Northumberland *Children and Young People's*

Safety Strategy

A partnership approach to keep children and young people safe from injury

2016 - 2020

Northumbria Healthcare NHS
NHS Foundation Trust

Northumberland
Northumberland County Council

Acknowledgements

Many thanks to the individuals and partners who have been actively involved in producing this strategy to address unintentional injury to children and young people in Northumberland.

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Foreword

Unintentional injury in children and young people is an important public health issue and a major concern for those aiming to improve health and reduce health inequalities. The term 'unintentional injury' is now used in place of 'accidents' to recognise that injuries are the result of events that can be prevented.

The early years are an extremely important time, and giving every child the best start in life is crucial to reduce health inequalities across the life course. Giving every child the best start in life highlights unintentional injury prevention as one of its key areas of impact in the under 5s. Unintentional injuries, such as suffocation, choking or falls, in and around the home are a leading cause of preventable death in the under 5s.

Children and young people in Northumberland are entitled to live active, healthy and happy lives. This strategy and action plan aims to reduce the risks and causes of serious injury and death that children face each day in their homes, on the roads and in external environments.

The valuable partnership working, collaboration, and continued commitment of all partner agencies in Northumberland will ensure the aims and objectives of the strategy are achieved, and make a significant contribution to improving outcomes for children and young people.

Penny Spring
Director of Public Health
Northumberland County Council

Executive summary

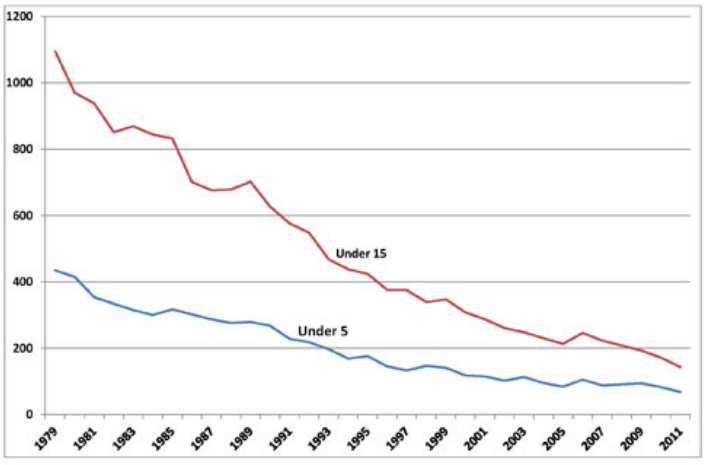
In the United Kingdom injuries are the most frequent cause of death in children after their first year of life, and unintentional injuries are the most common (RCPCH & NCB 2014). Around 300 children a year die as a result of unintentional injury and many more are injured and disabled. Treating unintentional injury costs the NHS over £2 billion each year (CMO 2013).

Unintentional injury also places a significant burden on individuals, families and communities, with injuries resulting in disability, painful treatments in hospital and work and school hours lost to hospital attendances or ill health. The inability of injured or disabled children, to participate fully in school and society could also lead to poor achievement in education and reduced social and emotional wellbeing. There is a disproportionately high number of deaths among children under 5 years of age compared to other age groups, and a large number of hospital admissions for unintentional injury in this age group (PHE 2014).

Unintentional injuries and health inequalities

Unintentional injuries are a major health inequality (PHE 2014). Although overall rates of deaths from injury in children have fallen in England and Wales there are significant differences in rates of unintentional injury among children between different social groups; the social gradient for deaths during childhood as a result of unintentional injury is steeper than that for any other cause of death (Marmot 2010). Although deaths from unintentional injury have decreased, children from poorer backgrounds are 13 times more likely to die in an accident, 21 times more likely to die as pedestrian on the roads, and 38 times more likely to die in a house fire (CAPT 2016).

Deaths due to unintentional injuries, birth - 14 years
England and Wales 1979-2011



(Source - Child Accident Prevention Trust, 2012)

Deaths due to unintentional injuries have reduced due to the implementation of a multi-sectoral, multi-pronged approach to child injury prevention.

The risk factors for unintentional injury are generally acknowledged to be a combination of child, family and environmental characteristics.

The physical, psychological and behavioural characteristics of children and young people make them more vulnerable to injuries than adults. The costs to children, families, and communities are also great. There are large numbers of children who are injured, scarred or disabled. The high number of school and work hours lost due to time in hospital and at follow up appointments can also have a significant impact on families and communities.

Preventing unintentional injury is an important component among wider efforts to improve health and reduce inequalities in health.

The under 5's also represent a significant proportion of children injured, with the majority of these occurring in or around the home. It has been estimated that one in five children under 5 will attend an accident & emergency department each year due to an injury sustained in or around the home.

In older children, injuries in the external environment, particularly road injuries are more common causes of injury (NCB 2010), as children begin to become more independent and spend more time away from the home.

Effective action to reduce unintentional injuries in children and young people

Interventions to reduce unintentional injury have usually been considered in the term of the "three Es" **enforcement, engineering**, and **education**, but this has now been expanded to include a fourth "E" of **empowerment** (PHE 2014)

- **Enforcement** – Through the use of standards, regulation and legislation to enforce safer behaviour, safer environments or safer products
- **Engineering** – Product or environment design can be modified to enhance safety and change behaviour. Often engineering and education work in tandem.
- **Education** – Educative approaches are often the best way of addressing issues with parents
- **Empowerment** – approaches that empower parents and carers can embed home safety behaviours.

Aims and Objectives

The aim of the Northumberland Children and Young People's Safety Strategy is to develop a coordinated approach with stakeholders and agencies in reducing the burden of unintentional injury in children and young people, including:

- Reduci**ng the occurrence of injuries**
- **Reducing the severity and adverse impact of injuries; and**
- **Reducing in**jury-related disability and death

Objectives
To enable targeted and coordinated delivery of initiatives to prevent and reduce unintentional injury.

To ensure that unintentional injury prevention is high on the local agenda and is incorporated into appropriate strategies and plans to improve children and young people's health and wellbeing.

This will be achieved by:

- **Working collaboratively with partners**
  Improve data collection methods in order to inform, target and evaluate services.

  Maintain and manage road safety partnerships including collaborative working with the Road Safety Strategy Group.

- **Improved communication**
  Incorporate unintentional prevention with local and national plans and strategies for children and young people's health and wellbeing.

  Develop a communication strategy to ensure a coordinated approach to publicity and campaign delivery.

  Disseminate information about national policy, evidence based guidance and effective interventions to partner agencies through local child safety groups.

  Develop policies for public outdoor play and leisure.

  Incorporate home safety assessments and equipment provision within local plans and strategies.

- **Supporting preventative education, advice and training**
  Capacity building of workforce including health visitors, nursery nurses, family support workers, childminders, early years providers, community safety managers etc by providing access to injury prevention training.

  Provide recommendations on installing and maintaining permanent safety equipment in social and rented dwellings.

  Provide education and advice on water safety.

- **Targeting bespoke programmes for vulnerable groups**

  Contribute to work to increase engagement, provide training and safety equipment to those groups identified as being of increased risk of unintentional injury e.g. minority ethnic groups or families on low income.

This Children and Young People's Safety Strategy offers a range of interventions, and will be coordinated and implemented by stakeholders and agencies working together across Northumberland. The recommendations in this strategy were informed by current and past government policy, academic literature on evidence of effective action to reduce unintentional injuries, and on NICE guidelines on reducing unintentional injury in under 15's (NICE 2016).

Links to other strategies

This strategy should not be seen in isolation, it compliments a range of other strategies, plans and guidance.

National

Reducing unintentional injuries in and around the home among children under five years 2014 (Public Health England)
https://www.gov.uk/government/publications/reducing-unintentional-injuries-among-children-and-young-people

Reducing unintentional injuries on the roads among children and young people under 25 years 2014 (Public Health England)
https://www.gov.uk/government/publications/reducing-unintentional-injuries-among-children-and-young-people

Preventing unintentional injury in under 15s, NICE quality standard (QS107) 2016
https://www.nice.org.uk/guidance/qs107/chapter/introduction

Local

NSCB Business Plan 2015-2016(Northumberland County Council)
Part 1 - http://www.northumberland.gov.uk/NorthumberlandCountyCouncil/media/Child-Families/NSCB-Business-Plan-2015-2016-Part-1.pdf

Part 2 - http://www.northumberland.gov.uk/NorthumberlandCountyCouncil/media/Child-Families/Business-Plan-Part-2-2015-2016.pdf

Northumberland Corporate Plan 2013-2017 (Northumberland County Council)
http://www.northumberland.gov.uk/default.aspx?page=11021

Achieving Health and Wellbeing in Northumberland April 2014 (Northumberland County Council)
http://www.northumberland.gov.uk/default.aspx?page=14509

Children and Young Peoples Plan 2015-2018 (Northumberland County Council)
http://www.northumberland.gov.uk/default.aspx?page=8131

Northumberland Early Help Strategy 2014
http://www.northumberland.gov.uk/default.aspx?page=8131

Reported Road User Casualties in Northumberland 2014
http://www.gateshead.gov.uk/ne-roadsafety/Library/Local-Overviews/LI-52-Northumberland-Overview-2014.pdf

1. Scope

This strategy uses the term 'unintentional injuries' rather than 'accidents' as the majority of injuries and their precipitating events are predictable and preventable (Hall & Elliman 2003). The term 'accident' implies an unpredictable and therefore unavoidable event. This terminology is supported by the National Institute of Clinical Excellence (NICE) Guidelines on the prevention of unintentional injury in under 15's (NICE 2016) and also by policy documents and academic literature. However, it is acknowledged that the term 'accident' is widely used with families, professionals and the media.

The term 'vulnerable' is used to refer to children and young people who are at greater than average risk of an unintentional injury due to one or more factors (see Box 1).

