PREVENTING UNINTENTIONAL INJURIES TO CHILDREN IN THE NHS GREATER GLASGOW & CLYDE AREA

Part 1 Creating a framework for action
Part 2 Action plan

Produced by the Short-life
Working Group on Unintentional
Child Injury Prevention

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PREVENTING UNINTENTIONAL INJURIES TO CHILDREN AND YOUNG PEOPLE IN THE NHS GREATER GLASGOW & CLYDE AREA

Part 1 CREATING A FRAMEWORK FOR ACTION

PREFACE

Children and young people[1] are entitled to have healthy lifestyles free from the risks of death, or serious or disabling injury. They have to be allowed to develop physically and socially, to learn about the environments in which they live and to be able to enjoy an active life. They cannot be wrapped up in cotton wool, free from all risks, as this would have serious consequences for their social development and for their physical health in later life.

These freedoms are enshrined in the United Nations Convention on the Rights of the Child[2] of which the United Kingdom is a signatory.

EXECUTIVE SUMMARY

The current situation

- Unintentional injury is one of the main causes of death and is the most common cause of emergency hospital admissions in children aged under 15 in Scotland and NHSGGC.
- The most common cause of death from unintentional injury over the last five years has been road casualties. The most common cause of unintentional injury resulting in emergency hospital admission in NHSGGC is falls (see figure 5).
- Unintentional injuries occur more often in males than females.
- A high proportion of unintentional injuries in children occur at home, and when the child is playing.

[1] This document focuses on children and young people aged under 15 years. Young people over this age have significant injury issues that should not be overlooked. However, while there is no sudden transition in the injury patterns between under and over 15s, those of the latter age group tend to be more closely associated with those experienced by youths and adults.

[2] Accessible at http://www.unicef.org/crc/crc.htm. Two Articles are particularly relevant to the prevention of unintentional injury:

- Article 19 requires signatories to ensure that they take all legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parent(s), legal guardian(s) or any other person who has the care of the child.
- Article 24 (e) requires signatories to ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of child health and nutrition, the advantages of breastfeeding, hygiene and environmental sanitation and the prevention of accidents.

- Unintentional injury is related to deprivation, with injury rates increasing with increased deprivation.

- Despite the fact that injuries to children in Scotland requiring hospital admission have fallen by 20% between 1999 and 2005, almost 10,000 children were admitted to hospital in 2005. In NHSGGC, the annual figure is around 2,000.

- Every year in Scotland, one child in five attends A&E departments following an unintentional injury – approximately 200,000 visits annually**. In NHSGGC, the figure is approximately 24,000.** Most of these events are not life-threatening but they consume considerable health service resources, cause distress for parents and children, have economic consequences for families through loss of work, and can impact on children's education with time off school.

- Within NHSGGC, East Glasgow CHCP and West Glasgow CHCP had the highest standardised discharge ratios for unintentional injury in 2008/09.

- Every year in NHSGGC, children's injuries cost the NHS an estimated £10 million and society generally around £100 million.

- Despite being identified in policy and the significant social and economic cost of injury to children and young people, neither Scotland nor NHSGGC has a coordinated child injury reduction strategy (unlike many other developed countries).

- This report outlines how NHSGGC and its partner agencies can take practical steps towards the reduction of child injury incidence and severity in the board's area.

The key strategic approaches

- The focus should be on injuries that result in death, serious or long-lasting injury, and those that are the most numerous.

- Wherever possible, prevention programmes should be based on sound knowledge of what is known to be effective. Where evidence is not readily available, best practice must be employed and appropriate research should be undertaken.

- The differential between the death rates of the poorest and wealthiest families in our society has to be reduced as a matter of urgency.

- Coordinated, multifaceted approaches using engineering and environmental changes, educational and publicity measures, enforcement of legislation, and empowerment of communities and workers are required to optimise success.

- Existing strategic and policy opportunities (see Annexes A and B) should be used whenever possible to provide a framework for injury prevention.

- All current prevention activity should be reviewed on a regular basis in light of evidence and best practice.

- Preventive measures have to strike a balance between children's need for active exploration and development and adults' responsibility to keep them free from death and serious injury.

Recommendations for action

- At both national and local levels, there is a need for clear leadership, coordination of activities and improved communication.

- Within the Scottish Government, the Health Directorates, which provide the services to treat the casualties, are well placed to undertake the unintentional injury prevention leadership role. Currently the Scottish Government have been developing an implementation plan which includes unintentional injury, titled Good Places, Better Health, with further information to be made available in March 2011.

- At local level, including within NHSGGC, there is a need for clearly defined responsibility for preventing unintentional injuries to children, bringing together those responsible for health, road, housing, and community safety. Coordination and communication are essential, both within and between agencies. Local planning mechanisms, including community safety partnerships, community health partnerships and children's services plans, can provide opportunities for improved local coordination.

- Community safety partnerships should be encouraged to adopt injury prevention as a core priority. The role of the NHS should be strengthened through taking the lead for injury prevention.

- To ensure that effective actions are taken, the following infrastructure improvements are required:

    - accessible, relevant and timely information and data, analysed to serve the needs of those commissioning, undertaking or evaluating prevention activities;
    - the development and maintenance of an evidence base that clearly identifies what works;
    - an appropriately trained and skilled workforce.

- This report outlines a board-wide plan of action on child injury prevention that should be developed further in the course of 2010 -11.
  Part 2 of the report:
    - Sets out the priority injury issues;
    - Suggests prevention programmes to be implemented locally, with an agreed set of outcomes;
    - Identifies clear lines of responsibility
    - Recommends performance indicators for the NHSGGC and partner agencies;
    - Indicates research needs to support effective injury prevention activities.

Our key recommendation is that the Board undertake further exploration and development of our thinking with a view to developing a more detailed and comprehensive 10 year implementation plan for child safety.

1. THE NEED FOR ACTION

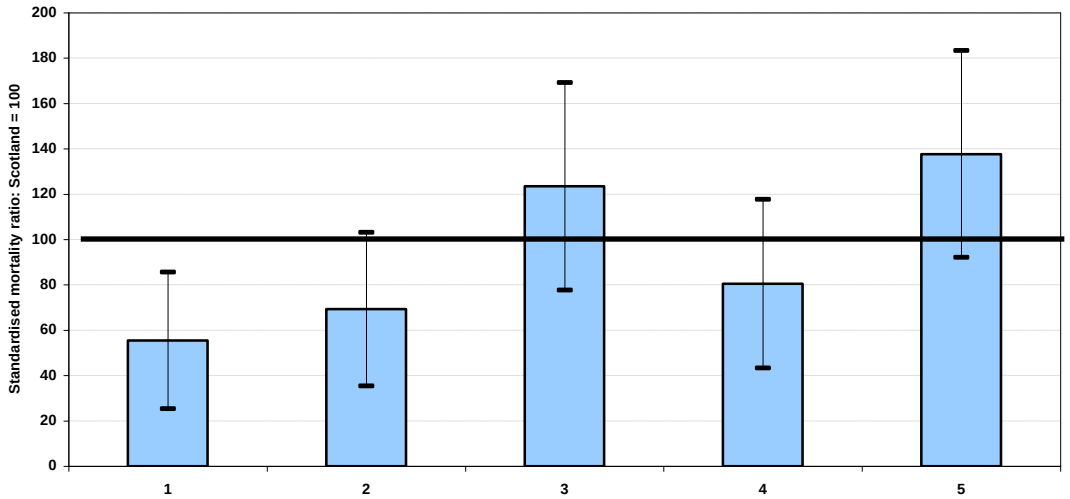
"Unintentional injury is one of the main causes of death and is the most common cause of emergency hospital admissions in children aged under 15."[3]

Epidemiology of unintentional injury in children in NHSGGC

Key epidemiological features

- Unintentional injury is one of the main causes of death and is the most common cause of emergency hospital admissions in children aged under 15 in Scotland and NHSGGC.
- Unintentional injuries occur more often in males than females.
- In Glasgow, younger children (0-4 years old) have been found to have more unintentional injuries than older children (10-15 years old)[4].
- A high proportion of unintentional injuries in children occur at home, and when the child is playing.
- Unintentional injury is related to deprivation, with injury rates increasing with increased deprivation (see figure 1) (ISD).

