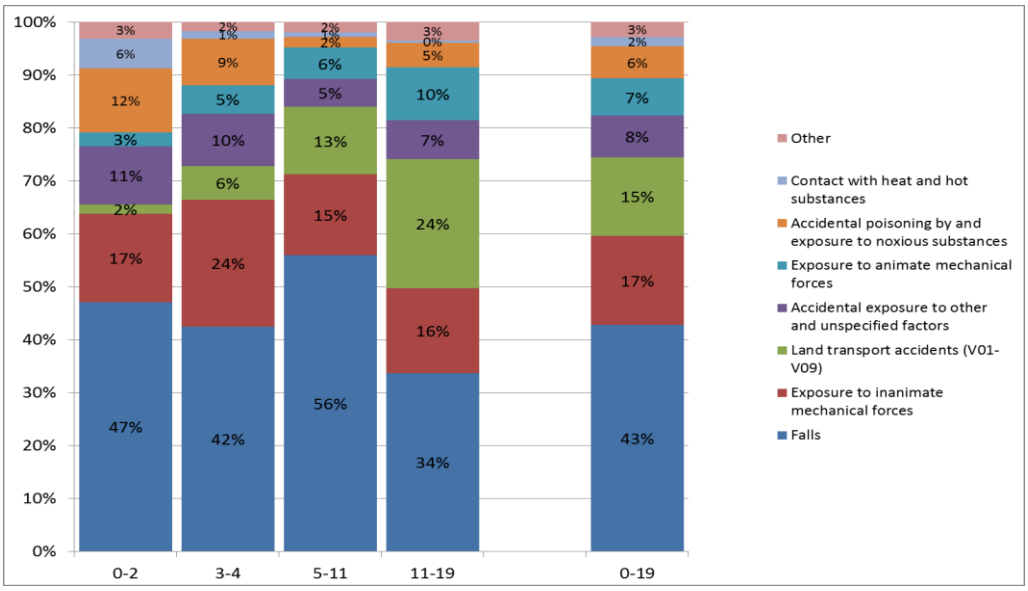
Road safety

1.11 National and local casualty reduction targets for road safety: A 50% reduction in the 2005-2009 average for children ages 5-7 years, KSI by 2020.

2. BACKGROUND AND CONTEXT

2.1 The type and causes of injuries changes during the life course of developing children is significantly associated with increased mobility and awareness of their surroundings. Coupled with this we see an evolving mix of accidental injuries which occur, with the most obvious change being the move from injuries such as poisoning and scalds in early years to a shift in teenage years to a situation where transport related accidents increase as a proportion of all injuries.

Figure 1: Somerset admissions to hospital following accidents, by age group and accident type, for 2008-13



Source: Secondary Uses Service (SUS)

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

2.3 Simple and cheap measures that have been proven can save lives and prevent children from serious disfigurement or disability. Implementing the guidance from the National Institute of Health and Care Excellence (NICE) locally may bring a reduction in the costs associated with emergency department attendances and hospital admissions for unintentional injuries among children and young people aged 14 and under.

2.4 Other potential savings from investment in prevention include: savings to the health service[vi], ambulance, police, fire and rescue services, transport and criminal justice; improved outcomes for children and young people – such as improved health, quality of life, school attendance and attainment; increased productivity for families and employers (by reducing the time that parents or carers have to take off from work to look after children and young people who have been injured); preventing short-term and permanent disabilities and death from unintentional injury; and reducing the emotional impact and trauma of unintentional injury for children and young people and their families[vii].

What is the situation in Somerset?

2.5 The 2013 population mid-year estimates were published in June 2014 show the estimated population for Somerset to have risen by 3,154 to a total of 538,104, consisting of:

- 29,485 0-4 year olds
- 58,700 5-14 year olds
- 88,186 children aged 14 and under

Figure 2: Population numbers of children aged 0-4 and 0-14 in Somerset (Mid 2013 population estimate)

District	Mendip	Sedgemoor	Taunton Deane	West Somerset	South Somerset
Aged 0-14	17,129	18,223	17,242	4,008	25,045
Aged 0-4	5,937	6,690	6,290	1,459	9,110

Source: ONS

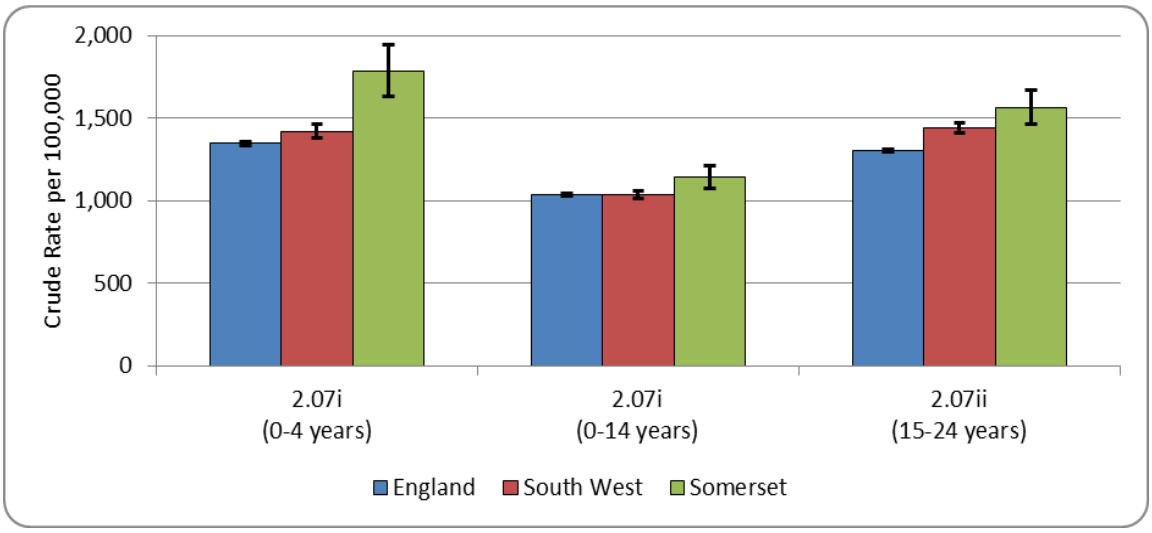
2.6 The national Public Health Outcome Framework (PHOF) produced by Public Health England (PHE) contains three indicators relating to hospital admissions of children and young people. These measure all hospital admissions of children (aged 0-4 and 0-14) and young people (aged 15-24) caused by all deliberate and unintentional injuries. These indicators provide the best available national and regional comparison for levels of avoidable accidents.

2.7 Deliberate and unintentional injuries are defined by PHE as any International Classification of Disease 10 (ICD-10) code of:

- S00-T79 (injuries, poisoning and burns)
- V01-V99 (road traffic accident)
- W00-X59 (other causes of accidental injury)
- X60-X84 (intentional self-harm)
- X85-Y09 (assault)
- Y10-Y34 (events of undetermined intent)
- Y35-Y36 (legal interventions and operations of war)

2.8 Figure 3 below shows that in 2012/13 Somerset had significantly higher rates of children being admitted to hospital for unintentional and deliberate injuries than both the South West and England averages. The rate for young people was also higher than both the South West and England values but this was only significant in comparison to England.

Figure 3: PHOF Indicators 2.07i and 2.07ii - *hospital admissions caused by unintentional and deliberate injuries in children and young people* in 2012/13 by area, crude rate per 100,000

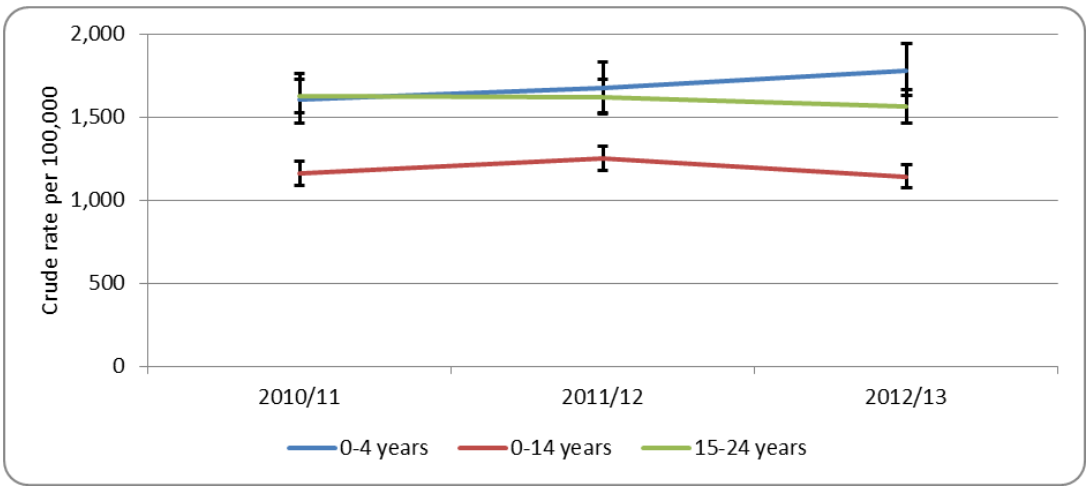


Source: PHE Public Health Outcomes Framework

2.9 Figure 4 illustrates the three year trend of local rates of unintentional and deliberate injuries for children and young people and shows that rates have declined slightly in Somerset and the rate for children under 4

appears to have increased slightly although neither of these changes is statistically significant.