Box 1. Possible indicators of increased vulnerability to unintentional injury

Children are at great risk if they are:

Aged under five (generally under 5's are more vulnerable to unintentional injuries in the home)
Aged over the age of 11 (generally, over 11s are more vulnerable to unintentional injuries on the road)
Have a disability or impairment (physical or learning)
Are from some minority ethnic groups
Live in a family on a low income
Live in accommodation which potentially puts them more at risk (this could include multiple-occupied housing ,social and privately rented housing)

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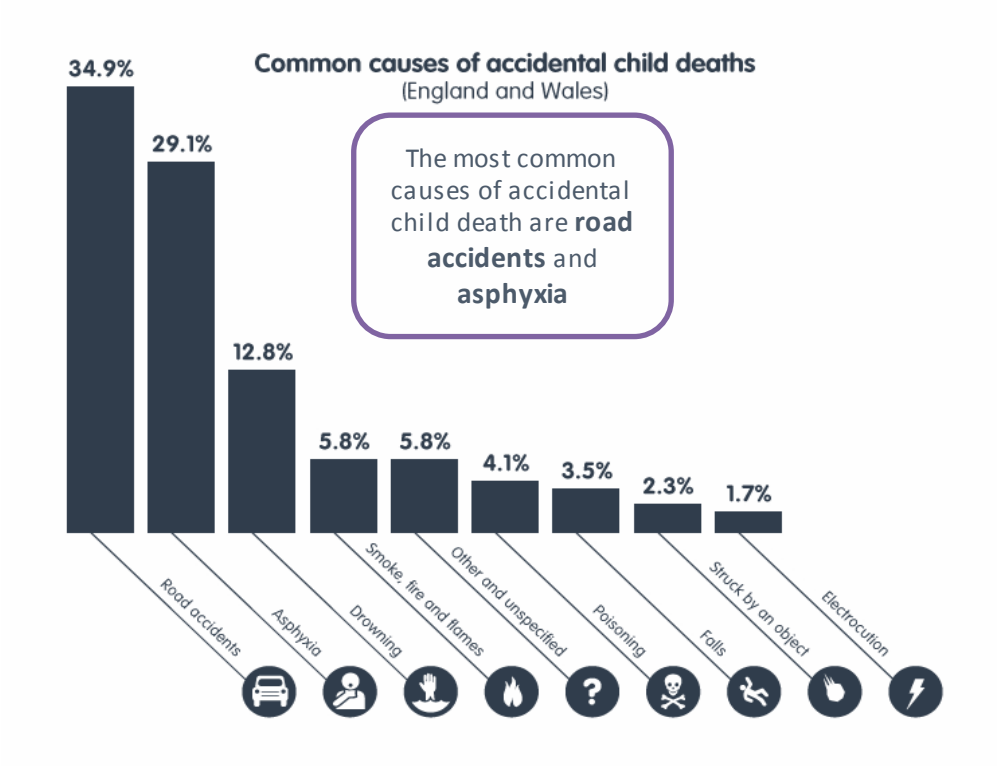
In Northumberland children and young people are classed as aged 0-19; this classification varies between settings, agencies, regions and countries. This strategy also covers young people who have additional educational or physical needs aged up to 25.

2. Background to unintentional injury

Worldwide, around 830,000 children under 18 die from unintentional injury – approximately the same number that die from measles, diphtheria, polio, whooping cough and tetanus, combined (WHO 2008). In the United Kingdom, unintentional injury is a leading cause of morbidity and mortality in children aged 1-14 (Audit Commission 2007) even though overall rates from injury have fallen in England and Wales (Rospa 2013), and puts more children in hospital than any other cause (DCSF 2009). Around 300 children a year die as a result of unintentional injury and many more are injured and disabled.

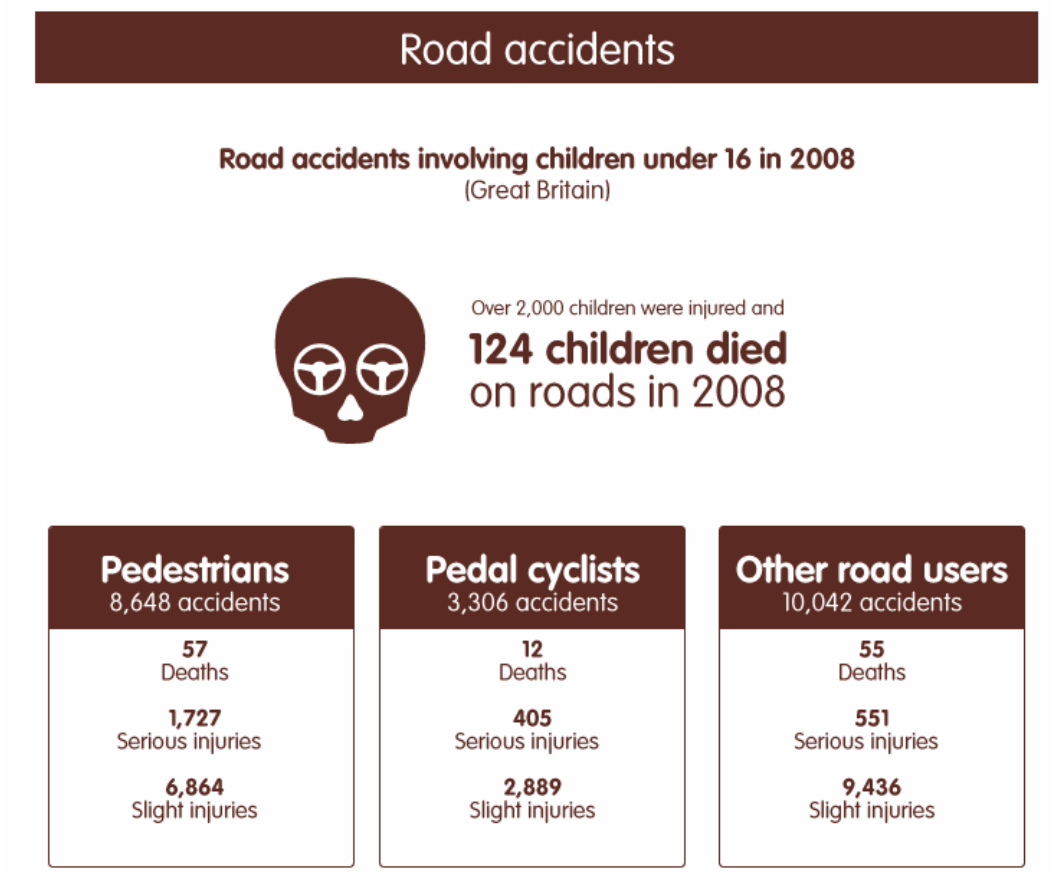
Wasted Lives –Child Accidents and Deaths



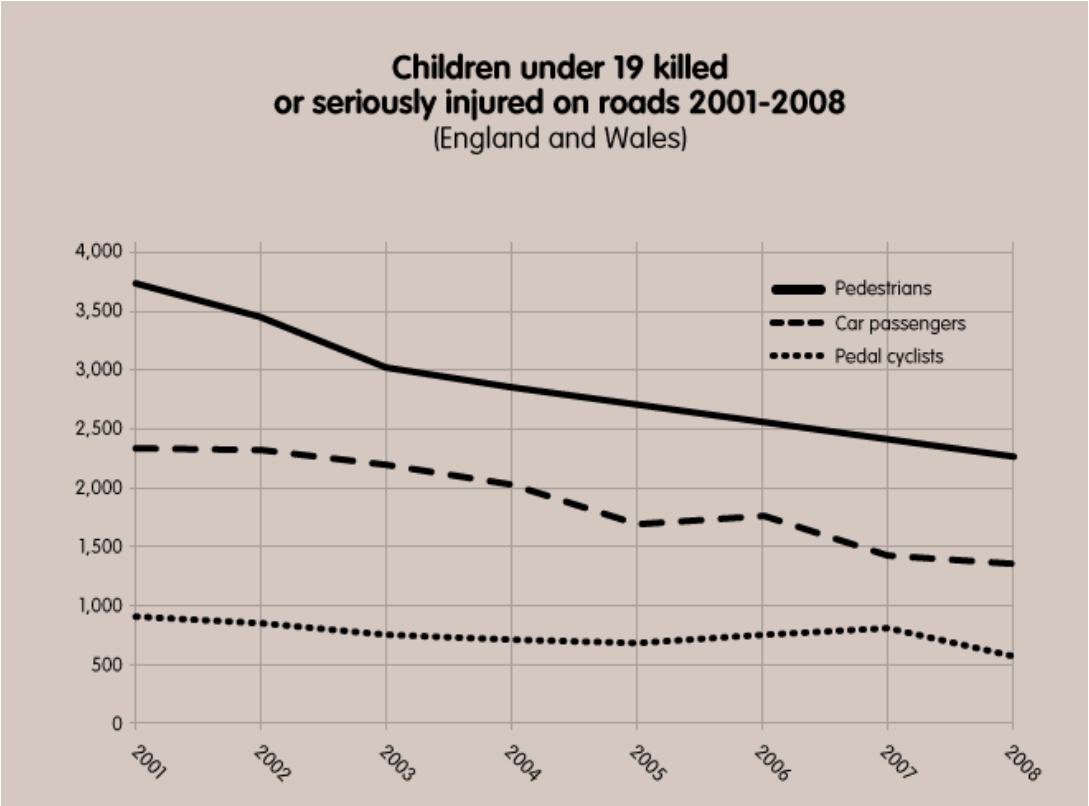
(Source – CHIMAT 2013)

(Source – CHIMAT 2013)

The most common cause for hospital admissions in the under 5s in England and Wales is falls.



(Source – CHIMAT 2013)



(Source – CHIMAT 2013)

Unintentional injury also places a significant burden on individuals, families and communities, with injuries resulting in disability, painful treatments in hospital and work and school hours lost to hospital attendances or ill health. The inability of injured or disabled children, to participate fully in school and society could also lead to poor achievement in education and reduced social and emotional wellbeing. There are a number of reasons why children are particularly at risk of unintentional injury (see Box 2).

Box 2. Why are children particularly at risk of unintentional injury?

Our environment is designed for adults and children's small size makes them vulnerable in this environment

It takes time to develop skills and experience that adults take for granted

Children are naturally inquisitive and learn by exploring

Older children actively seek out risk-taking activities. This is a normal part of growing up but can put them in danger

Unintentional injury and health inequalities

There are marked differences in risks of unintentional injury among children between different social groups and inequalities have widened (Audit Commission 2007). The death rate for children of parents classified as never having worked, or in long-term unemployment was 13.1 times that for children of parents in higher managerial/professional occupations (Edwards et al 2006). There is a 15-fold increase in child deaths due to house fires in the lower socio-economic groups.

There have been many studies that have tried to identify why socio-economic factors affect the risk of childhood injury (Dowswell & Towner 2002, Kendrick et al 2005). The factors which link social deprivation and increased risk of unintentional injury are complex and generally not well understood. However, the factors are generally acknowledged to be a combination of child, family and environmental characteristics (WHO 2014).

It should also be noted that factors may interact or exacerbate each other, resulting in an even greater risk of unintentional injury. A child's situation and therefore risk of injury can change. Factors such as family breakdown, moving to a new home or community, substance misuse in the household, family stress, disruption of routine, sleep patterns and many other factors can all increase risk of injury. It is therefore difficult to identify particular risk groups, as situations and circumstances of individuals and family's lives are so complex and transient.