Figure 1: Mortality from unintentional injury, children aged under 15 years of age by deprivation quintile, year ending 31 December, 2004-2008



Source: General Register Office for Scotland (GROS), Scottish Index of Multiple Deprivation (SIMD)

Unintentional injury in NHSGGC compared to the rest of Scotland

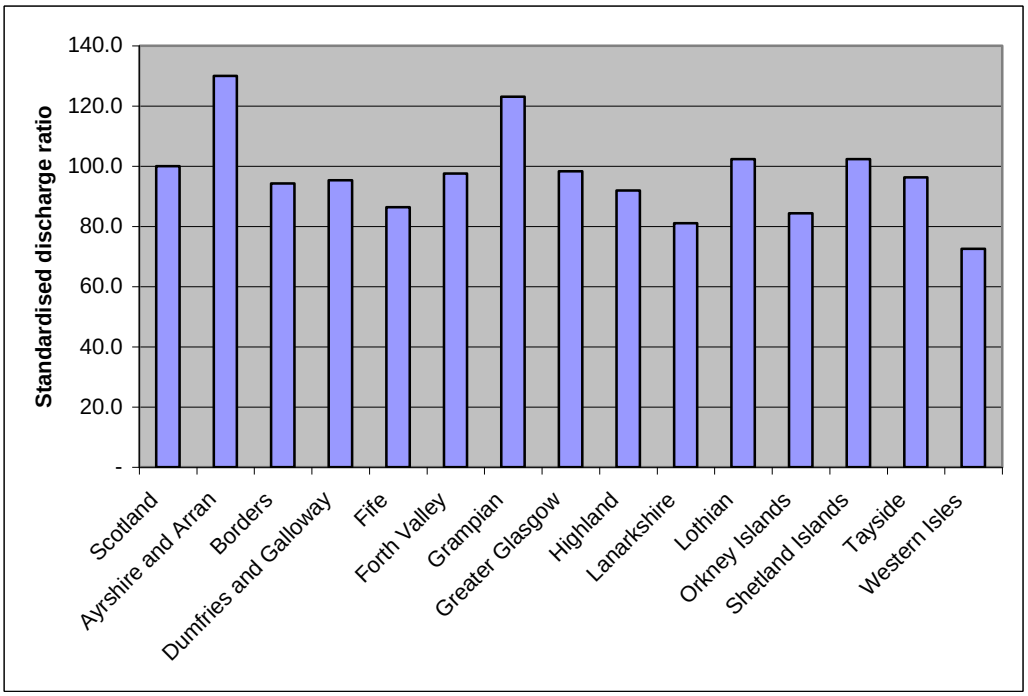
NHSGGC has a standardised discharge ratio for emergency admissions due to unintentional injury which is near the Scottish average (see figure 2). It should be noted that this graph is based on data with small numbers which may account for some of the variation. Also, the

[3] ISD Scotland website, http://www.isdscotland.org/isd/3066.html. Accessed 22 February 2007.

[4] Shipton D, Stone DH. The Pattern of Injuries in Children Presenting to an Accident and Emergency Department, Findings from the Yorkhill Children's Hospital Injury Reporting and Prevention Programme (Y-CHIRPP). Peach paper. 2007.

variation in discharge rate between health boards may partly be accounted for by differences in admission practices in different areas. [3] (ISD).

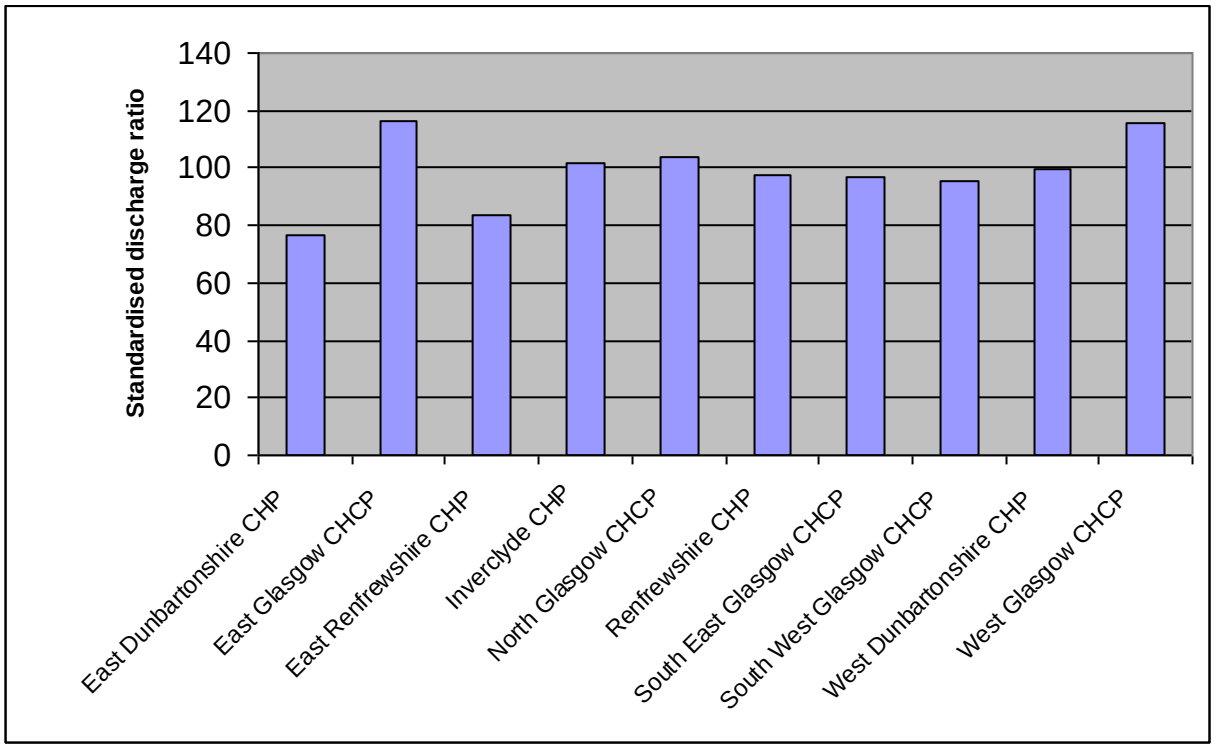
Figure 1: Standardised discharge ratio for unintentional injury in children under 15 across Scotland



Unintentional injuries in children across NHSGGC

Within NHSGGC, East Glasgow CHCP and West Glasgow CHCP had the highest standardised discharge ratios for unintentional injury in 2008/09, although it should be noted that these data are based on small numbers which is likely to account for much of the variation between the CH(C)Ps (ISD data) (see figure 3).3

Figure 3: Standardised discharge ratio for unintentional injury in children under 15 across the CH(C)Ps in NHSGGC



Note: In these data the value of 100 represents the average figure for Scotland, rather than for NHSGGC.

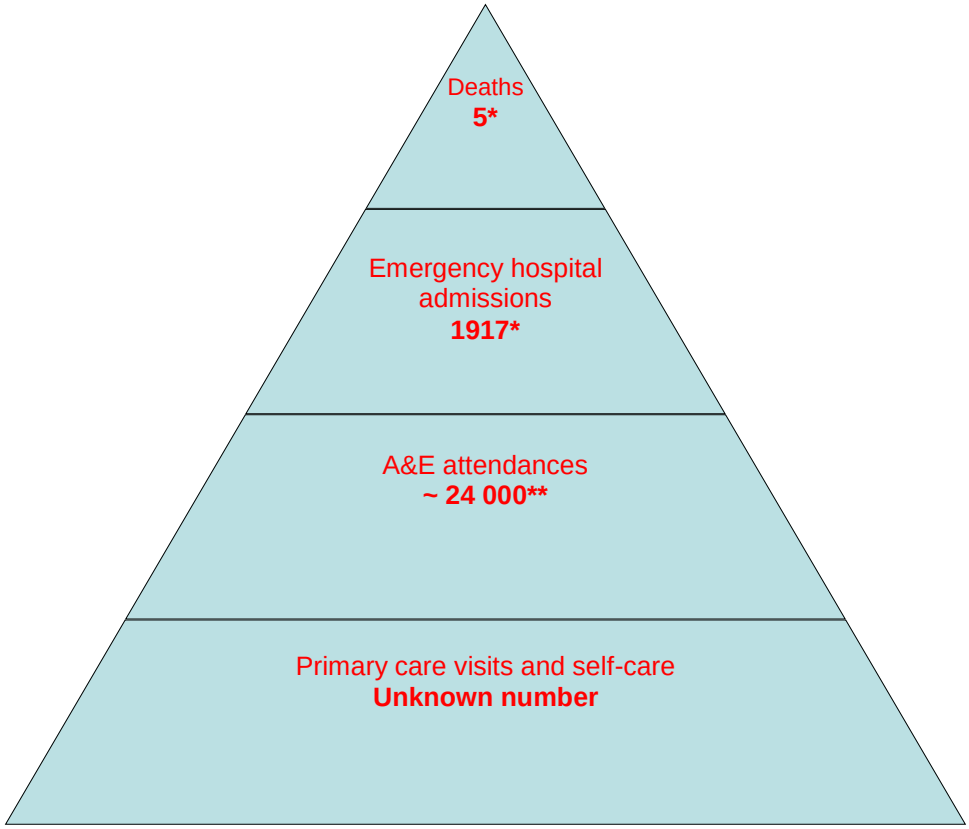
The Clinical Pyramid for Injuries in Children

In the European Report on Child Injury Prevention[5] the WHO outlined a pyramid of injuries in children. This is based on the principle that for each death there will be a greater number of hospital admissions, and in turn a greater number of attendances at A&E. At the base of this pyramid are children who have an unintentional injury and who either seek care from primary care or who self-care. This is the largest group of injuries in terms of numbers although these injuries are likely to be relatively minor. It is difficult to ascertain how many injuries occur in this section of the pyramid.

