Blackburn with Darwen Accident Prevention Strategy 2014-2017

Preventing unintentional injuries across the population
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‘Given the wider determinants that influence children’s safety and wellbeing—including families and parenting, housing and the built environment, roads and traffic, and community development—there is strong evidence of the need for effective joint working to reduce unintentional childhood injury. The experience of successful local partnerships confirms that a coordinated approach contributes to the achievement of wider health and wellbeing benefits for children and young people.’

Child Accident Prevention Trust, 2012
Executive Summary

Accidental injuries are the leading cause of preventable, premature mortality in the UK; equating for a quarter (23%) of all preventable years of life lost in 2010 to people up to the age of 60.\(^1\) This figure is ahead of preventable years of life lost to preventable cancers, suicide and alcohol-related causes.\(^1\) This is mainly because of the age of the individuals when accidents occur (ie many occur in childhood), whereas the preventable years of life lost are in relation to predominantly adult diseases. Therefore, there is such a large scope to change this situation.

Out of 150 local authorities in England, Blackburn with Darwen has:

- the 11th highest rate of hospital admissions due to injury in children aged 0-14\(^2\)
- the 27th highest rate of hospital admissions due to injury in children aged 15-24 in England
- the 2nd highest rate of children killed or seriously injured in road traffic accidents
- the 45th highest rate of hospital admissions due to falls in people aged 65+ years\(^3\)

All of which are significantly higher than the England average.

Evidence points towards increasing inequalities between socioeconomic groups, with areas of higher deprivation having a higher incidence of accidental injury.\(^4\) This social class gradient is greater in accidental injury than for any other cause of childhood death or long term disability.\(^5\) According to Public Health England,\(^6\) Blackburn with Darwen is the 15th most deprived Local Authority in England, presenting great challenges for accident prevention.

In addition to the human and emotional aspects, reducing accidents can make significant financial cost savings related directly to hospital admissions, health and social care. Wider than this, the cost of accidental injury is also borne by other public sector services such as transport, the police, fire and rescue services and the criminal justice system.\(^7\) Injuries also have high indirect, ‘human costs’ including enforced absence from school for children and young people, and the need for supervision or care during recovery for all age groups, which often involves family and carers taking time off from paid work.

The development of a local, multi-agency Accident Prevention Strategy supports commitments made within the Blackburn with Darwen Joint Health and Wellbeing Strategy\(^8\) in programme areas 1, 3, 4 & 5. The Accident Prevention Strategy will also contribute towards key accident related indicators in the Public Health Outcomes Framework 2013-2016.\(^9\)

A number of consultation and engagement activities have been undertaken to define priorities and action plans, which have influenced the strategy; ensuring that protected groups are appropriately
represented and voices of local people influence the local action plans. This includes a number of workshops, half day strategic vision event with key stakeholders and public engagement through focus groups and individual interviews appropriate to each of the priority areas.

Taking a population level approach to accident prevention, from ‘cradle to grave’, is ambitious, requiring commitment and strong leadership from all members of the Accident Prevention Strategy Group. This strategy takes a whole systems approach and considers all opportunities to reduce the prevalence and impact of accidents for local people. The strategy makes strong links between accidents and the wider determinants of health, setting out actions which have the potential to impact positively not just on accidents but also on other health improvement priorities including emotional health and wellbeing, social isolation and loneliness, physical activity and drug and alcohol use, offering the ‘added value’ possible from taking a public health approach with multi-agency collaboration, and linking with other strategies and key plans.

This Accident Prevention Strategy offers a range of interventions which are relatively easy to implement, and facilitates partnership working to reduce duplication and improve the efficiency and effectiveness of services aimed to reduce accidents. This approach is proven to show reasonably quick success in the reduction of accidental injury and the related personal, social and financial costs. Local partners are committed to reduce the incidence and associated harm of accidental injuries in Blackburn with Darwen, with a range of initiatives and services already in place to address the challenges faced across the lifecourse of residents. These include a Falls Prevention Service, a multiagency ‘Safety First’ scheme for children aged 0-5 years, and targeting of limited resources for road safety to where they are most effective including over 400 targeted streets which already have 20mph speed limits.

The strategic aims of this Accident Prevention Strategy have been based on the recommended priority areas as set out by The Royal Society for The Prevention of Accidents and on local discussions at multi-agency workshops, Accident Prevention Strategy Group and sub-groups. They are also based on national trends, intelligence and local needs assessment to capture the stories of local people. Overall, The Strategy aims to prevent and reduce accidental injuries across the lifecourse for all residents of Blackburn with Darwen, through greater partnership and collaborative working, by utilising the best available evidence of the problems in our community and what is known to work.
Key Strategic Priorities and Aims

The overall strategy objective is to *prevent and reduce accidental injuries across the lifecourse for all residents in Blackburn with Darwen* through greater partnership and collaborative working, by utilising the best available evidence of the problems in our community and what is known to work. There are four priority areas, each with a number of aims:

**Priority 1: Accidental Injuries to Children Aged 0-5 Years in and around the Home**

*Every child in our country should have the same right to life, regardless of where they live*

Aims:
- To support families and carers of young children to take protective steps to reduce the risk and incidence of accidental injuries to children aged 0-5 in any home environment
- To reduce inequalities in the prevalence of accidental injuries in this age group and ensure that interventions meet the needs of the most vulnerable as well as the wider population

**Priority 2: Accidental Injuries to Young People in their Leisure Time**

*We all want to live in a safe society, where young people can play and enjoy activities local to where they live*

Aims:
- To work with young people, their families and carers to ensure that young people are protected from un-necessary risks of accidental injuries in their leisure time
- To provide young people with the skills and resilience needed to respond appropriately to situations of risk, in order to avoid accidental injury
- To ensure that leisure activities for young people are accessible, affordable and safe and that they meet their needs, at a time and place which is appropriate
Priority 3: Accidental Injuries as a Result of Road Traffic Incidents

We want an environment where pedestrians, cyclists and drivers can move together... reducing danger and encouraging more people to travel by active, health promoting modes.

Aims:
- To reduce the number of adults and children killed, seriously or slightly injured on our roads.
- To offer added value of public health interventions which bring together multi-agency collaboration to improve effectiveness and cost efficiency, and utilise an assets based model to empower and support local people to address their own road safety needs.
- To support and encourage alternate methods of travel including walking, cycling and public transport.
- To ensure that local road safety interventions reflect local needs through the use of data and residents stories.

Priority 4: Accidental Injuries to People Aged 65+ in the Home

We want to enable people to live safely in their homes.

Aim:
- To reduce the number of accidental injuries for people aged 65+ in the home environment.
- To build upon the existing knowledge of the impact of falls in older people and local need, considering also the wider impact of other injuries on older people, their confidence, independence, quality and quantity of life.
- To support older people, their families and carers to build their knowledge of local services which can help them to reduce the risk of accidental injury and ensure that this service provision meets local need.
### Accident Prevention Strategy: Plan on a Page

#### Challenges
- Continuing poverty, deprivation and disadvantage
- Diverse population
- High rate of injury related admissions for children under 18 years
- Lack of previous co-ordination of accident prevention activities across all agencies in Blackburn with Darwen
- High rate of children killed or seriously injured on the road
- Higher than England’s average rate of falls for people aged 65+ years
- An aging population and increasing number of older people needing support

#### Priority Actions

**Programme Area 1: Accident injuries to children aged 0-5 years in and around the home**
- A universal and targeted approach to home safety assessment through all partner agencies including the voluntary, community and faith sector
- Home safety equipment provision and fitting
- Building regulations for new and refurbished properties
- Support and lobby for appropriate safety regulations in line with RoSPA campaigns
- To review the treatment pathways for children following an accidental injury
- Paediatric basic life support and first aid training for parents, families and carers

**Programme Area 2: Accidental injuries to young people in their leisure time**
- Review of local services and organisations who provide education and support to young people around risk taking behaviours
- Establish links with accidental injuries on the roads agenda for young people in their leisure time
- Introduce risk-benefit assessment as an alternative to standard risk assessment for all partners
- Local co-ordination of leisure activities for young people, their family and wider communities
- Ensuring that wider health and wellbeing services meet the needs of local young people

**Programme Area 3: Accidental injuries as a result of road traffic incidents**
- A local road safety partnership for Blackburn with Darwen to include wider partners, taking a lifecourse approach
- Community mobilisation
- Promote a unified zero tolerance approach to accidents and injuries on the roads in Blackburn with Darwen
- Ensuring appropriate speed limits and parking on all our roads across the Borough
- Using existing intelligence to implement interventions at a neighbourhood level
- Alternative methods of travel

**Programme Area 4: Accidental injuries to people aged 65+ in the home**
- Falls prevention measures
- Respond to emerging intelligence about local needs relating to accidents for older people
- Understanding wider accidents for older people
- Strengthen the existing networks of local services within Blackburn with Darwen who provide services to older people which reduce the risk of accidental injury
- Tackle social isolation and loneliness for older people
- Address alcohol consumption by older people and its relationship to accidental injury for older people

#### Key Outcome Measures

**Public Health Outcomes Framework**
- 10% reduction in rate of “Killed and seriously injured casualties on England’s Roads (all ages)”
- 10% reduction in rate of “Hospital admissions caused by unintentional and deliberate injuries in children (aged 0-4 years)”
- 20% reduction in rate of “Hospital admissions caused by unintentional and deliberate injuries in young people (aged 15-24)”
- 10% reduction in rate of “Injuries due to falls in people aged 65 and over”
- 10% reduction in rate of “Injuries due to falls in people aged 65 and over- aged 65-79”
- 10% reduction in rate of “Injuries due to falls in people aged 65 and over- aged 80+”

**Child Health Profile**
- 10% reduction in rate of “Children Killed or Seriously Injured in Road Traffic Accidents”
- 15% reduction in rate of “A&E Attendances (age 0-4 years)”
Governance

The accountability of the Accident Prevention Strategy is the responsibility of Blackburn with Darwen’s Accident Prevention Strategy Group, which is chaired by a representative from Public Health in the Borough Council. The membership comprises key partners and stakeholders, as outlined in Appendix A, and it is each members’ responsibility to ensure that as the Strategy develops, they engage and liaise with their organisation, community and peers to ensure wide cascade and ownership of The Strategy. This strategy will be achieved through the development of detailed yet dynamic action plans, each with identified leads, based upon evidence and local consultation. The identified leads will oversee the implementation of The Strategy as a whole, the monitoring and review of associated outcomes and the evaluation of The Strategy’s overall effectiveness. The Strategy and Action Plan implementation groups will be accountable to the Blackburn with Darwen Joint Health and Wellbeing Board, and will produce quarterly reports of Action Plan progress through Health and Wellbeing Board quality structures.

Action plans for each priority area have been drafted and will be updated periodically to reflect emerging evidence and local intelligence. These action plans will complement other strategic plans where accident prevention is a key issue:

- Blackburn with Darwen Joint Health and Wellbeing Strategy
- Community Safety Partnership’s Strategy
- Emotional Health and Wellbeing Strategy
- Transforming Lives (Early Action)
- Blackburn with Darwen Early Help Strategy
- Children’s Partnership Plans
- Alcohol Strategy
- Local Strategic Partnership 2030 Vision
- Local Authorities Corporate Aims and Objectives
- Workforce Wellbeing Plan (currently being developed)
- Young People’s Strategy (currently being developed)

EIA and HIA has been completed alongside the development of this Accident Prevention Strategy. Through this process, and the development of the local needs assessment, we consider the Protected Groups under The Equality Act 2010. It is acknowledged that in some areas, the level of research and evidence is relatively poor and more needs to be done to address this at a local and national level. There is limited local data available with regards to accidental injury at present and this will be addressed through engagement and consultation with local communities, keeping abreast of emerging evidence and intelligence and by ensuring that we utilise local data around accidental injury prevalence in protected groups as it becomes more readily available.
1. Introduction

‘Accidents are 100% preventable- so why not prevent them?’

The Royal Society for the Prevention of Accidents

This Strategy and action plan sets out the local, multi-agency response to address accidental injuries in Blackburn with Darwen. The Strategy and Action Plans take into account the local needs assessment which explores the current evidence base, national and local policy, the local injury profile and the links between accidents and the wider determinants of health. In the development of this Strategy, consideration had been given to current service provision so that a collaborative, multi-agency plan to reduce accidental injuries across the life span of residents within the population of Blackburn with Darwen can be realised to the benefit of everyone who lives and works here.

The use of a public health approach to accident prevention reflects emerging literature which supports the application of public health models, previously applied to reduce the incidence of preventable disease, to accidental injury prevention. A range of professional bodies have highlighted the staggering impact of accidents on preventable premature mortality in the UK, and the value of prioritising accident prevention within the wider public health agenda to the benefit of individuals, their families, communities and the wider UK economy.

Accident prevention offers a real opportunity to address health inequalities between socioeconomic groups, with areas of higher deprivation having a higher incidence of accidental injury. Inequalities in accidental injury are greater than for any other cause of childhood death or long term disability, presenting local challenges for accident prevention in Blackburn with Darwen.

Accident prevention interventions provide good value for money, are easy to implement and show reasonably quick success in the reduction of accidents; it makes sense to address accidental injuries. This strategy sets out our local, multi-agency action plan and commitment to reduce accident related health inequalities.
2. What do we mean by accidents?

There are a range of terms that are used to describe accidents in academic literature, policy and guidelines. National guidelines produced by NICE choose to say ‘unintentional injuries’ rather than ‘accidents’. An unintentional injury is any injury which has not been inflicted intentionally to oneself or another person.

The World Health Organisation (WHO) define an injury as:

“the physical damage that results when a human body is suddenly subjected to energy in amounts that exceed the threshold of physiological tolerance… The energy in question can be mechanical, thermal, chemical or radiated”.

Some literature and policy choose to use the term ‘unintentional injury’ because the term ‘accident’ implies an unpredictable or chance occurrence and therefore, unavoidable event, but in reality most injuries and their precipitating events are predictable and preventable.

The Public Health Outcomes Framework uses the term “unintentional and deliberate injuries in children and young people”.

In reality, the terms ‘unintentional injury’, ‘accidental injury’ and ‘accidents’ are, to some extent, interchangeable. However, the general population still regard the vast majority of unintentional injuries (falls, burns and scalds, fires, poisoning and choking) as ‘accidents’. Therefore in order to ensure that this strategy is meaningful to local people in Blackburn with Darwen, the term ‘accident’ will be used in the place of ‘unintentional injury’ throughout this Strategy and Action Plans. Local implementation will include engagement which focuses upon the fact that these events are preventable.

This Strategy and Action Plans are not intended to address intentional injuries, those which are intentionally self-inflicted or inflicted by others such as self-harm or childhood adversity. It is acknowledged that there may be some overlap in risk factors for accidental and intentional injuries which will be reflected in the action plans, through links made with safeguarding children and adult strategies and policies.
3. Why do we need to prevent accidents?
Accidents as a Public Health responsibility

Accidents are the principal cause of premature, preventable death for most of our lives. From birth to the age of 60, accidental injuries are the leading cause of preventable premature mortality with 23% of preventable years of life lost because of accidents in the UK. This figure is ahead of the number of preventable years of life lost for preventable cancers (21%), suicide (17%) and alcohol-related causes (12%) nationally.

Accidents are a major but preventable public health issue. Reducing accidents benefits society by preventing severe suffering, trauma and stress, in addition to providing huge financial savings. Prevention of accidental injury stops the cost of that injury and also stops the morbidity, rather than just reducing it as in the case of many other health promotion programmes.

For all ages, accidental injuries only account for 2% of all deaths. However, when considering the years of life lost (YLL) this increases to 11%; but when considering preventable years of life lost (PrYLL) for all ages, this increases further to a quarter (23%). See figure 3.1.

Figure 3.1: Proportion of accidents for all deaths, YLL and PrYLL
There is a need to address accidental injury in line with The Public Health Outcomes Framework 2013 to 2016, which sets out key indicators which relate directly to injuries across the lifespan. Most specifically relevant to this Strategy and Action Plans:

- Indicator 1.10: Killed and seriously injured casualties on England’s roads
- Indicator 2.24: Injuries due to falls in people aged 65 and over
- Indicator 4.14: Hip fractures in people aged 65 and over
- Indicator 2.7: Hospital admissions caused by unintentional and deliberate injuries in children and young people aged 0-14 and 15-24 years
- Indicator 4.3: Mortality rate from causes considered preventable

Other local and national policies and guidelines including Healthy Lives, Healthy People, The Marmot Review, NICE and Blackburn with Darwen Borough Council Health and Wellbeing Strategy detail the great potential impact of accident prevention programmes on population health and wellbeing, including those which address road traffic mortality and accidents experienced by children. These policies place importance upon co-ordinated, collaborative multi-agency working with strong local leadership, and empowerment of local communities to enable an asset based approach to behaviour change. Policy and guidelines underline the need to address inequalities in accidental injury, with particular focus upon socioeconomic deprivation as a predictor for increased rates of accidental injury. Initiatives and programmes need to support the development of infrastructure and engineering which facilitate healthier environments, alongside behaviour change of local populations. This local, multi-agency Accident Prevention Strategy supports commitments made within the Blackburn with Darwen Joint Health and Wellbeing Strategy in programme areas 1, 3, 4 and 5 because of the population level, systems based approach proposed.

There are high costs relating to accidents which include those for healthcare, social care, personal and wider economic costs. This Accident Prevention Strategy offers value for money opportunities for early intervention to reduce these costs to providers, individuals and the wider economy. Further detailed information relating to the wider policy context and costs of accidental injuries can be found in the Blackburn with Darwen Needs Assessment for Accidents (Appendix C).
4. Links to other Public Health agendas

Accidental injury prevention is not a concern which sits independent of other wider public health agendas. Accidental injury is strongly linked to the wider determinants of health and health improvement. Given these tangible associations, there is a need for effective joint working to reduce accidental injury, to provide added value to the advantage of wider health and wellbeing benefits.\(^{19,20,21,22,50,43,23,24,25,26,1,70,39,71,72,53,47,27,28}\)

**Tobacco Control and Smoking**

In 2010–11, 2,748 house fires were caused by smoking, killing 96 people and injuring more than 800; fires caused by smoking are a leading cause of fire injuries and deaths in the UK.

Public health interventions should support those ready to quit but also to reinforce safety messages to those who are not yet ready to quit (RoSPA, 2013a). Smoking cessation referrals can be made as part of a home safety assessment.

Smoking increases the risk of road traffic accidents due to distractions and delayed reaction times.

Children are at risk when they are in environments where others are smoking, through burns from cigarette lighters and poisonings through accidental chewing and swallowing of cigarette butts or E-Cig liquids (Leistikow et al, 2000a; Leistikow et al, 2000b; Lacobelli et al, 2008).

**Housing and Neighbourhoods**

Housing has a significant impact on children's safety. An unsafe environment increases the likelihood of accidents and injury, which could have implications for a child’s future, both physical and psychological.

Nearly half of all accidents involving children are associated with architectural features in the home. Housing in poor condition is more likely to contain hazards that could create an unsafe environment for a child, such as uneven floors or stairs, or faulty electrical wiring. Families living in properties that are in poor physical condition are more likely to experience a domestic fire but less likely to own a smoke alarm (Shelter, 2006).

Evidence suggests that environments containing older homes, with fewer amenities mean that children are more likely to play on the road, and coupled with high levels of on-street parking and high traffic volume, there are higher traffic injury risks (Christie, 1995).

**Deprivation**

There is a clear link between areas with higher levels of deprivation and a higher incidence of accidental injuries across all age groups and for all types of accidental injury, including those sustained as a result of road traffic incidents. Studies have also demonstrated that injuries can also increase socio-economic deprivation (Hippisley-Cox et al, 2002).

