Public Health Intervention Guidance

Preventing unintentional road injuries among under 15s - Consultation on the Draft Scope: Stakeholder Comments and Response Table

Monday 3rd November – Monday 1st December 2008

Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Association of Directors of Public Health		General	The Association of Directors of Public Health has been leading a collaborative initiative under the banner **Take action on active travel**, bringing together over 90 organisations (as at November 2008) from the public health, transport, architecture and social sectors. **Take action on active travel** calls on decision makers at all levels to act now to bring about a population-wide shift from sedentary travel to walking and cycling, by: • committing 10% of transport budgets to cycling and walking initiatives • a 20mph speed limit to be made the norm in residential areas • a coherent high quality network of walking and cycle routes that link everyday destinations • improved driver training and better enforced traffic laws • ambitious official targets to be set for increases in walking and cycling The full **Take action on active travel document** is attached below – and contains specific recommendations to make walking and cycling safer and more accessible.	Thank you. You will be interested to note that NICE have been asked to produce guidance on policies that promote walking and cycling.

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Association of Directors of Public Health		4.2.1	We support the activities and measures listed at 4.2.1. In particular, the redesign of roads and streets should aim at creating safe, attractive walking and cycling conditions, with coherent high quality networks linking all everyday destinations, so that walking and cycling are faster and more convenient than motor travel. The 20 mph zones should be the norm for residential streets and those used by shoppers, tourists and others, close to schools or public buildings, or important for walking and cycling or children's play. In urban areas only the busiest strategic traffic routes should qualify for higher speed limits	Thank you. Please note that the final scope has been expanded to include road design and environmental change. This will include examples such as walking and cycling networks, safe routes to school as well as modifications to reduce speed and speed limit signage.
Association of Directors of Public Health		4.2.2	We believe that changes to infrastructure alone will not achieve the required changes and improvements in outcomes. We are therefore concerned to see that primary and secondary prevention measures are not included, and would seek the inclusion of activities and measures that would: 1. **Tackle bad driving,** through improved driver training and awareness campaigns, backed by stronger and better enforced traffic laws and high quality cycle training. 2. **Support education and training** backed up by individualised travel marketing and school and workplace travel plans, • **Support behaviour change** for instance practical walking promotion programmes	We agree that this approach is not the only one necessary. However it is necessary to limit this scope to make the work achievable. The final scope indicates that we will undertake another piece of guidance to address injuries in this age group that will focus on education and equipment. Other issues of relevance will be taken up elsewhere, for instance in the NICE guidance on reducing road injuries in those aged 15 – 24 year olds and on transport policies that prioritise walking and cycling'

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Association of Public Health Observatories		General	The guidance should address issues of measurement, analysis, and intervention monitoring – both at local & national level. There is a key need to improve all three aspects to inform appropriate and cost-effective interventions. It would also be good to encourage collaborative approaches to injury measurement and injury prevention monitoring.	Issues of measurement, data collection and monitoring will be addressed as part of the 'Strategies to prevent unintentional injuries among under 15's ' programme work (http://www.nice.org.uk/Guidance/PHPG/Wave17/12)
Bradford & Airedale tPCT		4.3	One of the expected outcomes includes changes in knowledge and attitudes towards speed but the activities /measures to be covered in section 4.2.1 seems to focus more on the effectiveness of changing the structure of roads. Structural changes in roads may force drivers to slow down but as educational interventions aren't addressed how will the change of drivers attitude to speed be addressed?	We appreciate that change in attitude is unlikely to be the main reported outcome in these types of studies, however if this is reported it would be of interest. As you note, this is not the primary aim of the interventions of interest and so changes in attitude are included as secondary outcomes.
Bradford & Airedale tPCT		4.2.1	It would be helpful if NICE reviewed prevent unintentional injuries among children and young people aged up to the age of 18	The age limit is taken from the referral from DH

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Centre for Transport Studies, University College London		4.2.1	It is completely appropriate and very important to cover 'interventions to reduce motor vehicle speeds by road design or by modifying the road environment', but reducing motor vehicle speeds is not the only way in which road design and modifying the road environment can prevent or reduce unintentional injuries among children and young people on the road. Road design and modifying the road environment can also be used to encourage children and young people on foot and on bicycles to use routes for their journeys and places to walk and cycle for recreation so that: • they are alongside or sharing surfaces with motor traffic for a smaller proportion of the time they spend walking and cycling; • where they are alongside or sharing surfaces with motor traffic, they are exposed to lower flows of motor vehicles; • where they are alongside motor traffic they are separated from it by greater distances and more landscaping or appropriate road furniture; and • where they wish to cross flows of motor traffic the road design and road environment encourages them to do so at places where the risk of crossing is lower rather than higher. Design and modification with these objectives in mind is complementary to speed reduction and reinforces the injury preventing effect of speed reduction measures. Steps taken to identify interventions and approaches should include interventions with these objectives.	Thank you. The final scope has been expanded to include road design and environmental change. This will include examples such as walking and cycling networks, safe routes to school as well as modifications to reduce speed and speed limit signage. The final scope indicates that we will undertake another piece of guidance to address injuries in this age group that will focus on education and equipment. Please note also that other relevant interventions will be covered NICE guidance on transport policies that prioritise walking and cycling and reducing road injuries in 15 – 24 year olds .

Child Accident Prevention Trust		2 d	It would seem appropriate to add the current road safety strategy "Tomorrow's roads; safer for everyone"	Thank you. Although this document is relevant it was not included as progress towards achieving it is discussed in the document 'Second review of the government's road safety strategy' which is referenced.
Child Accident Prevention Trust		4.2.1	We feel that all of the activities/measures listed fall within the domain of traffic and highways engineers and are almost certainly not issues that could be addressed by anyone outside these professions, except possibly through advocacy. However, some of the approaches listed in 4.2.2 c (national and local media campaigns, leaflets and promotional activities) and incorrectly in 4.2.2 d (seat belt and safety seat use promotion) could be influenced by input from health and other sectors so an assessment of these approaches would be welcome. (See below for the reason why we believe there are conceptual errors in 4.2.2 d). Similarly, we argue that the promotion of helmets and the use of visibility aids (listed in 4.2.2.d where it is not clear whether it's their promotion, use or design that is being covered) should be assessed in the development of programme guidance, i.e. moved to 4.2.1.	Thank you. Many of the measures will be carried out by professionals such as those set out. However we feel this is an appropriate area for guidance. The final product may be helpful to those professionals in making a case for action, to those involved in local democracy and local communities and in supporting other professionals in working across sectors. We appreciate the importance of other approaches such as those listed. However it is necessary to produce a scope that is achievable given the time and resources available. The final scope indicates that we will undertake another piece of guidance to address injuries in this age group that will focus on education and equipment. Please note also that other relevant interventions will be covered in NICE guidance on transport policies that prioritise walking and cycling and reducing road injuries in 15 – 24 year olds. .