By applying data from NHS Greater Glasgow and Clyde it is possible to fill in the layers of the pyramid and to demonstrate that there will be large numbers of injuries which fit into the lower layers (see Figure 4).

[5] Sethi D, Towner E, Vincenten J, Segui-Gomez M, Racioppi F. European Report on Child Injury Prevention. WHO Europe, 2008.

Figure 4: Clinical pyramid for estimated annual number of unintentional injuries in children in NHSGGC

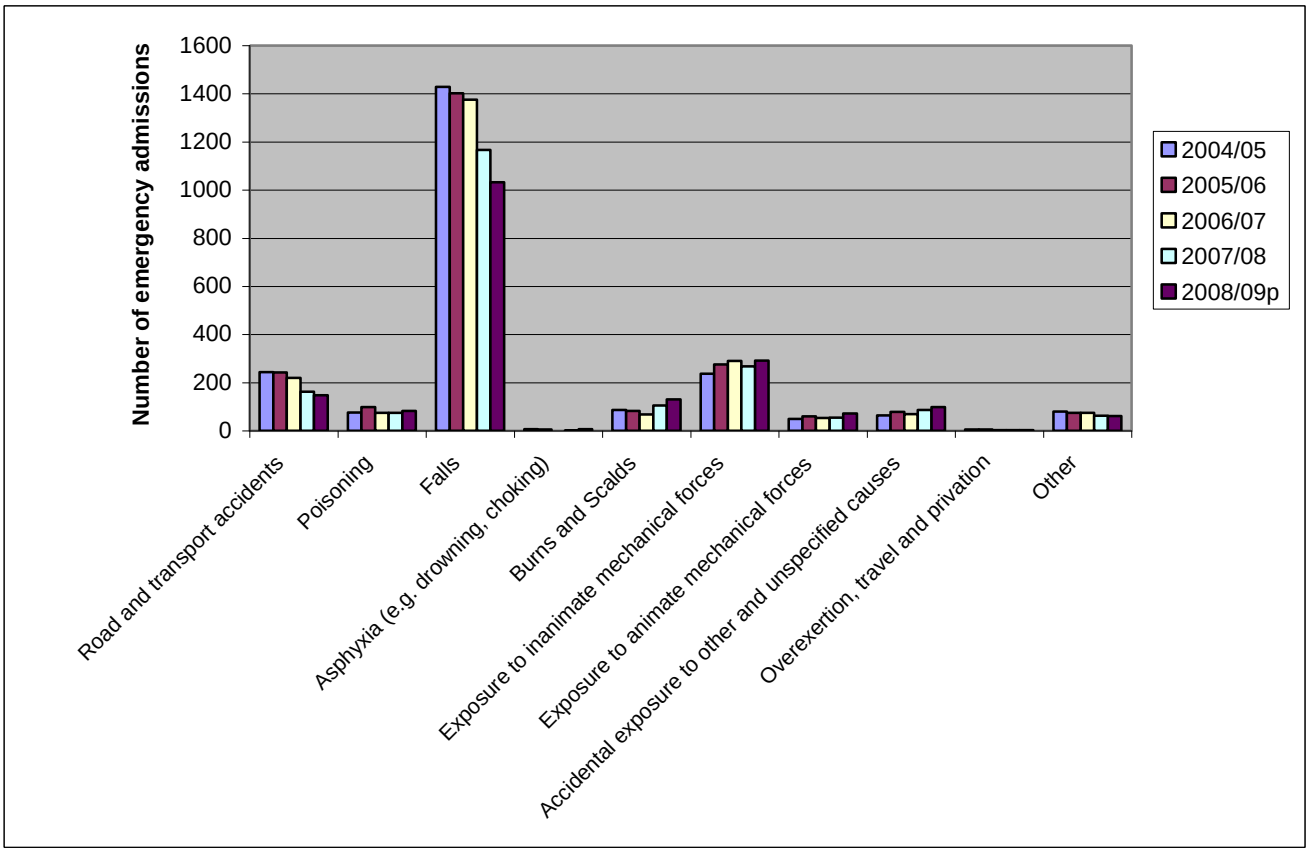


*Notes: * based on ISD data for NHSGGC. Number of deaths is a 5 year average due to small numbers. ** estimated using proportions in original WHO pyramid (129 admissions to 1635 A&E attendances).*

Common causes of unintentional injury in children in NHSGGC

The most common cause of unintentional injury resulting in emergency hospital admission in NHSGGC is falls (see figure 5).[3]The most common cause of death from unintentional injury over the last five years has been road casualties.

Figure 5: Number of emergency admissions due to unintentional injury by cause in NHSGGC.



Note: "2008/09p" is used by ISD to indicate that this is provisional data.

When compared with other EU countries, Scotland's record is good, but it does not compare well within the UK. The death rate from unintentional injuries in both Scotland and NHSGGC is 30% higher than that for England and Wales.[6]

Detailed costs of injuries and accidents in either Scotland or NHSGGC are not readily available, except for road casualties. Using the report of England's Department of Health's Accidental Injury Task Force as a source, children's unintentional injuries cost the NHS in Scotland an estimated £40 million and society generally around £400 million every year[7]. The equivalent figures for NHSGGC, by extrapolation, are £10 million and £100 million per annum.

[6] Child Safety Strategy: Child Safety Action Plan: Produced in Support of the Child Safety Action Plan for Europe, May 2007

[7] Department of Health. Preventing accidental injury – priorities for action. London: The Stationery Office, 2002.

2. WHAT CHILDREN AND YOUNG PEOPLE SAY

A survey of children and young people was commissioned to find out their views on unintentional injuries and their prevention, and to produce a snapshot of their risk-taking behaviour[8]. The survey, which was undertaken by Children in Scotland, included online and printed questionnaires. Although limited in size, the results are indicative of children's and young people's views and merit serious consideration. The issues raised warrant further in-depth examination.

The survey findings show that:

- children and young people do worry about being injured;
- having personal experience or personal knowledge of an unintentional injury requiring hospitalisation does not necessarily mean that the child's or young person's behaviour will be modified;
- a high proportion of children and young people either think they already know all they need to know to stay safe, or reject the whole idea that accidents can be prevented;
- a significant percentage of respondents admitted engaging often in behaviours that they knew could result in injury serious enough to require at least an overnight stay in hospital;
- reported seat belt wearing is high and knowledge of where to go and what to do in the event of a fire is very good;
- some respondents wanted to learn more about accident prevention and showed a marked willingness to take real responsibility for keeping themselves safe; and
- prevention strategies should tailor recommendations and programmes to take account of differing safety-related attitudes and behaviours based upon age and gender.

3. APPROACHES TO PREVENTION

In Scotland in general, and in the NHSGGC area in particular, at the start of the 21st century it is unacceptable that there is a large differential between the death rates of the poorest and wealthiest families in our society. These health inequalities must be reduced as a matter of urgency.

3.1. Striking a balance

Any preventive measures that are put in place have to strike a balance between children's need for active exploration and development and adults' responsibility to keep them free from death and serious injury.

[8] Children in Scotland (2007). *What I think matters: serious accidents and injuries*. Children in Scotland: Edinburgh. Accessible via http://www.childreninscotland.org.uk

Policies and programmes exist that encourage children and young people to walk, play and take part in sport and active leisure pursuits to improve and maintain their general health and wellbeing. These can lead to increases in the numbers of injuries. The challenge is to ensure that these injuries are neither life-threatening nor disabling.

3.2. Focusing on the most serious injuries

While we may wish to reduce the numbers and severity of all injuries, some cannot be prevented without seriously restricting children's activities or only at great cost. For example, many of the injuries that children suffer are a consequence of their natural development or being active – learning to walk or playing sports.