The reasons for this link have been attributed in literature to several factors including: overcrowded homes, lack of money to buy safety equipment, lack of a garden where children can play, greater exposure to through-roads and roads without parking, higher parental smoking rates, lack of accessible information, poor parental understanding of child development.
Obesity

Children are less exposed to traffic now than previously, as they are walking and cycling less (Racioppi et al, 2009). This increases health inequalities (Green & Edwards, 2008) and impacts on levels of physical activity and obesity.

There is recognition that many physical activities, whilst having a positive impact upon the reduction of obesity prevalence, can also increase the risk of accidental injury; therefore interventions to improve safety opportunities for activity can address both concerns.

A number of studies have concluded that for drivers of heavy commercial motor vehicles, being obese greatly increases the risk of being involved in a road traffic incident (Anderson et al, 2012).

There is evidence to suggest that that older people who are obese are more likely to fall, and some suggestion that any injury sustained will have a greater impact upon a person’s ability to maintain activities of daily living if they are obese (Himes et al, 2012).

Social Isolation and Loneliness

Reduction in social isolation and loneliness in older people has been shown to have a positive impact upon reducing the number of falls (Bernard, 2013). Furthermore, sustaining a fall is strongly linked to reduced mobility leading to social isolation and depression (DH, 2001); creating a cycle which links these two public health concerns for older people.

Motor vehicle traffic affects the ability of people to create and maintain social contact. One study showed that people who lived on streets with higher volumes of motorised traffic adapted by going out less and so had fewer friends and acquaintances on the street (RoSPA, 2014).

Social isolation and loneliness has traditionally been associated with older people. However, evidence points towards a growing number of children and young people who describe themselves as lonely or socially isolated (Windle et al, 2011; Collins & Wrigley, 2014). Across the lifecourse, but most notably in young people, social isolation and loneliness has been linked to an increased likelihood that a person will partake in risk taking behaviours (The Mental Health Foundation, 2010). These risk taking behaviours are linked with a greatly increased risk of accidental injury (RoSPA, 2012a).

Play and Physical Activity

There is some concern that an over-emphasis on children's safety limits their play, freedom of movement and development of relationships (Gill, 2007). There needs to be a better balance between protecting children from genuine threats and giving them rich, challenging opportunities through which to learn and grow. RoSPA (2012a) suggest that children should be "as safe as necessary, not as safe as possible" but that parents and educators have a responsibility to children and young people to ensure that they are able to make the distinction between manageable and unmanageable situations.

A parent, carer or child's perception of safety can influence the amount of time that children and young people spend on outdoor play and leisure activities. These perceptions can be influenced by the media. In addition, fear of litigation can influence the nature and extent of activities provided by educational and play organisations. We need to be careful that accident prevention strategies do not have a negative impact upon physical activity and healthy weight.

Drugs and Alcohol

Alcohol is a major contributor to unintentional injury in the UK; it is implicated in approximately one quarter of fatal injuries involving car users and pedestrians as well as being associated with falls, fires and drowning.

It is believed that around 30% of children in the UK live in a household with at least one binge drinking parent (Manning et al, 2009). In households where parents misuse alcohol, there is a higher risk of poor supervision, childhood injury and poor parental response to adverse events (Damashek et al, 2008).

Consumption of alcohol greatly increases a person's risk of accidental injury (McLeod, 1999). However, screening and treatment for alcohol as a cause of injury are often neglected at hospital admission (Hoskin et al, 2007). There is an emerging body of literature relating to Psychoactive Substances (legal highs) and risk of accidental injury, particularly for Young people who might be in in situations where they are vulnerable after consumption of these drugs (ICMD, 2011).

Alcohol misuse amongst older people is increasing, yet diagnosis and treatment of alcoholism are poor for this age group. Older people who drink large volumes of alcohol are at an increased risk of falling, due to the effects of alcohol, interactions with medicines and the impact of sensory deficits in older age.
5. Our vision and strategy

Development

The whole population approach and cross-cutting nature of this strategy means that responsibility for its development and implementation cannot sit with one single organisation. To develop and lead this strategy, The Accident Prevention Strategy Steering Group has been established with strategic representation from partner organisations. Expert groups for each of the priority areas have also been established, to ensure that the strategy becomes meaningful actions for local people and services.

The local multi-agency Accident Prevention Strategy for Blackburn with Darwen is informed by The Big Book of Accident Prevention and The RoSPA Accident Prevention Handbook\textsuperscript{29}, alongside NICE guidance, The World Report on Child Injury Prevention\textsuperscript{30}, Marmot Review and a review of published literature including systematic reviews from the Cochrane Collaboration.

This Strategy has undergone a wide and thorough engagement process to ensure the views of partner agencies, service users and the residents of Blackburn with Darwen are incorporated and that it is embedded within the practice of all partners. A Strategic Vision Event attended by strategic managers within partner organisations, focus groups with local people around the four priority areas and social and digital media have been utilised to capture views of local people and partner agencies.

Furthermore, The Strategy has undergone extensive consultation with key multi agency/ single agency committees prior to ratification. Public engagement and consultation has been supported by a full communication plan, including press and use of online, social and digital media.

Delivery, monitoring and review

Delivery of this Strategy will be overseen by the Accident Prevention Strategy Group and expert steering groups for each programme area. Action plans have been, and will continue to be, developed with a range of tasks required to implement this strategy. Through such action plans, it will be possible to determine progress against the Strategy’s aims and objectives. These plans will be regularly reviewed to ensure that the work is undertaken, that it continues to be informed by the needs assessments undertaken in the Borough and that interventions are evidence based. Action plans will also be updated to reflect changes in local delivery structures, national legislation and national and local policy.

We will ensure that information is shared with local communities about what partners are doing to address the harm through accidental injuries in the Borough through continued community engagement work.
Links to strategic priorities

There are a number of strategic priorities that are driving forward this Strategy, including:

- Reduce the incidence of accidental injuries and deaths across the lifecourse for local people in Blackburn with Darwen
- Improve the emotional health and wellbeing of children and young people in Blackburn with Darwen
- Support older people to remain independent for longer and reduce social isolation and loneliness

The nationally produced Public Health Outcomes Framework provides a model from which our outcomes are developed:

Domain 1:
Improving the wider determinants of health
  i. Killed and seriously injured casualties on England’s roads
  ii. Utilisation of outdoor space for exercise/health reasons
  iii. Social isolation

Domain 2:
Health improvement
  i. Hospital admissions caused by unintentional and deliberate injuries in children and young people aged 0-14 and 15-24 years
  ii. Self-reported well-being
  iii. Injuries due to falls in people aged 65 and over

Domain 4:
Healthcare public health and preventing premature mortality
  i. Infant mortality
  ii. Emergency readmissions within 30 days of discharge from hospital
  iii. Health-related quality of life for older people
  iv. Hip fractures in people aged 65 and over
  v. Excess winter deaths
6. Our Priority Programme Areas

6.1 Programme Area 1: Accidental Injuries to Children Aged 0-5 Years in and around the Home

Every child in our country should have the same right to life, regardless of where they live.

Aims:
- To support families and carers of young children to take protective steps to reduce the risk and incidence of accidental injuries to children aged 0-5 in any home environment
- To reduce inequalities in the prevalence of accidental injuries in this age group and ensure that interventions meet the needs of the most vulnerable as well as the wider population

Measurable Outcomes (Public Health Outcomes Framework & Child Health Profile):
- 15% reduction: A&E Attendances (age 0-4 years)
- 10% reduction: Hospital admissions caused by unintentional and deliberate injuries in children (aged 0-4 years)
- 10% reduction: Hospital admissions caused by unintentional and deliberate injuries in children (aged 0-14 years)

What You Said

- Parents of young children are worried about accidents
- Falls are the biggest cause for concern for children aged 0-5 years
- It often takes an adverse event to change behaviour
- Parents do not receive enough information or support to reduce the risks of accidents for their young children; this is noted to be a real gap for children aged 2 years and upwards
- Child safety equipment in the home is important but expensive
- Some parents would welcome a home safety assessment by an appropriately trained person; others would welcome self-assessment guidance and ‘top tips’ for the safety of the developing infant
- Social media and websites could be used to convey child safety messages
- Parents would generally consider either the GP or A&E following a childhood accident but had little awareness of other available Primary Care services

For information relating to this priority, see Appendix C, Needs Assessment
What We Know

- Unintentional injury is a leading cause of death and illness among children aged 1–14 years, and causes more children to be admitted to hospital each year than any other reason (The Audit Commission, 2007)
- In 2012/2013, there were 504 hospital admissions caused by injury in the 0-14 years age group in Blackburn with Darwen. This equates to an annual rate of 157.1 per 100,000 children, which is significantly higher than the England average of 103.8
- 16 wards in Blackburn with Darwen, have a higher rate of hospital admissions for injury in children aged 0-17 years than the England average. Evidence says that higher levels of deprivation are linked with higher levels of accidental injury.
- The most severe and preventable accidents that should be addressed for children aged 0-5 years are: choking suffocation and strangulation, falls, poisoning, burns and drowning (PHE, 2014)
- There is evidence that certain children are more at risk of accidents: children who live in areas of higher socioeconomic deprivation, parents with lower levels of education, who misuse drugs or alcohol, younger parents, parents with mental health problems and boys aged 0-5 years
- There is a need for better collation and access to accident data including A&E attendance, GP treatment and other primary care Services which provides significant challenges for Blackburn with Darwen

What Works

- Providing safe environments, not just focusing on individual behaviour change (Sethi et al, 2008)
- Installation of permanent home safety equipment including: stair gates, smoke and carbon monoxide alarms, thermostatic mixer valves and window limiters (NICE, 2010b)
- Home safety assessments for homes where children aged 0-5 reside (NICE, 2010b). NICE recommends that home safety assessments may be carried out by a trained assessor or by parents, carers and other householders using an appropriate checklist
- Improvements to home safety standards for new and refurbished homes (RoSPA, 2005)
- Community based interventions focused on changing community values and behaviours, and altering the physical environment

What We Will All Do

1. Improve home safety and reduce the risk of accidents
   a. A universal and targeted approach to home safety assessment through all partner agencies including the voluntary, community and faith sector
   b. Home safety equipment provision and fitting
   c. Building regulations for new and refurbished properties: all new homes built or refurbished in Blackburn with Darwen comply with enhanced standards as set out by The Royal Society for the Prevention of Accidents (Appendix C)
   d. Explore opportunities to extend action plans to include safety outside of the home
   e. Support and lobby for appropriate safety regulations in line with RoSPA campaigns

2. Improved outcomes following an accidental injury
   a. To review the treatment pathways for children following an accidental injury
   b. Paediatric basic life support and first aid training for parents, families and carers
6.2 Programme Area 2: Accidental Injuries to Young People in their Leisure Time

We all want to live in a safe society, where young people can play and enjoy activities local to where they live

Aims:
- To work with young people, their families and carers to ensure that young people are protected from un-necessary risks of accidental injuries in their leisure time
- To provide young people with the skills and resilience needed to respond appropriately to situations of risk, in order to avoid accidental injury
- To ensure that leisure activities for young people are accessible, affordable and safe and that they meet their needs, at a time and place which is appropriate

Measurable Outcomes (Public Health Outcomes Framework):
- 10% reduction: Hospital admissions caused by unintentional and deliberate injuries in children (aged 0-14 years)
- 20% reduction: Hospital admissions caused by unintentional and deliberate injuries in young people (aged 15-24)

What You Said
- Young people prefer to spend their leisure time in parks and the town centre rather than in organised activities
- There are not enough dedicated informal young person’s buildings
- There is not a lot of information about risk management and that which is available is patronising
- Young people should lead education programmes around accidental injury, using local case studies to make the dangers more real
- Young people might not go to their parents following an accident if it was embarrassing
- There is not enough information available about organised leisure activities in Blackburn with Darwen: a website, FaceBook page or smartphone app. is needed
- Young people do not have a voice to influence local leisure activities
- The new Skate Park in Darwen is a highly positive and well received development
- Young people have a good understanding of the benefits of participating in organised leisure activities but blockages to accessing these include cost, transport and location
- Young people want more activities near to home

For information relating to this priority, see Appendix C, Needs Assessment
What We Know

- The risk of accidents in this age group is highest for young people who are: male, using drugs or alcohol, living in the most socio-economically deprived areas, socially isolated or lonely or have poor emotional health and wellbeing.
- In 2012/2013, there were 329 hospital admissions caused by injury in the 15-24 years age group in Blackburn with Darwen. This equates to an annual rate of 167.0 per 100,000 children, which is significantly higher than the England average of 130.7.
- In the North West:
  - Rates of emergency admissions for accidental poisoning are highest among children aged 15-19 years with a rate of 71.1 per 100,000 population.
  - Emergency admissions for pedal cyclists injured in transport accidents are highest among those aged 10-14 years with a rate of 124.5 per 100,000 population.
  - The rate of emergency hospital admissions for while car occupants and motorcycle occupants injured in transport accidents peaks at age 15-19 years.
- Data for accidents to young people is limited and analysis is made difficult as the vast majority of injury attendances in A&E for this age group are coded as ‘other injury’.
- There are emerging risks relating to the use of Psychoactive Substances (legal highs) and the risk of accidental injury through young people putting themselves in situations where they might be vulnerable.
- The personal and financial costs of accidents in this age group are the highest for serious traumatic injury. By addressing the most severe accidents in this age group rather than the most common (which often result for sporting activities) we can have the greatest impact without negatively impacting on healthy behaviours.

What Works

- ‘Learning about safety by experiencing risk’ LASER activities.
- Moving to a ‘Risk-Benefit’ assessment of leisure activities and away from the traditional risk assessment.
- Targeting off road cycle safety, water safety and firework safety.

What We Will All Do

1. Support young people to manage risk taking behaviours to reduce accidental injuries
   a. Review of local services and organisations who provide education and support to young people around risk taking behaviour.
   b. Establish links with accidental injuries on the roads agenda for young people in their leisure time.
   c. Introduce risk-benefit assessment as an alternative to standard risk assessment for all partners.

2. Safe and fun leisure activities for children and young people
   a. Local co-ordination of leisure activities for young people, their family and wider communities.
   b. Ensuring that wider health and wellbeing services meet the needs of local young people.
6.3 Programme Area 3: Accidental Injuries as a Result of Road Traffic Incidents

“We want an environment where pedestrians, cyclists and drivers can move together... reducing danger and encouraging more people to travel by active, health promoting modes"  

Aims:  
• To reduce the number of adults and children killed, seriously or slightly injured on our roads  
• To offer added value of public health interventions which bring together multi-agency collaboration to improve effectiveness and cost efficiency, and utilise an assets based model to empower and support local people to address their own road safety needs  
• To support and encourage alternate methods of travel including walking, cycling and public transport  
• To ensure that local road safety interventions reflect local needs through the use of data and residents stories  

Measurable Outcomes (Public Health Outcomes Framework & Child Health Profile):  
• 10% reduction: Killed and seriously injured casualties on England’s Roads (all ages)  
• 10% reduction: Children Killed or Seriously Injured in Road Traffic Accidents  

What You Said  
• We all have a responsibility to make the roads safer and reduce accidents; individual behaviour change needs to be supported by actions of agencies and partners  
• A growing number of parents do not use child car seats because they are too expensive or because they cannot fit three child car seats in the back of a standard 5 seat car  
• Speeding cars make you feel unsafe in your local area  
• Local communities know their own local road safety problems, but sometimes feel powerless to influence changes  
• Some families would prioritise the price a taxi firm over the level of safety provided by that firm  
• Good parenting is essential to keep children safe on the roads but not all parents teach their children road safety messages  
• Lower speed limits on residential roads are ‘brilliant’ but are not adhered to by many drivers  

\(^c\) For information relating to this priority, see Appendix C, Needs Assessment
What We Know

- The risk of accidents on the roads highest for: young people, rural roads, males, 30mph roads, 60mph roads, people living in socio-economically deprived areas
- Many positive steps have been made through local casualty reduction initiatives to reduce the number of children killed and seriously injured on the roads in Blackburn with Darwen. The rate of per 100,000 children killed & seriously injured in Blackburn with Darwen have been reduced by 58% against a baseline originally set in 1994-1998 (Capita, 2014), in line with the national requirement of 50%
- Children living in the 10% most deprived wards are 5 times more likely to be involved in a road traffic collision than those living in the 10% most affluent wards (RoSPA, 2012a)
- Between 2010-2012, Blackburn with Darwen had the second highest rate (per 100,000 children) of children killed or seriously injured on the roads out of 160 local authorities in England (PHE, 2014)
- Children in the 0-5 years age group are most likely to be injured as a pedestrian or car occupant
- The risk of being injured in a road traffic incident greatly increases in the 16-20 age group and remains high until 45 years of age
- The risk of being injured as a pedal cyclist is highest in the 6-10, 11-15, 26-35 and 36-45 years age groups
- For people aged 56+ years, the risk of being injured on the road is greatest as a car occupant (driver or passenger), closely followed by pedestrians
- Blackburn with Darwen have a range of measures in place to target limited resources for road safety to where they are most effective including over 400 targeted streets which already have 20mph speed limits

What We Will All Do

1. Road Safety
   a. A local road safety partnership for Blackburn with Darwen to include wider partners, taking a lifecourse approach
   b. Community mobilisation
   c. Promote a unified zero tolerance approach to accidents and injuries on the roads in Blackburn with Darwen

2. Road Design and Modification
   a. Ensuring appropriate speed limits and parking on all our roads across the Borough
   b. Using existing intelligence to implement interventions at a neighborhood level
   c. Alternative methods of travel

What Works

- Maintaining and managing a local road safety partnership to improve collaborative working
- Carrying out local road safety reviews and public consultations at least every three years
- Using needs assessment to underpin road safety programmes
- Measures to reduce speed including 20mph zones and limits. Promote and enforce speed reduction interventions
- Using community assets through empowering and supporting local communities to effect change to road safety; supporting the Community, Voluntary and Faith Sector to play a leadership role in road safety programmes
6.4 Programme Area 4: Accidental Injuries to People Aged 65+ in the Home

'We want to enable people to live safely in their homes'

Aim:
- To reduce the number of accidental injuries for people aged 65+ in the home environment
- To build upon the existing knowledge of the impact of falls in older people and local need, considering also the wider impact of other injuries on older people, their confidence, independence, quality and quantity of life
- To support older people, their families and carers to build their knowledge of local service provision to reduce the risk of accidental injury and ensure that this service provision meets local need

Measurable Outcomes (Public Health Outcomes Framework & Child Health Profile):
- 10% reduction: Injuries due to falls in people aged 65 and over
- 10% reduction: Injuries due to falls in people aged 65 and over- aged 65-79
- 10% reduction: Injuries due to falls in people aged 65 and over- aged 80+

What You Said
- The most common accident for people aged 65+ years is a fall; followed by burns sustained by lifting pans of heavy water
- Older people are very proud and find it difficult to acknowledge their limitations, this leads to risk taking and accidents
- You don’t know about all the services in Blackburn with Darwen and how they might be able to help reduce the risk of accidents
- Some older people who are isolated are even less likely to know about or access preventative services
- Social networks are an important resource to reduce the risk of accidents and get help when you have one. Many people do not know their neighbours any more but mutual aid schemes would be well received
- Experiences and perceptions of Secondary Care Services might act as a barrier to seeking treatment following an accident; there is limited knowledge about alternative Primary care Services
- Many times that an ambulance is called following a fall, there is no need to go to hospital but family friends and neighbours had no alternative way to help that person up from the floor

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d For information relating to this priority, see Appendix C, Needs Assessment
**What We Know**

- The risk of accidents for older people is highest for: women, older people with multiple morbidities, taking 4 or more medications, sensory disorders, older people who are socially isolated or lonely, who smoke in the home or consume large volumes of alcohol, older people in winter
- Over 50% of accidental injury deaths, and over 60% of serious accidental injury, occur in people aged 65 and over (Cryer, 2001)
- Almost half of fatalities from accidental injuries in people aged 65 and over (and the majority of non-fatal injuries) occur in the home; a quarter occur on the street or road and nearly a fifth occur in residential institutions (Cryer, 2001)
- Data collection around accidents for people aged 65 and over is poor for general injuries experienced, although anecdotal intelligence from local partners suggests that the burden of these injuries is significant, which might include: burns, poisoning, wounds and head injuries
- In 2010/2011, Blackburn with Darwen had the 40th highest rate of hospital admissions for injuries due to falls in people aged 65 out of 150 local authorities in England, with a rate of 2344 per 100,000 of the population of older people, significantly higher than the England average
- Blackburn with Darwen has the 51st highest rate of hip fractures in people aged 65 to 79 years of age, out of 150 local authorities in England, with a rate of 587.3 per 100,000 of population. This is in line with the England average
- There are approximately 7000 falls in Blackburn with Darwen every year
- In the UK every hour, an older person will die as a result of a fall

**What Works**

- Routine enquiry by professionals in contact with older people regarding any falls in the past year
- Information provision regarding falls prevention and where to seek advice should be given to any individual at risk of a fall and their carers
- Falls prevention programmes which include strength and balance training, home hazard assessment, coping with low self-efficacy and vision assessment
- Older people with a history of falls should be offered a multifactorial risk assessment by a healthcare professional

**What We Will All Do**

1. Falls prevention
   a. Falls prevention measures
   b. Respond to emerging intelligence about local needs relating to accidents for older people
   c. Understanding wider accidents for older people

2. Co-ordination of local activities to reduce accidents to people aged 65+ in the home
   a. Strengthen the existing networks of local services within Blackburn with Darwen who provide services to older people which reduce the risk of accidental injury
   b. Tackle social isolation and loneliness for older people
   c. Address alcohol consumption and medication use by older people and its relationship to accidental injury
7. Contact Details

If you require further information of Blackburn with Darwen’s Accident Prevention Strategy, please contact Blackburn with Darwen Borough Council on the contact details below.