Box 3. Unintentional injury and health inequalities

The social class gradient for injuries is steeper than for any other cause of death in childhood

The death rate for children of parents classified as never having worked or in long-term unemployment was 13.1 times that for children in higher managerial/professional occupations

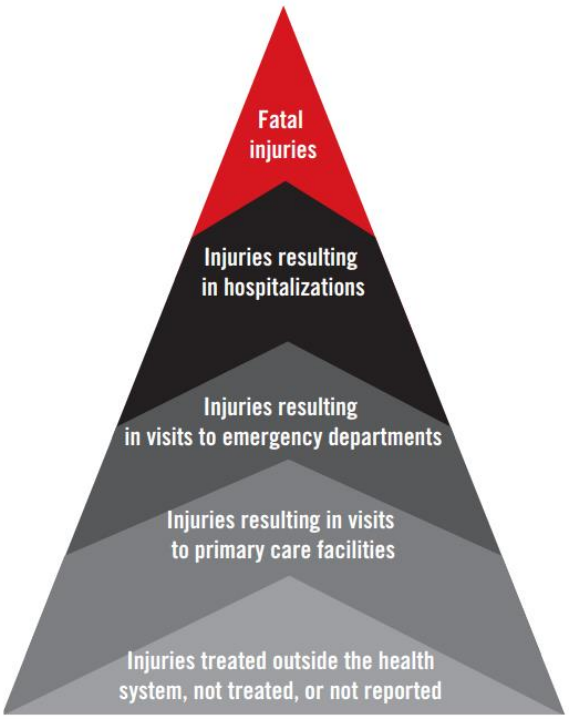
There is a 15-fold increase in child deaths due to house fires in the lower socio economic groups

Overall deaths from unintentional injury have decreased however there are persistent and widening inequalities between socio-economic groups

Unintentional injury in the under 5's

The under 5's represent a significant percentage of children injured and injuries within the home are a particular issue (NICE 2016). It has been estimated that one in five children under 5 will attend an accident & emergency department each year due to an injury sustained in or around the home. Behavioural characteristics could go some way to explain this, with most under 5's spending the majority of their time in the home. In older children, injuries in the external environment, particularly road injuries are more common causes of injury (DCSF 2009), as children begin to become more independent and spend more time away from the home.

Categories of Injury



Avoidable injuries can be categorised according to their severity, treatment type and reporting.

Fatalities represent a small number of those who are injured. Thousands of children and young people in the UK suffer injuries that will lead to hospitalization, emergency or general practitioner treatment, or treatment that does not involve formal medical care.

(Source - World Health Organisation, WHO)

3. Policy Context

Reducing unintentional injuries in and around the home among children under five years 2014 – Public Health England

This report sets out three actions for local authorities and their partners that will reduce the numbers of children injured and killed.

Three key action areas

(1) Providing leadership and mobilising existing services
(2) The early years workforce needs support and training to enable it to strengthen its central role in helping to reduce unintentional injuries
(3) Focusing on five kinds of injuries for the under-fives make sense

Because children under five account for a disproportionately high number of deaths and a large number of hospital admissions, Public Health England advise that local authorities may want to treat this group as a priority for action within wider unintentional injury prevention strategies. The document suggests five key priorities for action:

- Choking, suffocation and strangulation
- Falls
- Poisoning
- Burns and scalds
- Drowning

Reducing unintentional injuries on the roads among children and young people under 25 years 2014 – Public Health England.

This document also sets out three action areas to reduce the numbers of the children and young people injured and killed on our roads:

(1) Improve safety for children travelling to and from school
(2) Introduce 20 mph limits in priority areas as part of a safe system approach to road safety
(3) Action to prevent traffic injury and improve health must be coordinated

The Marmot Review – Fair Society, Healthy Lives: Strategic Review of Health Inequalities in England post 2010

This review highlights the impact of inequalities when looking at accident deaths among children.

4: Statistics and data

A recurring theme throughout government policy and academic literature is the challenge of data collection on unintentional injuries.

In order to inform, evaluate and target services effectively, data needs to be accurate, timely, relevant and complete. There is currently no national or local system which collects all data on unintentional injuries to children and young people. In Northumberland we have a number of different sources that provide data on different types or categories of injury and on hospital admissions.

The following information is included in order to attempt to give an overview of the problem of unintentional injury to children and young people in Northumberland. It is acknowledged that the data provided may not give an accurate picture of rates of unintentional injury and that data collection needs to be a priority in this strategy. It is also acknowledged nationally that there are weaknesses in the data that is available, as there is little known about unintentional injuries that do not result in hospital admissions but are treated in other health care settings or at home (PHE 2014).

Northumberland - Child Health Profile data
In a recent child health profile, a variety of sources of data was used to rate Northumberland's performance against a number of indicators, compared to the national average and other North East local authorities. (See table 1).

A summary of Northumberland's performance in indicators relating to injury, compared with England average, is included here:

Significantly worse than England average in the following indicators:

- Hospital admissions due to alcohol specific conditions (<18 years)
- A&E attendances (0-4 years)
- Hospital admissions caused by injuries in children (0-14 years)
- Hospital admissions caused by injuries in young people (15-24 years)
- Hospital admissions as a result of self-harm (10-24 years)

Close to England average in the following indicators:

- Children killed or seriously injured in road traffic accidents (<18 years)
- Hospital admissions due to substance misuse (15-24 years)

Table 1 Northumberland child health profile (March 2016)

Significantly worse than England average
Significantly better than England average
Not significantly different
Regional average

25th percentile — England average — 75th percentile

	Indicator	Local no.	Local value	Eng. ave.	Eng. Worst	Eng. Best
Premature mortality	1 Infant mortality	9	3.1	4.0	7.2	1.6
	2 Child mortality rate (1-17 years)	4	6.2	12.0	19.3	5.0
Health protection	3 MMR vaccination for one dose (2 years) >=90% <90%	3,143	95.6	92.3	73.8	98.1
	4 Dtap / IPV / Hib vaccination (2 years) >=90% <90%	3,228	98.2	95.7	79.2	99.2
	5 Children in care immunisations	230	90.2	87.8	64.9	100.0
Wider determinants of ill health	6 Children achieving a good level of development at the end of reception	2,139	64.9	66.3	50.7	77.5
	7 GCSEs achieved (5 A*-C inc. English and maths)	1,909	56.8	57.3	42.0	71.4
	8 GCSEs achieved (5 A*-C inc. English and maths) for children in care	5	27.3	12.0	8.0	42.9
	9 16-18 year olds not in education, employment or training	610	5.7	4.7	9.0	1.5
	10 First time entrants to the youth justice system	89	319.2	409.1	808.6	132.9
	11 Children in poverty (under 16 years)	9,265	17.7	18.6	34.4	6.1
	12 Family homelessness	130	0.9	1.8	8.9	0.2
	13 Children in care	370	62	60	158	20
	14 Children killed or seriously injured in road traffic accidents	9	17.6	17.9	51.5	5.5
Health improvement	15 Low birthweight of term babies	50	2.0	2.9	5.8	1.6
	16 Obese children (4-5 years)	298	9.5	9.1	13.6	4.2
	17 Obese children (10-11 years)	607	19.8	19.1	27.8	10.5
	18 Children with one or more decayed, missing or filled teeth	-	27.6	27.9	53.2	12.5
	19 Hospital admissions for dental caries (1-4 years)	67	518.9	322.0	1,406.8	11.7
	20 Under 18 conceptions	122	22.9	24.3	43.9	9.2
	21 Teenage mothers	37	1.4	0.9	2.2	0.2
	22 Hospital admissions due to alcohol specific conditions	30	50.4	40.1	100.0	13.7
	23 Hospital admissions due to substance misuse (15-24 years)	36	107.1	88.8	278.2	24.7
Prevention of ill health	24 Smoking status at time of delivery	381	14.2	11.4	27.2	2.1
	25 Breastfeeding initiation	1,798	67.2	74.3	47.2	92.9
	26 Breastfeeding prevalence at 6-8 weeks after birth	1,069	38.0	43.8	19.1	81.5
	27 A&E attendances (0-4 years)	9,414	599.5	540.5	1,761.8	263.6
	28 Hospital admissions caused by injuries in children (0-14 years)	622	127.1	109.6	199.7	61.3
	29 Hospital admissions caused by injuries in young people (15-24 years)	698	209.7	131.7	287.1	67.1
	30 Hospital admissions for asthma (under 19 years)	94	148.2	216.1	553.2	73.4
	31 Hospital admissions for mental health conditions	49	81.9	87.4	226.5	28.5
	32 Hospital admissions as a result of self-harm (10-24 years)	254	511.8	398.8	1,388.4	105.2

Northumberland CCG (Clinical Commissioning Group) and NECS (North of England Commissioning Support Unit)

The following data has been provided by Northumberland CCG and NECS.

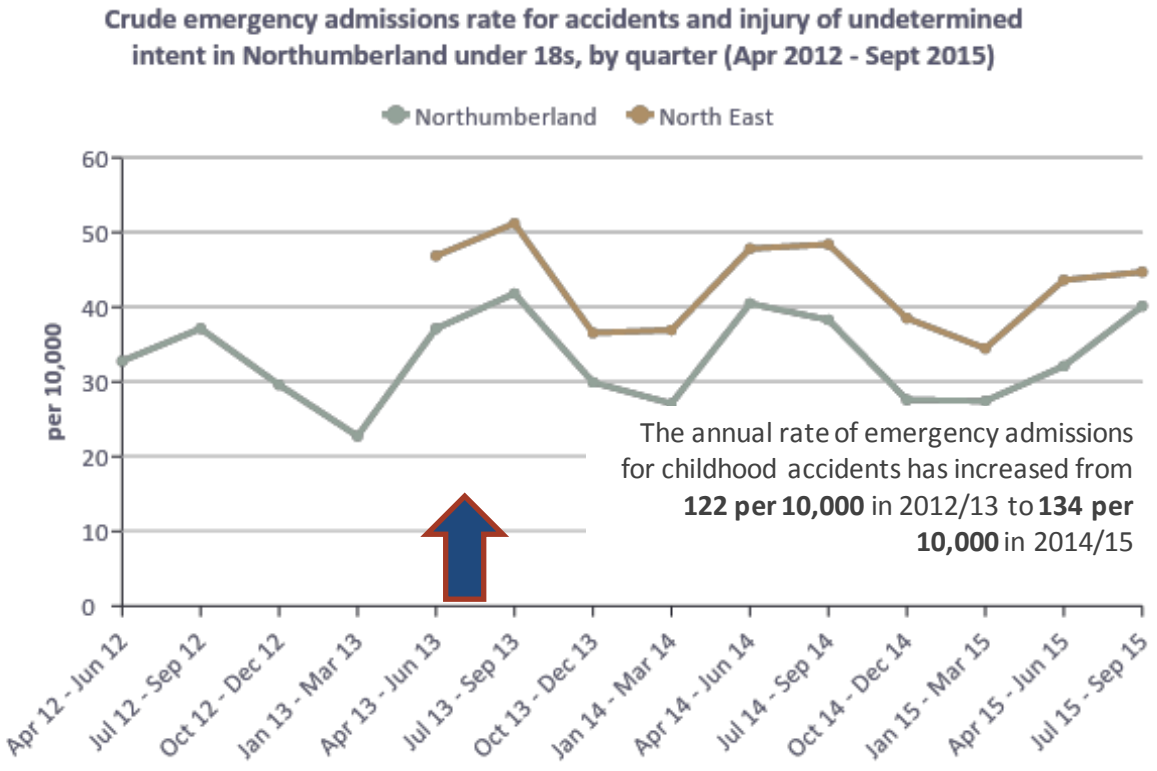
Childhood accidents activity – Northumberland CCG (2012/13 to 2014/15)
This information relates to emergency admissions and A&E attendances for hospital admissions caused by unintentional or deliberate injuries to children and young people aged 0-17 years.