For pragmatic reasons, not least limitations in resources, prevention activities have to be prioritised. This means focusing on the incidents that result in death, serious injury or disability – events that are "expensive" in treatment or social terms – and those for which there are prevention programmes where there is good evidence of effectiveness.

Injuries that are numerous also deserve attention, these include falls, exposure to inanimate mechanical forces, road traffic accidents, poisoning, burns and scalds, exposure to animate mechanical forces and other causes. While they may not individually cause serious injuries, taken together their burden is large. Where there is good information on how to reduce the numbers or severity of such events, the appropriate preventive measures should be implemented. In economic terms alone, this represents a sound allocation of resources: Miller and Hendrie (2005) estimated that $7 is saved for every $1 invested in prevention [9]
The National Institute for Health and Clinical Excellence have produced new NICE public health guidance – 29, 30 and 31 for preventing unintentional injuries among the under 15's.[10] They have also produced a costing report for implementing the NICE guidance documents, 29, 30 and 31. It states that it is not possible with any degree of certainty to quantify savings however it anticipates that implementation will:

- Reduce the costs associated with A&E attendances and hospital admissions.
- Make savings for GP's and other services such as ambulance, police and fire and rescue.
- Improve outcomes for children including improved health, quality of life, school attendance and attainment.
- Improve safety for all occupants of the home.
- Increase productivity for families and employers by reducing time off work.
- Prevent short term and permanent disabilities and death from unintentional injury
- Reduce the emotional impact and trauma of unintentional injury for children and their families.

By developing the recommendations and implementation plan it must be acknowledged that the same benefits will be replicated in NHSGGC.

3.3. Using effective programmes

[9] Christoffel T, Gallagher SS (2006). Injury prevention and public health

[10] www.nice.org.uk/guidance/PH29 Nice Public Health Guidance – Preventing Unintentional Injuries among under 15's

Wherever possible, prevention programmes should be based on reliable evidence of what is known to be effective. Where evidence is not readily available, best practice should be employed. There are a number of key reviews of effectiveness that can support local and national initiatives[11] [12] [13] [14].

A programme of research should be developed to fill the key gaps in terms of what works. In some cases, this may need to be coordinated across Scotland and the UK so that solutions can be identified more quickly.

Difficult decisions need to be taken. To maintain the improvements in child injury prevention and to enable work to become more focused, the effectiveness of each current programme may need to be reviewed. Consequently, consideration should be given to ending any existing programmes that cannot be shown to be reducing casualty rates, increasing knowledge, or improving behaviour or attitudes, or that do not employ what is now regarded as best practice.

In judging the value of programmes, it should be remembered that they may have benefits that extend beyond reducing casualties, changing behaviour, etc. Also, programmes located within local communities have to be measured (or reviewed) within the context of wider health improvement gains. Injury prevention programmes can act as vehicles to strengthen communities, create employment opportunities, enhance personal development, create or reinforce partnerships between agencies, build capacity and link to other initiatives, such as volunteering. Equally, they may contribute to other health and wellbeing initiatives that are already health board, local council or government priorities, such as the drive for greater physical activity.

3.4. A multifaceted approach to prevention

To optimise success, coordinated, multifaceted approaches using engineering and environmental changes must be used. This includes educational measures aimed at children, parents and carers, and the public more generally, publicity campaigns, the encouraging of the development and enforcement of legislation (including laws, local

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[11] Mackay M et al. (2006). *Child Safety Good Practice Guide: Good investments in unintentional child injury prevention and safety promotion*. Amsterdam: European Child Safety Alliance, Eurosafe. (Accessible online via http://www.actiononinjuries.org/csi/eurosafe2006.nsf/wwwVwContent/l4goodpracticeguide.htm)

(The above publication, which was developed as part of the European Child Safety Alliance action plan project, also contains good practice case studies from across Europe, including Scottish examples.)

[12] Millward LM, Morgan A & Kelly MP (2003). *Prevention and reduction of accidental injury in children and older people. Evidence briefing*. London: Health Development Agency. (Accessible online via http://www.nice.org.uk/page.aspx?o=502597)

[13] Towner E, Dowswell T, Mackereth C & Jarvis S (2001). *What works in preventing unintentional injuries in children and young adolescents. An updated systematic review*. London: Health Development Agency. (Accessible online via http://www.nice.org.uk/page.aspx?o=502353)

[14] Towner E (2002). *The prevention of childhood injury. Background paper prepared for the Accidental Injury Task Force*. London: Department of Health. (Available online via http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4072113)

byelaws and opportunities such as contracts between suppliers of goods and services and purchasers) and the empowerment of communities and workers.

In schools, safety and risk education can lead to an understanding of safety and create a culture within which other initiatives can be more easily developed. Linked to this is the need for parents and carers, children and young people to understand and more accurately assess risks.

THE WAY FORWARD

3.5. Structures for prevention

With the opportunities for the prevention of unintentional injuries cutting across a wide range of agencies and occupations, effective and clearly defined leadership, coordination of planning and action, and good communication are key to success. These need to be coupled with a strong commitment to partnership working among relevant agencies. These prerequisites apply equally at national (Scottish Government) and local (health board, local authority and community planning area) levels.

In the Scottish Government (SG), the Health Directorates, which have to provide the services to treat the casualties, are well placed to take the lead. They should ensure that there is a commitment to partnership working between the Directorates of the SG that currently have – or should have – an involvement in this subject, that strategies and activities are coordinated, and that effective channels of communication exist.

At health board/local authority level, there is a need for clearly defined responsibility for preventing unintentional injuries to children, bringing together those responsible for health, road, education, child and family welfare, play, environmental health, regeneration, housing and community safety. Coordination and communication are essential, both within and between agencies.

Local planning mechanisms, including community safety partnerships, community health partnerships and children's services plans, all provide opportunities for improved local coordination. Community safety partnerships should be encouraged to adopt injury prevention as a core priority. *The role of the NHS in community safety partnerships should be strengthened through taking the lead for injury prevention.*

For the greatest impact, preventive measures need to be integrated from top to bottom; from the national policy makers and funders to front-line staff in local government and health agencies. Other partners may include other statutory organisations such as the fire and coastguard services, the child-care sector, voluntary and community organisations, the private sector - and of course parents, carers and children and young people themselves.

3.6. Using existing policy and practice opportunities

Existing policy and practice opportunities should be used whenever possible to provide a framework for injury prevention. The World Health Organization has called for practitioners to recognise that every contact with patients or the public is a health improvement – including injury prevention - opportunity. The health and wellbeing of children and young people, including the need to keep them free from death and injury,

are incorporated into many existing activities. One example is the introduction of parenting support programmes (such as Triple P in Glasgow) that are known to reduce the risk of childhood injury.[15] These cover a range of sectors, including health, transport, fire safety, education, child and family welfare, play and sport, regeneration, housing, environmental health and the environment more generally. This illustrates the breadth of agencies with the responsibility and opportunity to act in this area. A list of the key national policies and potential funding streams is presented in Annex A, while those relating to NHGGC and partner agencies are shown in Annex B.

3.7. Long-term and short-term imperatives

Long-term and short-term approaches are needed to improve child safety in NHSGGC. These approaches do not overlap nor are they mutually exclusive.

In the long-term there is a need to change government policy so that the prevention of unintentional injuries becomes a priority – thus increasing funding, providing sustainability and improving efficacy of policies and practices.

In the short-term, the skills, opportunities and knowledge that already exist have to be built upon. These may include tapping into the funding streams of existing non-injury policies and practices, such as regeneration and the inequalities agenda, and structures such as integrated children's services plans, community planning processes and community safety partnerships, to progress the subject.

Opportunities should be used to promote safety and prevent unintentional injury. Evidence suggests that every contact is a health improvement opportunity and for this reason, unintentional injury should be incorporated in a structured manor into all education programmes with parents/ carers and families across NHSGGC.

In order to develop an education programme, the skills and knowledge that already exist on unintentional injury require to be built upon. Currently there are no formal or accredited learning and development opportunities and it must be acknowledged that those promoting safety and unintentional injury prevention would require the opportunity to develop new skills and be updated with new developments in the field of unintentional injury prevention. There is a need to develop training packages and learning and development opportunities for those who work closely with children, young people and families within and out with the NHS. [16]

3.8. Infrastructure needs

Accessible, relevant and timely data and information are needed to allow problems to be identified, solutions to be proposed, progress to be monitored and outcomes to be evaluated. NHSGGC is fortunate in having an emergency department information system (EDIS) in some hospitals, which can provide detailed information on children and young people attending their A&E departments. This information needs to be more fully exploited perhaps with the help of ISD as well as local information officers.