Figure 4: PHOF Indicators 2.07i and 2.07ii - *hospital admissions caused by unintentional and deliberate injuries in children and young people* in Somerset 2010/11-2012/13 by age, crude rate per 100,000



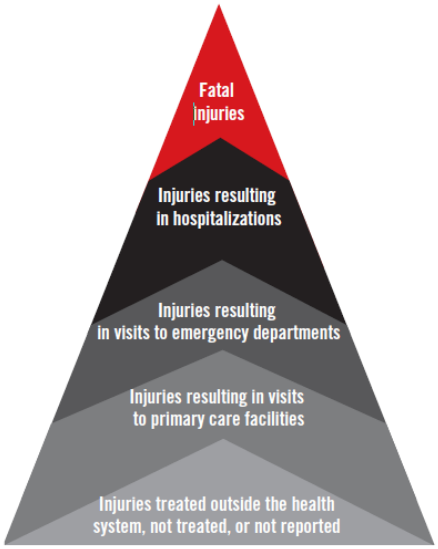
Source: PHE Public Health Outcomes Framework

Categories of injury

2.10 Injury analysis is notoriously difficult due to lack of robust data sources, difficulty obtaining small area data and lack of causality information.

2.11 The deaths that result from injuries represent only a small fraction of those injured. A large number of people suffer injuries that lead to hospitalisation, A&E attendance or general practitioner treatment, or treatment that does not involve formal medical care. Injuries can be categorised according to their severity, treatment type and reporting as per the World Health Organisation description:

Figure 5: Injury Pyramid[viii]



Who is at risk

2.12 NICE[ix] identifies that children and young people from lower socioeconomic groups are more likely to be affected by unintentional injuries[x]. Children whose parents have never worked (or are long-term unemployed) are 13 times more likely to die from an unintentional injury compared to children whose parents are in higher managerial or professional occupations. The social gradient is particularly steep in relation to deaths caused by household fires, cycling and walking.

2.13 A range of other factors also influence the likelihood of an unintentional injury. These include[xixiixiii]:

- personal attributes
  - such as age, physical ability and medical conditions
- behaviour
  - such as risk-taking
- the environment
  - for example, living in a house that opens onto a road or living in poor quality housing)

Cost of accidental injuries

2.14 There are six million visits to A&E departments in the UK each year as a result of unintentional injuries; around two million of these involve children and young people at a cost to the NHS of approximately £146 million a year[vi].

Admitting a child to hospital following injury is estimated to cost £16,900 and the cost for a road traffic injury is estimated to be three times this amount.

The NHS spends an estimated £131million per year on hospital admissions due to childhood injuries, and the approximate lifetime cost of medical, educational and social costs for one child with a severe brain injury stand at £4.89million[xiv].

Wider costs and impact

2.15 The cost of unintentional injury is also borne by other public sector services such as transport, the police, fire and rescue services and the criminal justice system. The long-term health needs and indirect 'human costs' for the family could include the repercussions of enforced absence from school, including the need for children and young people to be

supervised[xv]. This, in turn, could involve family and carers having to take time off from work.

2.16 Injuries cause major impacts on education, employment, emotional wellbeing and family relationships. The wider costs of a serious home accident added 0-4 years has been estimated at £33,200[xvi]. It has been approximated that the lifetime costs for a three year old who suffers a severe traumatic brain injury is £4.89 million.

2.17 The majority of injuries are however preventable. Relatively inexpensive interventions can be implemented and show a beneficial return on investment[v].

3. POLICY CONTEXT

3.1 In 1999, the White Paper *Saving Lives: Our Healthier Nation*[xvii], made the prevention of injury a priority. It highlighted unintentional injury at the time as the greatest single threat to the lives of children. It recognised that unintentional injury accounted for more children being admitted to hospital than for any other cause. The White Paper set two targets:

- To reduce the death rates from accidents (in all age groups) by at least one fifth
- To reduce the rate of serious injury from accidents by at least one tenth by 2010

3.2 The Marmot report[iv] highlights how the +single major avoidable cause of death in childhood in England is unintentional injury; death in the home for under 5's and on the road of 5-17 year olds. In recent years the Chief Medical Officer Report 'Prevention Pays; Our Children deserve better'[ii] highlighted childhood accidents as a leading cause of death and disability.

3.3 There is a range of national guidance published on the topic, available from:

Royal Society of the Prevention of Accidents
http://www.rospa.com/

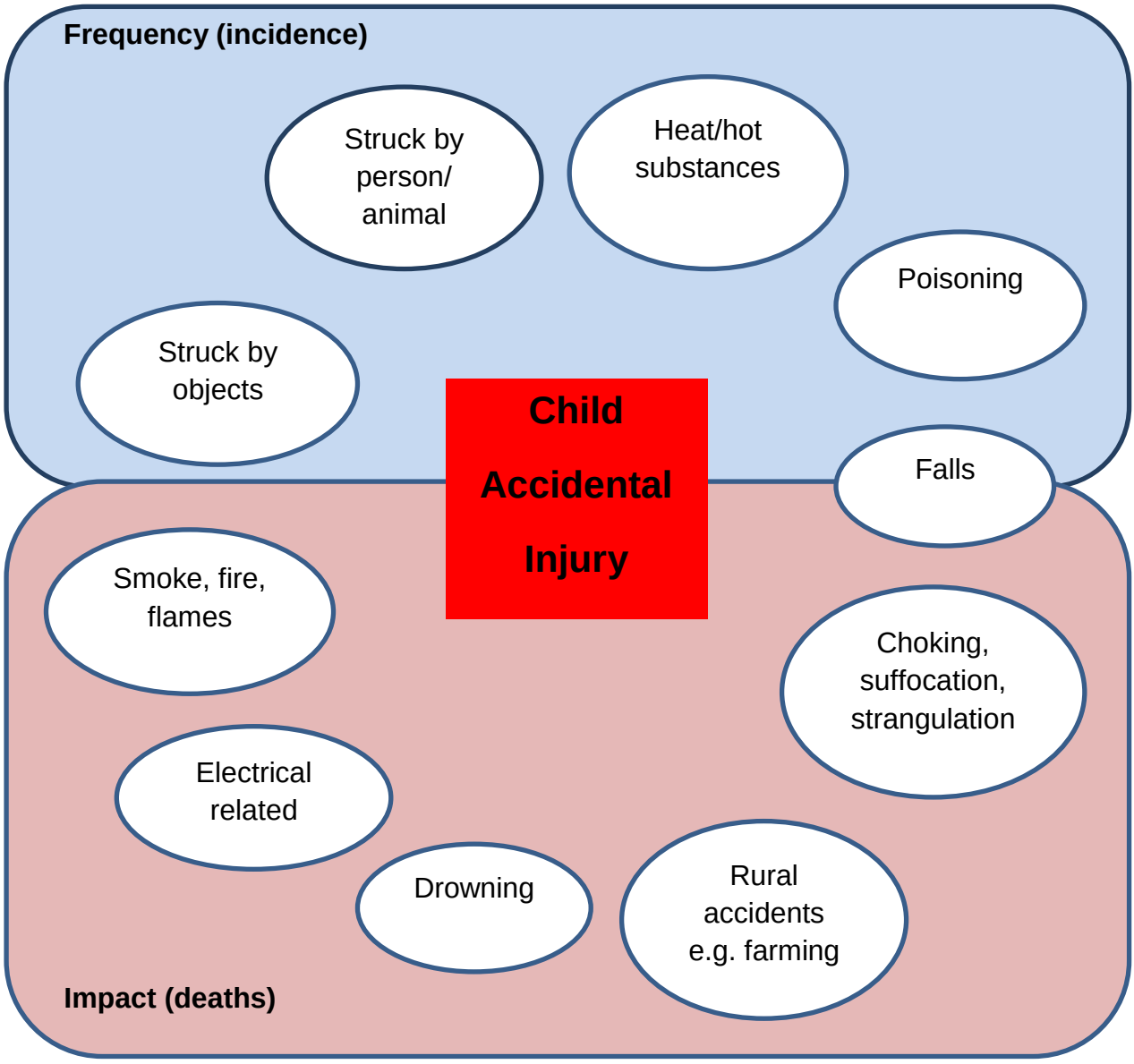
Child Accident Prevention Trust
http://capt.org.uk/

National Institute for Health and Care Excellence
https://www.nice.org.uk/

Public Health England
https://www.gov.uk/government/organisations/public-health-england

Figure 6: NICE guidance on unintentional injuries

Figure 7: Categories of injury grouped by high frequency and impact



4. THE LOCAL PICTURE

4.1 The data presented in this section provides a snapshot of the local picture, providing the context for the strategy and action plan. Data is presented for 0-14 year olds in Somerset.