Emergency admissions
The rate of emergency admissions of children and young people (aged 0-17 years) to hospital as a result of unintentional and deliberate injury, per 10,000 children and young people is shown.

The Northumberland emergency admission rate is lower than the north east average.

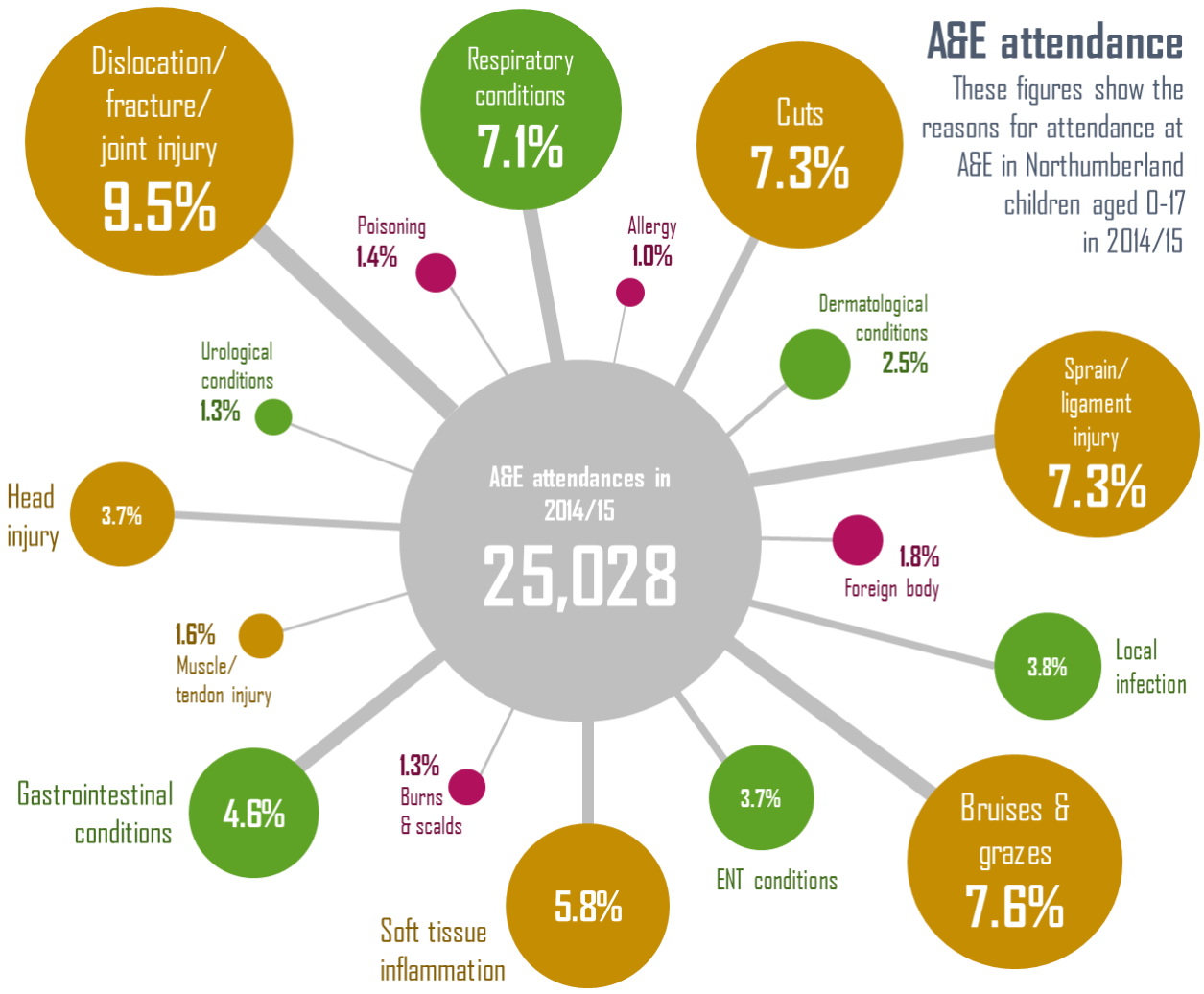
Data is presented at CCG (Clinical Commissioning Group) level, on a quarterly basis. Due to organisational changes and the move to CCGs from PCTs (Primary Care Trust's) the north east figure is only available from April 2013 onwards.

Emergency admissions fluctuate by quarter and are always highest in Q1 and Q2 of the financial years.



A&E attendances
By diagnosis

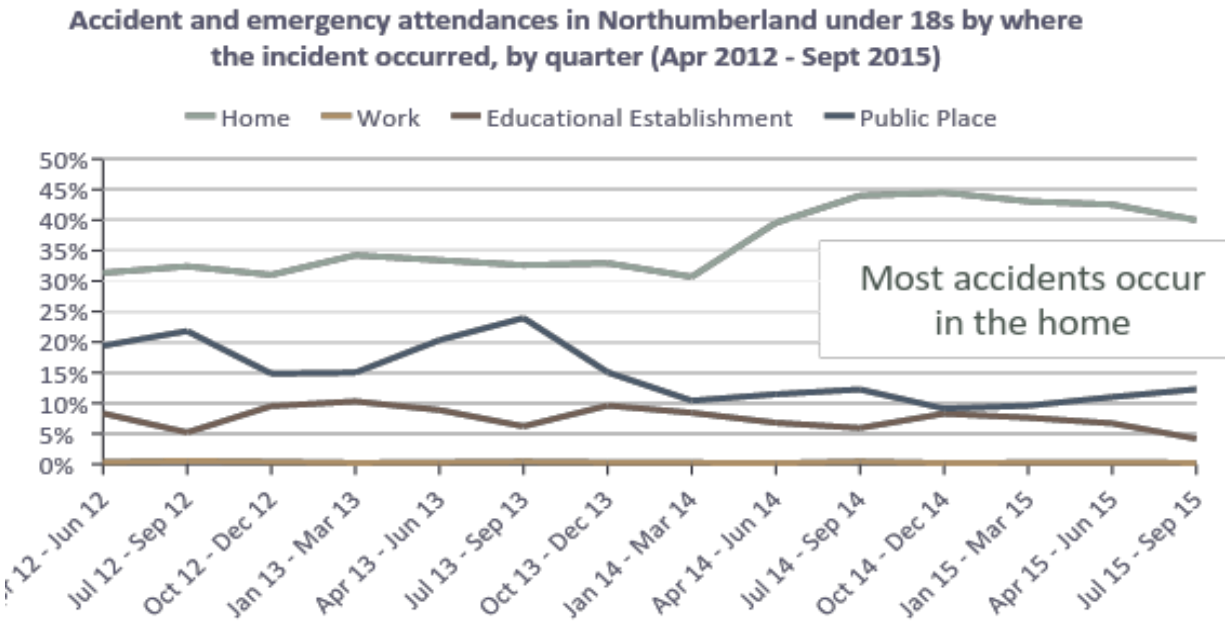
In 2014/15 there were 414 A&E attendances per 1,000 children and young people aged 0-17. This continues the slight increase from 408 per 1,000 in 2012/13. The most frequently recorded diagnosis is for dislocation/fracture/joint injury which rose from 8% in 2012/13 to nearly 10% in 2014/15. This is followed by contusion/abrasion at nearly 8% and laceration at approximately 7%. The proportion of attendances for head injury increased in 2014/15 compared to previous financial years.



By incident location type

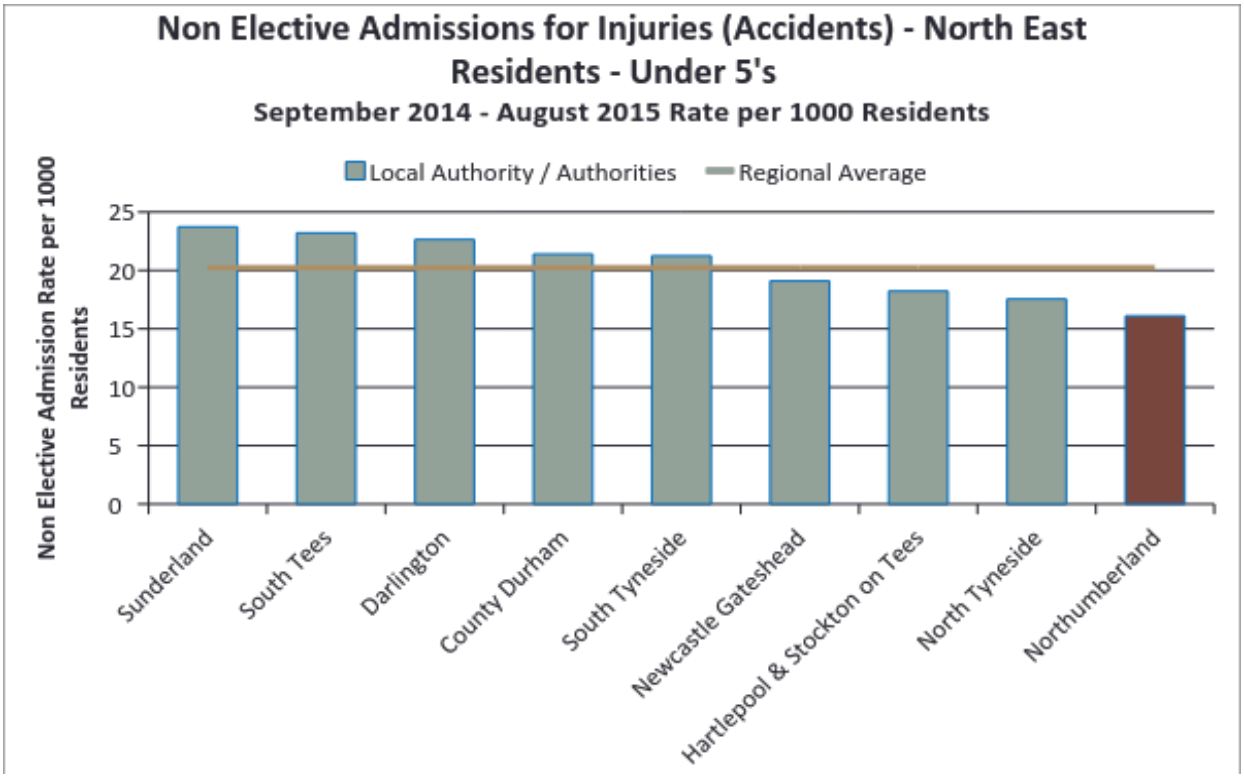
The chart below shows the incident location recorded within each A&E attendance for those aged 0-17 years, registered with Northumberland CCG.