Public Health Administration Team  
Blackburn with Darwen Borough Council  
Public Health Directorate  
6th Floor  
10 Duke Street  
Blackburn  
BB2 1DH  
Telephone: (01254) 585585  
Website: www.blackburn.gov.uk  
Email: publichealthadmin@blackburn.gov.uk
<table>
<thead>
<tr>
<th>What we will do:</th>
<th>How we will do it:</th>
<th>How we will know if we have achieved it:</th>
<th>Who will lead it:</th>
<th>By when:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Objective 1: Improve home safety and reduce the risk of accidents</td>
<td>A universal and targeted approach to home safety assessment through all partner agencies including the voluntary, community and faith sector</td>
<td>We will be able to demonstrate a reduction in the number of admissions and A&amp;E attendances for accidental injury causes. We will continue to take a partnership approach to the delivery of home safety assessments and advice through multi-agency initiatives at Universal and Targeted levels. We will have developed and implemented a training package to skill all professionals who visit homes with young children to carry out home safety assessments. Families with young children will be accessing the new ‘Safe Start’ programme at all Blackburn with Darwen Children’s Centres. Data sharing agreements will have been developed and implemented to allow access to hospital admission and attendance data for needs assessment purposes.</td>
<td>Public Health/All Partners, LCFT 0-19 Services/Early Years and Early Help, Public Health Early Years and Early Help, Early Years and Early Help, Public Health CCG, All partners</td>
<td></td>
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<tr>
<td>Home safety equipment provision and fitting</td>
<td>Local data is available regarding the number and demography of homes where affordable safety equipment has been provided and fitted. We will have developed an enhanced service for affordable home safety equipment provision for the most vulnerable families across the Borough. Reduced number of ‘falls’ injury attendances at A&amp;E for children aged 0-5 years</td>
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<td>DASH/Public Health, All Partners</td>
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<tr>
<td>Building regulations for new and refurbished properties</td>
<td>All new homes built or refurbished in Blackburn with Darwen comply with enhanced standards as set out by The Royal Society for the Prevention of Accidents (Appendix C)</td>
<td>Public Health</td>
<td></td>
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<tr>
<td>Accident prevention strategies are incorporated in local landlord licensing schemes</td>
<td>Private Sector Housing Solutions</td>
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<td>Parking arrangements which facilitate safer roads and outdoor play for children and young people will be accounted for in the planning of new home buildings and refurbishment.</td>
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<tr>
<td>Safety outside of the home</td>
<td>We will have undertaken further needs assessment to understand local risks to children aged 0-5 years outside of the home environment and have addressed these risks through ongoing action planning</td>
<td>All partners</td>
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<tr>
<td>Support and lobby for appropriate safety regulations in line with RoSPA campaigns</td>
<td>National regulation change</td>
<td>All partners RoSPA</td>
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<tr>
<td>Objective 2: Improved outcomes following an accidental injury</td>
<td>To review the treatment pathways for children following an accidental injury</td>
<td>CCG</td>
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<tr>
<td>Local communications and PR campaigns to increase awareness and use of appropriate unscheduled care services following an accidental injury</td>
<td>Public Health CCG</td>
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<tr>
<td>Work with GPs to review pathways for families who visit frequently with minor injuries and link this to current pathways between A&amp;E and 0-19 Services; to include training and referral systems for further advice and support following an accidental injury</td>
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<tr>
<td>Paediatric basic life support and first aid training for parents, families and carers</td>
<td>Complete a scoping exercise to identify what resources are locally available at present</td>
<td>Public Health</td>
<td></td>
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<tr>
<td>Explore opportunities to deliver paediatric basic life support and first aid across the lifecourse including antenatal, neonatal, infancy and early childhood</td>
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### Accident Prevention Strategy Action Plan 2014-2017

**Priority 2: Accidental injuries to young people (14-25) in their leisure time**

<table>
<thead>
<tr>
<th>What we will do:</th>
<th>How we will do it:</th>
<th>How we will know if we have achieved it:</th>
<th>Who will lead it:</th>
<th>By when:</th>
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</thead>
</table>
| Objective 1: Support young people to manage risk taking behaviours to reduce accidental injuries | Review of local services and organisations who provide education and support to young people around risk taking behaviours | We will have carried out local scoping of risk taking behaviour interventions and implemented recommendations in service provision  
We will have embedded the ‘Learning About Safety by Experiencing Risk’ LASER principles into risk taking behaviour provision  
We will have respond to recommendations following a local needs assessment on ‘legal highs’ being undertaken by partners  
We will have empowered and supported young people to take a leadership role in the dissemination of safety messages relating to risk taking behaviours | Public Health |  |
| | | | All Partners |  |
| Establish links with accidental injuries on the roads agenda for young people in their leisure time | We will increased the number of children and young people partaking in cycling and walking activities in their leisure time  
A Borough wide ‘Your Call’ campaign will have been completed to encourage and support local people to develop solutions to their own local road safety concerns | Public Health |  |
| Introduce risk-benefit assessment as an alternative to standard risk assessment for all partners | Partners will take a leadership role in transition away from standard risk assessment to risk-benefit assessment for all children’s leisure settings including parks and playgrounds | Public Health |  |
| Objective 2: Safe and fun leisure activities for children and young people | Local co-ordination of leisure activities for young people, their family and wider communities | We will have built upon the existing youth networks to develop a coordinated forum of all local providers of Youth Service including private, public and third sector organisations  
We will have responded to recommendations set out in the ISNA on Children and Young People’s emotional health and wellbeing and as a result, have improved access to appropriate leisure activities  
Young people, their families and communities will be accessing a resource for information provision about leisure activities in Blackburn with including public, private and third sector activities  
We will have continued to support and promote the Club Mark scheme | Public Health  
Young Peoples Services |  |
<table>
<thead>
<tr>
<th>Ensuring that wider health and wellbeing services meet the needs of local young people</th>
<th>We will have developed an ongoing engagement strategy with young people about gaps in current leisure/health and wellbeing service provision and blockages to access, and be using this to inform future service development</th>
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<tr>
<td></td>
<td>We will have developed and implemented a Health and Wellbeing Service for young people</td>
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<td>We will have explored opportunities for Children and Young People to access safe green spaces for leisure not previously accessible including school grounds and private land</td>
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<td>All partners</td>
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<td>Public Health</td>
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<td></td>
<td>All partners</td>
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<tr>
<td>What we will do:</td>
<td>How we will do it:</td>
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</tr>
<tr>
<td>Objective 1: Road safety</td>
<td>A local road safety partnership for Blackburn with Darwen to include wider partners, taking a lifecourse approach</td>
</tr>
<tr>
<td>Community mobilisation</td>
<td>We will have introduced and embedded an assets based approach to accidental injury prevention on the roads through all linked strategies and partnership interventions. We will have completed a ‘Your Call’ campaign across Blackburn with Darwen to encourage, empower and support local people to develop solutions to their own local road safety concerns. This will be supported by grants, available to Community, Voluntary and Faith Sector Groups. All road safety policies and initiatives will give consideration to how the local Voluntary, Community, Faith and Social Enterprise sector can be involved</td>
</tr>
<tr>
<td>Objective 2: Road design and modification</td>
<td>Ensuring appropriate speed limits and parking on all our roads across the Borough</td>
</tr>
</tbody>
</table>

- Lobby national government for a national 20mph limit in residential areas
- Implementation of an evidence-based model from the findings of the Council’s Mill Hill 20mph sign-only pilot, other local speed initiatives and national and regional evaluations, to determine the effectiveness of implementing reduced speed limits in residential areas. This will include a comprehensive range of measures.

- Using existing intelligence to implement interventions at a neighbourhood level
- A dynamic needs assessment will be continuously updated and used to provide intelligence to support future road safety, design and modification plans by the multi-agency local road safety partnership.
| Alternative methods of travel | All future planning, road design and modification will take into account ways to support cycling, walking and use of public transport. Consideration will be given to planning which meets the needs of all road users across the life course including children and older people. A range of practical programmes and interventions will be in place to support cycling, walking and public transport | Local multi-agency road safety partnership |

**Priority 4: Accidental injuries to people aged 65+ in the home**

<table>
<thead>
<tr>
<th>What we will do:</th>
<th>How we will do it:</th>
<th>How we will know if we have achieved it:</th>
<th>Who will lead it:</th>
<th>By when:</th>
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</thead>
<tbody>
<tr>
<td>Objective 1: Accident prevention strategies</td>
<td>Falls prevention measures</td>
<td>We will have redesigned and implemented a new local falls pathway to meet best practice standards, improving integration between falls services delivered by a variety of providers</td>
<td>LCFT</td>
<td>BwD Falls Prevention Team, Sustainable Neighbourhoods Service</td>
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<tr>
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<td></td>
<td>All Residential and Nursing homes in Blackburn with Darwen will have accessed a local multiagency, care home falls education programme and implemented best practice guidelines within the home</td>
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<td></td>
<td>We will have developed and delivered an education programme for all older people, their families, carers and wider communities around the risk of falls and self-care to prevent falls in older people</td>
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<tr>
<td>Respond to emerging intelligence about local needs relating to accidents for older people</td>
<td>We will have completed the ‘Integrated Strategic Needs Assessment for Falls’ and have responded to recommendations made</td>
<td>There will be strengthened collaborative working between all commissioners of services which reduce the risk of falls, including new services where gaps in provision are identified through needs assessment</td>
<td>All Partners</td>
<td>CCG, Adult Social Care, Public Health</td>
</tr>
<tr>
<td>Understanding wider accidents for older people</td>
<td>Data sharing agreements will have been developed and implemented to allow access to hospital admission and attendance data for needs assessment purposes, to understand in more detail accidents other than falls which impact on older people and target interventions effectively</td>
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<td>Public Health</td>
<td>Public Health</td>
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<td>All professionals visiting places of residence where older people live, will be skilled and aware to observe and report hazards and accident risks and be able to refer on to appropriate agencies</td>
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<td>All partners</td>
</tr>
<tr>
<td>Objective 2: Co-ordination of local activities to reduce accidents to people aged 65+ in the home</td>
<td>Strengthen the existing networks of local services within Blackburn with Darwen who provide services to older people which reduce the risk of accidental injury</td>
<td>The multi-agency ‘Falls Collaborative’ for Blackburn with Darwen will have been re-instated and developed</td>
<td>Public Health</td>
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<td>Local people, their families and carers have the knowledge and ability to access relevant and useful information about services available for older people in Blackburn with Darwen which may reduce the risk of accidental injury</td>
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<td>Public Health</td>
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<td>Engagement with older people will be ongoing to understand the impact and prevalence of injuries other than falls on their quality and quantity of life</td>
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<td>All partners</td>
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<td>We will have continued to assess local needs relating to accidents for this age group, through improved data collection, reporting and sharing. We will have used this intelligence to develop</td>
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<td>Public health</td>
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<tr>
<td>Preventative interventions, giving consideration to the 50+ age group if appropriate</td>
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<tr>
<td><strong>Tackle social isolation and loneliness for older people</strong></td>
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<tr>
<td>‘Mutual help networks’/Good Neighbour scheme will have been further developed and implemented to improve community cohesion, reduce social isolation and loneliness and reduce accidental injuries for older people</td>
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<tr>
<td>All partners</td>
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<tr>
<td><strong>Address alcohol consumption and medication use by older people and its relationship to accidental injury by older people</strong></td>
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<tr>
<td>We will support the implementation of The Blackburn with Darwen Alcohol Strategy and Action Plans for older people</td>
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<tr>
<td>All agencies will conduct routine enquiry regarding alcohol consumption with older people who have experienced an accidental injury</td>
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<tr>
<td>We will have developed collaborative initiatives to reduce the risk of drug related accidents for older people including, illicit, over the counter and prescribed medications</td>
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<tr>
<td>Public Health</td>
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<td>All Partners</td>
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</table>
## Appendix A  Accident Prevention Strategy Steering Group Membership

<table>
<thead>
<tr>
<th>Name</th>
<th>Organization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alison Abbott</td>
<td>Culture, Leisure and Sport. Blackburn with Darwen Borough Council</td>
</tr>
<tr>
<td>Alison Kay</td>
<td>Culture, Leisure and Sport. Blackburn with Darwen Borough Council</td>
</tr>
<tr>
<td>Amanda Barrass</td>
<td>Homestart Blackburn with Darwen</td>
</tr>
<tr>
<td>Bob McDonald</td>
<td>Inter Madrassah Organisation</td>
</tr>
<tr>
<td>Carol Holding</td>
<td>Early Years and Early Help. Blackburn with Darwen Borough Council</td>
</tr>
<tr>
<td>Caroline Best</td>
<td>Rapid Assessment Team. Lancashire Care NHS Foundation Trust</td>
</tr>
<tr>
<td>Cheryl Kenyon</td>
<td>Rapid Assessment Team. Lancashire Care NHS Foundation Trust</td>
</tr>
<tr>
<td>Claire Birchenough</td>
<td>Culture, Leisure and Sport. Blackburn with Darwen Borough Council</td>
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<tr>
<td>Debbie Summersgill</td>
<td>DASH Service. Blackburn with Darwen Borough Council</td>
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<td>0-19 Service. Lancashire Care NHS Foundation Trust</td>
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<td>Julie Haworth</td>
<td>Adult Services. Blackburn with Darwen Borough Council</td>
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<td>Kath Kenyon</td>
<td>Early Years and Early Help. Blackburn with Darwen Borough Council</td>
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<tr>
<td>Louise Procter</td>
<td>Environment, Housing &amp; Neighbourhoods. Blackburn with Darwen Borough Council</td>
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<td>Lynette Bannister</td>
<td>Sustainable Neighbourhoods Service. Blackburn with Darwen Borough Council</td>
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<td>Nicky Cook</td>
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<td>Paul Cooper</td>
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<td>Rosemary Molyneux</td>
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<td>Hodgkinson Sharon</td>
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<td>Capita</td>
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<td>Steve Flynn</td>
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<td>Stuart Pye</td>
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<td>Tom Lister</td>
<td>The Royal Society for the Prevention of Accidents</td>
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<tr>
<td>Vicky Shepherd</td>
<td>Age UK Blackburn with Darwen</td>
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<td>Wes Truran</td>
<td>Lancashire Fire and Rescue Service</td>
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<tr>
<td>Yvonne Hulse</td>
<td>The 50+ Partnership</td>
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Evaluation of RoSPA Training in Blackburn

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Evaluation of the RoSPA Training in Blackburn

The one day RoSPA training in Child Safety in the Home was held at on 16 May 2013 in Blackburn.

Evaluation Methods

This evaluation was carried out five months after the course and it was not feasible to ask course participants for accurate figures on the number of contacts they had with refugee and asylum seeker families. The data was originally intended to be captured in paper-based format. The data has therefore been collected through one-to-one telephone interviews, one joint face-to-face interview and one group meeting of refugee and asylum seeker parents. Telephone interviews were chosen as an appropriate method of collecting the data as this is cheaper and quicker than holding face-to-face interviews, and the subject matter was not sensitive, nor complex and therefore did not require a face to face interview. Short telephone interviews were also more convenient for busy professionals.

The telephone interviews were semi-structured using the original monitoring form as the basis of the interview guide.

The interviews were digitally recorded with the interviewees’ permission. Notes and quotations were taken from the recording. The individual responses of the interviews have been recorded on the monitoring form and are attached as an appendix.

This report provides (1) a profile of the interviewees, the number of contacts they have per month with refugee and asylum seeker families and the context in which these contacts take place, and (2) a thematic analysis of the interviews.

Profile of attendees and the approximate number of contacts they have with refugee and asylum seeker families per month since the training.
<table>
<thead>
<tr>
<th>Course Participant</th>
<th>Activities</th>
<th>Contacts per month</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Health Outreach Team Worker</td>
<td>Informal risk/safety checks, General discussion at Drop-in sessions</td>
<td>40</td>
</tr>
<tr>
<td>2 Health Outreach Team Worker</td>
<td>General discussion with 2 people since the training</td>
<td>Less than 1</td>
</tr>
<tr>
<td>3 Housing team (Floating Support Worker)</td>
<td>Informal risk/safety assessment (2 per month when people get new home) General discussions</td>
<td>60 (some of them the same family)</td>
</tr>
<tr>
<td>4 Children’s Society Manager</td>
<td></td>
<td>Sick leave</td>
</tr>
<tr>
<td>5 Children’s Society Support Worker/Manager (MLH)</td>
<td>Parenting Group – same as (16) Child safety activities, written material</td>
<td>20</td>
</tr>
<tr>
<td>6 Home School Liaison Officer (Refugees and Asylum Seekers)</td>
<td>Informal risk/safety checks</td>
<td>16</td>
</tr>
<tr>
<td>7 Well Being Champion – Children’s Society Volunteer</td>
<td>Drop-in, general conversation</td>
<td>500 per month</td>
</tr>
<tr>
<td>8 Well Being Champion – Children’s Society Volunteer</td>
<td>Group sessions giving child safety message and general discussions</td>
<td>60 per month</td>
</tr>
<tr>
<td>9 Geo Worker - Early Years Excellence Section of Children’s &amp; Education Dept</td>
<td>Parenting Group (same as (5) and (16) Displays at Drop-ins</td>
<td>20</td>
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<tr>
<td>10 Police Officer</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>11 Leaving Care Worker</td>
<td>Informal risk/safety assessment</td>
<td>1</td>
</tr>
<tr>
<td>12 Outreach Worker – Asylum and Refugee Community (ARC) Project</td>
<td>Drop-in, general conversation and Child Safety Week Posters.</td>
<td>100 (with 20 -30 families)</td>
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<tr>
<td>13 Volunteer – Asylum and Refugee Community (ARC) Project</td>
<td>Drop in and 3 visits per month to one family.</td>
<td>40</td>
</tr>
<tr>
<td>14 Children’s Society Support Worker/Manager (MG)</td>
<td>Parenting Group same as (5) Child safety activities, written material</td>
<td>20</td>
</tr>
<tr>
<td>15 Geo Worker - Early Years Excellence Section of Children’s &amp; Education Dept</td>
<td>Group meetings, general discussion</td>
<td>2</td>
</tr>
<tr>
<td>16 SERCO Housing Officer</td>
<td>Safety checks pre-occupation</td>
<td>200-300</td>
</tr>
</tbody>
</table>

**Themes**

*Changes refugee and asylum seeker families have made.*
It is difficult for professionals to assess changes that individuals have made to their home environment or in their attitude to child safety but there was some evidence that refugee and asylum seeker families had made changes.