Fatally injured

4.2 The mortality charts below consider 'avoidable accidents' defined as any death with an underlying cause coded as a road traffic accident and other causes.

4.3 The ONS Primary Care Mortality Database shows that there were fourteen children aged 0-14 who died in Somerset from an avoidable accident between 2006 and 2013.

4.4 Department of Transport STAT19 road accident statistics show that there were fewer than five child fatalities in each calendar year between 2009 and 2013. In 2013 six casualties out of 188 were seriously injured, but there were no fatalities.

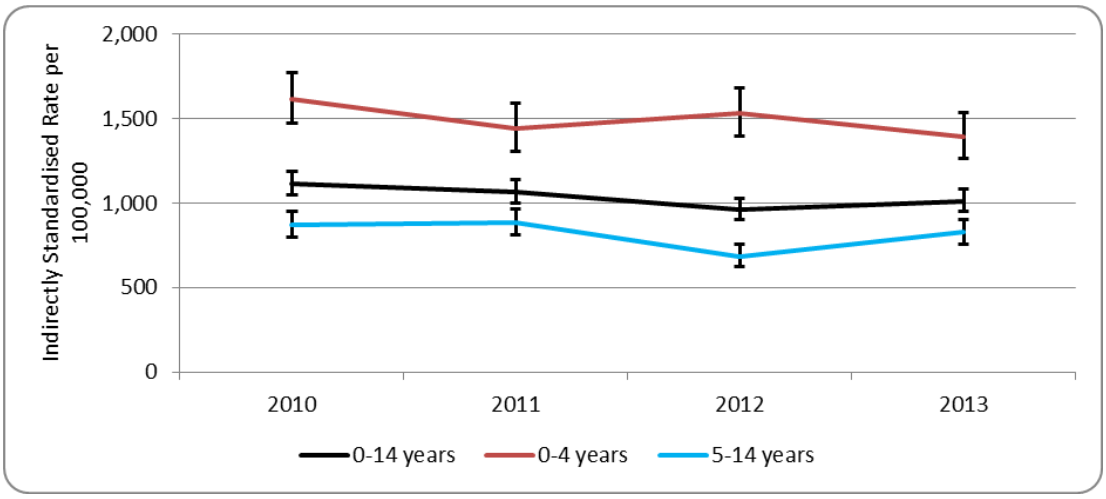
NB/ STAT19 statistics define children as any person under the age of 16.

Injuries resulting in hospitalisation (admissions)

4.5 Hospital admission data is defined as any hospital admission with a primary or secondary diagnosis coded as road traffic accident or other causes of accidental injury.

4.6 The rate of hospital admissions has been significantly higher for 0-4 year olds than for 5-14 year olds in every year between 2010 and 2013.

Figure 8: Hospital admissions of Somerset patients aged 0-14 linked to avoidable accidents between 2009 and 2013 by age, indirectly standardised rate per 100,000



Source: Secondary Uses Service (SUS)

4.7 The indirectly standardised rate of hospital admissions of children aged 0-14 linked to avoidable accidents has been significantly higher for males than females in every year between 2010 and 2013.

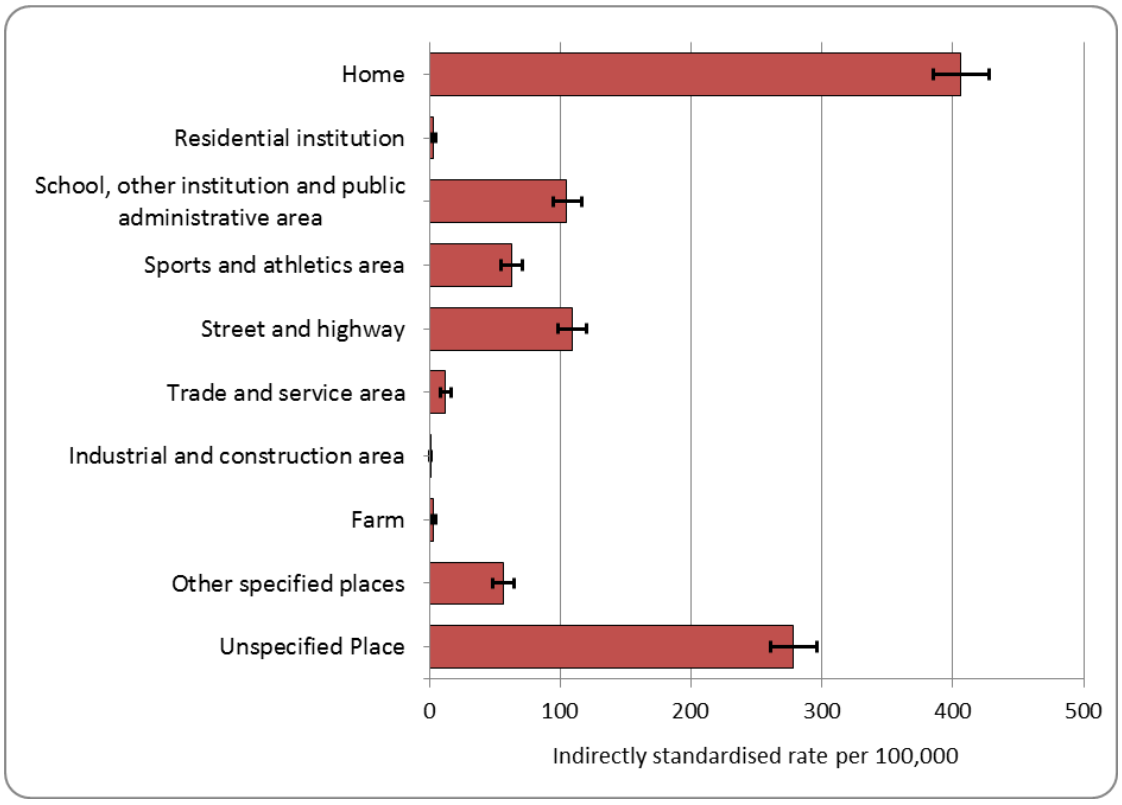
Admissions by location of accident

4.8 Hospital coding for accidents record the location of the accident where it is known. All admissions linked to transport accidents have been counted as taking place on a street or highway, and where an admission has more than one accident code the most prominent is used.