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Child Accident Prevention Trust		4.2.2 d	There appears to be a misunderstanding of what constitutes a secondary safety measure. Convention would define it as one that reduces the severity of injury, as opposed to preventing the event from happening. They are not interventions that change behaviour – these are primary prevention approaches. Therefore, seat belt and safety seat use promotion, and visibility should be moved to 4.2.2 (c). In the list here, only helmets are a secondary safety measure.	Thank you. This section has been reworded.
City of Bradford	City of Bradford Metropolitan District Council Presentation on Road Safety. Available from www.bradford.gov.uk	4.1.1	"high traffic volumes and speeds" – it may be difficult to determine what is high in relation to volumes and speeds. On residential roads anything in excess of 20 mph would be considered high – but lower speeds would be appropriate in congested/hazardous conditions. Injuries to children do occur on lightly trafficked residential roads as well as roads with more traffic.	Agreed.
City of Bradford		4.2.1	Injuries to children as pedestrians peak at 11, 12 and 13 years of age and the measures listed are more relevant to younger age groups. From 9 years and upwards children and young people are developing as independent travellers and more relevant traffic engineering measures would be; safer routes to school and to play facilities, links to the national cycling network, pedestrian and cycling facilities – networks and links, and particularly traffic measures on major roads – road space reallocation and measures to reduce road speeds. I have attached information from Bradford MDC illustrating the casualties by age – there is national information showing similar distributions. The peak in Bradford at 5, 6 and 7 years of age is not typical nationally and may be a feature of deprivation.	Thank you. The final scope has been expanded to include road design and environmental change. This will include examples such as walking and cycling networks, safe routes to school as well as modifications to reduce speed and speed limit signage. The final scope also indicates that we will undertake another piece of guidance to address injuries in this age group that will focus on education and equipment. Please note also that other relevant interventions will be covered NICE guidance on transport policies that prioritise walking and cycling and reducing road injuries in 15 – 24 year olds.

City of Bradford		4.3	"Expected outcomes" – If we are looking at the safety of children and young people whilst travelling or exposed to potentially hazardous road conditions then other objectives could be mobility, independence, access to community activities, goods and services, access to education and play and access to healthy transport activities – walking and cycling – dealing with other health issues such as obesity.	Thank you. We agree that many of these outcomes are important and may have impacts on aspects of health. We anticipate that consideration of these may form part of the modelling of the cost effectiveness of interventions and the discussions around developing recommendations.
CTC, the national cyclists' organisation		3	The need for this guidance is acknowledged and welcomed. We are particularly pleased that the role of reduced speed has been given such a high priority.	Thank you. Please note that while speed retains a high priority other areas have been added in line with comments from stakeholders (indicated below)

CTC, the national cyclists' organisation		4.2.1	We are concerned that you plan to study only 20 mph zones and not the effect of reducing speed limits without changes. The experience from Holland found that Zones 30 (equivalent to 20 mph zones) had a low take-up when requirements for traffic calming were prescriptive. By 2002, however, conditions for implementation were made easier and 50% of residential streets in Holland became subject Zones 30. The role of low-level traffic calming and 'sign-only' 20 mph limits is important because it allows a transition between the initial political support for 20 mph and the expensive, street-by-street re-engineering of streets necessary to achieve enforcement-free speed reduction. On streets where speeds are already low, signed only speed limits can achieve the necessary reductions. The local authority involved can retrospectively examine the case for traffic calming on streets where the limit is ignored. A growing numbers of UK local authorities are taking this approach, first piloted in Portsmouth. Newcastle has recently agreed to use this approach, as has Bristol. Note – 'kerb' is the correct spelling for the grade separation material that delineates the boundary between carriageway and footway, not 'curb'.	The final scope has been expanded to include road design and environmental change. This will include examples such as walking and cycling networks, safe routes to school as well as modifications to reduce speed and speed limit signage. The final scope also indicates that we will undertake another piece of guidance to address injuries in this age group that will focus on education and equipment. Thank you for this.

CTC, the national cyclists' organisation		4.2.2	We regret that the effect of 'safety cameras' will not be measured. While their use in 20 mph areas has heretofore been prevented by legislation, we understand that this anomaly may change and their role in the enforcement of low speed limits may be greater in the future. The effect of safety cameras has triggered a very large amount of often poorly evidenced public debate. The robust evidential basis of Nice's work may therefore be of great assistance in explaining some of the potential benefits of reduced speed, and the role of cameras in obtaining those speed reductions.	As indicated about, the scope has been expanded to include a number of additional areas while ensuring that this scope is achievable within the available time and resources. Please note that other relevant interventions may be covered in NICE guidance on transport policies that prioritise walking and cycling and reducing road injuries in 15 – 24 year olds. In particular, enforcement of legislation relevant to this scope will be covered in the associated programme guidance 'Strategies to prevent unintentional injuries among under 15's (http://www.nice.org.uk/Guidance/PHPG/Wave17/12)

CTC, the national cyclists' organisation		4.3	If part of the expected outcomes to question 1 include 'changes in… knowledge and attitudes towards speed', perhaps this subject could be included within the scope of the question? We believe that changing drivers attitude towards speed is extremely important. The barriers to children playing come primarily from the home – these barriers are raised by both actual and perceived danger on the streets. We believe that 20 mph zones can also have an effect on the perceived safety of a street, enabling more children to cycle and walk and allowing children to play. We believe therefore that the effect of 20 mph in changing attitudes of parents towards the risks posed to children must form part of this investigation. We are concerned that question 2 may have answers that will not appear in any evidence at a level robust enough to meet Nice's requirements. Possible answers to this question relate to the political nature of speed enforcement and local authority leadership, little of which is likely to be documented thoroughly.	Attitudes towards speed are important hence the inclusion of this in the section on outcomes of interest. Change in attitude is unlikely to be the main reported outcome in these types of studies, however if this is reported it would be of interest. However to ensure that the scope is achievable within the available time and resources it is not possible to look at all types of intervention which might more directly be intended to produce change through changing attitudes. We will endeavour to identify the best available evidence to answer this question. We would be interested to hear of any evidence that you are aware of that addresses this question.

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Cycling England		Title	Why is the scope restricted to road design? There are many more factors that influence traffic speed, notably speed limits and enforcement.	The final scope has been expanded to include road design and environmental change. This will include examples such as walking and cycling networks, safe routes to school as well as modifications to reduce speed and speed limit signage. However, it is important to produce a scope that is achievable within the available time and resources. Please note that other relevant interventions will be covered in NICE guidance on transport policies that prioritise walking and cycling and reducing road injuries in 15 – 24 year olds. In particular, enforcement of legislation relevant to this scope will be covered in the associated programme guidance 'Strategies to prevent unintentional injuries among under 15's (see http://www.nice.org.uk/Guidance/PHPG/Wave17/12) The final scope also indicates that we will undertake another piece of guidance to address injuries in this age group that will focus on education and equipment.
Cycling England		3e	We support the focus on primary prevention, and on reducing traffic speeds. However, as above, we do not see why this should exclude other non-design factors.	Thank you. Please see the response above.
Cycling England		4.1.1	We support the focus on children from disadvantaged areas	Thank you.