**Changes reported by refugee and asylum seekers**

One mother in the Parenting Group said she used to have a kettle in the bedroom to make it easier to have a hot drink in the morning. After discussions in the Parenting Group she decided this was not safe as she has a 2 year old who comes in the room, so she took it away. She also used to leave the hair dryer in the socket and now she makes sure it is unplugged before she leaves the house.

Another mother in the group, with a hyperactive 6 year old, reported that she had become more aware of making her home safe for her son and had obtained window restrictors so that he could not climb out of the windows.

One new professional in the Parenting Group reported that, although she had no children, there were children often visiting her house and so she cooked on the back rings of the cooker and had encouraged her mother to do the same.

As well as making practical changes, changes in attitude and awareness were also reported. The mothers in the Parenting Group said the statistics on child accidents in the home had made them much more aware of how important child safety measures were. However, one mother (not present at the group) initially found it difficult to accept that not paying attention to child safety was neglect. Over time she did come to understand the importance of child safety.

**Changes in parent behaviour reported by professionals**

All the interviewees brought up the topic of child safety when the opportunity arose. One interviewee described two opportunities to deliver a child safety message:

“I visited a house..... they left the baby (18 months) unattended on the bed and they were looking for their papers in the other room. I think the baby woke up at that time and his dummy fell on the floor and the baby was trying to get the dummy. Luckily I was there and the Mum realised at that time that the baby was trying to fetch his dummy, and then we discussed about that subject – not leaving the baby unattended”

This family didn’t have a cot for the baby.

“Again the bath is another problem. The majority haven’t got baby baths, and they usually put the baby in the normal bath, again somebody knocked at the door, I noticed that they go and open the door leaving the baby (3 years) unattended.”

As the interviewee pointed out it was not just a problems of lack of awareness with regard to child safety but also lack of equipment.
One interviewee recounted two occasions when she had given safety messages. On one occasion visiting a refugee and asylum seeker family, there was a baby in a bouncy chair on a table. The support worker pointed out the danger and the family put the chair and the baby on the floor. On another occasion a family had the fridge in the living room and whilst she was there the 4 year old child opened the fridge and took out medicine. She pointed out that this could be dangerous and that the medicine should be on a top shelf that the child couldn’t reach.

The support worker says she would have done this before the course because she is a mother herself. In both instances the child safety message was well received by the families.

**Difficulties in making the changes**

There are difficulties in obtaining safety equipment such as stair gates. Refugee and asylum seeker families are only given vouchers for food so it is difficult for them to afford equipment such as a stair safety gate.

The mothers in the Parenting Group reported that there were problems with some of the equipment; the stick on cupboard restrictors soon fell off, as did the corner cushions.

**Cultural differences**

The mothers in the Parenting Group confirmed that the cultures they came from did not have the same beliefs and awareness about child safety as in the UK. Their cultures don’t see the child’s safety as particularly the parents’ responsibility. Children are considered the community’s responsibility. They also come from countries where child safety does not have the same legal structure as in the UK, for example, the age at which a child can be left at home on their own.

Other risk areas are the technological differences between the UK and their home country. They may not have used electricity or gas before, and therefore don’t understand the dangers. They often come from hot countries and therefore feel very cold in the UK. This can result in them to leaving babies too near to heating without realising the danger this poses.

One interviewee felt that because it takes time for refugee and asylum seeker families to adapt to the UK culture on child safety that it should be the business of all professionals;

“it takes time for those safety issues to click into the mind and become routine in the family life. So there is a need for different professionals to be working together to keep reinforcing the message...I don’t see it like a one organisation business.”

Another interviewee pointed out that some refugee and asylum seeker families are worried that if they reveal any issues about child safety it may result in a visit from Social Services and affect their affect their claim for asylum.
The change in climate, as well as culture, for refugee and asylum seeker families added to the risk environment. One interviewee described the risks that may occur.

“A family coming from a hot country when they get here, even before the winter kicks in they are already freezing cold so you find that they won’t remember that the baby’s cot is next to that heater that leave on maximum maybe throughout the whole night, that’s going to affect the health of the baby. Plus it might cause burns during the night when the baby is fast asleep. Or those who may sleep with the baby, the baby may be left on the side of the heater because they want to keep warm, they don’t see the danger.”

Changes in professional practice

Most interviewees said that the RoSPA course had brought child safety in the home to the fore of their mind. One interviewee who regularly does informal safety checks only of the downstairs of the house said the course gave her more awareness on what to look for.

Another interviewee, who does health assessments, now takes the opportunity to do an informal child safety check as well.

“When I do the health assessment, now I do the health aspect of the house as well and do the assessment in the room I’m in and I talk to the family, if they would like me to look around the house and talk to them about any hazard I see and tell them about the safety”

He also explains about road safety and safety in the car. He generally finds the families respond well to the information.

An interviewee, who works with young people between 16 and 21 years, now records that she has done an informal home safety check and the advice she has given, which she didn’t do before the course. The training has triggered her to think more of safety issues for all young people, not just refugee and asylum seekers. She reported that the team she works with have a ‘Supported Lodgings’ scheme for care leavers. Some of them have children so they plan to include an initial home risk assessment but to date they haven’t had anyone with a child. The RoSPA training has been useful in the development of this addition to the scheme.

An office-based refugee and asylum seeker worker said the staff in the office were now more aware of the cultural aspects of child safety and the need to point out safety issues when families are in their offices, for example telling parents to keep an eye on their children and that they can’t just let children do what they want.

A volunteer, born abroad, said she learned a lot from the course and she’s applies the new knowledge, telling family members and friends about child safety issues when incidents occur. This includes raising child safety issues with her own family and after prayer meetings in the community.

Since the RoSPA course support workers at a community centre have established a new practice of not allowing parents to have hot drinks in the area where children are playing. They have also put together...
resources to teach about child safety using the materials from the RoSPA course which includes a large spiral bound book of illustrations. They select child safety topics to discuss at each session and the mothers choose a child safety goal for themselves after reflecting on the session and write it down. In the group the parents discuss the issues with each other and talk about incidents they have experienced. The support worker feels this is very beneficial because they are helping each other. They also take the opportunity to mention safety issues to others in the community centre, such as young singles who are playing table tennis. They make sure know they can’t go into the table tennis area with a hot drink and to play safely in a way that a child is not going to be hit by a ball.

One volunteer at the centre said he takes the opportunity to mention child safety when he sees a child at risk in the community centre. He also passes on child safety messages when visiting friends and family.

A support worker reported that the RoSPA training had been cascaded down to the members of the Geographical Team who run groups in Children’s centres and in the community.

A housing officer said that the organisation already carried out safety checks before the refugee or asylum seeker family moved in. However, he really found the course has given him a much wider knowledge of child safety and he thinks everyone should do such a course.

**Challenges in delivering the child safety message to refugee and asylum seeker families**

Languages are the most obvious barrier to getting the child safety messages to refugee and asylum seeker families but all the interviewees said they found ways round this. One volunteer said she was able to demonstrate non-verbally, for example, by taking a child off a chair when they were climbing on it and demonstrating the chair tipping over.

All the interviewees felt they gave the child safety messages in a sensitive way and, most of the time, the messages were taken well. A housing officer explained the importance of conveying good intentions.

“Some people take it better than others, you’ve got to be delicate about it, you know. You can’t just go in and say ‘oh you should be doing that’ and you’ve got to think about different cultures and things like that, it is different over here than it is in many other countries... as long as you’re sensitive about it most people take it quite well and they know that you’re meaning good.”

There were, however some occasions when the message was not very well received and the clients blamed poor quality accommodation, such as steep stairs or loose carpets.

“I think I need to be diplomatic with the kind of clients we get, often the client says ‘we know all these things’ we don’t need you to tell us about our house safety.”

One young male volunteer at a community centre felt that because he is only 26 years old and he has no children, some people don’t feel he is ‘qualified’ to give them advice on child safety. Consequently he doesn’t feel too comfortable giving the child safety message. If the parents won’t accept the invitation and stop what they’re doing, for example, drinking a hot cup of tea with a child on their knee or letting...
children play on the stairs, then he goes to get one of the three managers to give them the child safety message. On reflection he feels the fact that he has no children is irrelevant and the message is still the same.

“You don’t have to have a child to know this stuff”

Another important challenge in delivering the child safety message is the lack of time of professionals. One interviewee said that their team had been cut by 50% and so it was difficult to find the time to provide additional advice on child safety messages on home visits. Another said that more time would be necessary if he was going to do safety checks as well as health checks.

“I think we need more time when we do a visit because time is given for a health assessment and we use a health questionnaire. And to do home safety for the child, you need more time to speak to the clients”

Support that would enhance child safety in refugee and asylum seeking families

There were many suggestions on how professionals could be supported to enhance child safety in the refugee and asylum seeker community.

- It was generally agreed that written information for parents, based around illustrations, would be useful. The mothers in the Parenting Group wanted this to be in English so it would also help with learning English.
- Written information on child safety can be included in general information packs
- It would be useful to have a checklist of child safety issues would be useful in risk assessments, even if these were informal risk assessments.
- More time is needed on home visits to do child safety checks.
- Child safety training should be provided for refugee and asylum seeker families directly.
- Child safety checks should be routinized into the checks that all professionals carry out.
- Visual resources for primary school children and teenagers would be useful – for example, in comic strip format.
- It is difficult for refugee and asylum seeker families to afford safety equipment such as a stair gates because they only receive food vouchers from the government. The mothers in the Parenting Group felt it would be helpful for RoSPA to also provide safety equipment.

Comments on the RoSPA training

Most of the interviewees found the training very useful even though they may have previously highlighted child safety issues as part of their work. They appreciated the refresher and the training brought child safety to the fore in their minds.

“The training has triggered things off in my mind that I might have forgotten about...that’s got me thinking it though and looking at it in more depth really”
“…probably realising more, after that training, the different things to look out for, you know, just being mindful really of where accidents can happen”

“It highlighted to me and gave me a reminder that we need to point it out to people”

“The training was very beneficial... (it) was useful in bringing child safety to the fore and it was good to get together with other professionals and share experiences of child safety, discussing what works and what doesn’t work.”

For others, especially those from other cultures the training was revelatory.

“The training was very good, I found it very useful and I found it an eye opener. Previously I just went round and did a health assessment, now I’m more cautious and looking around if there’s a baby”

“It was wonderful, I really got a lot, because, I was born in Africa and had all my children in Africa and now as a Grandma, I’ve got all these people having children and I try to explain to them how to look after them and I explain that here the system is totally different to back home, so you need to be careful, you need to comply with the rules and the regulations and listen to what people are telling you because this is for your good and for your children’s good as well”

One person, not born in the UK, felt that the trainer spoke too quickly and too quietly

One interviewee felt that the RoSPA course was very basic and not as in-depth as the regular health and safety training she received as part of her job. She, and one other interviewee, noted that the information with regard to the age at which a child can be left on their own to eat, 18 months, was wrong.

Recommendations

- Provide illustrated information booklets with English text
- Illustrated booklet can be placed in currently used information packs
- Provide illustrated posters in several languages
- Make delivering the child safety message the responsibility of all health and social care professionals
- Reconsider the information on the age at which children can be left alone when they are eating
- Develop a checklist for formal and informal child safety checks
- A focus on younger people, even those without children can be useful in spreading the message
- Investigate ways to procure safety equipment, or normal baby equipment such as cots and baby baths for refugee and asylum seekers
- Consideration should be given to the fear of some refugee and asylum seekers that if they are open about child safety issues this make affect their claim to asylum.
Appendix C

Needs Assessment: Accidents in Blackburn with Darwen

Contents

1. Defining the issue
2. Why is this issue highlighted?
3. Who is at risk and why?
4. Level of need in the population
5. Good practice
6. Current services / initiatives
7. Gaps
8. Value for money
9. Involvement
10. Recommendations

1. Defining the issue

1.1 What are accidental injuries?

There are many terms that are used to describe accidents in academic literature, policy and guidelines. National guidelines produced by the National Institute for Health and Clinical Excellence (NICE) choose to say ‘unintentional injuries’ rather than ‘accidents’. An unintentional injury is any injury which has not been inflicted intentionally to oneself or another person.

WHO\(^{14}\) define an injury as:

*the physical damage that results when a human body is suddenly subjected to energy in amounts that exceed the threshold of physiological tolerance… The energy in question can be mechanical, thermal, chemical or radiated*.

Much of the literature and policy use the term ‘unintentional injury’ because the term ‘accident’ implies an unpredictable or chance occurrence and therefore, unavoidable event; but in reality most injuries and their precipitating events are predictable and preventable.

The Public Health Outcomes Framework uses the term “unintentional and deliberate injuries in children and young people”.

In reality, the terms ‘unintentional injury’, ‘accidental injury’ and ‘accidents’ are, to some extent, interchangeable. However, the general population still regard the vast majority of unintentional injuries
(falls, burns and scalds, fires, poisoning and choking) as ‘accidents’. Therefore in order to ensure that this strategy is meaningful to local people in Blackburn with Darwen, the term ‘accident’ will be used in the place of ‘unintentional injury’ throughout this Strategy and Action Plans. Local implementation will include engagement which focuses upon the fact that these events are preventable.

Literature, strategy and policy which use terms of ‘unintentional injury’, ‘accidents’, ‘accidental injury’ and ‘injury prevention’ have all been considered to contribute to the evidence base for the Blackburn with Darwen local multi-agency Accident Prevention Strategy and Action Plans. This Strategy and Action Plan is not intended to address intentional injuries, those which are intentionally self-inflicted or inflicted by others. It is acknowledged that there may be some overlap in risk factors for accidental and intentional injuries which will be reflected in the action plans, through links made with safeguarding children and adult strategies and policies.
2. Why is the issue highlighted?

2.1 The wider policy context for accident prevention

The Public Health Outcomes Framework 2013 to 2016

The Public Health Outcomes Framework 2013 to 2016 sets out key indicators which relate directly to injuries across the lifespan. Most specifically relevant to accident prevention:

- Indicator 1.10: Killed and seriously injured casualties on England’s roads
- Indicator 2.24: Injuries due to falls in people aged 65 and over
- Indicator 4.14: Hip fractures in people aged 65 and over
- Indicator 2.7: Hospital admissions caused by unintentional and deliberate injuries in children and young people aged 0-14 and 15-24 years
- Indicator 4.3: Mortality rate from causes considered preventable

Healthy Lives, Healthy People

Successful public health interventions need to put local communities at the heart of plans, enabling them to improve health throughout people’s lives, reduce inequalities and focus on the needs of the local population. Furthermore, there is a need for Local Authorities to consider the most effective way to secure public health services including the involvement of existing networks which include community groups and third sector providers in order to develop new relationships and approaches to improving health and wellbeing.

Accident prevention is highlighted as a key area for public health programmes, with specific emphasis upon strategies which address road traffic accident mortality and injuries particularly in children; it is also acknowledged that there are strong regional and social variations in the incidence of unintentional injuries and this lends itself to programmes which are tailored to address local issues. Additionally, it is identified that there is a need to address preventable falls in the elderly and the resulting high number of hip fractures which have significant financial costs to the NHS, predicted to continue to rise exponentially by 2050. National policy focuses strongly upon the social determinants of health and notes specifically that accidents due to alcohol are the leading cause of morbidity among 16-24 year olds.

The Marmot Review

The Marmot Review similarly underlines inequalities across a range of social and demographic indicators with regards to unintentional injuries and accidents. It identifies injuries and accidents at work as a key public health priority but explains that more robust reporting methods are necessary if prevention strategies are to be successful. Within the review, it calls for the implementation of 20mph road zone and traffic calming measures, claiming to reduce the speed and volume of traffic and reduce
the number of injuries as a result of road traffic incidents; this subsequently increases the number of people cycling and walking which have wider impacts upon general health. Moreover, Marmot advocates for collaborative home safety initiatives targeted at those most vulnerable, which can potentially prevent premature deaths, reduce GP consultations and hospital admissions improve multi-agency partnerships and increase community capacity to improve housing. There is strong evidence to suggest that parenting programmes and early intervention programmes can significantly improve safety for children and reduce the number of unintentional injuries.

**NICE**

NICE underline that unintentional injury prevention needs to be prioritised at a local and national level. NICE recommend the appointment of a local injury prevention coordinator who could promote a strategic framework for action and encourage local agencies to work together. It is recommended that the injury prevention co-ordinator works with local partnerships, develops a 2 to 3-year injury prevention strategy with these partners, networks at regional and national level with other injury prevention coordinators, raises local awareness, acts as a local source of information and advice on prevention, monitors progress made on the injury prevention commitments set out in local plans and strategies. NICE also recommend that there is a great need to develop a national injuries surveillance resource and that it is important to promote the development of an enhanced national emergency department dataset based upon best practice examples.

2.2 **Programme Area 1: Accidental Injuries to Children Aged 0-5 Years in and around the Home**

NICE describes a set of national recommendations for best practice in order to reduce unintentional injuries in the home for children. These guidelines focus upon the need for local profiling and interventions which respond to those most in need; specific recommended interventions to reduce unintentional injuries in the home for children aged 0-5 are the completion of home safety assessments and supply and install of home safety equipment.

The Healthy Child Programme: Pregnancy and the first five years of life\textsuperscript{32} sets out safety as a core component of Universal and Progressive Programme at all stages from pregnancy to five years of age. Suggested safety activities include raising awareness, information provision and facilitating access to safety equipment schemes with a specific focus upon car safety and home safety. The Health Visiting workforce is central to the delivery of The Healthy Child Programme in partnership with other community based professionals including Early Years and Early Help, General Practitioners and Midwives amongst others.\textsuperscript{32}
Safety for children is highlighted as a statutory responsibility in Working Together to Safeguard Children, which comments upon Part 1 of the Housing Act 2004 which places responsibility upon professional groups working with children and young people to ensure that landlords address any identified health and safety hazards in the family home environment.

Locally, the Blackburn with Darwen Joint Health and Wellbeing Strategy 2012-2015 recognises the need to address Indicator 2.7 of the Public Health Outcomes Framework which relates to hospital admissions resulting from unintentional injuries. Interventions within this strategy which can have a positive impact upon reducing unintentional injuries of children aged 0-5 in and around the home fall mainly under Programme Area 1: Best Start for Children and Young People and include those which are aim to improve the emotional health and wellbeing of children, parenting programmes, implementation of the RoSPA Safer Homes programme and the role of the Decent and Safe Homes (DASH) Service to reduce the number of accidents in homes.

2.3 Programme Area 2: Accidental Injuries to Young People in their Leisure Time

A developed NICE guideline: Preventing unintentional injuries among under 15s - outdoor play and leisure, was not published following consultation due to a lack of effective evidence and concerns that standalone guidance might encourage unwarranted risk aversion. However, some of the information gathered in this guideline has been incorporated into the NICE guideline: Strategies to prevent unintentional injuries among children and young people aged under 15. Although NICE does suggest that the number of injuries and deaths resulting from incidents at home and on the road are much greater than those sustained through leisure activities.