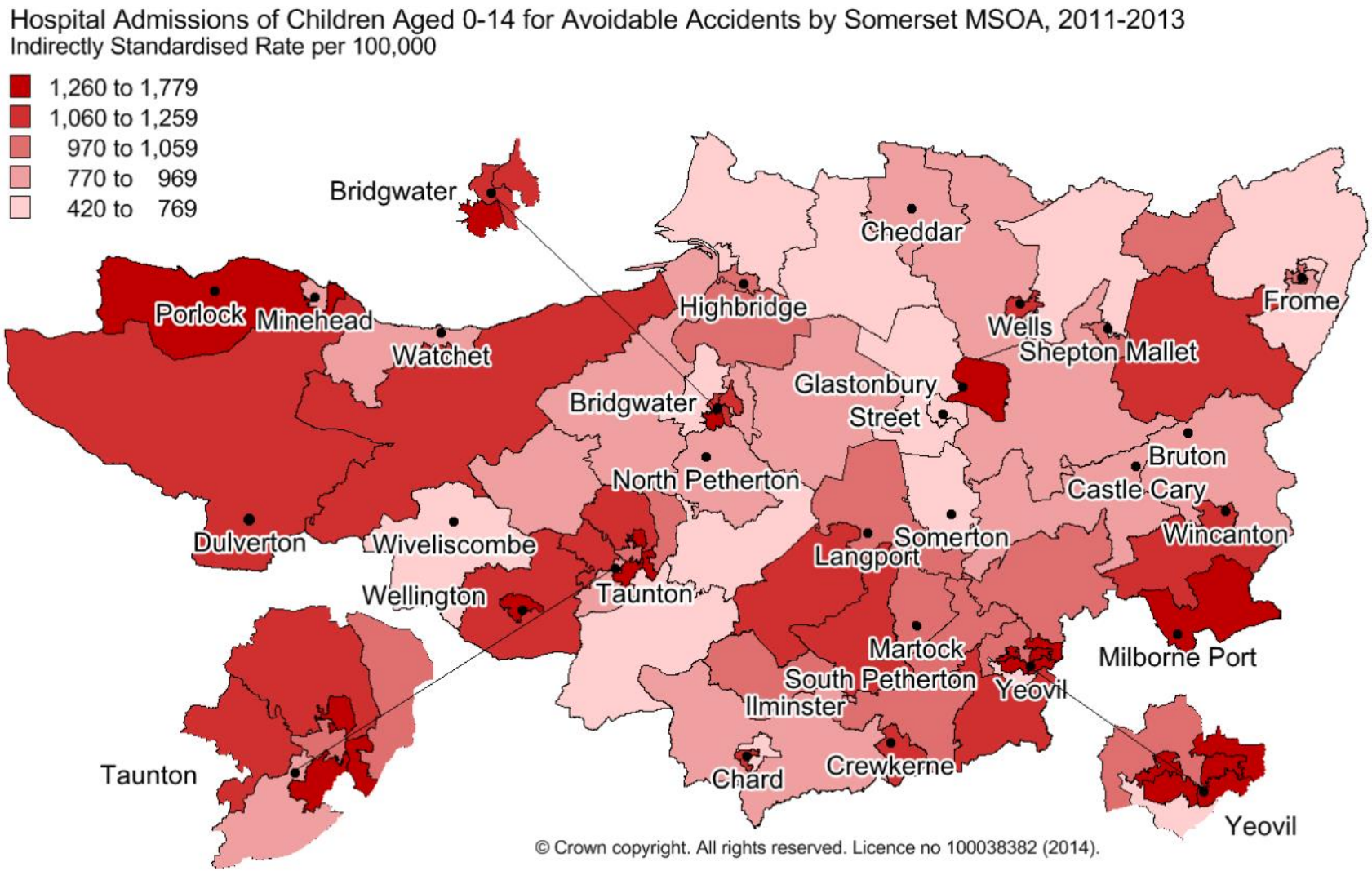
4.9 It must be noted that there were a large number of accidents with the location was not recorded. However, Figure 9 below shows the standardised rate for hospital admissions from accidents in the home was much higher than any other category.

4.10 The next highest rate was for accidents in streets and highways which included all transport accidents. The next most common locations were schools and other public buildings and sports and athletics area.

Figure 9: Hospital admissions of Somerset patients aged 0-14 linked to avoidable accidents in 2013 by accident location, indirectly standardised rate per 100,000



Source: Secondary Uses Service (SUS)

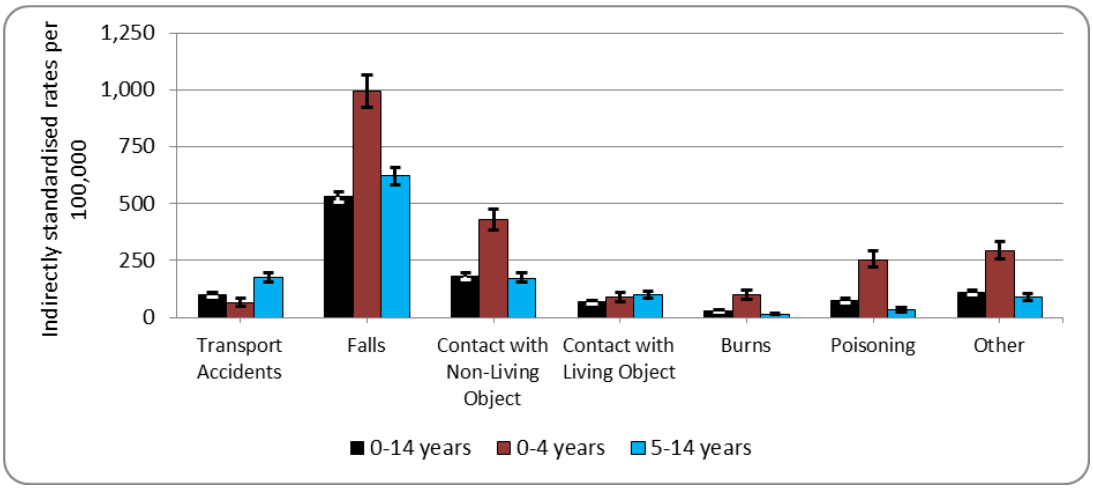


Sources: Secondary Uses Service (SUS), ONS Population Estimates

Causes of injury

4.11 Figure 10 shows the standardised rate of hospital admissions for falls was the highest for any accident group for all age bands. Falls, Contact with Non-Living Objects, Burns, Poisoning and Others all had significantly higher rates of admissions of 0-4 year olds than 5-14 year olds. The rate of transport accidents was the only one that was significantly higher for 5-14 year olds.

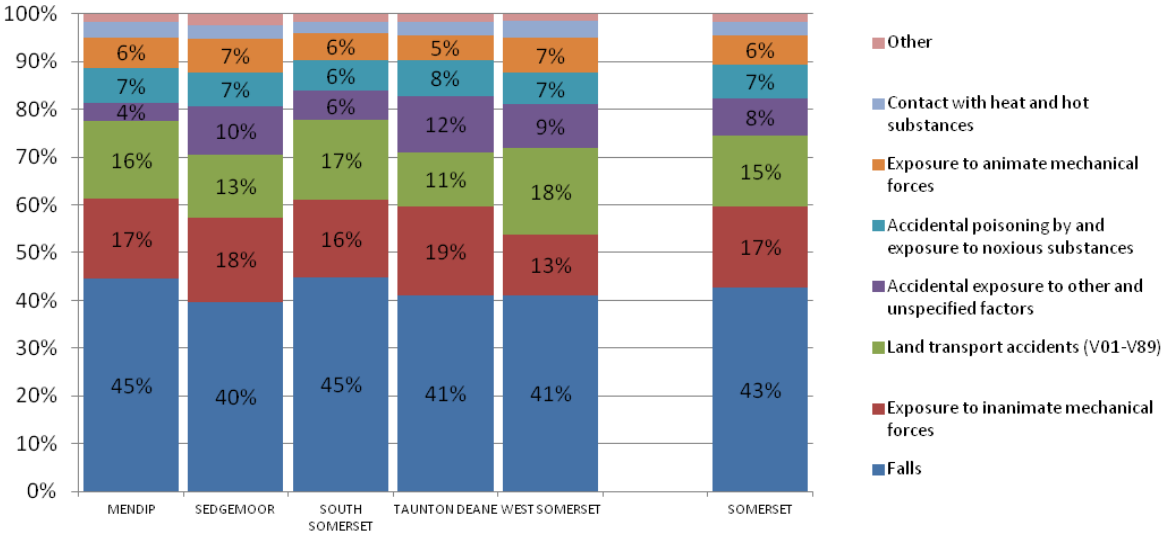
Figure 10: Hospital admissions of Somerset patients aged 0-14 linked to avoidable accidents in 2013 by accident group and age, indirectly standardised rate per 100,000



Source: Secondary Uses Service (SUS)

4.12 When analysing by sex, there were no accident types where the rate of hospital admissions was higher for females.

Figure 11: Somerset admissions to hospital following accidents, by cause and district, for 2008-13