The processing and interpretation of data to guide action is a specialist activity that may benefit from a centralised team servicing the needs of local practitioners. The role of

[15] Parenting interventions for the prevention of unintentional injuries in childhood
D Kendrick, J Barlow, A Hampshire
[16] NICE public health guidance 29: Strategies to prevent unintentional injuries among under-15s Page 12

such a team could be extended to advising on the most appropriate interventions, supporting local programmes, undertaking research and carrying out complex evaluations.

At community planning area level, staff who have to plan, manage, implement and evaluate programmes need appropriate skills and training. They also need to be able to share with, and learn from, the experiences of other workers across the board area and beyond through effective channels of communication. There may be opportunities to expand the injury prevention training skills of health improvement and health visiting staff via existing training and career development programmes.

3.9. Reviewing progress

Strategies and activities should be reviewed and amended in the light of successes and failures. Numbers of deaths and injuries change and new hazards emerge. Public attitudes towards safety and lifestyles evolve, changing the priorities for action. Funding streams come and go, and structures and responsibilities in the public sector vary over time. Technological developments can result in new products and opportunities emerging that allow us to consider new solutions.

4. THE NEXT STEPS – Part 2 of the report

To move forward from these general proposals, Part 2 of this report sets out the key steps of a child injury prevention Action Plan. A more detailed and comprehensive plan should be developed over 2010-11.

NHSGGC CHILD SAFETY STRATEGY

PART 2 of the Report of the Short-life Working Group on Unintentional Child Injury Prevention

CHILD SAFETY ACTION PLAN FOR NHSGGC AREA

Part 2 ACTION PLAN

Part 2 of our report:

- sets out the priority injury issues;
- suggests prevention programmes to be implemented either nationally or locally, with an agreed set of outcomes;
- identifies clear lines of responsibility, nationally and locally;
- recommends performance indicators for the partner agencies;
- advises on future planning research needs to support effective injury prevention activities.

This document expands on each of these aims and provides a plan of action to progress child injury prevention across NHSGGC and, where appropriate, Scotland, building on current activities and policies.

2. SETTING OUT PRIORITY INJURY ISSUES

While we may wish to reduce the numbers and severity of all injuries, some cannot be prevented without seriously restricting children's activities or only at great cost. For example, many of the injuries that children suffer are a consequence of their natural development or being active – learning to walk or playing sports.

For pragmatic reasons, not least limitations in resources, prevention activities have to be prioritised, focusing on the **incidents that result in death, serious injury or disability** – events that are "expensive" in treatment or social terms – and those for which there are **prevention programmes where there is good evidence of effectiveness**.

A second group of accidents deserve attention: **those that are numerous**. While they may not individually cause serious injury, taken together their burden is large. Where there is good information on how to reduce the numbers or severity of such events, the appropriate preventive measures should be implemented.

Using these parameters, we encourage urgent and concerted action to address the following issues:

- On the road
  - Pedestrian casualties
  - Cyclists casualties
  - In-car safety

- In the home
  - Smoke inhalation and burns associated with house fires
  - Falls down stairs and from windows and balconies
  - Burns and Scalds, especially bath scalds and scalds from hot liquids
  - General home safety issues

- Out and about
  - Creating and maintaining safe physical environments
  - Ensuring that play and leisure activities are challenging but safe

Work is already in progress in some parts of the NHSGGC area to address these issues but we need to ensure that it is undertaken effectively, uses programmes and methods for which there is evidence of a positive impact, is appropriately resourced and is thoroughly evaluated. Such work will benefit from good coordination between agencies, and strong leadership and support at national and local levels.

3. THE HIGH PRIORITY INJURY PREVENTION PROGRAMMES

The programmes identified below aim to address the injury issues highlighted in section 1 above. To implement these programmes, the broad outlines in the table would need to be expanded to cover topics such as development of programme materials, staffing, funding, training, etc.

Given the social class gradient that exists for many types of injuries, there is a need to focus greatest efforts on addressing the needs of disadvantaged families while not excluding other children merely on the basis of their circumstances.

Key prevention programmes	Lead agencies and partners	Indicators	Targets	Notes	Evidence
ROAD CASUALTIES					
Pedestrian injuries Pedestrian injury is the largest single cause of accidental death for children. Walking is an activity that should be encouraged for health reasons. Children report that they like walking to school with their friends. It is an environmentally-friendly mode of travel. It exhibits a significant social class gradient. Associated government policies include the reduction of health inequalities, encouraging physical activity,					
Practical pedestrian training schemes, especially in high risk areas (e.g. Kerbcraft)	The lead agency nationally would be Road Safety Scotland, supported locally by road safety departments. Partners would include primary schools and community organisations.	Proportion of children receiving effective pedestrian training. Proportion of children who walk to school. Mortality and morbidity rates for pedestrian injuries. Increasing the number of children actively participating in the Junior Road Safety projects	Practical pedestrian training programmes to be delivered in 100% of Primary Schools in NHSGGC.	Kerbcraft is being implemented in many schools with funding from the Scottish Government. The recently published national evaluation of Kerbcraft found strong statistical evidence of positive impact of training in all three skills - recognising safe versus dangerous crossing places, crossing safely at parked cars and crossing safely near junctions. The programme had an impact on schools, communities and volunteers. Kerbcraft improved relationships between the schools and parents. Positive opportunities were provided for volunteers to develop social contacts, feel valued and take advantage of educational and employment opportunities. Child Safety Good Practice Guide European Child Safety Alliance. www.childsafetyeurope.org	

Key prevention programmes	Lead agencies and partners	Indicators	Targets	Notes	Evidence
Enhanced provision of safe and easily accessible play facilities for children living in areas of social housing	The national lead would reside with the Scottish Government Partners would include road safety departments, social housing providers, play and recreation department of local authority and the health sector	Proportion of children who have a safe and accessible play area close to their homes. Increase in the numbers of children using local play facilities. Mortality and morbidity rates for pedestrian injuries	Programme to map locations of existing play facilities	Encouraging physical activity is an aim of the health sector. By providing safe environments in which children can play, it can reduce their play in unsafe situations such as on the road. http://guidance.nice.org.uk/PH29	
Increase the number of and extend 20mph speed limits to prevent road traffic incidents involving pedestrians	Partners would include road safety departments, Local authorities, Police	Reduction in morbidity and mortality rates for pedestrians	Programme to map 20mph zones	Child Safety Good Practice Guide European Child Safety Alliance. www.childsafetyeurope.org http://guidance.nice.org.uk/PH31	
Cyclist casualties The Scottish Government has a road casualty reduction target, including a child-related target – a reduction of 50% in the number of children killed or seriously injured. The health and other non-transport sectors should seek opportunities to complement and enhance measures to achieve the target. There are, however, opportunities for action such as those set out below that lie outside the remit of the transport sector, especially in the areas of children's play, off-road cycling, healthy living and certain areas of research, or where collaboration between sectors is necessary. Cycling injuries are a significant cause of accidental death and serious injury for children. It is an environmentally-friendly mode of travel and one that should be encouraged for health reasons.					

Key prevention programmes	Lead agencies and partners	Indicators	Targets	Notes	Evidence
Cycle training for all Scottish children	The national lead would be through Road Safety Scotland and Cycling Scotland. Local programmes are often led by road safety units in Local authorities. Schools, cycling clubs and community organisations or Sustrans can also have key roles.	Proportion of child cyclists aged 10 years and above who have participated in a training scheme. Rate of child cyclist casualties (casualties per 100,000 population). Proportion of children cycling to school. Proportion of schools participating in cycling proficiency training.	Increase the numbers of schools facilitating cycling proficiency training and an increase in the number of children participating.	Cycle training makes a difference. A recent survey by Cycle Training UK suggest that 80% of trainees felt the training made them more confident, leading to a 50% increase in the number of journeys made of over 3 miles, and a greater number prepared to cycle all year round. Very young children do not have the skills needed to be able to cope with traffic. For this reason, most formal cycle training in schools is offered to children in the upper primary and above. Cycle training courses offered to children of this age introduce the basic skills and knowledge necessary for safe cycling. Parents and carers are encouraged to show children how they can develop responsibility as a road user, bearing in mind that a bicycle on the road is a vehicle and not a toy. Child Safety Good Practice Guide European Child Safety Alliance. www.childsafetyeurope.org	
Initiatives to promote helmet wearing through schools.	The national lead would be through Road Safety Scotland, drawing on the experience of the Bicycle Helmet Initiative Trust. Road safety officers in local authorities, schools, and the media have key roles.	Helmet wearing rates.	Programme rolled out in the 6 local authorities on a pilot basis.	The programme developed by Bicycle Helmet Trust has proved successful in getting secondary school children to wear helmets. These children are historically the hardest age group to influence. Child Safety Good Practice Guide European Child Safety Alliance. www.childsafetyeurope.org	