NICE comment upon the difficulties in defining ‘leisure’ activity, giving the example that injuries resulting from cycling could be attributed to leisure activity or road traffic incident. Furthermore, this guideline underlines the importance that children should be "as safe as necessary, not as safe as possible". NICE guidelines explicitly recommend that play and leisure activities help children and young people to learn about the complex relationship between themselves and the world in which they live, and that exposure to a degree of challenge may be beneficial during these activities. NICE comment that media campaigns to promote injury prevention activities may increase health inequalities, as uptake is likely to vary among different groups. For example, disadvantaged families are less likely to respond to health information than families who are more advantaged.

With regards to unintentional injuries as a result of leisure and play, NICE has made recommendations about the value of promoting cycle helmets but not about making them compulsory. Furthermore, the
guideline\textsuperscript{12} comments on the importance of playground standards which aim to reduce the incidence of traumatic brain injury, broken arms and legs; all of which are common, potentially traumatic and can result in disability and deformity.

The Audit Commission report, “Better Safe Than Sorry”,\textsuperscript{35} underlines the need to ensure that safety is integrated in park and leisure strategies and that a national Leisure Accidents Surveillance System should be reinstated.

Locally, the Blackburn with Darwen Joint Health and Wellbeing Strategy 2012-2015 prioritises physical activity and leisure services for children and young people in Programme Area 1; furthermore Programme Area 4 identifies the reduction of unintentional injuries as a key outcome for the action of developing community assets for health which may include leisure facilities and activities.

2.4 Programme Area 3: Injuries sustained as a result of road traffic incidents

The Strategic Framework for Road Safety\textsuperscript{36} sets out the ambition that decisions regarding road safety should be made locally wherever possible, but also acknowledges that there is still a crucial role for National Government in providing leadership for road safety.

National strategy outlines a number of key themes for road safety; better education for children, young and inexperienced drivers, remedial education for low level offences, tougher enforcement for motorists who deliberately drive dangerously, supporting and building capacity of road safety professionals, provision of information to local communities to enable them to challenge priorities and local setting of speed limits. The Department for Transport Circular 01/2013\textsuperscript{37} recommends that, for residential streets and other town and city streets with high pedestrian and cyclist movement, local traffic authorities should consider the use of 20 mph schemes. They continue to report that 20 mph zones are very effective at reducing collisions and injuries.

The Department for Transport expresses an expectation that local authorities will prioritise road safety and make road safety information available to the public to increase the scope for challenge. Furthermore, the Strategic Framework for Road Safety expresses the importance of links with other local agendas with road safety initiatives including public health. Nationally, the Road Safety Outcomes Framework provides a measure of the effectiveness of local initiatives.
The Road Safety Outcomes Framework highlights fatalities and serious injuries as a result of road traffic incidents as a key indicator of the effectiveness of road safety strategy.

NICE recommends that a collaborative approach between health professionals and the local highways agency is key to effecting positive changes to the number of unintentional injuries sustained as a result of road traffic incidents. Furthermore, it is recommended that Local Highways Agencies undertake thorough needs assessment with engagement from other agencies and local communities to inform sound planning to reduce the number of unintentional injuries resulting from road traffic incidents.

Based upon evidence gathered, NICE strongly recommend the implementation of measures to reduce speed in streets that are primarily residential or where pedestrian or cyclist movement are high. These measures could include: speed reduction features such as traffic-calming measures on single streets or 20 mph zones across wider areas. NICE recommend the use of city or town-wide 20 mph limits and zones on appropriate roads, using factors such as traffic volume, speed and function to determine which roads are appropriate.

The Blackburn with Darwen Joint Health and Wellbeing Strategy 2012-2015 programme area 3, identifies road traffic incidents and the resulting injuries sustained as a key outcome to be addressed, pledging to make better use of planning, transport, environment and enforcement systems to reduce health inequalities, and to encourage walking and cycling through improving the quality of the environment.

2.5 Programme Area 4: Injuries to people aged 65+ years in the home

The National Service Framework (NSF) for Older People recognises the importance of addressing the wider determinants for older people in order to reduce accidents and their resulting injuries. Standard 6 of the NSF for Older People identifies falls as a major cause of disability and the leading cause of mortality due to injury in older people aged over 75 in the UK. The NSF identifies a number of consequences for older people following a fall including psychological problems such as fear and loss of confidence, loss of mobility leading to social isolation and depression, increase in dependency and disability, hypothermia, pressure-related injury and infection. The NSF for Older People identifies the need for population level and individual level interventions aimed to reduce the incidence and impact of
falls on older people. Suggested population level interventions include ensuring clear and safe pavements and effective street lighting, information provision, ensuring the safety of property and addressing wider public health concerns including diet, exercise and smoking. On an individual level, the NSF recommends the combinations of interventions which address multiple intrinsic risk factors for individuals with those which address environmental factors. The NSF for Older People identifies key intrinsic factors which include balance, gait or mobility, poly-pharmacy, visual impairment, impaired cognition or depression and postural hypotension. Risk factors in the home environment identified include: poor lighting, steep stairs, loose carpets, badly fitting clothing or footwear and lack of safety equipment such as grab rails. The NSF for Older People recommends that older people who fall should have access to a specialist falls assessment and subsequent services.

The NICE Guideline40, Falls: Assessment and prevention of falls in older people makes several recommendations to reduce the risk and prevalence of falls in older people. Firstly, identification of the older people who have had recent falls and those at risk. Secondly, those identified should be offered a multi-factorial risk assessment to include both intrinsic and environmental factors. Third, all older people with recurrent falls or assessed as being at increased risk of falling should be considered for an individualised multifactorial intervention which might include strength and balance training, home hazard assessment and intervention, vision assessment or medication review with modification or withdrawal of medicines. Fourth, older people should be encouraged to access falls prevention programmes and finally, older people identified as at risk of falls and their carers should be provided with information orally and in writing regarding measures to prevent falls and how to cope should a fall occur in order to reduce risks associated with a ‘long lie’.

Lancashire Fire and Rescue Service recognise that vulnerable adults aged over 60 years are more at risk of non-fatal and fatal injuries resulting from fires. The Risk Reduction Strategy for Older People 2010 – 201441 sets out Key Actions to reduce the risk of fires in this age group and the resulting unintentional injuries and deaths: development, implementation and evaluation of the Extended Home Fire Safety Check (HFSC) Support Programme, continue to develop links with service providers to vulnerable older people and provide appropriate training, actively explore opportunities to promote and encourage family involvement in the support of vulnerable older people to stay safely in their homes, develop data sharing practices with Health and Adult and Community Services, seek to develop new alliances with non-statutory partners including the Voluntary, Community and Faith Sectors, develop a programme aimed at early intervention aimed specifically at the 50 plus age group, employ a social marketing approach aimed directly at improving engagement with vulnerable older people, develop local and county-wide campaigns and initiatives to address fire risk to vulnerable older people.
The Blackburn with Darwen Older People Strategy 2011-2016 highlights, amongst others, ‘Staying Healthy’ and ‘Suitable Accommodation’ as priorities for people over 50 living in Blackburn with Darwen; effective unintentional injury prevention interventions can help to contribute to these ambitions. The Strategy, specifically discusses the role of the Decent and Safe Homes (DASH) service to enable older people to remain safe in their own homes through a range of interventions including: handyperson service, home safety service and home maintenance service.

The Blackburn with Darwen Joint Health and Wellbeing Strategy 2012-2015 identifies Programme area 5, promoting older people’s independence and social inclusion as a key priority. Within this programme area, it is further emphasised that the programme should focus upon keeping older people safe in their own homes and outside. Strategy aimed to reduce unintentional injuries in the home for people aged over 65 will undoubtedly support the achievement of these ambitions within Blackburn with Darwen.
### 3. Who is at risk and why?

#### Table 3.1  High Risk Groups for Accidents to Children aged 0-5 Years in and around the Home

<table>
<thead>
<tr>
<th>Risk</th>
<th>Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children living in poverty</td>
<td>Children who live in rented properties</td>
</tr>
<tr>
<td>Socioeconomic deprivation</td>
<td>Children who live in homes that are hazardous or cluttered</td>
</tr>
<tr>
<td>Parental substance misuse</td>
<td>Children in families who have low social capital or social cohesion</td>
</tr>
<tr>
<td>Parental problematic alcohol consumption/binge drinking</td>
<td>Children with disabilities including: epilepsy, autism, ADHD, limited mobility, and learning disability</td>
</tr>
<tr>
<td>Younger maternal age</td>
<td>Children whose parents have never worked or are long-term unemployed</td>
</tr>
<tr>
<td>Higher birth order of the child</td>
<td>Parental supervision and parenting skills</td>
</tr>
<tr>
<td>Parental depression or other mental health problem</td>
<td>Children who live in older properties</td>
</tr>
</tbody>
</table>

#### Table 3.2  High Risk Groups for Accidents to Young People in their Leisure Time

<table>
<thead>
<tr>
<th>Risk</th>
<th>Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Young people living in poverty</td>
<td>Young people who are socially isolated or lonely</td>
</tr>
<tr>
<td>Socioeconomic deprivation</td>
<td>Young people who have consumed drugs or alcohol including Psychoactive Substances (legal highs)</td>
</tr>
<tr>
<td>Young people with disabilities including: epilepsy, ADHD</td>
<td>Young people who have poor emotional health and wellbeing</td>
</tr>
<tr>
<td>Young males</td>
<td></td>
</tr>
</tbody>
</table>
Table 3.3 High Risk Groups for Accidents on the Roads\textsuperscript{54, 55}

<table>
<thead>
<tr>
<th>Risk</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Young people are most at risk of becoming a casualty of a road traffic collision</td>
<td>People on rural roads</td>
</tr>
<tr>
<td>Older people are more likely to be killed or seriously injured if they become a casualty of a road traffic collision</td>
<td>Males</td>
</tr>
<tr>
<td>Car users (drivers and passengers) are at a much higher risk of being injured in a road traffic incident than any other road user including motorcyclists, pedestrians and cyclists. This may be due to the demographic of road users in the North West.</td>
<td>Roads with 30mph speed limits</td>
</tr>
</tbody>
</table>

Table 3.4 High Risk Groups for Accidents to People aged 65+ Years in the Home\textsuperscript{56,57,40,39,58,14}

<table>
<thead>
<tr>
<th>Risk</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Older women are at greater risk of an accidental injury in the home than older men</td>
<td>Older people who live in homes with environmental hazards</td>
</tr>
<tr>
<td>Multiple morbidities</td>
<td>Poorly fitting footwear</td>
</tr>
<tr>
<td>Polypharmacy</td>
<td>Smoking in the home</td>
</tr>
<tr>
<td>Poor mobility, balance or gait</td>
<td>Alcohol consumption</td>
</tr>
<tr>
<td>Sensory impairment</td>
<td>Cold weather</td>
</tr>
<tr>
<td>Mental disorders</td>
<td>Greater risk of fires in homes of older people with low income and rented households</td>
</tr>
<tr>
<td>Social isolation and loneliness</td>
<td></td>
</tr>
</tbody>
</table>
4. Level of need in the population

4.1 Programme Area 1: Accidental Injuries to Children Aged 0-5 Years in and around the Home

Unintentional injury is a leading cause of death and illness among children aged 1–14 years, and causes more children to be admitted to hospital each year than any other reason. For every serious injury that results in an overnight hospital admission, there are 25–30 times as many visits to A&E due to less serious injuries. In 2010, these less serious injuries resulted in 4.51 million attendances to A&E by children and young people under the age of 20 – equivalent to one third of this age group.¹

The most severe and preventable accidents that should be addressed for children aged 0-5 years are: choking suffocation and strangulation, falls, poisoning, burns and drowning (PHE, 2014).⁵⁹

In 2012/2013, there were 504 hospital admissions caused by injury in the 0-14 years age group in Blackburn with Darwen. This equates to an annual rate of 157.1 per 100,000 children, which is significantly higher than the England average of 103.8.

Figure 4.11 Hospital admissions caused by injuries in children (0-14 years), 2012/13
According to a study of child accidents and injuries in the North West, falls are the most common cause of admission for accidents among children aged 0-4 years with a rate of 841.8 per 100,000 population.

- Rates of exposure to inanimate mechanical forces are the highest among children aged 0-4 years with a rate of 314.8 per 100,000 population.

- Rates of emergency admissions for accidental poisoning are highest among children aged 0-4 years with a rate of 197.0 per 100,000 population.

- The rate of emergency hospital admissions due to contact with heat and hot surfaces is highest in children aged 0-4 years with a rate of 134.2 per 100,000 population.

Given the predominance of falls, the NWPHO further examined the types of falls that were the cause of hospital admissions. For children aged 0-4 years, admission rates were significantly higher than for other age groups for falls on the same level from slipping, tripping and stumbling, those on and from stairs and steps, other
falls on the same level and those involving a bed or chair.

At a local ward level, 16 wards in Blackburn with Darwen, have a higher rate of hospital admissions for injury in children aged 0-17 years than the England average. Much of the literature for accidental injury suggests that higher levels of deprivation are often linked with higher levels of accidental injury. In the main part, this is also true for Blackburn with Darwen but with slight anomalies seen in Whitehall Ward where income deprivation is better than the England average, but admission for accidental injuries are worse than the England average. Conversely, in Little Harwood and Roe Lee Wards, income deprivation is worse than the England average, whilst admissions for accidental injury in these wards are similar to the England average.

Table 4.11 Crude rate of children and young people’s admissions for injury (aged 0-17 years), Blackburn with Darwen, 2006-11

<table>
<thead>
<tr>
<th>National Position for Rate of Admissions</th>
<th>Ward</th>
<th>Children’s and young people’s admissions for injury (Crude rate/100,000 aged 0-17)</th>
<th>%</th>
<th>Admissions Comparison with England</th>
<th>Admissions Comparison with BwD</th>
<th>Income deprivation (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>55</td>
<td>Mill Hill Ward, Blackburn with Darwen</td>
<td>2264.7</td>
<td>0.715308</td>
<td>Higher</td>
<td>Higher</td>
<td>26.4</td>
</tr>
<tr>
<td>68</td>
<td>Shadsworth with Whitebirk Ward, Blackburn with Darwen</td>
<td>2228</td>
<td>0.88438</td>
<td>Higher</td>
<td>Higher</td>
<td>40.9</td>
</tr>
<tr>
<td>168</td>
<td>Higher Croft Ward, Blackburn with Darwen</td>
<td>2016.5</td>
<td>2.18494</td>
<td>Higher</td>
<td>Higher</td>
<td>27</td>
</tr>
<tr>
<td>236</td>
<td>Sudell Ward, Blackburn with Darwen</td>
<td>1915.4</td>
<td>3.06932</td>
<td>Higher</td>
<td>Higher</td>
<td>25.2</td>
</tr>
<tr>
<td>239</td>
<td>Ewood Ward, Blackburn with Darwen</td>
<td>1905.6</td>
<td>3.108337</td>
<td>Higher</td>
<td>Higher</td>
<td>19.9</td>
</tr>
<tr>
<td>406</td>
<td>Sunnyhurst Ward, Blackburn with Darwen</td>
<td>1775.7</td>
<td>5.280271</td>
<td>Higher</td>
<td>Higher</td>
<td>21.1</td>
</tr>
<tr>
<td>524</td>
<td>Wensley Fold Ward, Blackburn with Darwen</td>
<td>1720.3</td>
<td>6.81493</td>
<td>Higher</td>
<td>Similar</td>
<td>34.1</td>
</tr>
<tr>
<td>611</td>
<td>Queen’s Park Ward, Blackburn with Darwen</td>
<td>1684.4</td>
<td>7.946417</td>
<td>Higher</td>
<td>Similar</td>
<td>38.2</td>
</tr>
<tr>
<td>713</td>
<td>Marsh House Ward, Blackburn with Darwen</td>
<td>1638.7</td>
<td>9.272987</td>
<td>Higher</td>
<td>Similar</td>
<td>14.1</td>
</tr>
<tr>
<td>798</td>
<td>Shear Brow Ward, Blackburn with Darwen</td>
<td>1603.6</td>
<td>10.37846</td>
<td>Higher</td>
<td>Similar</td>
<td>38.6</td>
</tr>
<tr>
<td>839</td>
<td>Meadowhead Ward, Blackburn with Darwen</td>
<td>1588.2</td>
<td>10.91169</td>
<td>Higher</td>
<td>Similar</td>
<td>21.5</td>
</tr>
<tr>
<td>940</td>
<td>Audley Ward, Blackburn with Darwen</td>
<td>1552.6</td>
<td>12.22526</td>
<td>Higher</td>
<td>Similar</td>
<td>42</td>
</tr>
<tr>
<td>1059</td>
<td>Whitehall Ward, Blackburn with Darwen</td>
<td>1524.7</td>
<td>13.77292</td>
<td>Higher</td>
<td>Similar</td>
<td>10.3</td>
</tr>
<tr>
<td>1155</td>
<td>Corporation Park Ward, Blackburn with Darwen</td>
<td>1501.8</td>
<td>15.02146</td>
<td>Higher</td>
<td>Similar</td>
<td>22</td>
</tr>
<tr>
<td>1190</td>
<td>Earcroft Ward, Blackburn with Darwen</td>
<td>1494.9</td>
<td>15.47665</td>
<td>Higher</td>
<td>Similar</td>
<td>16</td>
</tr>
<tr>
<td>1301</td>
<td>Bastwell Ward, Blackburn with Darwen</td>
<td>1474</td>
<td>16.92028</td>
<td>Higher</td>
<td>Similar</td>
<td>36</td>
</tr>
<tr>
<td>1488</td>
<td>Fenhurst Ward, Blackburn with Darwen</td>
<td>1429</td>
<td>19.35232</td>
<td>Similar</td>
<td>Similar</td>
<td>5.7</td>
</tr>
<tr>
<td>1833</td>
<td>Little Harwood Ward, Blackburn with Darwen</td>
<td>1367.6</td>
<td>23.83925</td>
<td>Similar</td>
<td>Similar</td>
<td>28</td>
</tr>
<tr>
<td>2567</td>
<td>Roe Lee Ward, Blackburn with Darwen</td>
<td>1267.9</td>
<td>33.38536</td>
<td>Similar</td>
<td>Lower</td>
<td>15.9</td>
</tr>
<tr>
<td>2761</td>
<td>Beardwood with Lammack Ward, Blackburn with Darwen</td>
<td>1242.2</td>
<td>35.90844</td>
<td>Similar</td>
<td>Lower</td>
<td>12.3</td>
</tr>
<tr>
<td>2800</td>
<td>East Rural Ward, Blackburn with Darwen</td>
<td>1238.5</td>
<td>36.41566</td>
<td>Similar</td>
<td>Similar</td>
<td>4.2</td>
</tr>
<tr>
<td>2801</td>
<td>North Turton with Tockholes Ward, Blackburn with Darwen</td>
<td>1238.5</td>
<td>36.42866</td>
<td>Similar</td>
<td>Lower</td>
<td>4.2</td>
</tr>
<tr>
<td>5980</td>
<td>Livesey with Pleasington Ward, Blackburn with Darwen</td>
<td>950.1</td>
<td>77.77344</td>
<td>Lower</td>
<td>Lower</td>
<td>5.1</td>
</tr>
</tbody>
</table>

Source: APHO
The data available regarding accidental injury relies on figures available for hospital admission for serious injuries and does not capture any of the minor injuries to which parents may apply first aid or visit the GP. Limited data is available for Accident and Emergency Department attendances which can provide some additional intelligence regarding the local picture for accidents in Blackburn with Darwen. The need for better collation and access to accident data is recognised by RoSPA and provides significant challenges for Blackburn with Darwen.