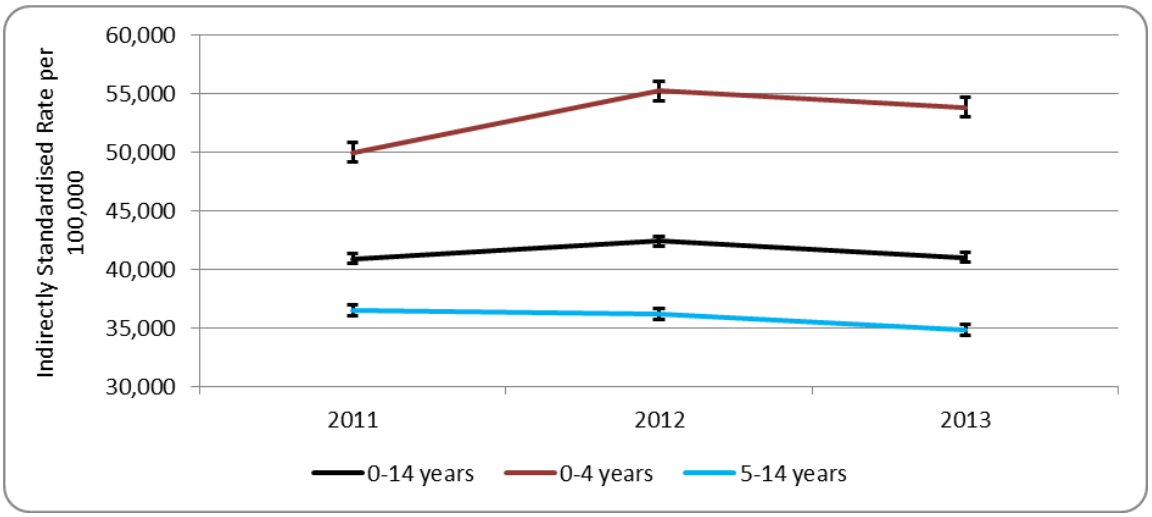
Source: Secondary Uses Service (SUS)

Injuries resulting in A&E attendance

4.13 It is not possible to identify Accident and Emergency attendances which were caused by avoidable accidents. However, the rates of overall attendances by children aged 14 and under can be used to give as a possible indication of how many avoidable accidents may have resulted in an attendance at an accident and emergency department.

4.14 The standardised rate of A&E attendances made by Somerset patients aged 0-14 was significantly lower in 2013 than it had been in 2012. The rate of A&E attendances for 0-4 year olds was significantly higher than for 5-14 year olds in each of the last three years.

Figure 12: A&E Attendances made by Somerset patients aged 0-14 in 2013 by age, indirectly standardised rate per 100,000

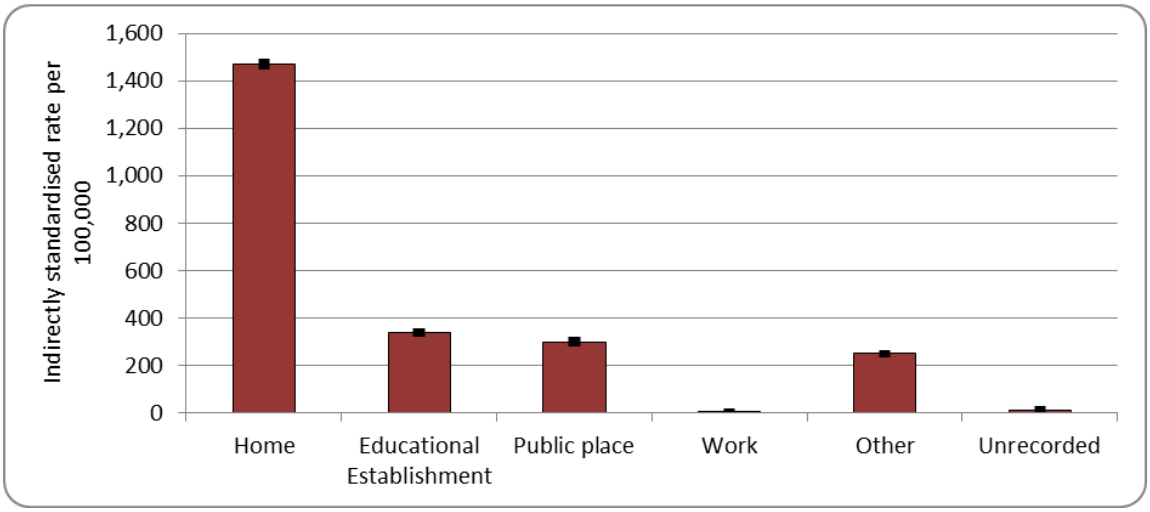


Source: Secondary Uses Service (SUS)

4.15 The A&E incident location identifier in the A&E data from the SUS gives a location for the incident which led to the attendance. These are listed below in Figure 14.

4.16 In 2013 the indirectly standardised rate of accident and emergency admissions which were a result of an accident at home were significantly higher than all other locations.

Figure 13: A&E Attendances of Somerset patients aged 0-14 in 2013 by incident location, indirectly standardised rate per 100,000



Source: Secondary Uses Service (SUS)

4.17 The patient group identifier in the A&E data from the SUS gives an overarching reason for an attendance. These are listed below in Table 1.

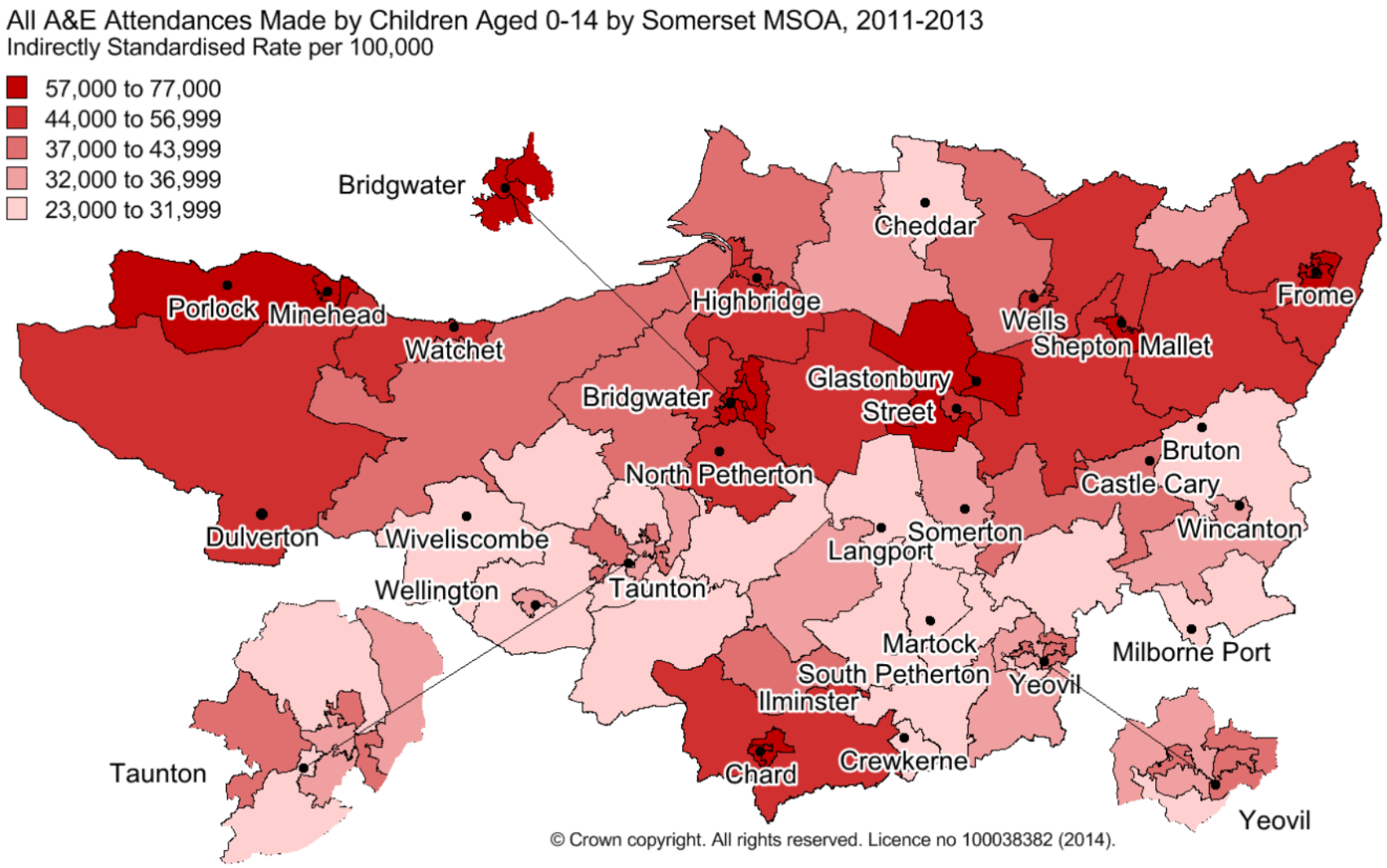
4.18 In 2013 over half of the attendances made by Somerset patients aged 0-14 have been coded as an Other Attendance or were unknown/uncoded.