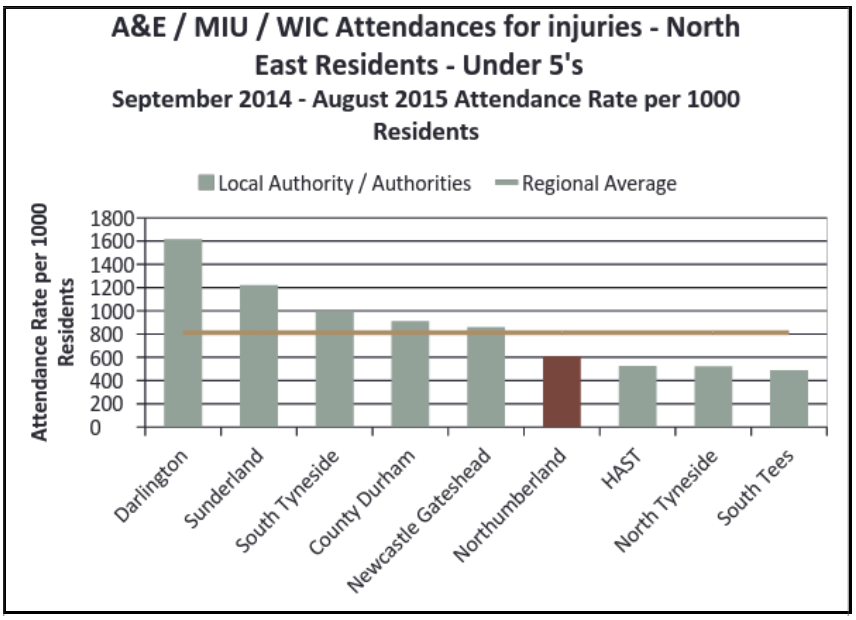
Most accidents occur in the home. Furthermore the proportion of incidents occurring at home has increased from approximately 31% (1,847 attendances) to 40% (2,719 attendances) since April 2014. However it is likely that the data recorded in this field has some data quality issues.



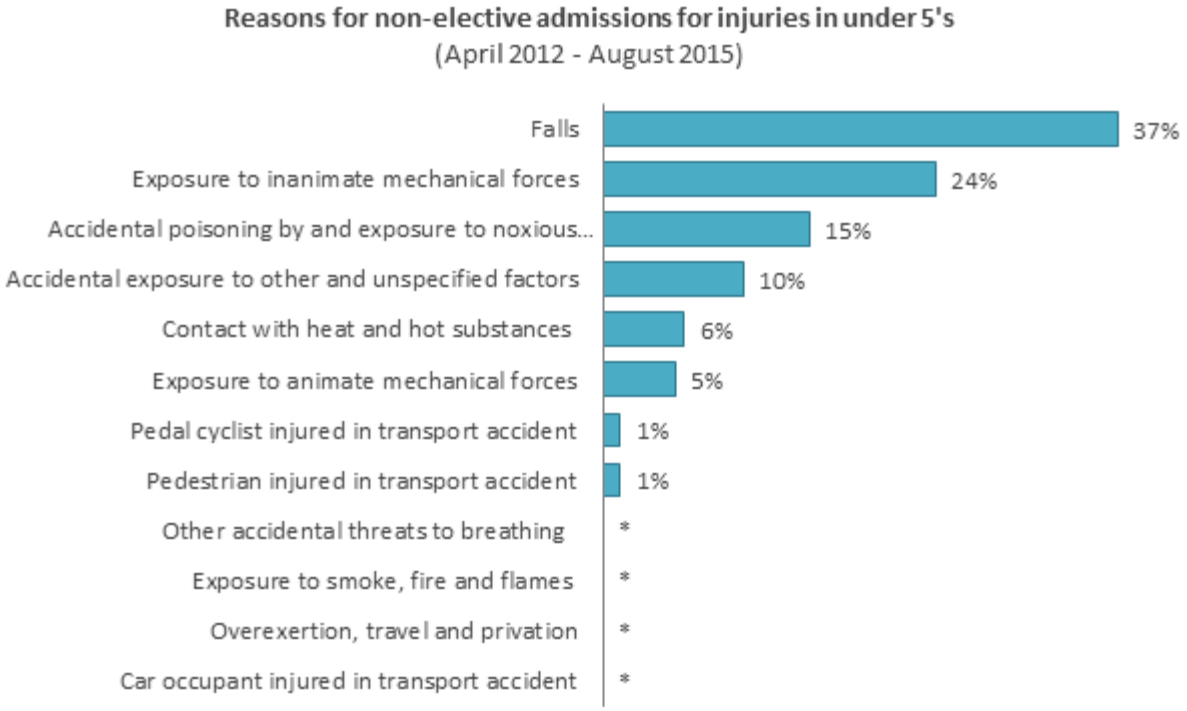
0-5s key points

Northumberland has the lowest rate of emergency admissions to hospital for injuries in children aged under 5 in the North East, but a higher rate than the England average. The rate of attendance at A&E, minor injury units and walk-in centres for injuries in under 5's is lower in Northumberland than in the North East as a whole.



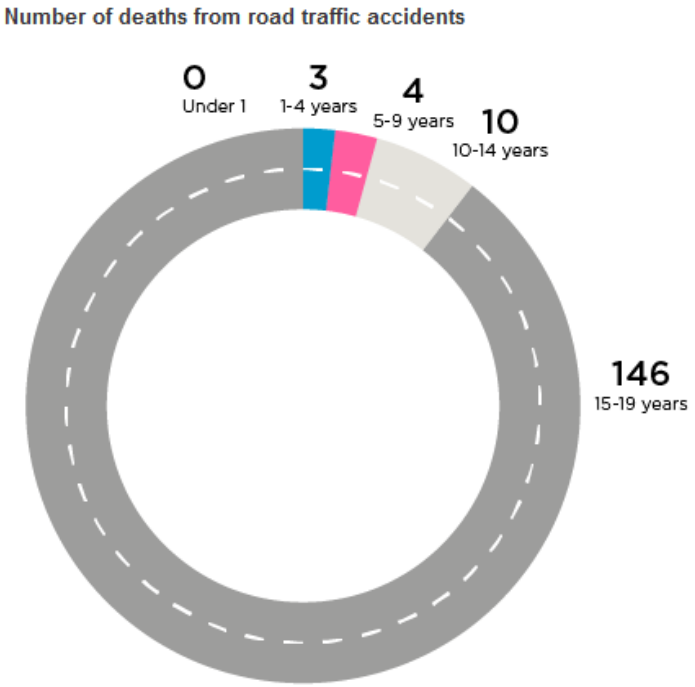


The number of attendances and admissions for injury in under 5s fluctuate throughout the year and are consistently highest in December and lowest in January. The reason for this has not been investigated. Most injury admissions between April 2012 and August 2015 were for falls (37%), followed by exposure to inanimate mechanical forces (24%) and poisoning (15%). Together these 3 reasons make up ¾ of all admissions.



Road Safety Data

Deaths from Road traffic accidents – United Kingdom



(Source - Royal College of Paediatrics and Child Health - Feb 2015)

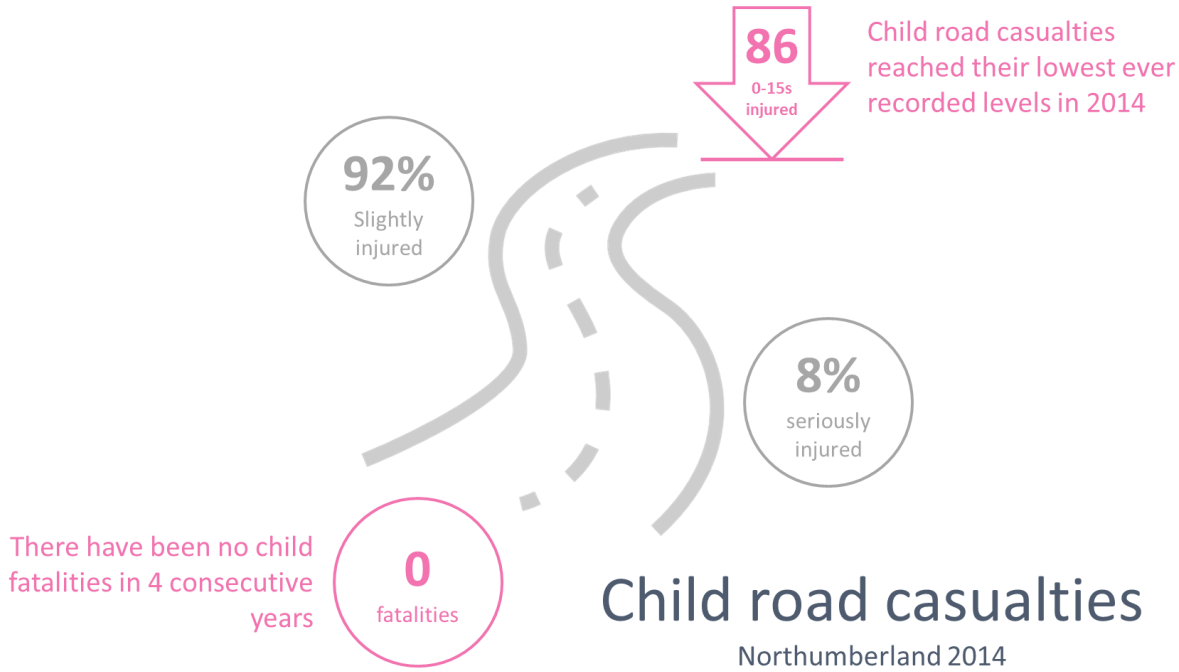
Child Casualties 0-15 years - Northumberland

The following data and information has been provided by the North East Regional Road Safety Group.

The total number of children who were injured in collisions in 2014 was 86. This is 10% less than in 2013 when 96 children were injured, 38% lower than the baseline average of 139, and is the smallest number of child injuries per year since records began.

17.6 per 100,000 children aged 0-15 were killed or seriously injured in Northumberland between 2012 and 2014. This is a decrease of 32% since 2008-10 (25.8 per 100,000). 2014 saw the lowest number of children killed or seriously injured seen in Northumberland since records began in 1978.