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Cycling England		General	We hope that the guidance will include issues specific to cyclists. This may include the extent to which cycle infrastructure contributes to traffic speed reduction and also the phenomenon of 'safety in numbers' where it is noted that higher volumes of cyclists and pedestrians are associated with lower casualty rates. This may be mediated by traffic speed (ie drivers slow down due to the higher volumes of cyclists increasing the perceived risk of a crash).	Some of this may be considered by PHIAC, however the guidance is aimed at reducing road injuries and deaths in all road users. You may be interested to see that we have been referred a topic on transport policies that prioritise walking and cycling.
Department of Health		General	From a National Healthy Schools Programme (NHSP) perspective, any guidance/information could helpfully be disseminated via our whole-school framework. As a programme, NHSP encourages children and young people to acquire the knowledge, skills and understanding to identify risk, and to make healthy choices in the broadest sense (so any guidance that supports this message will align itself to our programme).	Thank you. Dissemination of the final guidance is an important step and this suggestion will be passed on to the communications team.
Department of Health		General	It would be helpful to refer to the *"Changing Lanes"* report, dated 26 February 2007. In our opinion, road safety should be considered a key "quality of life" issue. Although Britain has a low level of death and injury compared to the rest of Europe, we feel that there are still many areas for improvement. The above report is intended to help local agencies work more effectively to reduce the number of deaths and injuries on our roads, and is available at: http://www.audit-commission.gov.uk/reports/NATIONAL-REPORT.asp?CategoryID=&ProdID=A199BBC7-6F37-4f0d-A99B-E291497C0C72	Thank you for this reference.

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Department of Health		General	In our view, the scope of the road safety strand is very limited, and there appears to be no rationale for limiting it to the physical road infrastructure measures that reduce vehicle speed. While this has a role to play, we feel that it is far from being the only measure that will help reduce child death and injury in road accidents. You may be aware that for the latest available year (2007), 18% of child (0 to15 years) fatalities happened in accidents in which either excessive or inappropriate speed was recorded as a contributory factor (21 deaths out of 116). For injuries, the equivalent figure was 10% (that is, 1,769 out of 18,149). This leaves many child deaths and injuries where excessive or inappropriate speed was not considered to be a contributory factor, and would be outside the proposed scope of this guidance. Could you please clarify the rationale for including only the matters in section 4.2.1., and leaving out those in section 4.2.2.	We agree that it is not the only measure that will help reduce child death and injury. The final scope has been expanded to include road design and environmental change. This will include examples such as walking and cycling networks, safe routes to school as well as modifications to reduce speed and speed limit signage. However, it is important to produce a scope that is achievable within the available time and resources. The final scope indicates that we will undertake another piece of guidance to address injuries in this age group that will focus on education and equipment. Please note that other relevant interventions will be covered in NICE guidance on transport policies that prioritise walking and cycling and reducing road injuries in 15 – 24 year olds. In particular, enforcement of legislation relevant to this scope will be covered in the associated programme guidance 'Strategies to prevent unintentional injuries among under 15's (see http://www.nice.org.uk/Guidance/PHPG/Wave17/12)

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Department of Health		General	Could you please clarify the scope of the audience for this guidance. We feel that it will not make a significant difference to those people in local highway authorities who are responsible for the things that affect vehicle speeds (i.e. highway engineers). In our view, it would be helpful if the guidance could make more of the things that help child road safety which are in the control of people in the health and child services sectors (i.e. those who are more likely to find information from this source that they do not normally). This would include things such as training and education for children and parents. Our view is that not forgetting this group could reinforce the view that road safety is only a matter for highways engineers.	The guidance is aimed at professionals, commissioners and managers with public health as part of their remit working within the NHS, local authorities and the wider public, private, voluntary and community sectors. It is particularly aimed at transport planners, road safety professionals, schools, parents, voluntary and community groups. It will also be of interest to all road users, children, young people, parents and carers. Many of the measures will be carried out by professionals such as those set out. However we feel this is an appropriate area for guidance. The final product may be helpful to those professionals in making a case for action, to those involved in local democracy and local communities and in supporting other professionals in working across sectors. The final scope indicates that we will undertake another piece of guidance to address injuries in this age group that will focus on education and equipment.
Department of Health		General	Could you please clarify the reasons for restricting the age limit to 0 to 14 years. International definitions of children and young people tend to go up to 18 years. The Department for Children, Schools and Families' (DCSF) child safety PSA target is 0 to17 years, while the Department for Transport's (DfT) casualty reduction target is 0 to15 years (inclusive).	This age range was specified in the referral from the Department of Health.

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Department of Health		General	Whilst we agree that injury reduction must be the primary focus, it would be helpful if you would consider including intermediate measures such as behavioural change, shifts in social norms etc. There is a huge amount of ongoing work across Government, which recognises that behavioural change is a key to delivering policies, for example, obesity or National Audit Office reports on measures to influence behaviour (a review of the THINK campaign).	Thank you. As indicated, if evidence of changes in attitudes is available in relation to the interventions under consideration this will be included. However, it is not our intention to increase the scope of this guidance to include other methods to change attitudes and knowledge. The final scope indicates that we will undertake another piece of guidance to address injuries in this age group that will focus on education and equipment..

Department of Health		Section 3(e), Page 6	The reference to risk-compensation may, in our view, overstate the effect. It says *"perceptions of safety, however, can alter behaviour (such as faster driving in a car with anti-lock brakes) so that actual risk remains the same (risk compensation)."* Could you please clarify whether this degree of risk compensation is borne out by the evidence. Whilst there may be some risk compensation, is it the case that the degree of compensation is sufficient to completely outweigh all casualty benefits? If this were true, then seatbelts would have had little effect, although we are aware that this is not the case. Whilst we need to acknowledge that (in some instances) there may be some behavioural modification resulting from risk compensation, we consider that this is very difficult to measure. With the implementation of safety measures, we would be assessing the net benefit when we evaluate their effectiveness but in many (if not all) cases, the net benefit is still likely to be positive. We are uncertain as to how far risk compensation declines over time, as people get used to new safety features, and we would appreciate clarification of this point.	Thank you. We agree that this is a complex area. This section has been altered to reflect some of this uncertainty and to reduce the suggested degree of compensation in the draft scope.
Department of Health		Section 4	We welcome the remit to include a focus on parents which, we assume, also includes carers.	Yes, it does include carers.

Department of Transport		general	"The figure of 121 child fatalities was quoted in two of the presentations as being a 2006 figure, though once for England and Wales and once for the UK. The road safety presentation gave the breakdown of 57 pedestrians and 13 cyclist fatalities. This breakdown confirms that these figures are in fact for 2007, and not 2006. They are also for Great Britain (not for England and Wales, nor for the United Kingdom). Also, they are for our standard child age range of 0 to 15 years, not the 0 to14 years age group that you have chosen to use. This makes a significant difference, as 30 of the 121 deaths were aged 15 years; therefore, the 0 to14 years total should read "91 deaths in Great Britain in 2007".	Thank you. The date given in the draft scope has been altered. The age range in the scope remains 0 – 14 as in the referral from the Department of Health.