4.2 Programme Area 2: Accidental Injuries to Young People in their Leisure Time

In 2012/2013, there were 329 hospital admissions caused by injury in the 15-24 years age group in Blackburn with Darwen. This equates to an annual rate of 167.0 per 100,000 children, which is significantly higher than the England average of 130.7.

Figure 4.21 Hospital admissions caused by injuries to children (15-24 years), 2012/13
According to a study of child accidents and injuries in the North West:

- Rates of emergency admissions for accidental poisoning are highest among children aged 15-19 years with a rate of 71.1 per 100,000 population.
- Emergency admissions for pedal cyclists injured in transport accidents are highest among those aged 10-14 years with a rate of 124.5 per 100,000 population.
- The rate of emergency hospital admissions for while car occupants and motorcycle occupants injured in transport accidents peaks at age 15-19 years.

Information regarding A&E attendance following an accidental injury provides some understanding of the type of injuries that young people experience. However, the data is somewhat limited by the process of coding by A&E staff which might lead to subjective interpretations of injury presentation type.
vast majority of injury attendances in A&E are coded as ‘other injury’, something which should be addressed to improve the local intelligence for accidental injury prevention.

### 4.3 Programme Area 3: Injuries sustained as a result of road traffic incidents

Many positive steps have been made through local casualty reduction initiatives to reduce the number of children killed and seriously injured on the roads in Blackburn with Darwen. The rate of per 100,000 children killed & seriously injured in Blackburn with Darwen have been reduced by 58% against a baseline originally set in 1994-1998, in line with the national requirement of 50%. Blackburn with Darwen is on track for a 25% reduction by 2015.

However, there are some real challenges for Blackburn with Darwen with regards to accidental injuries as a result of road traffic incidents. Children living in the 10% most deprived wards are 5 times more likely to be involved in a road traffic collision than those living in the 10% most affluent wards. But this is not to say that we shouldn’t and can’t start to identify what this link is and make steps to address wider factors relating to deprivation and poverty and their links to road casualties.

With a rate of 44.92 per 100,000 population killed or seriously injured for all age groups, Blackburn with Darwen has the 46th highest rate out of 160 Local Authorities.

Figure 4.31 Killed and Seriously Injured Casualties on England’s Roads (2010-2012), all ages

Source: APHO, 2013
The Child and Maternal Health Observatory 2014 local profile for Blackburn with Darwen shows that between 2010-2012, Blackburn with Darwen had the second highest rate (per 100,000 children) of children killed or seriously injured on the roads out of 160 local authorities in England. It is acknowledged that Blackburn with Darwen does have a high proportion of children and young people, this statistic compares rate per 100,000 children, allowing comparison with other areas regardless of child population size. The graph below shows the Local Authority Cluster Membership within which Blackburn with Darwen is categorised. These local authorities have a similar population demographic to Blackburn with Darwen including the index of multiple deprivation.

When we compare the rate per 100,000 children killed or seriously injured in road traffic collisions with England and North West averages, it is possible to see that there is potential to improve this outcome.
Positively, there have been no child fatalities in Blackburn with Darwen since 2006, and the number of children killed or seriously injured on the roads is low, which means that making any impact these figures is a real challenge. However, we see much higher numbers of 'slight injuries' which presents a significant opportunity to demonstrate improvement. Over a period of 8 years, the number of children slightly, seriously and fatally injured on the roads in Blackburn with Darwen has remained generally the same which can be seen be the plotted trend line below. This is despite a continuous reduction in rates for England and the North West as shown on the previous graph; indicating the Blackburn with Darwen is perhaps not improving at the same speed as the rest of the United Kingdom.

![Accidental Injuries to Children aged 0-17, as a result of Road Traffic Incidents in Blackburn with Darwen (2006)-2013](image)

<table>
<thead>
<tr>
<th>Year</th>
<th>KSI</th>
<th>Fatal</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006</td>
<td>15</td>
<td>2</td>
</tr>
<tr>
<td>2007</td>
<td>16</td>
<td>0</td>
</tr>
<tr>
<td>2008</td>
<td>16</td>
<td>0</td>
</tr>
<tr>
<td>2009</td>
<td>18</td>
<td>0</td>
</tr>
<tr>
<td>2010</td>
<td>13</td>
<td>0</td>
</tr>
<tr>
<td>2011</td>
<td>19</td>
<td>0</td>
</tr>
<tr>
<td>2012</td>
<td>9</td>
<td>0</td>
</tr>
<tr>
<td>2013</td>
<td>14</td>
<td>0</td>
</tr>
</tbody>
</table>
When we consider the profile for Blackburn with Darwen by age group:

- children in the 0-5 years age group are most likely to be injured as a pedestrian or car occupant
- the risk of being injured in a road traffic incident greatly increases in the 16-20 age group and remains high until 45 years of age
- the risk of being injured as a pedal cyclist is highest in the 6-10, 11-15, 26-35 and 36-45 years age groups
- for people aged 56+, the risk of being injured on the road is greatest as a car occupant (driver or passenger), closely followed by pedestrians

<table>
<thead>
<tr>
<th>Casualty type</th>
<th>Pedestrians</th>
<th>Pedal cyclists</th>
<th>Car occupants</th>
<th>Motorcyclists</th>
<th>Other</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-5</td>
<td>29</td>
<td>0</td>
<td>34</td>
<td>0</td>
<td>0</td>
<td>63</td>
</tr>
<tr>
<td>6-10</td>
<td>54</td>
<td>13</td>
<td>51</td>
<td>0</td>
<td>0</td>
<td>118</td>
</tr>
<tr>
<td>11-15</td>
<td>50</td>
<td>12</td>
<td>57</td>
<td>1</td>
<td>2</td>
<td>122</td>
</tr>
<tr>
<td>16-20</td>
<td>34</td>
<td>8</td>
<td>137</td>
<td>41</td>
<td>5</td>
<td>225</td>
</tr>
<tr>
<td>21-25</td>
<td>21</td>
<td>7</td>
<td>162</td>
<td>28</td>
<td>4</td>
<td>222</td>
</tr>
<tr>
<td>26-35</td>
<td>26</td>
<td>13</td>
<td>273</td>
<td>17</td>
<td>10</td>
<td>339</td>
</tr>
<tr>
<td>36-45</td>
<td>34</td>
<td>15</td>
<td>205</td>
<td>22</td>
<td>13</td>
<td>289</td>
</tr>
<tr>
<td>46-55</td>
<td>23</td>
<td>5</td>
<td>129</td>
<td>12</td>
<td>9</td>
<td>178</td>
</tr>
<tr>
<td>56-65</td>
<td>20</td>
<td>5</td>
<td>71</td>
<td>9</td>
<td>5</td>
<td>110</td>
</tr>
<tr>
<td>66-75</td>
<td>11</td>
<td>1</td>
<td>41</td>
<td>1</td>
<td>2</td>
<td>56</td>
</tr>
<tr>
<td>75+</td>
<td>15</td>
<td>0</td>
<td>23</td>
<td>0</td>
<td>7</td>
<td>45</td>
</tr>
<tr>
<td>Total</td>
<td>317</td>
<td>79</td>
<td>1183</td>
<td>131</td>
<td>58</td>
<td>1768</td>
</tr>
</tbody>
</table>

**Source:** Stats 19
4.4 Programme Area 4: Injuries to people aged 65+ years in the home

Over 50% of accidental injury deaths, and over 60% of serious accidental injury, occur in people aged 65 and over. Almost half of fatalities from accidental injuries in people aged 65 and over (and the majority of non-fatal injuries) occur in the home; a quarter occur on the street or road and nearly a fifth occur in residential institutions. Literature suggests that there are three areas which cause the highest burden of mortality from accidental injury in people aged 65 and over: falls 62%, road traffic accidents 13%, fire and flames 3%.

Data collection around accidents for people aged 65 and over is poor for general injuries experienced, although anecdotal intelligence from local partners suggests that the burden of these injuries is significant, which might include: burns, poisoning, wounds and head injuries. There is some good understanding about the local prevalence of accidental injuries resulting from falls in this age group. We do know that older people visiting A&E as a result of an accidental injury at home are more likely to be admitted than any other age group. Since the year 2000, the number of people aged over 60 needing inpatient care for a falls related injury has more than doubled, standing at more than 357,000 in 2010–11 in NHS hospitals in England.

In 2010/2011, Blackburn with Darwen had the 40th highest rate of hospital admissions for injuries due to falls in people aged 65 out of 150 local authorities in England, with a rate of 2344 per 100,000 of the population of older people, significantly higher than the England average.

![Figure 4.41 Directly standardised rate of emergency hospital admissions for injuries due to falls in people aged 65 and over, England, 2012/13](image)
Blackburn with Darwen has the 51st highest rate of hip fractures in people aged 65 to 79 years of age, out of 150 local authorities in England, with a rate of 587.3 per 100,000 of population. This is in line with the England average.

Figure 4.42 Directly age-sex standardised rate per 100,000 emergency hospital admissions for fractured neck of femur in persons aged 65 to 29, England, 2012/13

Source: PHIDF, 2014
5. Good practice

5.1 Programme Area 1: Accidental Injuries to Children Aged 0-5 Years in and around the Home

There is an emerging body of evidence around what works in the prevention of accidental injuries to children aged 0-5 years in and around the home. The World Health Organisation European report on child injury prevention\textsuperscript{65} highlights the importance of providing safe environments, not just focussing on changing individual behaviour. The report also identifies the importance of partnerships between different bodies for accident prevention and the need for cross-sectoral action to ensure safe environments, and the integration of safety measures within broader policies.

Figure 5.11 Broad approaches effective in reducing accidents to children aged 0-5 years in and around the home\textsuperscript{66}
NICE makes recommendations based upon the most cost effective measures for accident prevention interventions. General recommendations include co-ordination of accident prevention activities, workforce capacity building and improving data quality. For accidents to children aged 0-5 in the home environment, NICE recommends:

- installation of permanent home safety equipment including: stair gates, smoke and carbon monoxide alarms, thermostatic mixer vales and window limiters
- home safety assessments for homes where children aged 0-5 reside. A home safety assessment should include “systematically identifying potential hazards in these areas, evaluating the risks and providing information or advice on how to reduce them”. NICE recommends that home safety assessments may be carried out by a trained assessor or by parents, carers and other householders using an appropriate checklist

The national evaluation of the RoSPA Safe at Home scheme which supported the provision of free stair gates and fireguards to all children at six months of age, estimated that the cost of equipment for each child in receipt of the scheme was £95.99 per head, against the estimated treatment cost of a non-fatal home injury to a child aged 0-4 years of £10,600.

There are two Cochrane reviews which provide an overview of research evidence for effective interventions to prevent accidents to children aged 0-5 years in the home. The first review examines home safety education and provision of safety equipment, taking into account 98 separate studies, and concludes that research evidence supports this intervention, especially with the provision of safety equipment. The second review considers the evidence base for parenting interventions to reduce accidental injuries, taking into account 22 separate studies and concluded that parenting interventions may be effective in reducing accidents to children aged 0-5 years in the home.
RoSPA advocate for improvements to home safety standards for new and refurbished homes, which exceed current Building Regulations in the United Kingdom. RoSPA make 10 recommendations for safety standards which make a significant contribution to the reduction of accidents for children aged 0-5 years in the home:

Figure 5.12 RoSPA recommended home safety standards

- Provision of secure cupboards which cannot be accessed by children for storing chemicals and/or medicines, located at 1.5m in the kitchen.
- Staircase with provision for fixing for a European Standards EN1930 stair gate.
- Fireplace with adequate provision for fixing of British Standard fire guard.
- Installation of window restrictors on windows above ground level.
- Window controls to be easily accessible. Windows in kitchens or bathrooms should be operable at worktop level, or the windows and high-level vents should be provided with some low level mechanical means of opening.
- Provision of second handrail to staircases within and around the home.
- Provision of grab rails to the bath and WC of all new dwelling irrespective of age, or level of mobility of the occupants.
- Depth of stair treads in houses to be reduced with the rise not exceed 170mm and a going of at least 250mm.
- Water temperature to be safely controlled. Water at the point of delivery to baths to be controlled by a Thermostatic Mixing Valve, limiting temperature to no more than 46 degrees centigrade.
- Provision of safety advice for the home and garden to be fixed, with a protective cover, on a wall in an appropriate visible location in the house.
5.2 Programme Area 2: Accidental Injuries to Young People in their Leisure Time

We need to be careful that accident prevention strategies do not have a negative impact upon physical activity and healthy weight. There is some concern that an over-emphasis on children's safety limits their play, freedom of movement and development of relationships. There needs to be a better balance between protecting children from genuine threats and giving them rich, challenging opportunities through which to learn and grow. RoSPA suggest that children should be "as safe as necessary, not as safe as possible", but that parents and educators have a responsibility to children and young people to ensure that they are able to make the distinction between manageable and unmanageable situations.

Accidental injury prevention for this age group needs to take into account leisure time spent in a variety of different settings, broadly encompassing supervised and unsupervised activities. In order to address these injuries, we therefore need to equip young people with the skills to assess and manage risk when they not informal leisure settings, encourage and empower young people to access organised leisure activities whereby risk can be more easily managed through risk assessment, and support the organisers of leisure activities for young people to strive for high levels of safety.

A growing number of children and young people who describe themselves as lonely or socially isolated. Social isolation and loneliness has been linked to an increased likelihood that a person will partake in risk taking behaviours. These risk taking behaviours are linked with a greatly increased risk of accidental injury.

‘Learning About Safety by Experiencing Risk’ (LASER) is an approach used by a number of schemes across the United Kingdom. Practical, interactive scenarios teach children aged 9–11 how to deal with hazards in a fun and exciting way to prepare them for their teenage years. “Learning by doing” benefits children hugely throughout life as it teaches them to assess risks and become more independent so they can enjoy activities, such as climbing trees, safely. Children need to be taught how to enjoy the world around them while keeping themselves free from injury. Evidence shows that LASER teaching methods enable children to retain information such as hazard recognition and rescue procedures more effectively, and for longer periods of time, than classroom-based study. The LASER Alliance is hosted by RoSPA and provides a network of agencies who use the LASER approach to share good practice on a local and national level.
Some LASER schemes run all-year-round at permanent venues, whilst others take the form of annual multi-agency schemes that operate for one to four weeks and can reach large numbers of pupils in a short space of time.

**Figure 5.21 NICE recommendations to reduce the risk of accidental injury in outdoor play and leisure**

<table>
<thead>
<tr>
<th>Developing policies for public outdoor play and leisure which:</th>
<th>Providing education and advice on water safety</th>
<th>Water safety advice for leisure providers</th>
<th>Conducting local firework safety campaigns</th>
<th>Advising on off-road cycle safety</th>
</tr>
</thead>
<tbody>
<tr>
<td>take a balanced approach to assessing the risks and benefits of play and leisure environments and activities</td>
<td>know which groups of children and young people are at high risk of drowning</td>
<td>use risk analysis and management procedures to identify where there may be a risk of drowning</td>
<td>use emergency department surveillance data to inform local firework injury prevention campaigns</td>
<td>use local information campaigns and ongoing education to encourage cycle training and promote the use of correctly fitted and fastened cycle helmets while cycling off the road</td>
</tr>
<tr>
<td>counter excessive risk aversion</td>
<td>help parents, carers, older children &amp; young people identify &amp; address the potential risks from water in the wider environment</td>
<td>encourage children, young people, their parents and carers to become competent swimmers</td>
<td>conduct local firework injury prevention campaigns during the lead up to all celebrations and festivals where fireworks are used</td>
<td></td>
</tr>
<tr>
<td>take into account children and young people’s preferences</td>
<td>ensure swimming lessons include water safety information</td>
<td>provide water safety information in a range of languages and formats, displayed at appropriate locations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>are inclusive, taking into account the needs of all children and young people</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Blackburn with Darwen Accident Prevention Strategy 2014-2017
Supporting recommendations set out by the National Institute for Health and Clinical Excellence, The National Children’s Bureau recommend that politicians, directors and senior managers need to be involved at a policy level to establish the framework within which risk in play is managed. The Bureau set ambitious targets to move from a conventional risk assessment model to a risk-benefit assessment model which allows young people to negotiate manageable risks which have the positive outcomes of increased resilience and risk taking capacity.

Table 5.21 Risk-benefit assessment: model questions

<table>
<thead>
<tr>
<th>Questions for Consideration</th>
<th>Possible Sources of Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>What are the benefits – for children and young people, and for others?</td>
<td>These will vary depending on the topic under consideration.</td>
</tr>
<tr>
<td>What are the risks?</td>
<td>They could include:</td>
</tr>
<tr>
<td>What views are there on the nature of the risk, and how authoritative are they?</td>
<td>• common sense, experience</td>
</tr>
<tr>
<td>What relevant local factors need to be considered?</td>
<td>• observation of play space/equipment in use by</td>
</tr>
<tr>
<td>• characteristics of the site</td>
<td>• children</td>
</tr>
<tr>
<td>• local population and likely users</td>
<td>• standards</td>
</tr>
<tr>
<td>• other play opportunities nearby</td>
<td>• guidance and resources from relevant agencies</td>
</tr>
<tr>
<td>What are the options for managing the risk, and what are the pros, cons and costs of each?</td>
<td>• expert opinion</td>
</tr>
<tr>
<td>• increase the opportunities for engagement</td>
<td>• views of colleagues and peers</td>
</tr>
<tr>
<td>• (with good risk)</td>
<td>• relevant experience from other providers</td>
</tr>
<tr>
<td>• do nothing</td>
<td>• national data sources</td>
</tr>
<tr>
<td>• monitor the situation</td>
<td>• local data sources</td>
</tr>
<tr>
<td>• mitigate or manage the risk</td>
<td>• research studies</td>
</tr>
<tr>
<td>• remove the risk</td>
<td>• local knowledge</td>
</tr>
<tr>
<td>What precedents and comparison are there?</td>
<td></td>
</tr>
<tr>
<td>• from other providers</td>
<td></td>
</tr>
<tr>
<td>• from comparable places, spaces, services and activities</td>
<td></td>
</tr>
<tr>
<td>What is the risk-benefit judgement?</td>
<td></td>
</tr>
<tr>
<td>How should the judgement be implemented in the light of local political concerns, cultural</td>
<td></td>
</tr>
</tbody>
</table>
5.3  **Programme Area 3: Injuries sustained as a result of road traffic incidents**

In systematic reviews of research and literature, carried out by the Cochrane Collaboration relating to strategies to reduce the incidence and severity of injuries sustained as a result of road traffic incidents, there is significant evidence to suggest:

There is great emphasis placed upon the use of community assets to reduce the number of casualties on the roads in The Strategic Framework for Road Safety. Specifically, the Department for Transport (DfT) recommend improved provision of information to local communities to enable them to challenge local priorities and local setting of speed limits. Furthermore, the Voluntary, Community and Social Enterprise (VCSE) sector play an important role in promoting the importance of road safety and helping to deliver it in areas such as educating children, raising awareness and driver initiatives. There is a need to work with the VCSE community to improve advice, practical implementation and to support these groups to take a leading role in delivering road safety initiatives.