4.19 Almost all patients with a code recorded attended for an "other accident" reason. This might suggest that a large proportion of the "other attendances" could also have been for accidents as well.

Table 1: Initial A&E Attendances made by Somerset patients aged 14 and under by reason for attendance, 2013, number and percentage

Reason for Attendance	Number	Percentage
Road traffic accident	182	1%
Sports injury	1909	6%
Other accident	14,042	46%
Firework injury	8	0%
Non-Accident Codes	70	0%
Uncoded	194	1%
Other Attendances	14,042	46%
Total	30,447	100%

Source: Secondary Uses Service (SUS).



Source: Secondary Uses Service (SUS), ONS Population Estimates

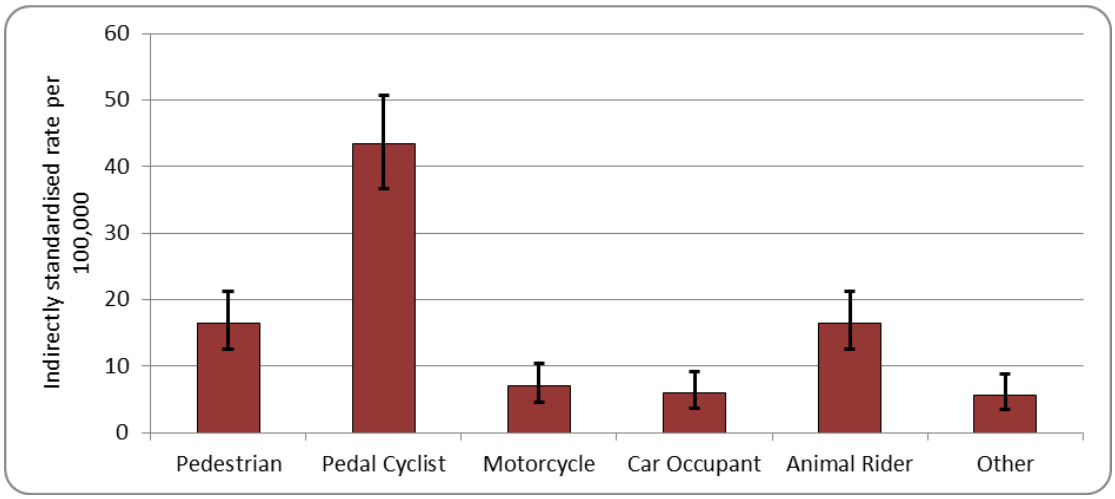
4.20 The standardised rate of A&E attendances for males was significantly higher than for females in each year between 2011 and 2013.

Transport accidents

4.21 Figure 14 below shows the standardised rate of hospital admissions of pedal cyclists in 2013 was significantly higher than for any road user. Rates of hospital admissions were significantly higher for pedestrians and animal riders than for the remaining road users.

4.22 Over two-thirds of all admissions for pedal cyclists and almost all for motorcyclists were of males aged 5-14. Three in seven admissions for accidents were of females aged 5-14 more than any other age/sex group. Almost all admissions of animal riders were of females aged 5-14. Two-thirds of admissions for all other accidents were of males.

Figure 14: Hospital admissions of Somerset patients aged 0-14 linked to transport accidents in 2013 by road user, indirectly standardised rate per 100,000

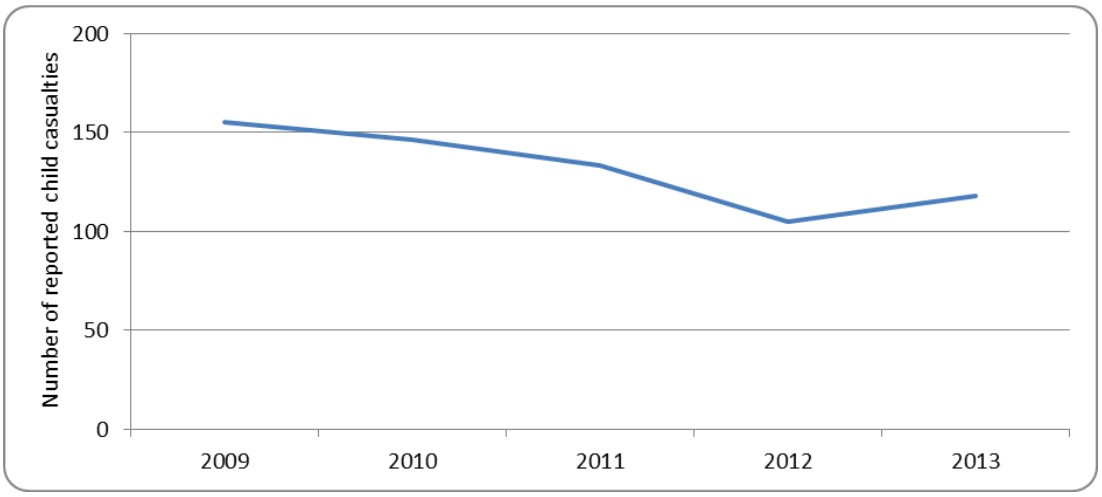


Source: Secondary Uses Service (SUS)

4.23 Department of Transport STAT19 road accident statistics show that there were 118 casualties (injuries) for children aged 0-15 on Somerset's roads in 2013. 30 were attributed to pedestrians and 23 to pedal cyclists. Figures for other road users are not provided for children.

4.24 Figure 15 below shows that the number of reported casualties for children aged 0-15 fell between 2009 and 2012 but did increase slightly in from 105 in the previous year.

Figure 15: Reported child casualties on Somerset roads between 2009 and 2013, numbers



Source: Department of Transport: STAT 19 Road Accident Statistics

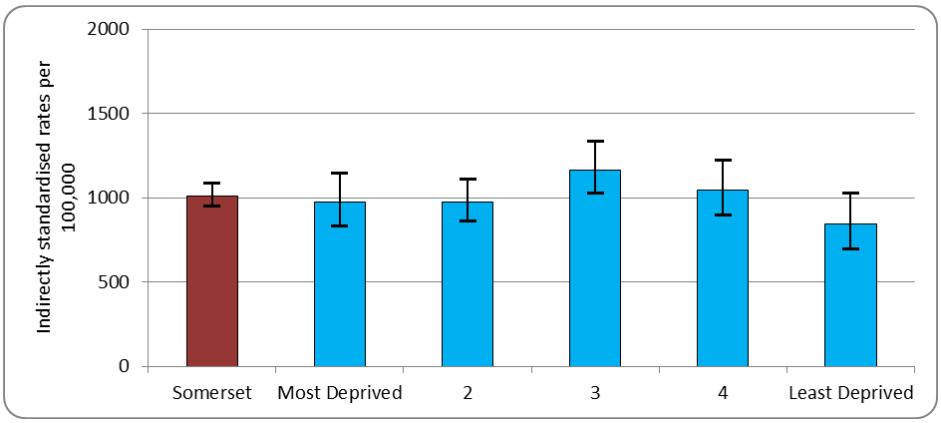
Injury and deprivation

4.25 Overall rates of death from injury in children have fallen in England and Wales over the past 20 years. However, rates for children living in disadvantaged social and economic circumstances have not seen the same improvement. Children from the most disadvantaged backgrounds are at significantly increased risk of injury. Compared to their peers, children from the poorest homes are:

- 13 times more likely to die in an accident
- 21 times more likely to die as a pedestrian on the roads
- 38 times more likely to die in a house fire

4.26 With regard to hospital admissions for accidents, locally the inequality in relation to deprivation is not apparent. In 2013 children aged 0-14 registered with GP surgeries in the least deprived Somerset quintile were less likely to have a hospital admission for an avoidable accident. Children in the middle deprivation quintile had a higher rate of admissions. However, these variations were not statistically significant.