Department of Transport		General	We would like to query the international comparisons, made in the road safety presentation, which said that our overall road safety rates were at the European Union (EU) average. In our view, this is not the case. We have one of the best rates in the EU, that is, 5.4 deaths per 100,000 of the population in Great Britain. In 2006, the only EU countries with lower rates were Malta (which has very low numbers, and is not typical), Netherlands and Sweden. Outside the EU, Switzerland and Norway also had slightly lower rates than Great Britain. The EU27 average was 10.2, almost twice that here. It is true that our performance on pedestrian and child (0 to 14 years) pedestrian fatality rates is less good when compared with other countries (although there is no full EU average, as data is missing for many member states, including Ireland and Italy - at least in our published data). On pedestrians of all ages, the rate in Great Britain is 1.1 per 100,000 of the population; the average for the random sample of 16 EU countries with 2006 data is 1.6.	Thank you. These figures have been clarified in the final scope

Department of Transport		general	On child pedestrians (age 0 to14 years) the rate in Great Britain is 0.6 per 100,000 of the population; the average for the random sample of 15 EU countries with 2006 data is 0.5. In our opinion therefore, we are amongst the best overall and around average for child pedestrians. Perhaps this may not be good enough, but it is much better than it was and, we feel, not as stated in the NICE presentation. Could you please note that international data is a year behind our statistics for Great Britain (that is, 2006 and not 2007) and a different child definition (0 to14 years, the same as NICE, again due to data availability) is used.	Thank you. This has been amended in the final scope.
Department of Transport		general	All these figures are taken from the Department of Transport's (DfT) annual publication, which includes many more detailed road accident and casualty statistics, at: http://www.dft.gov.uk/pgr/statistics/datatablespublications/accidents/casualtiesgbar/roadcasualtiesgreatbritain20071 Table 34 includes a single-year age breakdown to distinguish "0 to14 year" from "0 to 15 years". DfT statisticians may be able to provide more detailed breakdowns on request, including for "0 to14 years", and for England only.	Thank you. The age range in the scope remains 0 – 14 as in the referral from the Department of Health.

Department of Transport		General	"NRSI" was mentioned in the NICE presentation. For reference, more information is available at the NRSI website at: http://www.nrsi.org.uk Could you please note that DfT's evaluation of NRSI is still in preparation, and has yet to be published. However, you may wish to look at other published road safety research on the DfT website at: http://www.dft.gov.uk/pgr/roadsafety/research as much of this could be relevant to your project."	Thank you. We will follow your link for suitable evidence.
Guide Dogs for the Blind Association		General	Guide Dogs for the Blind Association (Guide Dogs) welcomes the opportunity to respond to this consultation.	Thank you.

Guide Dogs for the Blind Association		General	Guide Dogs are the UK's largest single provider of mobility and other rehabilitation training for blind and partially sighted people. Each year, we help thousands of visually impaired clients to live independent lives, either with a guide dog or long cane. Our vision is for a world in which all people who are blind or deaf/blind and partially sighted enjoy the same rights, opportunities and responsibilities as everyone else. We help blind or deaf/blind and partially sighted people to achieve independence and mobility through the provision of guide dogs and rehabilitation services – yet this independence is limited by the environment in which blind or deaf/blind and partially sighted people must live. We therefore campaign for equal access to transport and the built environment, shops and services, health and social care.	
Guide Dogs for the Blind Association		4.1.1	Groups that will be covered: We request that this includes children who are blind or partially sighted and those with other disabilities. Appendix B lists a range of issues that it is anticipated would be considered including the impact on people with disabilities or mobility impairments. It would be useful if this is specified in 4.1.1	Children who are blind or partially sighted are included in the scope. It is not possible to include an exhaustive list of those who should be considered
Guide Dogs for the Blind Association		4.1.1	There are an estimated 20,000 blind children between 5 and 15 years of age who need special reading materials including large print, audio and Braille. There will be more who have a serious sight condition resulting in mobility difficulties. Some may have additional impairments including hearing loss.	Thank you

Guide Dogs for the Blind Association		4.1.1	Many blind and partially sighted children and young people will need to, and want to, go out into the public realm unaccompanied and independently. They need to be fully integrated into society. This independence is essential to social development. Their disability however does make them vulnerable to injury if the environment is inherently unsafe. The design measures listed in 4.2.1 may have a greater impact on blind and partially sighted children and young people.	Agreed.
Guide Dogs for the Blind Association		4.2.1	The list of local or regional interventions to reduce motor vehicle speeds by road design or by modifying the road environment includes naked streets; 'woonerven'; and home zones – all of which have been linked to 'shared space' which is often implemented through shared surfaces. There is often confusion or lack of clarity when using the terms 'shared space' and 'shared surface'. Guide Dogs concerns relate to shared surfaces, where the footway (pavement) and road are at the same level and there is no kerb or effective demarcation between pedestrians and motor vehicles and cyclists. There are also often no controlled crossings in such street schemes. These are also features of naked streets. Pedestrians are expected to negotiate with other road users through eye contact, placing blind and partially sighted people at an immediate disadvantage. Guide Dogs research in the Netherlands and the UK has raised serious concerns about the use of shared surfaces, which severely affect the safety, confidence and mobility of blind and partially sighted people.	Thank you. We would be very interested in the research you mention.

Guide Dogs for the Blind Association		4.2.1	Guide Dogs concerns about shared surface are shared by others and a coalition of organisations representing people with physical, sensory and learning disabilities have endorsed a joint statement on this issue.	Thank you. We would be interested in this.
Guide Dogs for the Blind Association		4.2.1	We welcome the statement that steps will be taken to identify ineffective as well as effective interventions and approaches. We also welcome and endorse the NICE statement that recommendations must be based on valid research.	Thank you.
Guide Dogs for the Blind Association		4.2.1	Those promoting the concept of shared space or variations such as naked streets have yet to produce any credible evidence that these will work for all pedestrians, or detailed guidance of how to implement these design concepts in a fully accessible way.	Thank you. We will endeavour to find the best available evidence.
Guide Dogs for the Blind Association		4.2.1	Further points to be considered include lighting and weather conditions - is eye contact possible between a driver and sighted pedestrian in adverse weather conditions, driving rain, and after dark?	Thank you
Guide Dogs for the Blind Association		4.2.1	The Department for Transport has recently announced a two year research project intended to lead to guidance on how 'shared space' can work for all users. We have not yet seen the specification for this research but it is hoped that this will take full account of the requirements of blind and partially sighted people and other disabled people, and of children and other vulnerable pedestrians. This research may be useful to consider within this NICE enquiry.	Thank you for highlighting this.