Key prevention programmes	Lead agencies and partners	Indicators	Targets	Notes	Evidence
In-car safety Child restraints are known to be highly effective when fitted and used correctly. However, research indicates high levels of incorrect fitting and use. There are few places where parents and other carers can turn for independent expert advice on what type of restraints are appropriate and whether or not they are fitted correctly. With changes to the law in September 2006, more children now have to use child restraints. Crashes on rural roads are among the most severe so given the rural nature of Scotland steps have to be taken to ensure that rates of restraint use and in particular correct restraint use are high.					
Training of personnel to check child car restraints	The lead agency nationally would be Road Safety Scotland supported by the Justice Department of the Scottish Government. Partners would include road safety departments, fire and rescue services, specialist retailers, and child restraint manufacturers (to provide the training). ROSPA currently provide annual updates and training.	Proportion of children: - using appropriate child restraints - using child restraints correctly	All road safety departments and permanently staffed fire stations to have at least two people competent to check and advise on the correct use of child car restraints. Shadowing opportunities for newly trained personnel.	Schemes exist in the USA, Canada and New Zealand that train and accredit personnel in child car occupant safety. These could act as a model for a scheme in Scotland. Child Safety Good Practice Guide European Child Safety Alliance. www.childsafetyeurope.org	
Education programme for the safe carriage of babies and children in cars.	NHS Health Scotland regarding resources for distribution e.g Good Egg Guide for In car safety.	Number of education programmes and contacts with families.	Training on the topic to have been incorporated into professional education programmes. All maternity units to have written policies on advising parents about in-car safety	NHS staff have the opportunity to pass on appropriate advice at a key time – in the ante natal phase when purchase of infant carrier is required, when the baby and mother are being discharged from hospital, and when being visited in their own homes. Child Safety Good Practice Guide European Child Safety Alliance. www.childsafetyeurope.org	

Key prevention programmes	Lead agencies and partners	Indicators	Targets	Notes	Evidence
IN THE HOME					
Smoke inhalation and burns from house fires Statistics consistently show that Scotland has the highest rate of fire fatalities in the UK. The Scottish Government, working with the Scottish Fire Services, has developed "Don't give fire a home"; a national fire safety campaign for Scotland in an effort to improve Scotland's poor record of fire deaths and injuries. Community fire safety is a central plank of the fire service in Scotland and is widely practised. The priority populations for such programmes are families with babies and young children, those living in the most disadvantaged areas, and homes where there are smokers.					
Provision, fitting and checking of smoke alarms	Fire and rescue services would provide the national lead through its community fire safety network.. Partners would include health visitors, community midwives, tenants' associations, and social housing providers. (These partners would identify people who needed the services provided by the fire and rescue services	Admission rates due to house fires in children under 15 years. Ownership of working smoke alarms.	Training programme and resources developed for partners Formal mechanism for referrals by health visitors, community midwives and other relevant parties of families needing smoke alarms or smoke alarm checks in place.	This programme is already in progress but needs to continue. It is moving to the phase when alarms that were installed some years ago will need replacement. Scotland Together – A study examining fire deaths and injuries in Scotland.	

Key prevention programmes	Lead agencies and partners	Indicators	Targets	Notes	Evidence
Audit and advice on home fire safety during home visits	The lead would reside with the Scottish Government's Health Department. Partners would include health boards, in particular community nursing and community midwives, fire and rescue services and family support organisations.	Admission rates due to house fires in children under 15 years. Ownership of working smoke alarms. Number of households given home fire safety advice.	To be included in assessments undertaken by health visitors and community midwives	Scotland Together – A study examining fire deaths and injuries in Scotland.	
People who smoke should be informed of the risks of smoking in relation to their own and others health and in relation to fire safety.	Scottish Government ASH Scotland Health Scotland All those who come into contact with parents and carers such as Health Visitors, Primary Care Staff, Smoking cessation services	Reduce smoking prevalence for all age groups and populations Reduce the numbers of smoking related house fires / smoke inhalation	NHS Boards to provide targeted services to support 8% of the smoking population to quit successfully (at one month post quit) by the end of 2011	There are many strategies in place that aim to reduce smoking prevalence such as prevention, protection and cessation measures. This ranges from legislation such as increasing the age of sales, advertising ban to local education and delivery of services such as smoking cessation and education within schools. Glasgow Tobacco Strategy	
Scalds, especially bath water scalds and scalds from hot drinks / liquids Bath water scalds are severe injuries, often requiring long-term treatment, and resulting in disfiguring injuries. Severe burns are very expensive injuries for the health service because of the need for prolonged treatment. An effective intervention is available.					

Key prevention programmes	Lead agencies and partners	Indicators	Targets	Notes	Evidence
Installation of thermostatic mixing valves (TMVs) in social housing	The national lead agency would be the Scottish Government's Housing Division. Local authority housing departments, housing associations and the plumbing trade would be local partners. Tenants' associations and health visitors would also have a role in informing tenants of the benefits of TMVs.	Proportion of homes with bath water outlet temperature below 50^{o}C. – Hospital admission rates for bath water scalds in children aged under 5 years	Develop information and training materials for housing providers and plumbers. Mapping of provision across NHSGGC	This measure would also benefit older people who also suffer bath water scalds in significant numbers. The Scottish Building Code can be interpreted as requiring TMVs but also is regarded as being ambiguous. Recent research undertaken in Scotland has indicated that, while there is a need to provide information to people moving into properties fitted with TMVs, water from the hot bath tap can be reliably reduced to temperatures that do not scald but are hot enough to allow normal bathing. NICE PH Guidance 29 and 30 http://guidance.nice.org.uk/PH29 http://guidance.nice.org.uk/PH30	
Scalds from hot liquids and hot drinks	Health Visiting Staff , NHS or specifically trained personnel from other organisations provide home based social support / home safety education	Numbers of standardised HV programmes providing a detailed unintentional injury prevention programme.	Increase in numbers of interventions and decrease in numbers of admissions.	A detailed prevention programme provides opportunity to discuss all elements of home safety. NICE PH Guidance 29 and 30 http://guidance.nice.org.uk/PH29 http://guidance.nice.org.uk/PH30	
Firework burns Fireworks are now used throughout the year for private parties, religious festivals, new year celebrations, etc.					

Key prevention programmes	Lead agencies and partners	Indicators	Targets	Notes	Evidence
Enforcement of legislation pertaining to sale and usage of fireworks	Local authority trading standards departments would take the lead in the sales aspect of this initiative. The police would be responsible for enforcing safe use.	Number of prosecutions for illegal sale and use of fireworks Legislation is most effective when supported by educational activities.	Enforcement and education programmes.	In 2005 there was a significant increase (32%) from the previous year, of the number of children attending accident and emergency departments as a consequence of firework burns. Child Safety Good Practice Guide European Child Safety Alliance. www.childsafetyeurope.org Nice PH Guidance 29 http://guidance.nice.org.uk/PH29	

Falls from heights in the home

Deaths from falls are not as frequent as from road accidents and house fires but still constituted about 5% of unintentional injury deaths. Children suffer falls and associated injuries – bumps and bruises, lacerations and fractures – in large numbers. These injuries are often linked with children's natural development as they learn to walk, run and climb. The great majority of falls result in injuries that are not life-threatening. However, falls from heights, such as down stairs, from landings, balconies and windows can lead to serious injuries, especially head injuries that can result in long-term disability and occasionally death. For babies, even falls from relatively low structure, such as from furniture where they have been placed in a baby seat or to change a nappy, can result in serious injury.

Only education of parents and other carers can address unsafe practices such as placing babies on furniture, but the fitment and use of safety equipment can reduce falls from heights.

The priority populations for programmes are families with children under five years.

