

variation in incidence using all incidence (AI) and LBF indicators in the development of robust indicators.

**Methods** This study was carried out using data supplied to the European Injury Data Base (IDB) from 2009–2013 as part of the Joint Action on Monitoring Injuries in Europe (JAMIE) project and now part of the BRIDGE-Health (BRIdging Information and Data Generation for Evidence-based Health Policy and Research) development. Data were supplied by 26 countries. More detailed analyses were possible using data from 16 countries. European age-standardised incidence rates were calculated using estimated catchment populations.

**Results** The proportion of LBFs varied from 31% to 2%. There was greater (15x) variability in the LBF indicator than in the AI indicator (3x). The impact of a number of health service system effects was obvious.

**Conclusions** The results indicated variation in incidence that is largely due to differences in health service provision, sample data collection and estimates of catchment areas. Further work is ongoing to correct for these issues in deriving more robust indicators, e.g. using variation between observed and expected hip fracture rates as a potential correction factor.

## Parallel Sessions Tuesday 20.9.2016 11:00–12:30

### Safe Communities, ESCON

#### Parallel Tue 1.1

#### 227 KEY SUCCESS ON PARTICIPATION IN NATIONAL AND INTERNATIONAL SAFE COMMUNITIES NETWORKS

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More than twenty years, Safe Community Movement is one of the most important international interventional program of WHO in the field of injury prevention and safety promotion. The program has started in WHO CC CSP in Karolinska institutet in Stockholm, Sweden. Safe Community is the style, method and philosophy of life. Improving the quality of life, reduce morbidity and mortality from injuries and violence are the results of numerous studies and activities that are integrated into the seven indicators for safe communities. Local communities are taking the initiative from the down to the top to meet the proclaimed seven indicators and thus create a national and international network of Safe Communities. The basic principles from Manifesto for Safe Communities, "All human beings have an equal right to health and safety" is a fundamental aspect of the WHO, Health for All strategy and for the WHO Global Programme on Accident Prevention and Injury Control. The success of Safe Community Movement is result of different programs, education and trainings, safety products, safety environment and change behaviour. This premise has led to community action around the world actions leading to Safe Communities. From the first Safe Community Lidköping, Sweden, (1989), from the smallest Safe Community Northcottm Australia (2006), from the biggest Safe community Zhongshan District, Dalian, China (2011) to today there are 349 designated safe communities in International network. That is the real success of leader Leif Svanstrom, safe

communities experts and local people around the around the world, and their wishes to make world the safer place for life.

#### 228 SAFE COMMUNITY NETWORK DEMONSTRATING COLLABORATION AND OUTCOMES

*Tania Peters. Safe Communities Foundation New Zealand, New Zealand*

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**Background** As at July 2015 there were 28 designated Safe Communities in NZ covering just over 50% of the New Zealand population. All accredited Safe Communities in NZ are the result of many years of collaborative partnership and leadership on safety being established within their local areas. A focus on modifiable risk factors and proven or promising interventions is the cornerstone of this evidence-based approach to community safety.

**Methods** This presentation will begin by providing an overview of some of the resources/support identified by communities as being helpful to them in their Safe Community journey. It will then provide selected examples of the structures adopted by a range of different New Zealand Safe Communities that have been accredited. It will then outline the implementation of Results Based Accountability to demonstrate outcomes within a local Safe Community and potentially the wider network.

**Results** Community Coalitions are an essential component for a successful Accredited Safe Community. Inclusion of both strategic and operational foci, individuals and organisations with both expertise and interest in the problem and the solution is important. Having access to relevant data, to see how local initiatives fit within the larger policy context and an opportunity to share relevant information, to identify opportunities and challenges are all also essential. Involvement of the Mayor, CEO and some elected officials can also provide a powerful incentive for a Council's community safety efforts.

Demonstrating outcomes is an important tool for evaluating progress and guiding direction. The use of results based accountability was trialled to collate data across three different communities with common population indicators. Utilising current RBA tools Safe Communities have been able to map programmes to provide the line of sight and demonstrate the outcomes of their collaborative efforts.

**Conclusions** Safe Communities is a call for action. Most local governments also have a goal of improving community safety for its residents and visitors. By working collaboratively and using a common language communities are able to demonstrate the outcomes.

#### 229 A NORWEGIAN PATHWAY TO COMMUNITY SAFETY – BASED ON NORWEGIAN LAWS AND REGULATIONS AND THE SAFE COMMUNITY CONCEPT

*Eva Jakobson Vaagland. Norwegian Safety Forum*

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**Background** Norwegian Safety Forum (NSF) was established in 1985 to provide information on all aspects of injuries and safety, and to promote co-operation between private and public sector and non-governmental organisations. It's a well established meeting place with a wide range of experience in the field of injury prevention and safety promotion. NSF has been the national

centre for Safe Community-work in Norway since 2004, and also functions as an "International Safe Community Support Centre".