Guide Dogs for the Blind Association		4.2.1	The Disabled Persons Transport Advisory Committee (DPTAC), statutory adviser to the Government, has published a statement of concern about shared surfaces calling on Local Authorities to be aware of their disability equality duty and not create shared surface streets which discriminate against blind and partially sighted and other disabled people.	Thank you.
Guide Dogs for the Blind Association		4.2.1	To relate the concerns about shared surface street design to the context of children and young people under 15: A blind child is unlikely to have a guide dog to assist as the provision of guide dogs to children less than 16 years is still under research. However a child may have had training with a white stick or long cane. Those with only a slight vision loss may have no mobility aid. Young blind and partially sighted people will be given mobility training which will teach them how to travel along streets using the building line and kerb line as essential reference points. These designate the limits of the safe area for pedestrians. Young people will also be instructed in how to use tactile paving as an aid to orientation. They will be instructed to cross at a controlled crossing using the audible or tactile rotating signal if installed. They will also be instructed to stop at a kerb before crossing a road if there is no controlled crossing available in the vicinity. It follows that removal of kerbs, tactile paving and controlled crossings will put a visually impaired young person at serious risk.	Thank you.

Guide Dogs for the Blind Association			We believe that sighted children are also at risk if the customary features of the street architecture are radically changed. For many years children have been trained to stop at a kerb and check for approaching vehicles before crossing. As is recognised in the Department for Transport's Child Road Safety Strategy, children are easily distracted and do not always pay attention to, or are fully aware of, their surroundings. The Scope document notes that children are also less visible to motorists. (Organisation for Economic Cooperation and Development 2004). As outlined above, shared surface streets rely on pedestrians and other road users negotiating movement through eye contact – very difficult with small children.	Thank you.

Guide Dogs for the Blind Association		4.3	Key questions and outcomes: These focus on the reduction of vehicle speeds and road injuries. These are of course very important, but we would ask that you also consider further factors: We support measures to reduce vehicle speed, and note that speed reduction of vehicles to 20mph significantly increases a pedestrian's chance of surviving a crash. However any physical injury resulting from road design and vehicle operation should be avoided. As well as physical injury it is important to consider the psychological damage to a child involved in a collision or even in a "near miss" situation. It can destroy a child's confidence for a very long time and even make independent mobility impossible. Our streets must be as safe as possible for children, including blind and partially sighted children. They must also be designed to promote and encourage safe independent use by children and young people. For blind and partially sighted children this requires safe pedestrian footways separated by a kerb, or another delineator that is demonstrated through robust research to be equally effective; pedestrian controlled crossings; and sufficient environmental cues, or reference points, to enable them to make and then execute decisions for orientation and navigation. We would contend that such features are also important for all children.	Thank you.
Guide Dogs for the Blind Association		4.3	We therefore request that an additional question and outcome be defined relating to street design that promotes safe independent use by children and young people, including those who are blind or partially sighted or have other disabilities.	Thank you. Ensuring streets promote safe use is an important aspect which we hope will be considered in this guidance.

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Guide Dogs for the Blind Association		General	Guide Dogs welcome the interest of NICE in this matter and are pleased to have this opportunity to contribute to this consultation on the scope. We believe that the interests of blind and partially sighted and other disabled children must be taken into account and feel sure that other disability organisations would wish to contribute. Guide Dogs are willing to co-operate in this research.	Thank you for your interest. We aim to ensure that our guidance takes account of the issues of groups such as those with visual impairments.
Guide Dogs for the Blind Association		General	The Guide Dogs research referred to in this response can be found on our website at www.guidedogs.org.uk/sharedsurfaces	Thank you for this link. We will pass it to the team compiling the evidence.
Guide Dogs for the Blind Association		General	For further information please contact Carol Thomas, Access and Inclusion Manager, Guide Dogs. email carol.thomas@guidedogs.org.uk	Thank you.
Healthcare Commission		General	The Healthcare Commission welcomes the proposed NICE guidance on preventing unintentional road injuries among under 15s as outlined in the draft scope. This is in line with the Healthcare Commission's recommendation that the Department of Health commission NICE "to develop guidance on the prevention of unintentional injury for children under 15 years of age". Assessing healthcare organisations in relation to their use of NICE guidance is an aspect of the Healthcare Commission's current annual health check for all NHS healthcare organisations (specifically in relation to *Standards for Better Health* core standard 23), so additional guidance will be helpful and will contribute to clarity on the part of healthcare organisations about best practice.	Thank you.

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Healthcare Commission		General	From April 2009, the Care Quality Commission will take over the work of the Healthcare Commission, Commission for Social Care Inspection and the Mental Health Act Commission, and will consider guidance for use in registration requirements for healthcare organisations.	
Healthcare Commission		General	In addition, the Audit Commission's Comprehensive Area Assessment (CAA) includes health components as well as a focus on young people. CAA frameworks are currently under development; this proposed series of guidance may also be helpful in relation to CAA.	Thank you.
Healthcare Commission		General	It will be helpful for NICE to include this proposed series of guidance in its mapping of NICE guidance in relation to the operating framework – vital signs.	Thank you. We will include these in the mapping you refer to.
Injury Minimization Programme for Schools		General	Why are you only concentrating on road design and speed and not education of drivers, pedestrians etc. by concentrating on road design you are taking the responsibility for safer driving and road use is taken away from users	The scope has to narrow the possible work to something which is achievable within the available time and resources. The final scope indicates that we will undertake another piece of guidance to address injuries in this age group that will focus on education and equipment. Other aspectswill also be addressed by other NICE guidance, such as that to reduce injuries associated with young people aged 15 – 24.
Injury Minimization Programme for Schools		General	Inconsistent data collection and recording – ambulance, police and hospital	This is a common problem. Issues of measurement, data collection and monitoring will be addressed as part of the programme work 'Strategies to prevent unintentional injuries among under 15's

Injury Minimization Programme for Schools		3 (f)	Surely car design contributes greatly to speed – drivers feeling comfortable, sound proof, 'safe themselves' therefore more likely to drive fast.	Agreed. However it is not possible to cover every potential issue. It is necessary to limit the size of the scope to ensure the work is achievable within the time and resources available. The final scope indicates that we will undertake another piece of guidance to address injuries in this age group that will focus on education and equipment. Please note that other relevant interventions will be covered in NICE guidance on transport policies that prioritise walking and cycling and reducing road injuries in 15 – 24 year olds. In particular, enforcement of legislation relevant to this scope will be covered in the associated programme guidance 'Strategies to prevent unintentional injuries among under 15's (see http://www.nice.org.uk/Guidance/PHPG/Wave17/12)
Injury Minimization Programme for Schools		4.3	How can your expected outcome of 'changes…. Knowledge and attitudes towards speed' if there if primary prevention is not included?	It is possible that environmental changes may produce changes in attitude and if so we would be interested in these outcomes