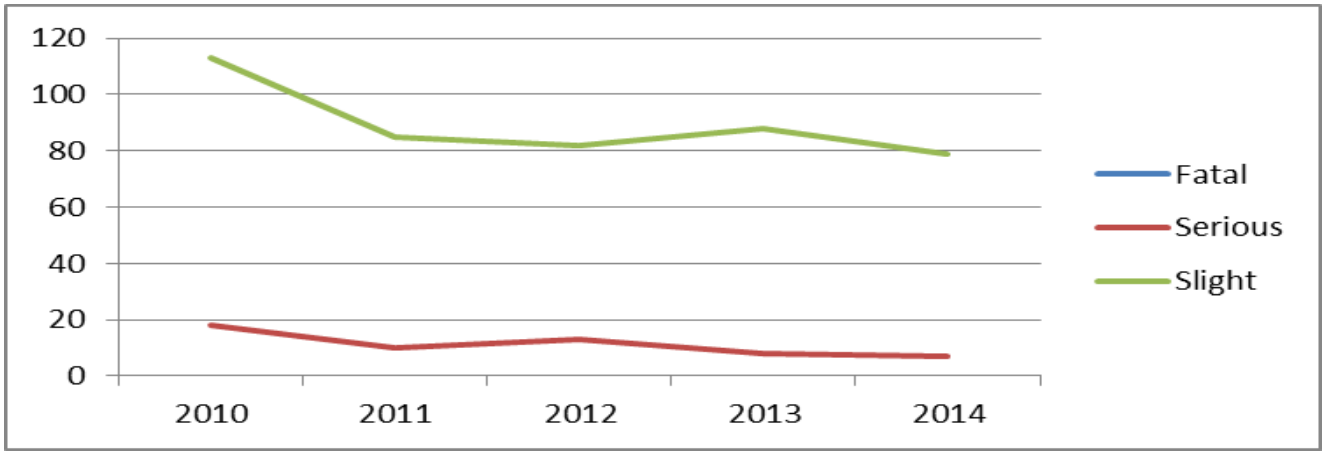
There were no child fatalities in Northumberland in 2014 for the fourth consecutive year compared to an average of 0.2 children per year between 2005 and 2009.



Northumberland 2010-2014

Child Casualties by Severity and Year

Casualty Severity	2010	2011	2012	2013	2014	Total
Fatal	1					1
Serious	18	10	13	8	7	56
Slight	113	85	82	88	79	447
Total	132	95	95	96	86	504



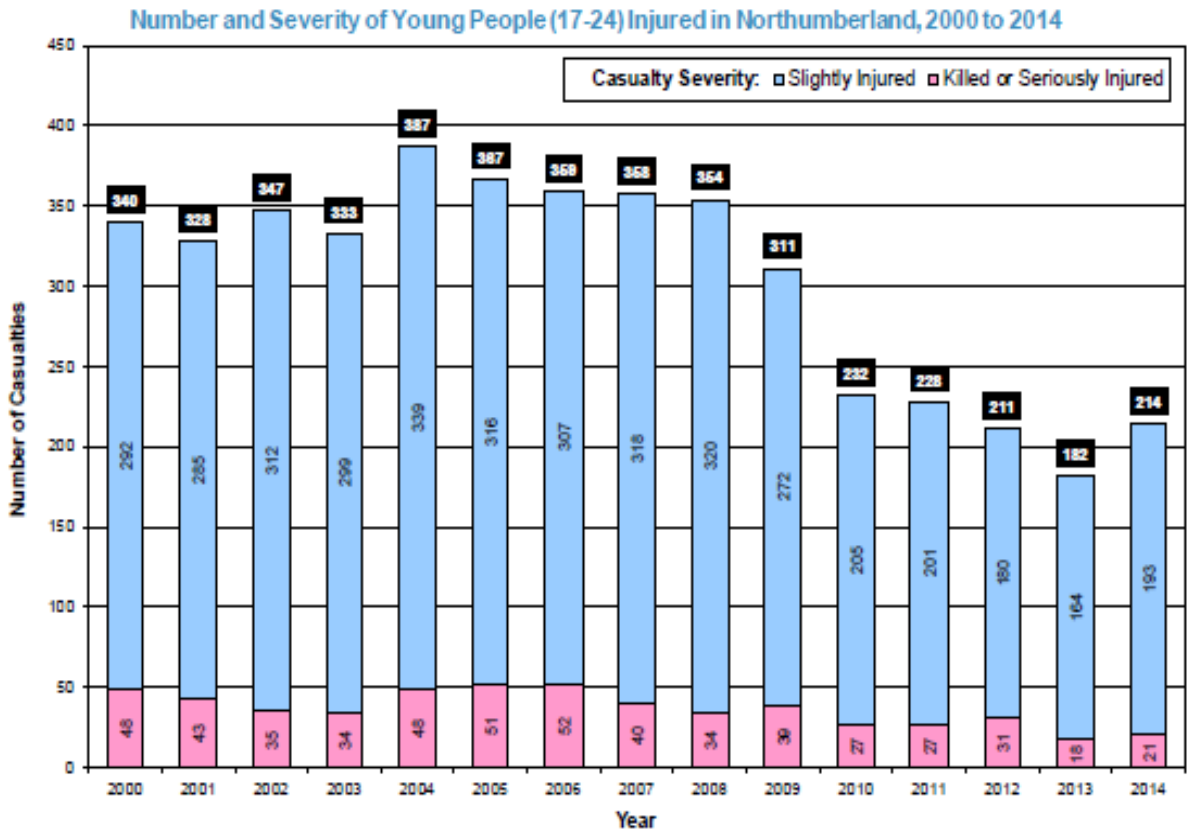
Injuries sustained by Young People aged 17-24 in Northumberland

The total number of young people who were injured in collisions in 2014 was 214. This is 18% more than in 2013 when the total number of casualties was 182 but 39% lower than the 2005 to 2009 average of 350.

The number of young people killed or seriously injured in collisions increased by 17% to 21 in 2014 from 18 in 2013, but reduced by 51% from the 2005 to 2009 baseline average of 43.

There were 2 young people killed on Northumberland's roads in 2014. This was the same as 2013, but was a reduction of 62% from the baseline average of 5.2.

Figure 28: Number and Severity of Young People Injured by Year



5. Opportunities for Prevention

Leadership

Local authorities now have responsibility for improving health and reducing health inequalities, with a key role in delivering the Public Health Outcomes Framework indicator 2.7 to reduce hospital admissions from unintentional and deliberate injuries for children and young people. Local children's boards and health and wellbeing boards are in an ideal position to provide strategic leadership and coordination under the direction of the Director of Public Health and the Director of Children's Services (PHE 2014).

Financial constraints mean resources need to be focused where they will make the most impact. The prevention of unintentional injuries among young children will have significant long term benefits for individuals, families and society.

What works (including addressing inequalities)

NICE guidance highlights five recommendations for local planning

(1) Prioritising households at greatest risk
(2) Working in partnership
(3) Co-ordinating delivery
(4) Ensuring families with children at high risk of injury are provided with home safety assessments and advice and referred to safety equipment schemes
(5) Integrating home safety into other home visits

Children's Centres are well placed to provide information and support to families around prevention of child accidents. Health visitors, GP's and practice nurses are also ideally placed to help identify households at greatest risk and provide advice about future prevention following minor injuries.

Educating parents about issues such as safe sleeping, scalds from hot drinks and the danger of drowning in a bath are also effective.

Enforcement through trading standards and environmental health with the use of standards, regulations and legislation will enforce safer behaviour, safer environments or safer products to reduce the risk of injury.

Mobilising Existing Services and Working in Partnership

NICE Public Health Guidance PH30 (reviewed December 2014), Preventing Unintentional Injuries among the Under-15s in the Home, highlights the benefits of integrating home safety into professionals' other visits. Through the Healthy Child Programme, Health Visitors lead and support delivery of universal injury prevention work for infants and young children; children centres share this aim and are key partners.

Broader partnership working with the public, private, voluntary and community sectors is essential, bringing together early years providers including childminders, GPs, midwives, social housing including housing associations, fire and rescue, care and repair, and safety equipment suppliers, nurseries and schools.

A&E departments and minor injuries units also have an important role advising parents about future prevention when they see an injured child.

The following is a list of interventions or actions, identified by the Health Development Agency, which have been judged to have evidence that they reduce injury, mortality or morbidity or that the interventions change behaviour in a positive way (Millward, Morgan & Kelly 2003).

Interventions judged to have 'good' evidence of effectiveness:

Road environment

20 mph zones
Cycle helmet education campaigns
Cycle helmet legislation
Child restraint loan schemes
Child restraint legislation (leading to behaviour change)

Home environment

Smoke detector programmes/installation of smoke alarms
Child resistant packaging (in relation to poisoning)

Interventions judged to have 'reasonable' evidence of effectiveness:

Road environment

Area-wide urban safety measures
Education aimed at parents about pedestrian injuries
Cycle training
Cycle helmet legislation
Child restraint education campaigns
Seat belt education campaigns
Child restraint legislation (leading to injury reduction)

6. Local context of unintentional injury prevention

If unintentional injury prevention programmes are to be successful, partnership working is essential. In Northumberland a number of agencies contribute to activities and services to prevent unintentional injuries in children and young people. In order to inform this strategy, a mapping of current activities was carried out. The results of mapping are included (see page 29 - What are we doing now).

6.1 Background to Children & Young People's Safety Reference group

The Children and Young People's Safety Reference Group (previously known as the Child Safety Strategy Group) was established by Northumberland Safeguarding Children Board (NSCB) to provide a strategic response to local and national evidence of high levels of unintentional injury to children. The group is a subgroup of the Northumberland Safeguarding Children Board and reports to and receives direction from the Business Sub Group. (See additional document - Monitoring of the Strategy and Reporting Structure).

For further information relating to the safeguarding children structure, please refer to the NSCB Business Plan 2015-2016 and specifically the structure chart (page 5- Part 2) which indicates the inter- relationships between the various groups and the lines of accountability:

NSCB Business Plan 2015-2016
Part 1 - http://www.northumberland.gov.uk/NorthumberlandCountyCouncil/media/Child-Families/NSCB-Business-Plan-2015-2016-Part-1.pdf

Part 2 - http://www.northumberland.gov.uk/NorthumberlandCountyCouncil/media/Child-Families/Business-Plan-Part-2-2015-2016.pdf

6.2 Local Child Safety Groups

The CYP Safety Reference Group agreed to the establishment of four local child safety groups to deliver local child safety programmes. These are in the North, the West, Wansbeck/Morpeth and Blyth Valley. Children's Centre Coordinators (or a deputy appointed by them) chair these groups. In order to maintain regular and effective communication between the CYP Safety Reference group and the Local Child Safety groups, a representative for the coordinators of the local groups attend the CYP Safety Reference Group meetings. An update is presented from each locality group to highlight key activity.

6.3 Other unintentional injury prevention groups

As well as the CYP Reference Group, unintentional injury prevention work is also informed and steered by the Northumberland Road Safety Group. Effective regular communication links are established between this group and the CYP Safety Reference Group.

7: What are we doing now

Mapping of current activities to prevent unintentional injuries to children in Northumberland

Universal service plus additional targeting as needed by Health Visiting NHS Team.