Figure 16: Hospital admissions of Somerset patients aged 0-14 linked to avoidable accidents in 2013 by Somerset deprivation quintile, indirectly standardised rate per 100,000

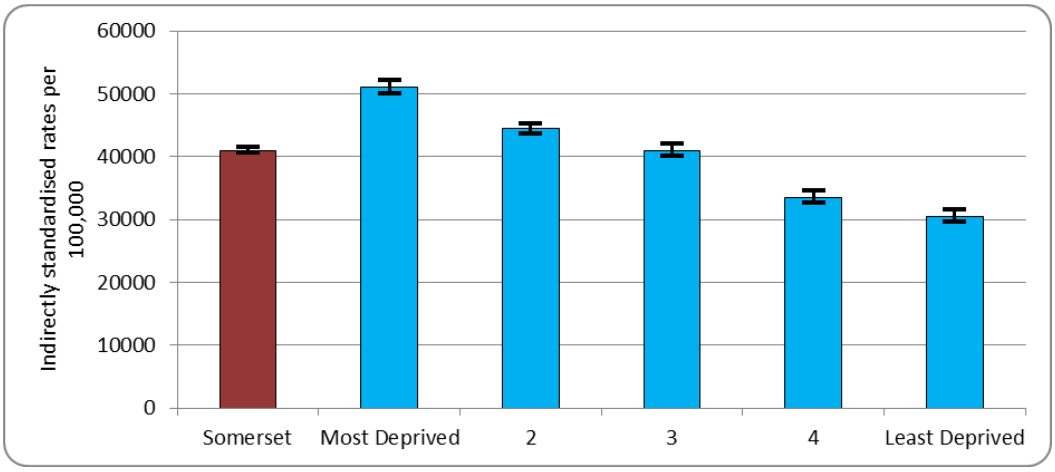


Source: Secondary Uses Service (SUS)

4.27 Unlike the rates for hospital admissions by deprivation for children aged 0-14, there is clear correlation with A&E attendances and deprivation Somerset quintiles.

4.28 Figure 17 shows that the rate of attendances for children registered in the least deprived quintile is significantly lower than for all others. Additionally the rate for children in the most deprived quintile was significantly higher. This difference in trend could be indicative of a misuse of services by those in more deprived groups, illustrated with a greater use of A&E services where admissions were not required, which would theoretically be preventable.

Figure 17: A&E Attendances of Somerset patients aged 0-14 in 2013 by Somerset deprivation quintile, indirectly standardised rate per 100,000



Source: Secondary Uses Service (SUS)

5. WHAT WORKS

5.1 Approaches to preventing unintentional injuries range from education (providing information and training) to product or environmental modifications and enforcement (regulations and legislation). It has been suggested that the most effective strategies use a combination of approaches[xviii]

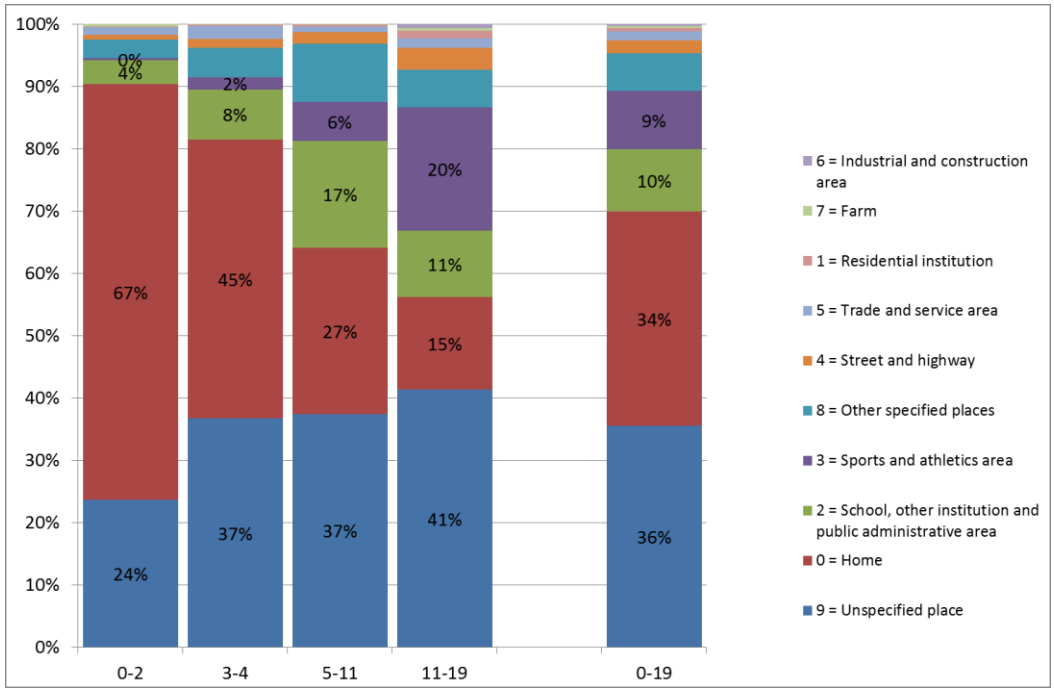
5.2 There is a strong argument to focus on tackling the leading, preventable causes of death and serious long-term harm. Analysis of national data identifies that five injury types could be prioritised: choking, suffocation and strangulation; falls; poisoning; burns and scalds; and drowningxiv.

Home

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

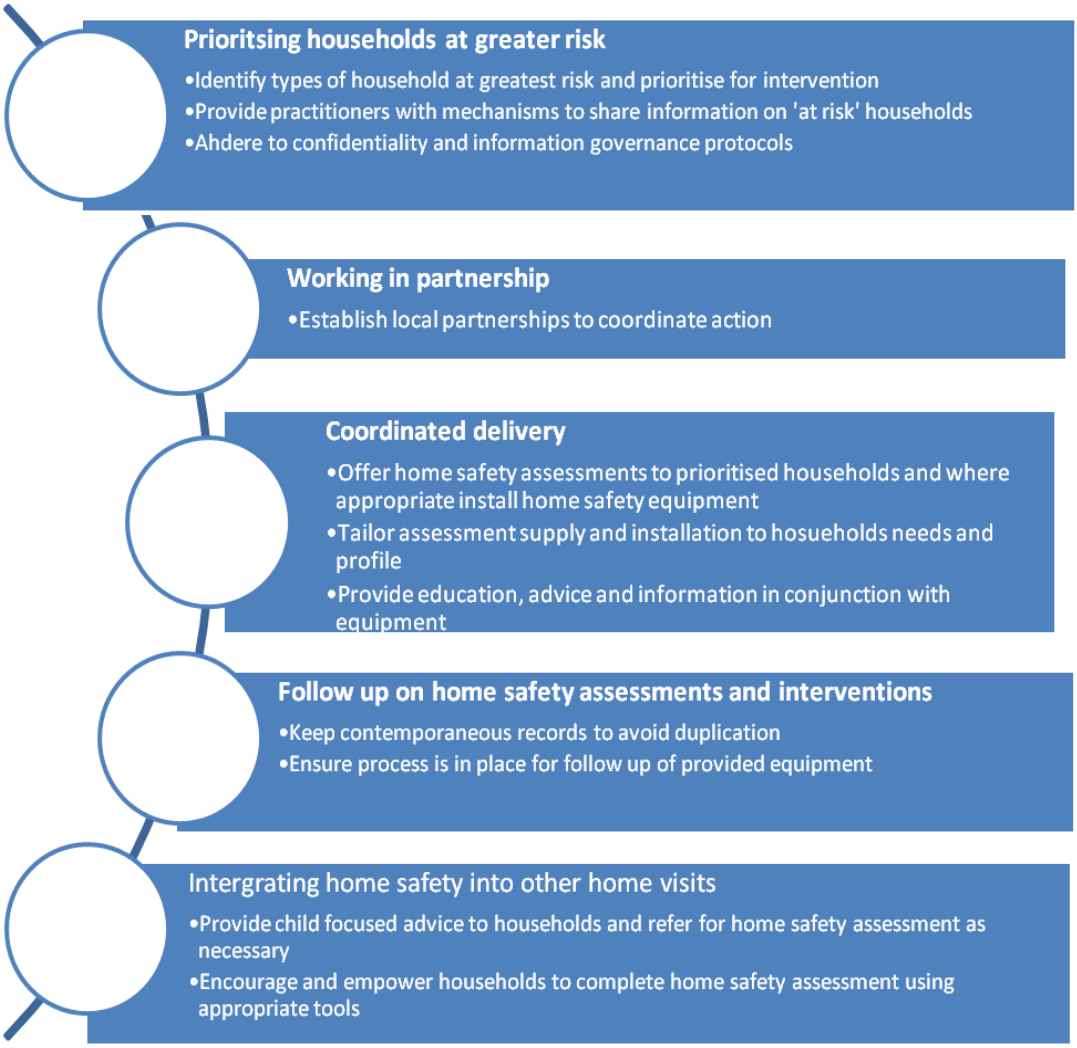
- child development
- the physical environment in the home
- the knowledge and behaviour of parents and other carers (including literacy)
- overcrowding or homelessness
- the availability of safety equipment
- new consumer products in the home

Figure 18: Somerset admissions to hospital following non-transport related accidents, by location of accident, for 2008-2013



Source: Secondary Uses Service (SUS)

5.4 NICE PH30 focuses on action that can be taken to address unintentional injuries in the home, setting out a series of guidelines:



5.5 Work has taken place within Somerset to implement these guidelines, with a case study of the Somerset Public Health Safer Homes Initiative detailed over the page.