Injury Minimization Programme for Schools		general	Unintentional outcome may be then broader based programmes e.g. Injury minimization programme for schools (I.M.P.S.) may be jeopardised financially if the government take a narrow focus on road safety.	The current guidance is of necessity restricted. This is to ensure that the scope is achievable within the available resources. It does not indicate that we feel that a narrow focus should be adopted, and other related work will be covered in NICE guidance on transport policies that prioritise walking and cycling and reducing road injuries in 15 – 24 year olds. The final scope indicates that we will undertake another piece of guidance to address injuries in this age group that will focus on education and equipment.. Enforcement of legislation relevant to this scope will be covered in the associated programme guidance 'Strategies to prevent unintentional injuries among under 15's (see http://www.nice.org.uk/Guidance/PHPG/Wave17/12)
Injury Minimization Programme for Schools		General	Obviously reducing speed is crucial if we are to lower the number of children and young people killed on UK roads every year. Road engineering measures are most effective in helping to achieve this but children/young people can still be seriously injured/require hospitalisation if they are hit by vehicles at lower speeds (20mph or less). Multi-pronged approaches are said to be the best way of tackling child accidental injury and primary and secondary prevention (education, behaviour changes, etc) in association with legislation are equally important.	We agree that reducing speed is 'crucial', hence its position in this guidance. The final scope indicates that we will undertake another piece of guidance to address injuries in this age group that will focus on education and equipment. Other related work will be covered in NICE guidance on transport policies that prioritise walking and cycling and reducing road injuries in 15 – 24 year olds. In particular, enforcement of legislation relevant to this scope will be covered in the associated programme guidance 'Strategies to prevent unintentional injuries among under 15's (see http://www.nice.org.uk/Guidance/PHPG/Wave17/12)
Injury Minimization Programme for Schools		General	How can the expected outcome of a change in knowledge and attitudes towards speed be achieved without education?	It is possible that environmental changes may produce changes in attitude and if so we would be interested in these outcomes

LARSOA		1	The title sets out the focus for the guidance, ie that the focus is on road design. This would appear inappropriate for guidance from NICE. Guidance on road design is already available for Highways Engineers from DfT, IHT, etc. It is doubtful whether NICE could add anything to this technical expertise and whether Highways Engineers would pick up this guidance. The focus on under 15s also is in conflict with the DfTs definition of a child which is "persons under 16 years of age".	NICE has produced guidance for many sectors outside the NHS. This guidance may also be of use to those in health sectors and the community who have an interest in injury reduction. The age range in the scope remains 0 – 14 as in the referral from the Department of Health.
LARSOA		3 b)	Although 'people from lower social classes are more likely to live in neighbourhoods with unsafe roads and high speed traffic,' many of the physical measures that this guidance will focus on such as traffic calming, 20mph zones, homes zones and 'naked' streets may well be inappropriate for the types of major roads dissecting these neighbourhoods. 'Soft' or 'secondary' measures such as education and equipping children with the skills to deal with their own road environment may be more effective. Moreover evidence suggests that whilst young children 0-8 may be more likely to sustain injuries closer to home, older children may be more likely to sustain injuries further afield which may not be classified as their own neighbourhood.	We agree that not all approaches are appropriate for all roads and that other approaches are likely to be needed. The final scope indicates that we will undertake another piece of guidance to address injuries in this age group that will focus on education and equipment. Other related work will be covered in NICE guidance on transport policies that prioritise walking and cycling and reducing road injuries in 15 – 24 year olds. In particular, enforcement of legislation relevant to this scope will be covered in the associated programme guidance 'Strategies to prevent unintentional injuries among under 15's (see http://www.nice.org.uk/Guidance/PHPG/Wave17/12)

LARSOA		4.2.1	Health professionals can have little or no impact on road design or the modification of the road environment. This is the remit of Highways Engineers. As such, the activities to be covered by this guidance are unnecessary. Consideration should be given to how the removal of lines, road markings, kerbs and so on may affect members of the public with disabilities. Consultation with disability groups is essential to ascertain their views and comments.	Health professionals are not the only target for the guidance, however they may also have a role to play in advocacy, supporting change and through their involvement with emergency services who are may be opposed to changes.
LARSOA		4.2.2	The activities not to be covered by the guidance would seem to be the very areas where health professionals could make a huge impact on reducing the number of children injured on the roads. Lobbying for driver legislation and providing supporting education about the dangers of excessive speeds etc could be an incredibly worthwhile process.	The final scope indicates that we will undertake another piece of guidance to address injuries in this age group that will focus on education and equipment. Other related work will be covered in NICE guidance on transport policies that prioritise walking and cycling and reducing road injuries in 15 – 24 year olds. Enforcement of legislation relevant to this scope will be covered in the associated programme guidance (see http://www.nice.org.uk/Guidance/PHPG/Wave17/12)
LARSOA		4.2.2	Working to change the behaviour of drivers and the parents of children is another area that health professionals could be involved in. Training Health visitors to give advice and fit child car seats, for example, could prevent dozens of injuries; making parents aware of the consequences of excessive speed could also encourage them to consider their own behaviour.	Thank you. The final scope indicates that we will undertake another piece of guidance to address injuries in this age group that will focus on education and equipment. Please note that other related work will be covered in NICE guidance on transport policies that prioritise walking and cycling and reducing road injuries in 15 – 24 year olds. In particular, enforcement of legislation relevant to this scope will be covered in the associated programme guidance 'Strategies to prevent unintentional injuries among under 15's (see http://www.nice.org.uk/Guidance/PHPG/Wave17/12

LARSOA		4.2.2	The independent watchdog the Audit Commission published a report, 'Changing Lanes – Evolving roles in road safety', in February 2007. Amongst it's findings were that: • "Returns from engineering are diminishing, because many accident black spots and dangerous stretches of roads have been improved." • Human behaviour contributes to almost all accidents; road conditions and vehicle defects are involved in fewer than 20%." • "The most effective approach (to road safety) is to achieve a balance across the three 'E's: engineering; education, training & publicity and Enforcement."	Thank you. As indicated above, other related work will be covered in NICE guidance on transport policies that prioritise walking and cycling and reducing road injuries in 15 – 24 year olds or as other work within this referral. In particular, enforcement of legislation relevant to this scope will be covered in the associated programme guidance 'Strategies to prevent unintentional injuries among under 15's (see http://www.nice.org.uk/Guidance/PHPG/Wave17/12)
LARSOA		4.3	The first key question again asks about road design. For all the reasons previously stated we do not believe this to be the appropriate question to ask. However, even given this question, the expected outcome will probably not result in increased knowledge and attitude towards speed, rather an increased frustration at the imposition of traffic calming.	The example given (frustration at the imposition of traffic calming) is an example of a possible outcome that would be of interest and might have a bearing on how, where and when schemes are implemented
LARSOA		General	The scope for this guidance is misplaced. Guidance on road design for reducing speed already exists by those authorities to which Highways Engineers are responsible. Health Professionals that would look to guidance from NICE would be much better directed to look at how they could reduce injuries by educating and informing drivers and parents of young children.	See comments above