Regular discussion of safety issues from primary visit onwards.

3-4 month contact carried out by Health Visitor or Nursery Nurse which explicitly addresses child safety - Universal.

Universal Home safety assessment, advice on safety issues, referral to free or low cost safety equipment scheme.

Vulnerable families referred to Fire and Rescue Service for home and fire safety assessment and fitting of smoke alarms.

Additional contacts up to 1 year with some families targeted for additional contacts. Safety issues advised as necessary.

Home visits, targeted -as identified by Health Visiting Team following child's attendance at A&E with an unintentional injury.

Baby lifesaving and first aid courses - bespoke.

Child accident prevention courses for parents and carers - bespoke.

Children's Centres - variety of activities throughout county, including the following, but varying in different areas. Services are universal but may be targeted in some areas.

Provide child safety information and welcome pack to all new births via children's centre registrations.

Target home safety assessments and referral to free or low cost safety equipment schemes as appropriate.

Referral to Fire and Rescue Service for home and fire safety assessment and fitting of smoke alarms.

Regular child safety events throughout year, including child safety week, safety days with other agencies, child safety road shows, poster displays.

Child Safety locality groups to engage with relevant partners and joint promotion of locality themes.

Baby lifesaving and first aid courses - variable.

Child prevention for parents and carers e.g. car seat safety workshops.

Other courses provided including for example safe babysitting, fire safety stay and play, fire safety training.

Target specific groups of areas of concern including: high attendances at A&E, e.g. gypsy traveller safety and rural child safety.

Car restraint training for mums, dads and carers.

Provision of high visibility jackets for first school aged children.

One off and regular events including Child Safety Week, Road Safety Week and 'Beep Beep' Day.

Injury Prevention Coordinators (NHS)

Collaborate with child safety locality groups to maintain a coordinated approach to preventing unintentional injuries among child and young people 0-19 years.

Identify and contribute to national and local safety themed campaigns.

Deliver child safety and accident prevention training to frontline practitioners.

Promote resources to support injury interventions.

Contribute to education campaigns to encourage water, road and cycle safety.

Public Health School Nursing

Address safety as part of targeted health needs assessment.

School health support for children and young people with particular behaviours and lifestyle risks, identifying risk factors and promoting resilience and engagement.

Northumberland County Council Road Safety Department

Safer Routes to Schools - a dedicated School Travel Advisor who assists all Northumberland schools with producing school Travel Plans. These address road safety concerns such as dangerous parking around school gates and include measures to encourage walking, cycling and other healthier, more sustainable ways of getting to school.

School Crossing Patrols.

20 mph zones and advisory signing.

A child pedestrian safety training scheme, 'Kerbcraft' targeting year 1 and year 2 children.

A Road Safety Training presentation, 'safer places' and 'Crossroads', adapted for children between preschool age and 11 years.

A recent new road safety resource, 'Ghost Street' is now being introduced into schools, aimed at the 11 yr - 16 yr age groups.

Present/facilitate Road Safety scenarios at 'Safety Works' in Newcastle, whenever schools from Northumberland attend.

Support and have an ongoing cycle training scheme, 'Bikeability' for both level 1 & 2, targeting children between the ages of 8 yrs to 11 yrs.

Work with the 'Northumberland Community Initiatives', (Castle Morpeth Disability Association), visiting 1st schools providing road safety messages from the perspective of disabled people.

Participation with the 'Good Egg Guide' National safety campaign programme for the correct fitting of child car safety seats, with Sure Start Children's Centres within Northumberland. It is intended to develop this programme as an information safety resource within Northumberland.

An annual poster campaign relating to Drink Driving at Christmas time, particularly targeting the young driver.

Northumberland Fire and Rescue Service

Home Fire Safety Checks (including Enhanced Check)

Home Fire Safety Checks (HFSCs) are assessments of fire risk in the home, which are conducted by NFRS personnel throughout Northumberland.

This service, which includes the installation of smoke alarms, is free of charge and also

involves the provision of alarms designed for those who are hard of hearing. Referrals are received from a number of partner agencies including Adult Services, Supporting Families Team and Social Housing providers.

Young Firefighters Association (YFA)

YFA is a cadet scheme, branches of which are based at a number of fire stations throughout Northumberland. Membership is open to young people aged 13-18 years and, as well as learning basic firefighting techniques and working towards a BTEC in Fire and Rescue Services in the Community, cadets learn about the importance of keeping themselves and their communities safe.

Schools and Community Education

NFRS personnel deliver key safety messages in schools and to other community settings; e.g. Sure Start, where the focus of education provided for parents centres on a reduction in the number of burns and scalds sustained by children. Sessions in schools tend to cover broader safety areas including water and road safety and raise awareness of the role of the Fire and Rescue Service in keeping with the community safe.

Firesetters Intervention Programme

Education about the dangers and consequences of fire-setting or making hoax calls is delivered by NFRS personnel to children and young people who have been responsible for such behaviour. Referrals are received via a number of routes including Target Adolescent Services, family members and schools.

Prince's Trust Team Programme

A twelve week personal development programme aimed at 16-25 year olds who are not in employment, education or training. Whilst the course's primary focus is on improving the employability prospects of young people through raising self-esteem and developing key skills, this is fostered in an environment that fosters safety and well-being. Although unintentional injuries are less pertinent for this age group, young people may experience injury as a symptom of other 'unintentional' issues such self harm associated with poor mental health.

8. Strategic Action Plan

The recommendations in our strategic action plan (see separate document Northumberland Children & Young People's Safety Strategy: Plan on a page and Strategy Priorities 2016-2020), were informed by current and past government policy, academic literature on evidence of effective action to reduce unintentional injuries and NICE guidelines on reducing unintentional injury in under 15's (NICE 2010 and NICE 2014).

The aim of the Northumberland Children and Young People's Safety Strategy is to develop a coordinated approach with stakeholders and agencies in reducing the burden of unintentional injury in children and young people, including:

- reducing the occurrence of injuries
- reducing the severity and adverse impact of injuries; and
- reducing injury-related disability and death

Appendix 1

Terms of Reference Northumberland Children and Young People's Safety Reference Group

Purpose

Unintentional injuries in and around the home are a major cause of death and disability, particularly amongst children under 5yrs and in those children and young people living in deprived communities. The majority of these injuries are preventable through mobilising existing services, building on strengths and developing capacity. The remit of this group is to reduce in incidence of frequency and impact of non-accidental injury in the resident 19 years population, and in young people who have additional educational or physical needs aged up to 25.

There is a need for strong leadership that supports co-ordination of resources to add value and enable partnership working. The workforce needs support and training to strengthen their role and capacity in order to link child development, knowledge of parents and carers and tackle challenging physical environments.

The Northumberland CYP Safety Reference Group will be responsible for taking this work forward locally, through directing topic based programmes via the Sure Start Children's Centres locality based child safety groups.

The Northumberland CYP Safety Reference Group will be responsible for monitoring the evaluation reported back from locality groups and for cascading good practice and risks to the Northumberland Health & Wellbeing Board and FACT Board.

Objectives

The group will work collaboratively to oversee the development and implementation of a county wide plan that will:

Use available data to identify local need and priorities in relation to reducing unintended child injury.

Support the development of pathways that facilitate timely and effective preventative interventions across the county.

Ensure the needs of more vulnerable groups are identified and met.

Ensure that priorities will be aligned through local data and be responsive to the views of the local community particularly those groups and communities identified as being more likely to experience childhood injury.

Topic themes will be underpinned by national policy and guidance and will include:-
Road Safety
Choking, suffocation and strangulation
Falls
Poisoning
Burns and Scalds
Drowning

Appendix 2

Membership of the Northumberland CYP Safety Reference Group

Name	Title	Organisation
Yvonne Hush (Chair of Group)	Public Health Manager	Northumberland County Council
Karen Herne	Senior Public Health Manager	Northumberland County Council
Theresa Illey	Early Years Sustainability Officer	Northumberland County Council
Jackie McCormick	Children's Centre Improvement Partner	Northumberland County Council
Claire Douglas	Fair Trading Officer	Northumberland County Council
Nina Livings	Community Safety Delivery Manager	Northumberland Fire and Rescue Service
Maureen Turner	Accident Prevention Specialist Practitioner Lead	Northumbria Healthcare
Natasha Potter	Minor Adaptation Service Manager	Northumberland County Council
Louise Stobbart	Senior Community Safety Officer	Northumberland County Council
Les Gilbert	Road Safety Officer	Northumberland County Council
Margaret Tench	Designated Nurse Safeguarding Children	Northumberland CCG
Carol Leckie	Team Manager – Health & Wellbeing Team	Northumberland County Council
Kay Vincent	Senior Manager for 0-19 Services (Health Visiting & School Nursing)	Northumbria Healthcare NHS Trust
Emma Shields	Health Improvement Practitioner - You're Welcome Support and Participation Lead	Northumbria Healthcare NHS Trust
Julie Young	Housing Services Manager	Northumberland County Council (on Distribution List)
Diane Munro	Housing Policy Officer	Northumberland County Council (on Distribution List)
Mary Connor	Senior Manager - Early Intervention and Prevention	Northumberland County Council (on Distribution List)
Caroline Friend	VCS Development Worker	Voices Northumberland (On Distribution List)
Rachel Micheson	Head of Commissioning	Clinical Commissioning Group (CCG) (On Distribution List)

(Additional members will be invited as appropriate to facilitate the work of the Reference Group)

Membership of Local Child Safety Groups

Membership will include partners who have a responsibility and role in preventing or responding to unintentional injury in children including; Health Visitor, School Health Advisor, Police, Fire and Rescue, Play Representative, Sport and Leisure Representative, Child Care Development Worker, Early Years Representative, Childminder's Representative. Other members as locally decided.

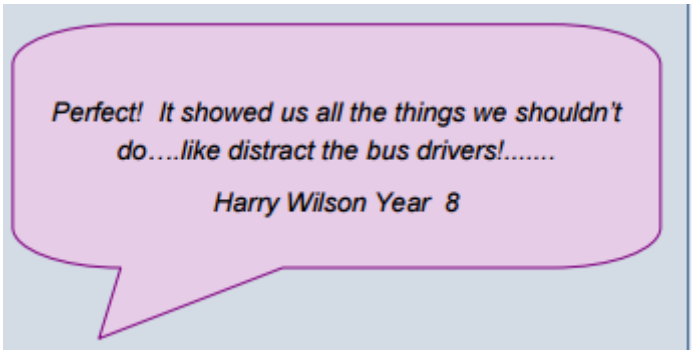
Appendix 3

'Josh Green Posted on Your Wall' Year 8 and Year 9 North East Tour 2014 – Evaluation

Objectives

Theatre& were contacted by the Road Safety Teams at Gateshead, Newcastle and North Tyneside, Northumberland, South Tyneside, and Sunderland Councils to deliver a five week tour predominantly to Year 9 Students. Focusing on pedestrian safety, and supported by a multimedia backdrop, the event confronted and explored the common factors relating to the consequences of irresponsible pedestrian behaviour.