Key prevention programmes	Lead agencies and partners	Indicators	Targets	Notes	Evidence
Provision of safety equipment to disadvantaged families at the same time as providing education on home safety.	Local partners who would have to be responsible for handling safety equipment would be local voluntary organisations and health visitors. Fire and rescue services, gas engineers and care and repair schemes would also have key roles.	Hospital admission rates due to falls in children aged under five years. Proportion of families with children under five years in the household in the most disadvantaged areas with correctly fitted safety gates, fireguards, smoke alarm and carbon monoxide detectors (as appropriate).	Funding made available and . schemes implemented particularly in more deprived areas.	In England, the government has announced that £18 million is to be made available to fund safety equipment schemes. As equipment cannot address all fall injuries, such schemes would also have a role in assessing home safety risks and providing safety advice to families. The development of key resources for this should be considered including developing a consistent approach to safety advice and using a HI approach. NICE PH Guidance 29 and 30 http://guidance.nice.org.uk/PH29 http://guidance.nice.org.uk/PH30	
Home safety generally					
Home safety risk assessments	The national lead for such an initiative should reside with the Justice Department as local coordination should be led by community safety partnerships. A number of agencies visit homes as a routine part of their work – health visitors, social services, family support agencies, etc – or for specific safety reasons – fire and rescue services, etc.	Proportion of families in the most disadvantaged areas who have received a home safety risk assessment and follow up with appropriate equipment, if appropriate.		Such programmes could cover a range of injury topics, including poisoning, hazards associated with lighters and matches, knives and other sharp objects, trip and stumbles, electrical safety, sun safety etc. As well as identifying and advising on home hazards, they can provide tailored advice, support materials, contacts with relevant local agencies and possible funding opportunities. This initiative is one that would benefit greatly from good, local collaboration between agencies. NICE PH Guidance 29 and 30 http://guidance.nice.org.uk/PH29 http://guidance.nice.org.uk/PH30	

Key prevention programmes	Lead agencies and partners	Indicators	Targets	Notes	Evidence

3. LINES OF RESPONSIBILITY

Part 1 of our report identified the need for clear lines of responsibility nationally and locally. While the table above sets out where lead responsibility for programmes, nationally and locally. However, there is a need for a defined lead at government level to ensure that there is coordination between departments. This lead should reside with the minister with responsibility for health and well-being or for children's interests

Within NHSGGC and its partners, the prevention of unintentional injuries and the promotion of the health and well-being of children cuts across the interests of several departments and agencies. Community safety partnerships should be required to take child injury prevention into their remit.
Glasgow Community and Safety services have withdrawn the free fitting of home safety equipment for vulnerable groups in Glasgow due to funding costs.

4. PERFORMANCE INDICATORS

These include: injury mortality rates, by age, sex and deprivation category (SIMD score), in NHSGGC; hospital discharge rates, by cause of injury, age, sex and deprivation category in NHSGGC; A&E attendances (where available) by cause of injury, by age, sex and deprivation category.

Injury surveillance in A&E is often regarded as a panacea for identifying need and monitoring performance. This is far from the case. Data derived from A&E presentations should be viewed in the context of the injury problem as a whole. Moreover, such data are subject to a range of flaws and biases, quite apart from the practical problems of generating them.

Experience with CHIRPP, a Canadian injury surveillance system that ran for 10 years at the RHSC, Yorkhill – suggests that three critical professionals are required as part of the resource commitment to surveillance. These are an enthusiastic senior clinician "on the front line," a data manager with appropriate IT skills, and a public health professional who is capable of interpreting, disseminating and applying the data for prevention.

ISD Scotland are about to implement a pilot regarding unintentional injury data. ISD intend to publish as much information as they can regarding injuries and to link it up with current SMR output regarding injuries. In addition they will work with all injuries stakeholders to identify the sort of information that is required for policy making. They have a steering group of health board representatives, clinicians, information managers and stakeholders meeting early next month to start this process. The following are the data items they hope to collect:

- Intent of Injury
- Activity when injured
- Time since Injury
- External cause of injury

- Nature of Injury
- Object involved in Injury
- Alleged Perpetrator of Injury
- Common Preventative Measures

These data items will also be available and are being collected separately to Injuries.

- Location of Incident
- Alcohol Involved

NHS Health Scotland are currently reviewing their home safety resources and it is anticipated that these resources will be distributed across Scotland which will raise the profile and importance of unintentional injury prevention.

5. FUTURE PLANNING AND RESEARCH NEEDS

This document has outlined some key strategic principles and practical actions that the NHSGGC, working closely with national government and local partner agencies, might take in the coming years.

Planning

Given the short life nature of the working group, our main recommendation is that the Board undertake further exploration and development of our thinking with a view to developing a more detailed and comprehensive 10 year implementation plan for child safety.

Research

The West of Scotland benefits from having a number of academic departments and agencies such as ISD / ScotPHO that are well equipped to undertake research into the causes of children's injuries, the development of new, effective prevention initiatives and monitor progress towards targets. We recommend:

1. That the Public Health Resource Unit monitors and disseminates key research publications (e.g. recent WHO and NICE guidance) on evidence based strategic and practical action to prevent childhood injuries;
2. That the NHSGGC undertakes an option review to determine the most appropriate injury surveillance system for the health board population that allows problems to be accurately identified, and programmes to be monitored and evaluated;
3. That experience gained in developing Logic Models in planning health improvement (e.g. smoking cessation) or community safety should be exploited further for the purpose of child injury prevention
4. That the Board's Director of Public Health commissions research from local or national academic centres of excellence to inform the further development of the NHSGGC child safety strategy.

Acknowledgments
This report was informed to a great extent by the work of the Scottish Child Safety Alliance.

ANNEX A – NATIONAL POLICIES FOR CHILD INJURY PREVENTION IN SCOTLAND

There are close links between all of the policies in this annex but what is described here ranges from broad policy areas to very specific policy initiatives. In addition, though there are some over-arching principles, these agenda do not always fit very neatly together. This annex outlines relevant policies at present in Scotland, government policies that contain or may create opportunities for action in child injury prevention.

ROAD SAFETY

Tomorrow's roads - safer for everyone
In March 2000, the UK Government, the Scottish Executive and the National Assembly for Wales introduced new national road safety strategy and casualty reduction targets for 2010. The target, relating to child casualties, is by 2010 there will be a 50% reduction in the number of children killed or seriously injured compared with the average for 1994-98.
http://www.dft.gov.uk/stellent/groups/dft_rdsafety/documents/pdf/dft_rdsafety_pdf_504644.pdf

Transport (Scotland) Act 2001
Puts a Statutory Duty on local authorities to produce Local Transport Strategies.
http://www.opsi.gov.uk/legislation/scotland/acts2001/20010002.htm

The Traffic Calming Act 1992
Enables roads authorities to introduce a wide range of traffic calming measures. Traffic Calming (Scotland) Regulations 1994 introduced 20 mph zones in Scotland.

Road Traffic Act 1988
Puts a Statutory Duty on local authorities to undertake studies into road accidents, and to take steps both to reduce and prevent accidents.

Go Safe On Scotland's Roads – Scotland's Road Safety Framework to 2020 – Safer Scotland, Scottish Government

COMMUNITY FIRE SAFETY

Scottish Fire and Rescue Service Youth Development Plan (2007)
This document sets out the principles and priorities for improving communication and engagement between Scottish Fire and Rescue Service and young people.
www.scotland.gov.uk/Resource/Doc/1100/0045051.pdf

Fire (Scotland) Act 2005
The principle legislation setting the direction for fire safety in Scotland.

Fire and Rescue Framework for Scotland (2005)
The framework sets out the priorities for the Fire and Rescue Authorities (FRAs) to prevent fires and manage risk, including the development of Integrated Risk Management Plans (IRMPs). FRAs are required to develop a planned programme of community fire safety work, including evaluation, which responds to the needs and risks identified in their communities by the IRMP, and targets resources on vulnerable or high-risk communities.

Scottish Fire and Rescue Service Community Fire Safety Strategy (2005)
The strategy and development plan to reduce the risk from fire and other emergencies in Scotland, and a mechanism for delivering safer communities.
http://www.scotland.gov.uk/Publications/2005/02/20739/53235

Scotland Together - A study examining fire deaths and injuries in Scotland.

HEALTH

Delivering a Healthy Future: An Action Framework for Children and Young People's Health in Scotland (2007)
This framework presents the Scottish Executive approach to delivering improvements in healthcare for children and young people in Scotland for the next ten years.
http://www.scotland.gov.uk/Publications/2007/02/14154246/0

Delivering for Health (2006)
This makes a specific call on the NHS to address health inequalities and reduce the inequality gap.
http://www.scotland.gov.uk/Publications/2005/11/02102635/26356

Health for all Children 4 (Hall 4) (2002)
Sets out proposals for preventive health care.