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LARSOA		General	LARSOA feel that close liaison between relevant government departments such as the Department of Health, the Department for Transport and the Department for Children, Schools & Families is essential and **must** form a fundamental part of any work aimed at improving road safety and achieving casualty reduction targets. The Audit Commission (in it's report published in Feb 2007) stated in its' recommendations that a consistent approach across all Central Government departments (should be taken) when considering issues of road safety.	Government departments are involved in the production of NICE guidance as stakeholders and we welcome comments on our scopes, the evidence and draft guidance.
London School of Hygiene & Tropical Medicine	Woodcock J, Banister D, Edwards P et al. (2007) Energy and Health 3: Energy and transport 1. Case study: A low-carbon London 2. Transport and Millenium Development Goals 3. Londoners' physical activity	General	My main comment is that the interventions being considered have many more important public health outcome than injury. Dangerous streets - with fast moving traffic also has important implications for physical inactivity, air pollution, and climate change to name just a few. Considering only injury as an outcome is like doing a clinical trial and failing to include all clinically relevant outcomes, or looking at the effect of an anti-smoking intervention on lung cancer forgetting it is also a cause of cardiovascular disease.	Thank you. The referral is to consider unintentional road injuries. We agree that there are other outcomes which may be significant, and the influence of the environment on physical activity has been considered in other guidance. It is possible that these issues will be included in modelling work carried out and considered by PHIAC or in other pieces of work (for instance on spatial planning, see http://www.nice.org.uk/Guidance/PHPG/Wave17/12)

London School of Hygiene & Tropical Medicine		General	Second, comment is that we should also consider car free cities which will be required to avert climate change.	Thank you. We would be interested in any evidence that considers this. However, as indicated above, other outcomes such as carbon dioxide emission are not the prime focus of this guidance.
NHS Cambridgeshire		General 1	The focus is too narrow and there is a real danger of diversion of resources to implement guidance at the expense of interventions that might have much greater impact.	Thank you. It is important that the scope sets out work that is achievable within the given time and resources. Please note that the final scope indicates that we will undertake another piece of guidance to address injuries in this age group that will focus on education and equipment and that other related work will be covered in NICE guidance onpolicies that prioritise walking and cycling and reducing road injuries in 15 – 24 year olds) l. In particular, enforcement of legislation relevant to this scope will be covered in the associated programme guidance 'Strategies to prevent unintentional injuries among under 15's (see http://www.nice.org.uk/Guidance/PHPG/Wave17/12
NHS Cambridgeshire		General 2	This narrow focus is not at all family friendly. We need to be taking an approach of raising safety awareness in disadvantaged families with practical advice and support so that they are empowered to prevent accidents in their home and community. It needs a much more holistic approach.	The aim of the scope is to set out guidance which will produce recommendations which will support the development of communities which are inherently less dangerous (from the point of view of road injuries). As indicated above, other approaches may form the basis of other guidance to address injuries.
NHS Cambridgeshire		General 3	This will struggle to engage family communities, public health or probably anyone but highway agencies.	Danger imposed by vehicles is frequently a cause of concern for communities and for public health professionals.
PEACH Unit (Dept. of Child Health, University of Glasgow)		4.2	The exclusion of legislation and enforcement, along with primary/secondary/tertiary prevention, leaves very little within the remit.	The scope aims to cover environmental change to reduce injuries. The final scope indicates that we will undertake another piece of guidance to address injuries in this age group that will focus on education and equipment. Enforcement of legislation relevant to this scope will be covered in the associated programme guidance 'Strategies to prevent unintentional injuries among under 15's.

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Royal College of Nursing		General	The document is comprehensive, clear and easy to read.	Thank you.
Royal College of Nursing		1.1	'Under 15s' is too ambiguous. We think the word 'people' is important too and should be included.	Thank you. The age range in the scope remains 0 – 14 as in the referral from the Department of Health.
Royal College of Nursing		4.3	This does not flow. 'Expected outcomes' (which presumably should form a separate part of the document) is slotted between questions 1 & 2. Also, one expects that there is more than one expected outcome but these do not feature in the document.	The expected outcomes section indicates the range of information that might be provided by the included research. As indicated, this varies from numbers of deaths and injuries to attitudes to the implementation of interventions under consideration
Royal College of Paediatrics and Child Health		General	The exclusion of legislation and enforcement removes some of the most potentially effective measures from the remit of the review.	Enforcement of legislation relevant to this scope will be covered in the associated programme guidance 'Strategies to prevent unintentional injuries among under 15's (see http://www.nice.org.uk/Guidance/PHPG/Wave17/12)
Royal College of Paediatrics and Child Health		General	The exclusion of primary, secondary and tertiary prevention is puzzling, draconian and unnecessary.	The scope includes elements of primary (pre crash, prevention of a crash occurring) and secondary (to reduce the severity of an injury by reducing the speed at which it occurs) prevention as indicated. This section sets out what will not be considered, which is important as the scope needs to be limited to a size which is achievable within the resources and time available.

Royal College of Paediatrics and Child Health		General	The current scope does not fulfil the terms of the referral, focusing solely upon engineering. Enforcement and wider environment interventions (e.g. providing safe play spaces) are also essential to achieving reductions in injuries. Obviously, the terms of the original referral are so broad as to be unworkable – the scope is almost limitless in terms of what / who may cause injuries to under 15s. The question then becomes is the scope too narrow. The College believes that it is and needs to be wider than is stated, perhaps looking at graduated vehicle licensing, since although the group that are focussed on here are too young to be driving (legally), many are likely to have older friends who do drive and drive in a manner to put this group at risk. It would also be beneficial to look at the provision of safe play / recreation spaces, since these are a considerable influence on the use of the road. This, along with the above suggestion would also provide more balance to the review, producing engineering, enforcement and environment elements.	The scope is intended to identify work within the referral that is achievable. We agree that the referral is potentially extremely broad. The final scope indicates that we will undertake another piece of guidance to address injuries in this age group that will focus on education and equipment . Other related work will be covered in NICE guidance ontransport policies that prioritise walking and cycling and reducing road injuries in 15 – 24 year olds. In particular, enforcement of legislation relevant to this scope will be covered in the associated programme guidance *'*Strategies to prevent unintentional injuries among under 15's see http://www.nice.org.uk/Guidance/PHPG/Wave17/12)
Royal College of Paediatrics and Child Health		General	Further to the above, engineering is a difficult area to act as an advocate in. This is for many reasons, eg, cost and current approaches to engineering, beliefs that engineering 'belongs' to transport / highways not health, and we are sure this will be reflected in the analysis of barriers. Therefore, in terms of a wider aim of guiding public health action in the future, by expanding the scope of the guidance there is greater potential for effective action.	One of the benefits of NICE guidance in an area will be to support those from a health perspective to act as advocates as appropriate and for others to understand the health case.