To achieve this **Theatre&** developed a powerful and challenging piece of theatre, which brought to life the serious issues young people face on our roads or when using public transport. An interactive workshop further embedded the key messages of the performance and explored the main messages in more detail.



(Y8 Student Haydon Bridge)

Key learning outcomes were a greater understanding of:

- Pedestrian safety is not just about walking (public transport)
- Distractions (iPod's/mobile phones/showing off)
- Risk- taking and misadventure (near misses)
- Impaired decision making because of alcohol or substance misuse
- Coping with and challenging peer pressure
- The consequences of our actions (how our behaviour impacts on others)
- Challenging and changing attitudes and popular misconceptions (e.g. 'it won't happen to me')

Overview

- 50 schools booked the performance/workshop but unfortunately 2 were cancelled.
- 49 performances/workshops were delivered in total
- Over 6,800students saw the performance and took part in the workshop

Key Evaluation Outcomes

Students & Adults

- 23.1% of students think that messing about on the pavement is dangerous or very dangerous
- 7.2 % more students think texting or wearing headphones when crossing the road is dangerous or very dangerous
- 37% more students think that messing about on a bus is very dangerous
- 85.7 of students will now always or often think about the effect their behaviour can have on others
- 64.2% of students have increased confidence to challenge peer pressure always or often
- 68.9% of adults felt that our performance and workshop was much better or better than others they have seen
- 97.3% of students feel that the performance and workshop has made them think more about road safety
- 100% of teaching staff think the presentation has been beneficial for students

Appendix 4
Priority Themes promoted in 2015

Poisons

It is estimated a minimum of 1,208 parents/carers accessed poisons information through events, parent groups or by generally attending Children's Centres in Northumberland.

Presenting information

The parents/carers were provided with relevant information through discussions, leaflets and interactive games and during regular group sessions with additional provision at local library story sessions, 4 Dads event and in family homes. The key messages focused on:-

Medication e.g. cold remedies, paracetamol, ibuprofen
Household cleaning products eg liquid-tabs,
Button batteries
Handbag contents

Parents/Carers said….

"I never knew that about batteries, I'm going home to check what they are in"
"I can't believe how much of a hazard the contents of my handbag could be to my child"
"These displays are always eye catching and make me aware of every day hazards that I wouldn't have given a second thought too"
"Showing pictures of what really happens really makes you think"
"The information on the display refreshes your memory about every day dangers"
"Ever since seeing the liquid tabs on the display I notice them all the time on the television and how the bright colours are inviting for the children"
"The handbag information made me think more about the risks involved"
"I enjoyed finding answers on the display and validating my knowledge, confident in my ability to inform others of risks"
"Anything I was unsure about, the poisoning display board located in the setting helped me understand"
"It is a hard point to get across as shown by the number of children who attend A&E with poisoning. Any attempt to get the message across helps"

Choking

228 families were counted as accessing choking information through parent groups and a minimum of 722 accessed information whilst passing through Children's Centres in Northumberland.

Presenting information

Families were provided choking information through discussions, leaflets, information packs, interactive activities that focused on the following areas:

Choosing age appropriate toys and encouraging older siblings to keep their toys with small parts away from younger family members.

Being aware of small items such as buttons, coins, batteries, pen tops, cleaning wipes, tampons, deflated and burst balloons, marbles, boiled sweets, jewellery.

Supervising children when eating, not prop feeding, cutting food into baton shapes instead of balls, avoiding nuts particularly peanuts due to a release of aracus oil.

Groups watched demonstrations of the choking doll then practiced removing an obstruction, the ambulance service provided additional advice and demonstrations. Parents were shown choking tubes to show the size of a young child's windpipe and looked at types of foods more likely to create a blockage.

Parents/Carers said….

"I didn't know to put the baby on my knee so the pressure would help get the obstruction out"
"I was worried about breaking bones"
"I know to keep the small batteries away from where she can reach them"
"The information on the display refreshes your memory about every day dangers"

Falls

It was estimated that a minimum of 1185 parents/carers accessed information on falls whilst attending Children's Centres in Northumberland.

Presenting information

Information was provided via displays, leaflets, sporty Friday events and parents groups which included practical activities.

The key mechanisms were questions to generate discussion and share personal experiences focusing on the following:

- Is our child at risk of a serious fall?
- during tidy time informal awareness raising of keeping floors clutter free
- visual images
- identifying appropriate safety equipment and recommended use
- considering prevention actions such as not placing furniture and large plants next to windows
- presenting current Northumberland A&E data

Parents/Carers said they learnt....

"Of dangers around their home"
"They need to make sure there is no clutter on stairs"
"How surprised they were the recommended age for using a cabin bed was 6"
"To make sure safety straps are always used"
"What to do when my child has a fall"
"Now my baby is mobile how he is more at risk of falls"
"Everyday things can cause accidents with children"
"The session on falls was very informative and had provided an information refresher"
"To be more aware of trips and falls"

Appendix 5

Halloween Press Release (October 2016)

With Halloween parties and trick or treating just around the corner, Northumberland Fire and Rescue Service (NFRS) is reminding parents be aware of potentially flammable fancy dress costumes.

Halloween costumes are classed as toys and are not tested in the same way as normal clothes. Many of the costumes have been found to ignite and burn at a rapid pace posing a serious fire risk to children.

Firefighters across the country are encouraging parents to check their children's fancy dress costumes and look out for the manufacturer's name, address and telephone number and a registered trademark.

Halloween costumes should be purchased from a reputable seller and should be accompanied by instructions and safety information.

Anyone wearing a costume should keep away from naked flames and parents are encouraged to use LED candles in pumpkins and other decorations to reduce risk.

Councillor Dave Ledger, deputy leader of Northumberland County Council with responsibility for the fire and rescue service said: "Halloween costumes are often made of flammable materials which could cause life changing injuries if they are caught with a naked flame.

"Parents must be cautious when buying fancy dress costumes and remember that cheaper products are more likely to be counterfeit and could burn quickly if they catch fire.

"We're also urging parents to swap dangerous naked flames in decorations and lanterns for battery operated lights which are much safer"

If clothing catches fire remember to STOP, DROP and ROLL.

- Stop where you are and do not run
- Drop to the ground and lay flat with your legs out straight
- Cover your eyes and mouth with your hands
- Roll over and back and forth until the flames are out
- Get help straight away

Annex 1

Good practice for child passenger safety
Child passenger restraints
Legislation of safe child passenger restraints
Community-based interventions combining information dissemination on child passenger restraint safety with enhanced enforcement campaigns
Community-based interventions combining child passenger restraint distribution ,loaner programmes or incentives with education programmes
Seat belts
Legislation requiring seat belt use in older children

Good practice for child pedestrian safety
Area wide engineering solutions to reduce pedestrian risk (including pedestrian facilities and/or traffic calming infrastructure)
Vehicular modifications to reduce the risk of pedestrian fatalities (e.g. safer car fronts)
Legislation / policy reducing vehicle speeds in residential areas
Enforcement of legislation / policy reducing vehicle speeds in residential areas
Community-based education / advocacy programmes to prevent pedestrian injuries in children 0-14 years
Pedestrian skills training to improve child pedestrian road crossing skills
National implementation plans which comprise a wide range of measures: low speed limits, speed reduction measures, promotion of secondary safety and publicity aimed at both children and their parents and drivers

Good practice for child cyclist safety
Use of bicycle helmets
Area wide engineering solutions and traffic calming measures (e.g. speed reduction zones)
Area wide engineering solutions to reduce cyclist risk (including cycling lanes and pathways)
Legislation of bicycle helmets
Community-based education / advocacy programmes around child helmet wearing
Cycling skills training to increase knowledge and riding skills in the children

Good practice for child water safety
Use of a personal floatation devices (PFD) for boating and other water recreational activities
Signage regarding safe behaviours around water displayed using clear and simple signs
Legislation requiring isolation fencing with secure self-latching gates for all pools public, semi-public and private including both newly constructed and existing pools
Safety standards for swimming pools
Lifeguards (adequately staffed, qualified, trained and equipped)

Community-based education / advocacy to increase PFD use
Water safety skills training (including swimming lessons) to improve swimming performance

Good practice for fall prevention in children
Window safety mechanisms to prevent children from opening windows, such as bars and position locking devices
Stair gates at the top of stairs in households with small children
Surfacing materials such as sand or wood chips to a depth of 23-31 cm (9-12 inches) under playground equipment. Optimal equipment height to reduce risk of head injury is 1.5 m (5 feet)
Legislation banning baby walkers OR requiring product modification to remove the mobility issue
Enforcement of standards requiring safe depth of specified types of surfacing materials under playground equipment and regular maintenance of those materials
Educational programmes encouraging use of fall prevention safety devices such as window safety mechanisms to prevent children from opening windows and down stairs

Good practice for burns & scald prevention in children
Product modification, specifically child resistant cigarette lighters and self-extinguishing cigarettes
Legislation requiring a safe pre-set temperature for all water heaters
Legislation requiring installation of smoke detectors in new and existing housing combined with multi-factorial community campaigns and reduced price coupons
Legislation regulating flammability of sleepwear
Legislation banning the manufacture and sale of fireworks combined with enforcement
Smoke detector give away programmes targeting high-risk neighbourhoods and multi-faceted community campaigns with specific objective of installation of working smoke detectors
Education / advocacy campaigns around fireworks are useful as supplemental efforts and can be used to build support for legislation
Fire safety skills training to increase knowledge and behaviour of both children and parents

Good practice for poisoning prevention in children
Secure storage for poisons
Legislation of child resistant packaging
Poison control centres with education of public regarding the use of centre

Good practice for choking / strangulation prevention in children
Product modification of existing entrapment hazards such as crib/cot design and enforcement through legislation
Product banning of unsafe products through legislation
Legislation requiring product warning labels to include an explanation of the specific hazard

Good practice for general child home safety
Home safety counselling (addressing issues such as using window bars, stairgates, other home safety equipment and not using baby walkers ,bath seats and other injury hazard producing equipment)
Home based social support, such as home visiting programmes for new mothers
Individual-level education/counselling on unintentional childhood injury prevention in the clinical setting

Good practice for general community-based child injury prevention
School based injury prevention education to increase safety-related knowledge and behaviour
Interactive education and training approaches for children

Good practice for country leadership, infrastructure and capacity to support child injury prevention
Capacity building activities such as conferences, workshops and continuing education programmes
National leadership to establish direction and develop a vision of the future ,develop change strategies, align people, inspire, energise
The collection and dissemination of data to support monitoring and evaluation of injury prevention programmes and the development of policy and practice

Engineering (modification of a product/ environment),

Enforcement (policy/legislation and measures to ensure compliance), or

Education (education/behaviour change strategies).

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