Health for all Children 4: Guidance on Implementation in Scotland (2005)
Here unintentional injuries are cited as the most common cause of death and a cause of considerable morbidity in children between the ages of 1 and 14 years. Reducing incidence, and the social class gradient, are highlighted by *Hall 4* as an important objective, requiring multi-agency collaboration and investment at national and local levels. *Hall 4* suggests that a home visit by a health visitor or other community worker following an unintentional injury to a child may help to prevent further incidents.
http://www.scotland.gov.uk/Publications/2005/04/15161325/13312

Health in Scotland (2004)
The Chief Medical Officer's Annual Report mentions *Injury in Children* below.
It has a section on unintentional injury in children, which was highlighted in Health in Scotland 2002 as being a major cause of death and disability.
http://www.scotland.gov.uk/Publications/2005/03/20877/54846

Improving Health in Scotland: the Challenge (2003)
The Scottish Executive's vision for Health Improvement in Scotland. Setting out a framework to support a more rapid rate of health improvement across Scotland. Key objectives include health improvement programmes for early years and children.
http://www.scotland.gov.uk/library5/health/ihis-00.asp

Towards a healthier Scotland (1999)
This White Paper sets out the Government's vision for improving health for all in Scotland. Section 73 refers to safety and accidents with the following commitments: to develop national criteria for data collection; to encourage local inter-agency accident prevention work; to develop a website database of best practice.
http://www.scotland.gov.uk/library/documents-w7/tahs-00.htm

Good Places, better health. A new approach to environment and health in Scotland-Implementation Plan – Scottish Government 2008

Equally well, Implementation plan – Scottish Government.

The Scottish Government, (2008). *Scotland's Future is Smoke-free: A Smoking Prevention Action Plan.* The Scottish Government, Edinburgh

Child Safety Strategy for Scotland , 2007

CHILDREN'S POLICY

Getting it right for every child: Implementation Plan (2006)
The Plan places a duty on agencies to be alert to the needs of children and to act to improve a child's situation; to co-operate with each other in meeting the needs of children and to establish local co-ordination and monitoring mechanisms;
http://www.scotland.gov.uk/Publications/2006/06/22092413/0

Integrated Children's Services Plans for 2005-2008
Plans are joint productions by local authorities, NHS Boards, police, local Children's Reporters, voluntary sector, community groups and children and families. Plans to include previously separate plans for school education, children's social work, child health and youth justice. Plans to cover both universal services (eg education and healthcare) as well as those services providing more specialist and intensive interventions to support vulnerable /at risk children and youth offenders. Local partnerships are invited to set out local vision shared objectives and priorities based on assessed needs, structures for multi-agency management and delivery and ways in which progress and outcomes are to be measured.

For Scotland's children: better integrated children's services (2001)
Revised guidance on children's services plans. Sets out strengths and weaknesses in existing services. Emphasises the importance of ensuring inclusive access for all children to relevant and universal services in health and education.
http://www.scotland.gov.uk/library3/education/fcsr-00.asp

Children (Scotland) Act (1995)
Section 19 of the Act requires local authorities, as corporate bodies, to plan for the provision of relevant services for children within their area through integrated children's service plans.
http://www.opsi.gov.uk/acts/acts1995/Ukpga_19950036_en_1.htm

EDUCATION

Curriculum for Excellence
Mentions developing children and young people's awareness of, amongst other areas, risks to health, and laying important foundations for their future life, including parenting.
http://www.acurriculumforexcellencescotland.gov.uk/index.asp

The Schools (Health Promotion and Nutrition) (Scotland) Act (2007)
A Bill to make provision about the promotion of health in certain schools and certain school hostels;
http://www.scottish.parliament.uk/business/bills/68-SchoolsHN/index.htm

COMMUNITIES

Working and learning together to build stronger communities (2004)
The Scottish Executive's guidance for community and learning development sets out a long term framework for its promotion and development.
http://www.communitiesscotland.gov.uk/stellent/groups/public/documents/webpages/cs_008336.hcsp

Safer communities through partnerships – a strategy for action (1998)
Along with crime, and the fear of crime, community safety should include other issues such as road and fire safety, and the provision of safe play areas.

COMMUNITY REGENERATION

In July 2004, when the Community Regeneration Fund was launched, the Scottish Executive identified objectives for individuals, groups and communities which form the basis for Closing the Opportunity Gap targets announced by Ministers in December 2004 to replace the Social Justice milestones. The objectives include improving the confidence and skills of the most disadvantaged children and young people and increasing the rate of improvement of the health status of people living in the most deprived communities.

Better communities in Scotland – Closing the Gap: the Scottish Executive's community regeneration statement.
http://www.scotland.gov.uk/library5/social/bcis-00.asp

COMMUNITY PLANNING

Community Planning is the process through which service providers work in partnership for better services for the communities they serve. Each partnership will have published a Regeneration Outcome Agreement.
www.communityplanning.org.uk

Engaging children and young people in community planning (2006)
This Advice Note aims to help Community Planning Partnerships (CPPs) and their individual partners to interpret their responsibilities under the Local Government in

Scotland Act 2003 and other relevant legislation in relation to engagement with children and young people.

Local Government in Scotland Act (2003)
This places a duty on local authorities to initiate, facilitate and maintain the community planning process in consultation with public and community bodies: the text of the Act that made community planning a legal requirement:
http://www.opsi.gov.uk/legislation/scotland/acts2003/20030001.htm

RESEARCH

Injury in children: a research briefing paper (2004)
Briefing paper published by NHS Scotland and compiled by David Stone and Suzanne Jeffrey. Calls for a national strategy for child injury prevention to be developed as a matter of urgency.
http://www.healthscotland.com/documents/429.aspx

Towards a child injury prevention strategy seminar (2004)
Seminar report published by Health Scotland.

National Institute for Health and Clinical Excellence- Public Health draft guidance for preventing unintentional injuries among children and young people aged 15 and under : Information, advice and education for outdoor play and leisure.

National Institute for Health and Clinical Excellence – Public Health Guidance for preventing unintentional injuries among children and young people aged 15 and under in the home

National Institute for Health and Clinical Excellence – Preventing unintentional road injuries among children under 15: road design and modification.

National Institute for Health and Clinical Excellence – Strategies to prevent unintentional injuries among under 15's : Public Health Guidance

Preventing unintentional road injuries among under 15's: education and protective equipment : Public Health Guidance.

INTERNATIONAL POLICY

Child and Adolescent injury prevention: a global call to action (2005)
UNICEF has suggested that "For most of the causes of child injury deaths there are now proven strategies for prevention."
http://www.unicef.org/crc/crc.htm

Children's Environment and Health Action Plan for Europe (CEHAPE)
Regional priority goal II aims to prevent and substantially reduce health consequences from accidents and injuries and pursue a decrease in morbidity from lack of adequate physical activity, by promoting safe, secure and supportive human settlements for all children. It speaks of addressing the overall mortality and morbidity due to external causes in children and adolescents by:

(a) developing, implementing and enforcing strict child-specific measures that will better protect children and adolescents from injuries at and around their homes, playgrounds, schools and workplaces;
(b) advocating the strengthened implementation of road safety measures, including adequate speed limits as well as education for drivers and children, and enforcement of the corresponding legislation (in particular the recommendations of the WHO world and European reports on road traffic injury prevention)
http://www.euro.who.int/childhealthenv/policy/20020724_2

United Nations Convention on the Rights of the Child (1989)
Article 24 (e) requires signatories to ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of child health and nutrition, the advantages of breastfeeding, hygiene and environmental sanitation and the prevention of accidents
http://www.unhchr.ch/html/menu3/b/k2crc.htm

Prevention of injury and promotion of safety recommendations
In December 2006, the European Parliament adopted a non-binding report on a list of recommendations addressed to the Member States on the prevention of injuries and to set out Commission tasks supporting the prevention of injuries as well as the promotion of safety.
http://www.europarl.europa.eu/sides/getDoc.do?type=REPORT&reference=A6-2006-0398&language=EN&mode=XML

ANNEX B

POLICIES FOR CHILD INJURY PREVENTION IN NHSGGC AND PARTNER AGENCIES

NHS Greater Glasgow and Clyde – Health Improvement Policy Framework, 15/03/2010

NHS Greater Glasgow and Clyde – Acute Services Plan 2010 – 2013

NHS Greater Glasgow and Clyde Board Children and Families planning framework for 2010 – 2013

Report of the Director of Public Health into the health of the population of Greater Glasgow and Clyde and priorities for action An Unequal Struggle for Health 2009 – 2011

Glasgow Tobacco Strategy 2009 – 2014

Glasgow Community and Safety partnership's Safe Theme Strategic Assessments 2009/10 and 2010/11

Community Safety Action Plans

CEL 15 - 30th April 2010 Refresh of Health for All Children (HALL 4) Reinforcing the key messages.