Case study: Somerset Public Health Safer Homes

Somerset's Home Safety Project specifically focuses on preventable injury to children under 5 with a focus on those families who experience the greatest health inequalities. This will be achieved by the provision and installation of home safety equipment to eligible households upon referral, in conjunction with a home safety visit, a fire risk assessment and educational material that reduces the risk of childhood accidents and fire. The format of this programme will be based on ROSPA's Safer Homes Community Initiative model / Safe At Home – *The National Home Safety Equipment Scheme* http://www.rospa.com/homesafety/safeathome

Based on this report the key features of Somerset's programme include:

- Workforce awareness raising and training
- An easy to use home safety audit
- Access to free safety equipment (and fitting) for families in need
- Developing a partnership approach to home safety
- Programme evaluation and monitoring against indicators

Somerset's programme will be led through Family Focus and GetSet services and be delivered by a range of providers working directly with children and their families' i.e.

- Family Focus Key workers
- GetSet Service Family Support Workers
- Health Visitors
- Others as identified and appropriate

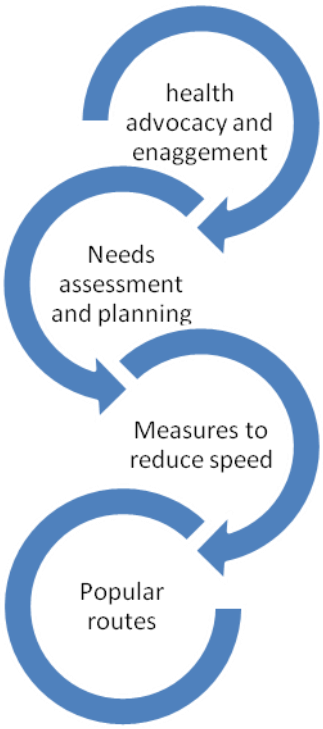
Eligible households are identified by meeting the following criteria:

- Family accessing GetSet services
- Household includes one or more children under 5 years of age (at date of referral)

In collaboration with:

Road

5.6 Measures to address child injury on the road are detailed in full in NICE PH31 and are summarised below:



Health advocacy and engagement

Ensure a leading is identified who is responsible for the health sector's involvement in injury prevention and risk reduction. Work should be coordinated between health professionals and highways authorities to promote changes to the road environment to support and promote changes as part of a broader strategy to prevent injuries and the risk of injuries.

Needs assessment and planning

Work with other partners to introduce engineering measures to reduce speed as part of a broad strategy to prevent injuries and the risk of injuries. Work should; consider risk of injury and charactistics of victims, be in line with good practice; take into account all road users; utilise community engagement; be based on local priorities for modifying the transport structure; be evaluated in terms of reducing risk and rates of injuries and unintended consequences

Measures to reduce speed

5.7 Introduce engineering measures to reduce speed in streets that are primarily residential or where pedestrian and cyclist movements are high. Implement city or town-wide 20 mph limits and zones on appropriate roads. Use factors such as traffic volume, speed and function to determine which roads are appropriate and consider changes to speed limits and appropriate engineering measures on rural roads where the risk of injury is relatively high, in line with Department for Transport guidance.

Popular routes

5.8 Consider opportunities to develop engineering measures to provide safer routes commonly used by children and young people, including to school and other destinations (such as parks, colleges and recreational sites). This should be done as part of the development of a broad package of measures to address travel, for instance when developing school travel plans and should include school governors and head teachers in

discussions about changes relating to school travel and involvement in 'safer communities' projects.

Play

5.9 Leisure time and play is an essential element of child development. NICE PH17 Promoting physical activity for children and young people makes a series of recommendations which detail how safety can be considered to support physical activity:

5.10 Providing local indoor and outdoor opportunities for physical activity where children and young people feel safe.

5.11 Physical activity partnerships establish and deliver multi-component interventions involving schools, families and communities, promoting safe play.

5.12 Local transport and school travel plans are coordinated so that local journeys can be carried out safely using a physically active mode of travel. This may include provision of cycle lanes and availability or provision of cycle helmets.

5.13 Safety education in schools and local safety procedures to ensure that accidental injuries are prevented where possible, while not limiting the contribution that free play provides child development.

5.14 Research[xix] shows the value of education and awareness of risks as an effective way to reduce the risk of accidental injury during play. For example teaching older children to swim reduces the risk of drowning and protective devices are available for many sports. Many have not been formally evaluated although they show potential to reduce injury.

Table 2: Risks and interventions to reduce injuries at play

Risk	Intervention
• Sports related injuries • Drowning • Sunburn/heatstroke • Fireworks related injuries	• Adult supervision at pools • Pool design and protection • Adult supervision at beaches • Specific targeted interventions e.g. sun safety and safe firework usage

6. HOW CAN THE EVIDENCE BE APPLIED?

6.1 NICE Guidance PH298 recommends that local authority children's services and their partnerships, in consultation with local safeguarding children boards, and other local authority services that may have a remit for preventing unintentional injuries such as education, environmental health and trading standards, should ensure there is a child and young

person injury prevention co-ordinator to help achieve the commitments set out in local plans and strategies for children and young people's health and wellbeing.

6.2 The effectiveness of local actions depends on:

7. MEETING LOCAL NEEDS

7.1 In order to meet local needs a culture of proactive action and action on prevention should exist within and between services. This can take the form of being proactive in the following areas:

- Collate and respond to local data – District Council Area, deprivation Indices and local intelligence

- Supporting Health Promotion campaigns, national and local to early year's settings and school aged children. By circulation of quarterly Child Accident Prevention Newsletter to early years settings by email and schools through S.H.W.I.L.P(Somerset Health and Wellbeing in Learning Programme) e –bulletin http://www.somersethealthinschools.co.uk

- Capturing data from Health promotion/education initiatives and using the information to review effectiveness

- Targeting families in need as identified by the Get Set Services and Health Visitors supporting the Public Health Safer Homes Project

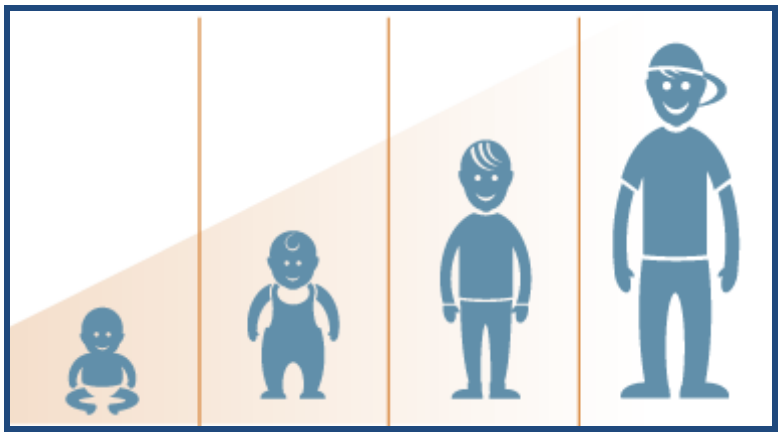
- Identification of key partners in child accident prevention work and formulate cohesive approach to support work across Somerset

7.2 In addition to these actions, an ability to be reactive to information and data will enable services to:

- Be responsive to need where and when arises
- Respond to new alerts around child safety as received by external sources
- Be responsive to new guidelines and research papers as published, ensuring evidence based interventions are utilised

7.3 The needs of the population vary with age and the following categories are used to plan stakeholder actions:

Figure 19: Categories of age addressed in the action plan



0-2yr Babies	3-4yrs Toddlers	5-11yrs Children	12-14yrs Adolescents

8. MONITORING OF THE STRATEGY AND REPORTING STRUCTURE

8.1 The Children's and Young People Health and Wellbeing Group have oversight of the development and ratification of this strategy. The group is chaired by a Consultant in Public Health and reports to the Children's Trust Board.

8.2 The action plan is an iterative document and stands alone from the strategy.

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