Figure 5.31 Evidence Based Interventions to reduce Accidents on the Roads

- **Speed camera installation and maintenance are a worthwhile intervention to reduce the number of road traffic injuries and deaths** (Wilson et al. 2010)
- **Pedestrian safety education can result in improvement in children’s knowledge and observed road crossing behaviour. It is not known if this reduces injuries sustained on the roads. Changes in safety knowledge and observed behaviour decline with time: safety education must be repeated** (Duperrex et al, 2002)
- **Non-legislative interventions, particularly community-based interventions and those providing free helmets are effective in increasing cycle helmet use** (Owen et al. 2011)
- **Bicycle helmet legislation appears to be effective in increasing helmet use and decreasing head injury rates in the populations for which it is implemented** (Macpherson & Spinks, 2008)
- **Interventions to increase acquisition and use of booster seats among children age four to eight years are effective when they combined with incentives such as booster seat discount coupons or gift certificates** (Ehiri et al. 2006)
- **Street lighting may prevent road traffic crashes, injuries and fatalities** (Beyer & Ker, 2009)
- **Visibility aids have the potential to increase visibility and enable drivers to detect pedestrians and cyclists earlier** (Kwan & Mapstone, 2006)
- **Area-wide traffic calming in towns and cities may be a promising intervention for reducing the number of road traffic injuries and deaths** (Bunn et al, 2003)
The National Institute of Health and Clinical Excellence make two sets of recommendations which provide cost effective interventions to reduce the number of children killed or seriously injured as a result of road traffic incidents:

Figure 5.32 NICE recommendations to reduce Accidents on the Roads
Public Health England make three recommendations which will have an important impact in reducing injuries and deaths on the roads among children and young people under 25 years:

- **Reducing unintentional injuries on the roads among children and young people under 25 years**

  - **Improve safety for children travelling to and from school:** school travel plans, engineering measures, consideration of active travel support
  - **Introduce 20mph limits in priority areas as part of a safe system approach to road safety:** 20mph zones and limits, education and publicity, appropriate road engineering measures, and enforcement activities
  - **Action to prevent traffic injury and improve health must be co-ordinated:** co-ordinated to encourage active travel and create liveable streets, planning and evaluation of road safety activities should consider the impact on other health issues

![Figure 5.33 Strategies to reduce unintentional injuries on the roads among children and young people](image)

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Blackburn with Darwen Accident Prevention Strategy 2014-2017 78
Measures to reduce speed: 20mph zones and limits

Many positive steps have been made in Blackburn with Darwen towards the implementations of 20mph speed limits within the Borough. There are already 442 roads in Blackburn with Darwen that have 20mph limits. A pilot to evaluate new 20mph limits in Mill Hill is currently underway, using speed radar reading before and after the new speed limit is in place.

20mph Zones
20mph zones use traffic calming measures to reduce the adverse impact of motor vehicles on built up areas. The principle is that the traffic calming slows vehicles down to speeds below the limit, and in this way the zone becomes “self-enforcing”. Speed humps, chicanes, road narrowing, planting and other measures can be introduced to both physically and visually reinforce the nature of the road.82,83

20mph Limits
20mph limits are areas where the speed limit has been reduced to 20mph but there are no physical measures to reduce vehicle speeds within the areas. Drivers are alerted to the speed limit by 20mph speed limit repeater signs. There has been an expansion of 20mph limits in the UK recently. The reasons for this are not solely for road safety reasons, with many being introduced to contribute towards healthier environments.82,83

There is a national move towards 20mph zones and limits, with The Department for Transport Circular recommending that, for residential streets and other town and city streets with high pedestrian and cyclist movement, local traffic authorities should consider the use of 20mph schemes. They continue to report that 20mph zones are very effective at reducing collisions and injuries. This is further supported by Living Streets84 who recommend that “local authorities should implement 20 mph limits where people live, work and shop as the single intervention with the most impact on civilising our streets”, linking 20 mph to reduced injuries but also to a boosted local economy supported by shoppers on foot.

Research carried out for the report ‘Why Children Die’85 found that over three quarters of injury deaths in 10-18 year olds are due to traffic incidents, more than 80% of child road casualties occur on 30mph limited streets. Wolfe et al85 found that around 2,000 additional children per year—5 a day—die in the UK compared to Sweden, where there is a ‘vision zero’ for deaths on the roads. Policy recommendation 23 aligning to ‘Why Children Die’, expresses that the national speed limit in built-up areas should be reduced to 20mph.86 Blackburn with Darwen will lobby national government for a national default 20mph in all residential areas.
The Swedish ‘Vision Zero’ is an ethical, political and scientific approach to road safety which aspires to zero deaths on the roads.\textsuperscript{82}

Figure 5.34 The Swedish ‘Vision Zero’ Model

**Ethical**

It is not acceptable that people are killed or seriously injured whilst using the roads and that health should not be traded for mobility. Therefore, the aim should be to eliminate deaths from injury entirely rather than just reduce them.

**Scientific**

This is supported by a scientific statement: the only way to achieve this is to prevent exchanges of energy that would be likely to cause death.

**Political**

Road users cannot achieve ‘vision zero’ on their own and that responsibility for doing so is shared between the road designers, who design a safe system, and the road users themselves. Rather than stating that road users should not make errors, this admits that often they do occur, but also that roads and cars should be designed so that these errors do not result in death.
A modelling exercise by the North West Public Health Observatory has concluded that if all residential roads had had 20mph limits, 140 fewer children would have been killed or seriously injured on the region’s roads each year between 2004 and 2008. In Blackburn with Darwen, this would have saved approximately four child deaths or serious injuries each year.

There is a growing body of evidence to support the implementation of 20mph zones. A Cochrane review of 22 studies found that area-wide traffic calming in towns and cities are a promising intervention for reducing the number of road traffic injuries and deaths. An analysis conducted of all the previous studies to work out the best estimate of effect, found that traffic calming schemes reduced the number of injury accidents by about 15% on average. Schemes in residential areas showed a greater reduction in injuries.

Danny Dorling⁸⁷ explains that there is controversy over what some call ‘signs-only 20mph’, as most of the evidence that 20mph zones are effective comes from areas where some physical barriers have also been added, such as road humps, to slow down cars and lorries. However, the lack of evidence from signs-only 20mph areas is due to there being fewer such areas as yet, and thus fewer studies.

The National Institute for Health and Clinical Excellence make specific recommendations in relation to 20mph speeds which reflect reflecting the current evidence available and expert discussions:

- Introduce engineering measures to reduce speed in streets that are primarily residential or where pedestrian and cyclist movements are high. These measures could include: speed reduction features (20mph zones) or changes to the speed limit with signing only (20 mph limits) where current average speeds are low enough, in line with Department for Transport guidelines.
- Implement city or town-wide 20 mph limits and zones on appropriate roads. Use factors such as traffic volume, speed and function to determine which roads are appropriate.
- Consider changes to speed limits and appropriate engineering measures on rural roads where the risk of injury is relatively high, in line with Department for Transport guidance.
- Take account of the factors identified in local needs assessments when introducing measures.
The broader benefits of 20mph

Reducing deaths on the roads is just the first of number of reasons why introducing 20mph limits makes sense. People should not have to risk such a high chance of death or serious injury wherever and whenever they want to walk or cycle. There are also wider public health benefits to 20mph limits:

- 20mph is better for drivers – drivers cut their spacing as braking distances contract. Shorter gaps mean more vehicles can use the available road space, reducing standing traffic.\(^\text{88}\)

- Filtering at junctions becomes easier. It is far easier for motorists to pull into traffic travelling at 20mph than at 30mph. It is also much easier for cycles to avoid being cut up by cars and lorries when they are travelling more slowly and turning left less rapidly.\(^\text{89}\)

- Motor traffic volumes decrease, since slower speeds encourage active, sustainable and shared travel. Walking and cycling levels rose by up to 12% after Bristol's 20mph limit was introduced.\(^\text{90}\)

- Buses operate more efficiently. The reduced length of traffic queues means that bus journey times decrease, and become more reliable. Buses become a more attractive alternative to the car.

- More children are likely to walk or cycle to school on their own. Parents are not tied to the school run, and children have their freedom increased.

- Older people are less fearful of going out of their home, trying to cross the street, or of driving their own cars at a reasonable (i.e. slower) speed, rather than always at 30mph; with the potential to reduce social isolation and loneliness.

- All those people who are afraid to cycle become more likely to cycle. The population as a whole benefits from not sitting in cars and gaining weight.

- Pollution is reduced and less petrol is consumed with environmental benefits.

- Neighbourhoods work better locally. There is a greater incentive to use local shops rather than drive to supermarkets. 20mph is very good socially, locally as well as environmentally, globally.

- People learn that, if they can alter their environment to make it more sociable in terms of speed, then maybe there are other things they can change.
5.4 Programme Area 4: Injuries to people aged 65+ years in the home

Falls

There is very little evidence or research to make recommendations regarding general injuries experienced by older people in the home. However, there is range of evidence to support interventions to reduce the risk of falls for older people including the NICE, The World Health Organisation and a Cochrane Review of 159 trials.\textsuperscript{91} make recommendations for cost effective interventions to reduce the risk of falls in older people in the community:

Figure 5.41 Evidence Based Interventions to reduce the risk of falls in Older People\textsuperscript{40,14,91}
Alcohol and Older People

It is widely recognised that problematic consumption of alcohol leads to an increased risk and incidence of accidental injury. There is growing body of evidence to suggest that a growing number of older people participate in problematic alcohol consumption activities, but that these go largely unreported due to poor screening of older adults for alcohol problems; and inappropriate alcohol screening tools for use with older people (Dar, 2006). Evidence suggests that interventions to reduce problem drinking appear to reduce injuries and their antecedents including falls and road traffic incidents, therefore routine enquiry regarding alcohol consumption for all older people who present for treatment of an accidental injury may offer new opportunities for accident prevention through alcohol interventions.
### 6. Current services/initiatives

The tables below demonstrate activity being undertaken by partners but should not considered as an exhaustive list.

<table>
<thead>
<tr>
<th>Programme Area</th>
<th>Agency</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accidental injuries to children aged 0-5 years in the home</td>
<td><strong>Lancashire Care NHS Foundation Trust, 0-19 Service</strong></td>
<td>Universal home safety assessment/information provision at core visits across the healthy child programme. Targeted home safety assessment in Safety First Scheme at 6 months of age in the bottom 10% deprivation LSOA. Safety equipment to children age around 6 months in the bottom 1% SOA, fitted by BwD DASH Service. Annual safety messages calendar designed by local school children and given to every reception class child.</td>
</tr>
<tr>
<td></td>
<td><strong>Blackburn with Darwen DASH Team: Home Safety Technician</strong></td>
<td>Vulnerable families with a child under 24 months living in the bottom 1% LSOA’s. Fitting of 2 x Safety Gates and 1 x Fireguard in the homes of vulnerable families. Equipment fitted in 200 properties per year. Referrals to this service made by LCFT Nursery Nurses during their visit at 6 months home safety assessment visit.</td>
</tr>
<tr>
<td></td>
<td><strong>Blackburn with Darwen Early Years and Early Help: Early Years Family Support Geo Team</strong></td>
<td>Safer Sleep Campaign for families with new babies. Chemical Soup: poisoning awareness for families with young children. General information for all families: road safety, burns, fire prevention, car seat safety, falls, trips, choking.</td>
</tr>
<tr>
<td></td>
<td><strong>Lancashire Fire and Rescue Service</strong></td>
<td>Fire home safety assessments and fitting of free smoke alarms on request or referral.</td>
</tr>
<tr>
<td></td>
<td><strong>Alcohol Strategy</strong></td>
<td>Acknowledgement in Blackburn with Darwen Alcohol Strategy of the relationship between parental alcohol misuse and accidents.</td>
</tr>
<tr>
<td></td>
<td><strong>Homestart</strong></td>
<td>Home-visiting family support through trained volunteers; 55-60 families every week. Make referrals for home-safety equipment.</td>
</tr>
<tr>
<td></td>
<td><strong>Paediatric Pathways Group</strong></td>
<td>Action for 2015/2015 to complete work around appropriate access to care for young children following accidents (better use of Primary Care Services).</td>
</tr>
<tr>
<td>Programme Area</td>
<td>Agency</td>
<td>Activity</td>
</tr>
<tr>
<td>----------------</td>
<td>--------</td>
<td>----------</td>
</tr>
<tr>
<td>Accidental injuries to young people in leisure time</td>
<td>Multi-agency collaboration</td>
<td>Streetwise scheme, a three week event for pupils in year 6 who each spend one half day at the event. This is a multi-agency approach to risk taking behaviours in preparation for the move to High School. Partners may vary on an annual basis but has previously included: swimming development, Lancashire Fire and Rescue Service, Road Safety Team, Transport Police, Red Cross, RNLI, Lancashire Constabulary.</td>
</tr>
</tbody>
</table>
| | Leisure Services | Stay Safe for Summer Programme  
‘Rookie Lifeguard’ course lasting 1 week, advertised in leisure centres and to children having swimming lessons  
National curriculum swimming lessons for those schools that choose to participate |
| | Young People’s Services | Deliver a wide range of activities for young people in Blackburn with Darwen including after school and youth clubs, holiday activities and young people’s councils. |
| | Lancashire Care NHS Foundation Trust 5-19 Service | School Health Needs Assessment for each school, some schools have safety as an identified need  
Safety First Scheme annual safety calendar; competition for Primary School children |
| | Alcohol Strategy and Action Plan | Links with priority areas, licensing and protection of the community  
Need to establish more clearly what the link between alcohol consumption and accidental injuries is  
Need better data to demonstrate this relationship locally |
| | Voluntary Sports Sector | All coaches and volunteers must meet minimum standards before they can operate  
Includes need for welfare officers and first aid risk assessments.  
Club Mark programme (national) - to encourage clubs to strive towards minimum standards and improve delivery of activities  
Community Sports Leader Awards |
| | Blackburn Youth Zone | All volunteers and staff are first aid trained  
Educational programmes and safety messages to all young people who attend  
Community Sports Leader Awards  
Website and facebook to deliver messages to young people |
| | Community Sports Forum | Voluntary organisations providing sporting activities |
| | Uniformed Groups | Delivery of safety messages  
Explorer skills |
<p>| | Bright Sparks | Community Safety Partnership funded campaign: Lancashire Fire and Rescue Service and Lancashire Constabulary to address firework safety |</p>
<table>
<thead>
<tr>
<th>Programme Area</th>
<th>Activity</th>
<th>Outputs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Injuries sustained as a result of road traffic incidents</td>
<td>Parking around schools: High profile targeted campaign</td>
<td>To progress this via a specific, visual Your Call campaign on road safety around schools borough wide. Information gathering exercise on the number of accidents around schools, how many fines issued around schools. Continue to work with schools in densely populated urban areas to roll out events out of schools to target drivers parking inconsiderately or illegally with the help of school children. Targeted engagement days at local community and neighbourhood centres.</td>
</tr>
<tr>
<td>Wider Community: Targeted campaign re. Seat Belts</td>
<td></td>
<td>To progress this via your Call and a continuation of Accredited Training Courses undertaken with provider Child Seat Safety Limited (as seen on BBC Television in March 2014). To work with Lancashire Constabulary on random roadside spot checks. Complementing work done by the BwD DASH service with selected families receiving home safety equipment provision. Targeted engagement days at local community and neighbourhood centres.</td>
</tr>
<tr>
<td>Pre school and Infant school aged children</td>
<td></td>
<td>As part of the Council’s “Cradle to Grave” approach. Nursery talk on road safety: 30 minute interactive session with pre school children. Reception talk on road safety: 30 minute interactive session with reception children. School Assemblies: Interactive 20 minute presentation</td>
</tr>
<tr>
<td>Junior school age children</td>
<td></td>
<td>School Assemblies: Interactive 20 minute presentation. Junior Road Safety Officers: Continuous year round engagement with nominated year 5 or 6 road safety champions. Pedestrian training: 10 week intensive course. Year 5 lesson: 1 hour 30 minute practical session</td>
</tr>
<tr>
<td>High school age children and teenagers</td>
<td></td>
<td>School Assemblies: Interactive 20 minute presentation. Pre driver courses</td>
</tr>
<tr>
<td>Mosque Marshalling</td>
<td></td>
<td>550 pupil sessions delivered as well as training and facilitation of Marshals who assist children across the road</td>
</tr>
<tr>
<td>Bikeability</td>
<td>Bikeability (ages 11-14): Practical on road cycle course to help raise children’s awareness and confidence on roads. 8 hours tuition in total on road during one week.</td>
<td>To continue to be robust in relation to Parking Enforcement around schools and to develop proposals for “smartcar” enforcement and postal PCNs. Enforcing parking offences via smartcar and fixed camera</td>
</tr>
<tr>
<td>Highways Infrastructure &amp; Neighbourhoods</td>
<td>The Morning After</td>
<td>Joint campaign initiative with LPRS, Fire and Rescue and CRT targeting young drivers in relation to risk and consequences of drink driving. Build on Alcohol Strategy and Action Group.</td>
</tr>
<tr>
<td>Lancashire Fire and Rescue Service</td>
<td></td>
<td>Develop a new KPI for road safety. Need to develop and support this activity.</td>
</tr>
<tr>
<td>Lancashire Partnership for Road Safety (LPRS)</td>
<td></td>
<td>To investigate the future role of the LPRS in relation to future pressures on budgets.</td>
</tr>
<tr>
<td>Programme Area</td>
<td>Agency</td>
<td>Activity</td>
</tr>
<tr>
<td>-----------------------------------------------------</td>
<td>------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| Accidental injuries to people aged 65+ in their own homes | Blackburn with Darwen Decent and Safe Homes (DASH) Service            | Handyperson service for people aged 60+ and adults in receipt of DLA. Complete small DIY type repairs free of charge for the first two hours, there is a small fee thereafter.  
Energy efficiency service available to all residents of the Borough. Provide advice and support across a range of energy efficiency and fuel poverty issues.  
Home safety assessment for people aged 60+ who have had a fall, are at risk of a fall or have a fear of falling. A DASH liaison officer carries out an environmental, room by room hazard assessment of a client’s home to identify risks. Advice is provided and referral to a handyperson made if appropriate. Small aids can also be provided and referral to other agencies is made as appropriate.  
Enhanced Housing Options for people aged 60+ and adults in receipt of DLA. Offers free, confidential and impartial advice on the various housing options available taking into account a person’s often complex reasons for considering a move. Assists with the BwithUS registration process to ensure the correct banding is allocated.  
Home Maintenance service is available to all homeowners. Offers free internal and external survey of property to identify areas of disrepair and to prioritise remedial works. |
<p>| Independent Living Service, Adult Services          | Blackburn with Darwen Council                                          | Available for all vulnerable adults aged 18+ years providing a range of aids and home modifications to enable local people to live independently in their own home. This might include occupational therapy equipment, sensory equipment, assistive technology or moving and handling equipment. |
| Re:Fresh Falls Prevention Service                   | Age UK                                                                 | For people aged 65+ years who have had a fall, are at risk of falling or who have a fear of falling. Services include: home assessments, exercise sessions in the home of community setting, education and other relevant sessions in conjunction with the lifelong learning, prevention and educational campaigns to the wider population. |
| GP Practices                                        | Lancashire Fire and Rescue Service                                    | Priority age group for people aged 65+ years. Provide targeted home fire safety check, will fit smoke alarms as required Electric blanket testing with Age UK |
| Age UK                                              | Lancashire Fire and Rescue Service                                    | A wide range of local service for people aged 50+ years including: Advice and Information Service, Aging Well Project, Befriending, Digital Tuition, Daycare Centres, Footcare Service. |
| Care Network                                         | Care Network                                                          | Third sector organisation for vulnerable adults. Match local people with assured local providers to undertake a range of services including building work, plumbing etc. Care Network employees make onward referrals as appropriate if home safety hazards are identified. |
| 50+ Partnership                                      | 50+ Partnership                                                       | Integrated Strategic Needs Assessment on falls is underway                                                                                                                                             |</p>
<table>
<thead>
<tr>
<th>Community Wellbeing Coordinators</th>
<th>Targeted community level initiatives aimed to reduce social isolation and loneliness; this includes a Good Neighbour Scheme and providing support to community groups to apply for funding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sustainable Neighbourhoods Service</td>
<td>Provide a range of education programmes for older people in the community. These include ‘Keeping warm and safe in winter’ (slips trips and falls, hypothermia awareness), ‘Accidents in the home’ (fires, falls, malnutrition, hydration), and a wide range of other health improvement programmes to meet the expressed needs of local communities.</td>
</tr>
</tbody>
</table>
8. Value for money

8.1 The cost of accidental injuries

The cost of accidental injuries in the UK:

Accidental injuries accounted for 12.5% of emergency hospital admissions in 2010/11.