An updated Law of Public Health was introduced in Norway in 2012 where preventive efforts were given a broader attention. The same focus was echoed in the health sector reform, the Strategy for Universal Accessibility and the Planning- and Building Act. These laws and regulations give Norway a supportive framework, and a potential to gain interest for safety work on community level.

**Results** A new model for community safety has been developed based on Norwegian laws and regulations and the Safe Community concept. The national model is developed to meet the specific political and administrative demands on Norwegian municipalities in terms of health, safety, plan processes etc. The model is based on long term, systematic, evidence based safety efforts. It promotes inter- and cross-sector cooperation, sustainable projects and broad participation from all parts of society. The model is a useful tool for communities turning national policies into local realities.

**Conclusion** The national model was launched in 2014. It has motivated new municipalities to join the national network and put community safety on the local agenda. The Norwegian national network includes nationally as well as internationally designated communities. 1 all 22 municipalities and 2 counties are designated, and another 15–20 are part of the network but not yet designated. NSF's work with community safety is specifically mentioned in the new National Program for Public Health.

## 230 THE SAFER HOMES PROGRAMME

Sheila Merrill. *The Royal Society for the Prevention of Accidents (RSPA)*

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**Background** Home accidents are a leading cause of death and injury in the UK. Falls among older people lead to over 4 million hospital bed days each year. Almost 1 million children require emergency care following home accidents. Partnership working is vital to address this key public health issue.

**Description** The Safer Homes Programme provided a package of consultancy, training and intervention across 30 local authority areas with higher than average hospital admission rates for accidents. The programme helped partners, who included local authorities, home improvement agencies, charities, Fire Services and NHS, to develop strategic plans and business cases. It trained local practitioners to plan, implement and evaluate community interventions including home safety checks, falls and burns interventions and advice to vulnerable families.

**Results** Over 740 staff received the home safety training. The community interventions and advice given to families reached over 166,000 people. An independent evaluation by ICF International found increased home safety awareness among staff; improved partnership working and the development of clear injury prevention strategies. Training increased confidence of staff to raise awareness among client families. Families demonstrated practical safety improvements and behaviour change. One area reported a 12% drop in hospital admissions due to falls.

**Conclusions** The programme raised the profile of accident prevention among local partners at a crucial time of change as well as making homes safer within their local communities. Learning about effective strategic development and local delivery of interventions has been shared between partners and more widely to improve practice.

## 231 SAFETY WEEK SKI MUNICIPALITY, NORWAY

Liv Marit Bølset. *Health Promotion Adviser, Ski Municipality, Norway*

10.1136/injuryprev-2016-042156.231

**Background** In 1991 it was a very terrible accident with a small bus. Parents with many children were hurt and no one used seatbelts. Our public health nurses started to ask the parents about seatbelts and this was the start of the Safety Week. Since then the Safety Week has developed into a judge arrangement once a year. This is also the beginning of Safe community in Ski.

**Methods** This is a cross sectorial work with many professionals from health, education, police, fire department and doctors. Three working groups organise the lessons for the target groups. The lessons are given during 7 days and for seniors there are several courses over a long period. The target groups are: parents for children up to 18 months, students in 8<sup>th</sup> degrees and minorities groups, seniors and employees. The themes for the lessons are: first aid, road safety, fire prevention and domestics' violence.

**Results** Safety Week is held once a year in September while more simplified days throughout the year, whether it is linked with Safety Week. Most of the teaching is both theoretical and practical. About 1000 inhabitants distributed among the various target groups participating in the teaching organised by Safety Week each year. The youth in 8<sup>th</sup> degrees are new every year. Instruction for this group results in a systematic training in the population. The schools follow up the teaching.

**Conclusions** Feedback from audiences and from professionals who teach shows that teaching is of high quality and is very relevant.

## 232 ESTABLISHMENT OF THE FIRST RUSSIAN INJURY REGISTRY IN SHENKURSK

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**Background** External causes of death are the second main killers in several parts of Russia. However, no systematic collection and analysis of injury data exists hindering development of effective prevention. Our aim was to establish an injury registry in Shenskursk (Arkhangelsk region) and present the structure of injuries in January–June 2015.

**Methods** All injuries admitted to Shenskursk district hospital during 1.1.2015–30.6.2015 were registered using standard form. It includes items on type, place, time, preceding circumstances, and mechanism of accident, mechanism of injury and socio-demographic data of the injured. Distributions of injuries across these variables were used to identify typical injury cases and risky circumstances.

**Results** Altogether, 673 non-fatal injury cases were recorded (76%). Injuries to the head (21.6%), injuries to the wrist and hand (18.3%), injuries to the knee and lower leg (10.7%) were the most common. By severity, 64%, 28.7% and 6.2% of injuries were minor, moderate, and serious, respectively, 2 cases were severe, and one was critical. Hospitalisation rate was 9.2%.