Accidents claimed the lives of 13,505 people in the UK in 2010/2011. Just under 5,000 people died as a result of a home accident.

Accidents cost society an estimated £150 billion every year.

Home and leisure accidents alone cost society £95 billion, at least £25 billion of this is paid by taxpayers through healthcare and benefits costs (RoSPA, 2012).

Research suggests that the cost of the 2.7 million home accident casualties who visit A&E in the UK each year was an estimated £45.6 billion, based on an average cost of £16,900 per victim. The findings were based on: lost contribution to the economy (lost output); the value of avoidance of injury (the amount the community would be prepared to pay to avoid the chance of an injury happening); and the cost of medical, social security and other support services. Costs to the individual and long-term care were not included and this figure does also not include the cost of home accident deaths, for which the cost per fatality is estimated at £1.61 million.

Children and Young People

Hospital admissions among under-5s following an accidental injury have been rising by five percent per annum. The average cost for A&E treatments leading to admission is £146 per patient, and £66 for minor injury services leading to an admission. This would correspond to a minimum total Accident & Emergency cost of about £9 million for unintentional child injury per year in England. Accidental injury to children and young people is estimated to cost £15.5–87 million in short-term hospital costs per annum, and in the case of traumatic brain injury to children, £640 million–£2.24 billion per annum. Those in the lowest social class have 13 times the rate of death and injury of those in the most affluent class. Injuries to children and young people also have high indirect, ‘human costs’ including enforced absence from school and the need for supervision during recovery, which often involves family and carers taking time off from paid work.
**On the Roads**

The emergency service, health service and economic output costs of road traffic injuries are significant. It is estimated that every road traffic casualty costs £1,686,532 if fatal, £189,519 if serious and £14,611 if slight. Furthermore, the economic welfare costs of road traffic injuries are estimated at £16 billion per year with insurance pay outs for motoring claims worth £12 billion per year. In 2012, the annual cost of serious injuries from road traffic accidents in BwD was estimated to be £4 million. Wider than the financial costs of accidental injuries sustained as a result of road traffic incidents, the impact of collisions and incidents on congestion, reliability and resilience of the road network are a major national and local economic cost.

**The Cost of Accidental Injuries to Older People**

For older people, the primary cause of accidental injury is from falls. Falls are estimated to cost the NHS more than £2.3 billion per year; the health care cost alone to treat a hip fracture is estimated to be £28,000 per patient. This does not include ongoing social care costs following a fall estimated to be £3325 in the year after a fall, nor does this take into account the personal costs experienced through reduced independence and increased social isolation resulting from include distress, pain or loss of confidence. Falling can also have a knock-on effect on productivity costs in terms of carer time and absence from work, anxiety, worry and potential tensions within family relationships. Accident prevention measures for older people have great potential positive impacts upon quality of life of older people, their families and carers, healthcare and social care costs and the costs to wider society.
Figure 8.1 Unintentional Injury: a framework for costs and prevention

Early interventions to prevent child injuries: framework

**Primary prevention interventions**

Examples include:
- For RTIs: Cycling path
- Helmets on bikes
- Seat belts in cars
- Speed limit enforcement
- Traffic calming measures
- For burns: Home safety regulations
- Home safety equipment
- For sport injuries: School interventions

**Injury**

*Main causes of injury:*
- Road traffic injuries
- Poisoning
- Falls
- Burns

*Most serious types of injury:*
- Head injury (incl. traumatic brain injury)
- Burns
- Spinal cord injury

**Secondary prevention interventions**

- Organisation of care in the emergency room
- Clinician-targeted interventions
- Responsiveness of the health system
- Choice of treatment
- Discharge intervention, etc.

**Death**

Number of lives that could be saved

**Short-term costs**

- Healthcare costs: Accident & Emergency treatments
- Treating injury
- Occupational therapy
- Primary care

**Good health**

**Long-term costs**

- Healthcare and social care costs: Occupational therapy
- Primary care
- Social care costs
- Disability benefits

**Other costs:**

- Poor social functioning
- Impact on physical and emotional development
- Days off school
- Psychological wellbeing of carers and family

**Economic costs:**

- Lifelong loss of productivity
- Impact on parents' productivity
Potential of Intervention

We need to prevent accidents in Blackburn with Darwen because it is proven that this activity is highly successful in reducing injuries. There are a wide range of interventions available to commissioners and service providers which are relatively low cost, easy to implement and show reasonably quick success in the reduction of accidental injury. Over the last 10 years, a co-ordinated national plan to reduce road accidents across the UK has proved highly successful; this demonstrates that a similar co-ordinated approach could have a significant impact on other types of accidents. The cost effectiveness of these interventions compared to the high financial, social and personal cost of accidents makes accidental injury prevention an obvious priority for public health both nationally and local.

A study by the Child Safety Network\textsuperscript{99} suggested that significant financial savings are associated with the use of safety products, such as smoke alarms, bicycle helmets, and child passenger restraints, as described in Table 8.1

<table>
<thead>
<tr>
<th>Every Dollar Spent On</th>
<th>Saves Society</th>
</tr>
</thead>
<tbody>
<tr>
<td>Childproof Cigarette Lighter</td>
<td>$72</td>
</tr>
<tr>
<td>Booster Seat</td>
<td>$71</td>
</tr>
<tr>
<td>Bicycle Helmet</td>
<td>$48</td>
</tr>
<tr>
<td>Child Safety Seat</td>
<td>$42</td>
</tr>
<tr>
<td>Zero Alcohol Tolerance, Driver Under 21</td>
<td>$25</td>
</tr>
<tr>
<td>Smoke Alarm</td>
<td>$17</td>
</tr>
<tr>
<td>Poison Control Centre</td>
<td>$7</td>
</tr>
</tbody>
</table>
9. Involvement

9.1 Programme Area 1: Accidental Injuries to Children Aged 0-5 Years in and around the Home

Individual interviews and small focus group sessions have been undertaken to ensure that the stories of local people are reflected in this Accident Prevention Strategy and Action Plans. Four focus groups were conducted several different Children’s Centre settings, with parent’s attending groups with their child; this was with the exception to one Father’s focus group which was especially convened with the intention of discussing the development of the Accident Prevention Strategy. Parents in the focus groups had children aged 6 months-4 years of age, and many parents also had older children aged under 10 years; focus group membership varied from 4-13 members.

**Types of injury for children aged 0-4 experienced by their parents:**
Parents asked, felt that boys aged 0-4 years have more accidents than girls in this age group. Whilst few of the parents asked had experienced a significant accidental injury which required secondary care attention, parents were in agreement that they are worried about their child having accidents, being most aware of falls when learning to walk and the risks of falling down the stairs. A small number of parents discussed previous incidents whereby their child had digested a toxic substance and were insightful that this was due to lack of supervision. Parents in general report that it often takes an adverse event for them to make changes to reduce the risk of accidents for their children.

**Current child safety information provision:**
Most parents asked felt that they had not been given enough information or support to reduce the risks of accidental injury for their young children. Only one parent had received the home safety assessment offered by the Health Visiting Service as part of the ‘Safety First’ scheme and was surprised to be told that this was not offered universally.

“The safety visit was really useful; there were a lot (of hazards) that I had not thought about. I think all first time mums should get that”

Parent
There was acknowledgement from other parents that they had been advised to purchase safety gates by the Health Visiting Service or Early Years and Early Help (Children’s Centre) staff but did not feel that they had been given appropriate information about other safety risks for their child. Several parents felt that they did not have access to Health Visiting Services once their child had turned one year old and felt that more information between one and two years of age is important due to the changes in risks for accidents as their child develops. For those parents who had been supported by the Children’s Centre geographical team, this was reported to be a great support in accident prevention amongst other issues.

Many parents related their accident prevention activities to “common sense”, whilst others suggested that they would copy the environment in the Children’s Centre in their own home. Fathers in particular related their knowledge of accident prevention to their local networks of family, friends and social networking sites. Many parents expressed that they made changes to reduce the risk of accidents for children in a reactive manner following a childhood accident. Many parents explained that they use online forums and websites to obtain child safety information.

When discussing home safety equipment, parents who participated in engagement sessions placed high importance upon the need for safety gates and other equipment including cupboard locks, table corners and plug socket covers. However, participants expressed that they know of many other parents who do not prioritise this equipment because it is too expensive and difficult to fit; many parents knew of others who did not have any safety gates in their home.

“To be honest, safety gates are a pain for the adults in the house”

Parent

Parents explained that they would purchase this equipment when local suppliers had reduced the price in a sale event, or might source secondhand equipment from car boot sales or through friends on social networking sites. None of the parents participating were aware of any guidelines relating to when safety gates should be removed; one parent explained that he would not take the safety gates down because he used them to control the movement of a family pet and wouldn’t know what to do with them if he did remove them.
Desired child safety information and equipment provision:
All parents expressed a desire for more child safety information to help them to reduce the risk of accidental injury. One mother had accessed antenatal pediatric first aid and resuscitation training through a private company; other parents in this focus group felt that this is something that they would have like to have accessed.

Parents expressed mixed feelings regarding a home safety assessment. Whilst some parents felt that a home safety assessment completed with the support of a trained practitioner would be highly useful, others expressed that this might be intrusive and would not be well received. All parents felt that information to complete a self-assessment of accident risks in the home environment would be highly useful, and would be likely to be used by the majority of parents.

Parents felt that information about child safety needs to be specific to their child’s developmental age and should be revisited frequently as their child gets older. Parents felt that information in leaflet form would be appropriate for this topic, some suggested that inserts for the child’s red book with ‘top tips’ for child safety would be a good idea. Parents felt that a website would be useful and those who use parenting forums felt that a local parenting forum would be good for networking as well as seeking support on accident prevention and other topics. The majority of parents asked did not use Twitter and did not feel that this would be a good way to convey child safety messages. Some parents felt that a Facebook page with topics tips for each day and the ability to ‘ask an expert’ would be highly useful, although other parents felt that Facebook does not provide a credible source of information and would be unlikely to trust information provided here. Parents were interested in a child safety app for smartphones but were unsure what this might include.
Parents did not have a preference for the professional who should deliver home safety messages but did suggest that it needs to be someone that they trust (for some this was Children’s Centre staff and for others the Health Visiting Service). Parents felt that a group session in the Children’s Centre to address child safety would be useful but that it would be unlikely to be accessed unless it was “disguised as something else”. Parents felt that providing information and “freebies” at local events such as Blackburn Festival, in play-centres, The Mall or at shops which sell items for children would be well received and would attract the biggest audience.

Parents would all welcome a local scheme for reduced cost home safety equipment and felt that they would be very happy to pay around £10 per safety gate. Many parents felt that a safety gate fitting service would be well received by all parents, particularly those who live in older properties where it is difficult to fit equipment. Parents expressed that properly fitted safety gates would give them confidence.

*Local services to treat accidental injuries:*

The majority of parents suggested that they would visit their GP if their child experienced an accidental injury; parents would attend Accident and Emergency only in extreme circumstances. None of the parents who participated were aware of other Primary care treatment opportunities including Blackburn with Darwen Walk-In Centres.

One parent who had moved to England from Poland 4 years ago expressed that information should be provided to parents regarding basic first aid following an accidental injury and the warning signs that should be observed to suggest that medical attention should be sought.
9.2 Programme Area 2: Accidental Injuries to Young People in their Leisure Time

Engagement with the Central Youth Forum in Blackburn with Darwen provided insight into the reality of accidental injury for young people. They told us that young people spend their leisure time in parks and the town centre when not in organised activities or settings. We are told that young people are most likely to take risks which might lead to accidents in unused buildings, landfill sites, reservoirs and other open water.

Young people tell us that there are not informal settings where they can spend their leisure time in a safe way; there should be more dedicated young people’s buildings.

The young people asked told us that there is not a lot of information, support or advice regarding risk management and keeping themselves safe. They told us that feel that the information they do receive is mostly from schools and colleges, and that this is often patronising. Young people asked told us that education and information to help them manage risk and keep safe from accidental injury should be led by young people themselves and might incorporate social media, especially video links.

The young people who took part in this engagement work told us that local stories about real young people who have experienced an accidental injury make the risk seem more real. They suggested that anonymous videos of local stories could be posted on FaceBook to have maximum impact.

We were interested in what services young people might access if they suffered an accidental injury, they told us that this would depend on the injury: if it was embarrassing they would be unlikely to tell their parents or carers. Young people told us that they might visit the Blackburn with Darwen ‘Everybody Centre’, but that this service did not also have the capacity required for young people.

When asked if young people are interested and motivated to access organised activities in their leisure time, they told us that this depends on each individual and whether local services provide activities that interest them. The young people consulted told us that some young people will access The Youth Zone or youth clubs organised by Young People’s Services. They told us that they do not have enough information about all the leisure activities that are available for Young People in Blackburn with Darwen, including community voluntary and faith groups, and that a website or Facebook page is needed. This information could then be supported by information sharing with young people by youth workers, their friends, social media, a
smartphone app, a website and by making sure that parents and carers also have information about local leisure activities.

The young people that we spoke to told us that they do not feel that they have enough opportunity to tell Local Authority leisure centres what activities they would like to be provided. They suggested that leisure centres could facilitate ‘teenage only’ sessions and make a Young People’s Suggestion Box available for ideas and comments.

The young people we spoke to told us that the opening of a Skate Park in Blackburn with Darwen is positive, and is desired leisure activity for young people that has previously not been available; they told us that they would like an information bus with youth workers who could give information and advice in different areas across the Borough.

Young people are aware of the benefits of accessing organised leisure activities including increased fitness, making friends and improving community cohesion; but told us that the blockages which prevent some young people from accessing these activities are the cost of activities (such as bowling, cinema and ice-skating) and the cost of transport. They told us that Young People’s Centres are not always in the most convenient location. Young people told us that there is a need to increase activities in neighbourhood areas that interest young people.
9.3 Programme Area 3: Injuries sustained as a result of road traffic incidents

Individual interviews and one focus group were undertaken to gather local people’s views on local road traffic challenges and potential solutions. Local people asked were all parents of children whose ages ranged from 2-18 years of age, who attend local Children’s Centres.

When asked about child car seat use by parents, participants felt that a growing number of parents do not use car seats for their children, with this being more common in younger parents. The reasons for this were thought to be: the price of car seats being too expensive and it not being possible to fit enough car seats in the car for the number of children to be carried (ie, it was believed by participants that it is not possible to fit three child car seats in the back of a standard 5 seat vehicle).

Parents all expressed that they were highly confident that the child car seat fitting service provided by large stores such as Halfords or Mothercare would be of high standard and that this information could be trusted. Participants expressed that it would be highly unlikely that parents would chose to attend an organised ‘drop in’ for child car seat fitting checks but that the presence of this type of service at local events such as the Blackburn Festival would generate more interest from parents. Participants in the focus group of dads suggested that a ‘car seat challenge’, with a time and safety element would be a good way to involve and interest parents in child car seat safety information provision.

When discussing taxi transport, parents believed that price was primarily prioritised over the potential safety of a taxi firm, and did not have any real complaints that taxis are not required to provide child car or booster seats when children are passengers.

Parents asked all felt that local communities know their own local road safety problems but are powerless to influence changes, giving the example of a local school who they believed needed an organised school crossing patrol. Participants all expressed a strong belief that parenting is important in order to keep children safe on the roads but that they have noticed some friends who fail to teach their children basic road safety messages.

All parents asked felt that 20mph speed limits were ‘brilliant’ and noted their particular importance in residential areas and around schools and Children’s Centres. However, a few parents felt that 20mph limits are not well adhered to by drivers, including those of public transport, and that better enforcement is required. Parents suggested that a 20mph limit on a road would not prevent them for taking further measures to ensure their child’s safety.
9.4 Programme Area 4: Injuries to people aged 65+ years in the home

A focus group of 15 people aged 60-91 years of age was undertaken following a Falls Prevention Service balance and mobility class.

Injuries experienced

When asked about the types of accidents experienced, the majority of participants reported that they often fall, trip or stumble leading to accidental injury; stairs and steps were reported to cause the greatest number for problems for falls injuries. Some of the participants did report that they have experienced burns through trying to lift pans boiling pans of water that are too heavy but there was little acknowledgement of other injuries experienced.

Some participants demonstrated a good level of self-awareness regarding their own limitations and were able to vocalise strategies they use to reduce the risk of accidental injury. All participants were in agreement that older people are very proud and sometimes find it difficult to accept their limitations, meaning that they might take risks that could lead to an accidental injury. When discussing the use of pendant alarms, there was a lack of recognition that these can be used in a preventative, early intervention model with one participant clear that she is “not at that stage yet”.

“\textit{I've stopped using the step ladders now}”

Focus group member

Local services

The participants of the focus group had a good general knowledge of local services available in Blackburn with Darwen which have been identified as having a role to play in accidental injury prevention. It was clear through discussions that no-one in the group knew all of the services available in Blackburn with Darwen; when discussing with others in the group, most participants were able to identify at least one service that they had need to use and were able to obtain contact details so that they could make a self-referral. Participants expressed concern that some of their more isolated friends or neighbours, who do not access regular local groups, would not have any way of knowing about local services by word of mouth as they currently do.
Participants of the focus group felt that where they did know about different local services, they were unclear about the difference between services, how these services might overlap and how to access different services. There was a great deal of positive feedback for ‘Your Support. Your Choice’, Age UK, the falls prevention service and the DASH service, from those who had used their services. Participants felt that there was a need to collect all of the information about local services for older people in one single place/document, which they suggested might also include a brief guide of what to do or where to seek help following an accidental injury, and details about local regular social events.

“The problem is, we just don’t know who runs what or when”
Focus group member

Support and treatment following an accidental injury
Focus group participants were all clear that their social networks are of high importance for support in the prevention of accidents and treatment following an accidental injury. Many of the participants felt that they did not know their neighbours well anymore, and would not necessarily feel that they could ask people in the community in which they reside to provide assistance with small tasks that they are not able to complete for themselves anymore without risk of accidental injury. Older people in the focus group expressed that they felt that they did not necessarily understand the diverse cultures that now make up the population of Blackburn with Darwen, and that communication within some communities is a real problem for them.

Very few of the focus group participants were aware of primary care services for treatment following an accidental injury other than the General Practitioner (GP). None of the participants asked felt that they would attend a Pharmacy for minor injury self-care advice and few had any knowledge about the local walk-in centre provision; the one lady who had used the services at Barbara Castle Way described them as ‘really good’. Some participants described a good experience of local Emergency Department care, but there was a general theme that participants fear ‘being left for four hours with no treatment’ and would avoid attending where possible.
Following a fall themselves or for a partner or family member, focus group participants expressed some frustration that ‘the only option is to call an ambulance’ because they are unable to get up from the floor, there was a wide recognition that although an ambulance is called, there is often no need to attend the hospital. To have to support of neighbours, friends or a falls pickup service to meet this need was expressed as the best solution to the problem of a fall with no treatment needed.

10. Recommendations

- The development and implementation of a local, multi-agency, Accident Prevention Strategy and Action Plans
Appendix D References


The Mental Health Foundation (2010) *The Lonely Society?* London: The mental Health Foundation


North West Public Health Observatory (2013) *Child Accidents and Injuries in the North West.* Liverpool: NWPHO