Royal College of Paediatrics and Child Health		General	The College wonders whether one reason for the limited scope may be that there is concern as to whether "health" may be seen as impinging on the work of other departments, e.g. policing and the Home Office for enforcement, Education for education. If this is the case, then the same does of course hold for the scope as it stands, with engineering being very much in the transport / highways domain. This is also a key barrier to be addressed in section 4.3	This is not a reason for the limitations set out in the scope. These are the result of the need to identify work that is achievable within the allotted resources.
Royal College of Paediatrics and Child Health		4.2.1 / 4.2.2. (b)	There is some confusion and contradiction in the terms listed as being listed as covered and excluded. 20mph zones are included, but enforcement including local setting of speed limits with no change to the road design is excluded. But, many 20mph zones do not include changes to the road design. It may help to clarify what is meant by 'road design'. In addition, 20mph zones are generally regarded as advisory, not mandatory, and are not enforced. It should perhaps be a part of this scope to compare the effectiveness of advisory vs mandatory limits.	The final scope has been widened to include other road design or environmental change to promote safety. This would include signing of relevant speed limits. National legislation and enforcement will be considered as part of the associated programme work 'Strategies to prevent unintentional injuries among under 15's' . http://www.nice.org.uk/Guidance/PHPG/Wave17/12

Royal College of Paediatrics and Child Health		4.3	The College believes that NICE must consider whether the evidence exists to be able to answer the stated questions and obtain the expected outcomes to a degree that means that this guidance will build on previous work (e.g. Bunn et al, systematic review of area wide traffic calming, Cochrane review). Again, taking traffic calming as an example, there are still many questions that primary research need to answer about the effectiveness of traffic calming before clear guidance can be issued. There tends to be clear demarcation between what is presented in health literature (casualties and injury outcomes) and that presented in transport literature (crashes and vehicle outcomes). Aligning these to produce coherent guidance is likely to be a significant challenge.	Our processes aim to bring together the best available evidence on which to base recommendations. These frequently include recommendations for further research. We agree that there are many challenges involved in producing coherent guidance where the available evidence may be less than perfect.
Royal College of Paediatrics and Child Health		4.3 Question 1	See above. In addition, changes in injury severity should not be included. The reasons for fluctuations are too varied and the classification is a police one, not medical. It should also be noted that child pedestrian casualties are usually underestimated by police data.	This information may come from a variety of sources. We agree that frequently it may not be based on a medical assessment. Where this information is available and is valid it seems appropriate to include it and consider how if can be used.
Royal College of Paediatrics and Child Health		4.3 Question 2	The College thinks that this is a very interesting area and likely to provide valuable information for advocacy. However, we would again question how much information is available. Work has been done which shows that there is little understanding of how different factors influence the location of traffic calming.	Thank you. We hope to be able to identify the best available evidence to address this question.
Royal College of Paediatrics and Child Health		4.3	One question should focus on which methods effectively reduce inequalities and how we ensure that distribution contributes to reductions.	Thank you for this point. This is important and will form part of the deliberations of the committee

Royal College of Paediatrics and Child Health			This is an important and timely issue, especially given that some councils are beginning to abandon and reverse previously taken decisions on the installation of traffic calming.	Thank you. We hope NICE guidance will be effective in supporting evidence based interventions.
Royal College of Paediatrics and Child Health			The College is disappointed by the scope of all three documents and would like to see more work and consultation on the scope of the proposals before the full assessment process begins. Without this, the College believes that significant effort will be required to produce guidelines that will have relatively little impact or value.	The scopes are intended to identify work within the referral that is achievable. The referral is potentially extremely broad and so it is inevitable that these initial pieces of work will not address all the issues that arise. The final scope indicates that we will undertake another piece of guidance to address injuries in this age group that will focus on education and equipment , and other related work will be covered in NICE guidance ontransport policies that prioritise walking and cycling and reducing road injuries in 15 – 24 year olds). In particular, enforcement of legislation relevant to this scope will be covered in the associated programme guidance 'Strategies to prevent unintentional injuries among under 15's (see http://www.nice.org.uk/Guidance/PHPG/Wave17/12)
Royal College of Paediatrics and Child Health			This initiative is extremely welcome and long overdue - the DH Accidental Injury Task Force Report was published in 2002 with little follow up action.	Thank you.
Royal College of Paediatrics and Child Health			The focus of the guidance appears to be England and Wales. What will be the status of the guidance in the other home countries? As N Ireland and Scotland have historically had higher injury mortality rates than the rest of the UK, it is essential that these countries become fully engaged in the initiative.	NICE has a remit to produce guidance for England only.

Royal College of Paediatrics and Child Health			The four topics - homes, roads, leisure and strategies - appear sensible, except that three are settings while the fourth is a policy response. The rationale for this approach is unclear.	The three intervention guidance topics (home, road and leisure) are taken from the referrals from the DH. The decision to focus the programme work on strategies to reduce injury is intended to enable this work to complement the intervention guidance and to address 'macro' level issues that cannot be fully considered in the intervention guidances (http://www.nice.org.uk/Guidance/PHPG/Wave17/12).
Royal College of Paediatrics and Child Health			The remit is to identify evidence of effectiveness and cost-effectiveness of preventive measures. An equally or more useful econometric analysis would be cost-benefit analysis as a means of demonstrating the enormous savings that are achievable through effective prevention.	Agreed. We will be interested in a variety of economic analyses of the interventions that are relevant to various professional groups.
Royal College of Paediatrics and Child Health			The consultation process is confusing and unwieldy in that three separate sets of documents are involved when one would have been sufficient.	We agree that there is some duplication of material. However, it is important that each piece of work has a scope that is able to stand alone. We will consider what changes to the process are possible for future referrals which are most appropriately packaged together.
Royal College of Paediatrics and Child Health		General	Title if very restrictive 'Road design to prevent unintentional injuries' whereas the title given in Page 1, paragraph 1 (i.e., Preventing unintentional road injuries among under 15s) is far broader and more appropriate	The title reflects the content of the draft scope and was chosen to reflect the fact that the scope excludes other areas of injury prevention. 'Preventing unintentional road injuries among under 15s' would suggest, for instance, that educational approaches would be included whereas they are expressly excluded from the scope of this work.
Royal College of Paediatrics and Child Health		4.2.1	Should include cycle helmet – impact of usage/design/mandated usage	These issues are not included in this work as the scope needs to be restricted to be achievable. These issues may be considered in other work to address the referral

Royal College of Paediatrics and Child Health		4.2.1	Should include any increased risk to children because of use of audio devices e.g., radio/mp3 etc and strategies to reduce this risk.	These issues are not included in this work as the scope needs to be restricted to be achievable. These issues may be considered in other work to address the referral
Royal College of Paediatrics and Child Health		2.0	Should also be aimed at the automotive industry, highways, cycle and cycle helmet manufacturers, law enforcement (e.g., re. speeding, driving under influence of drugs/alcohol etc).	The scope needs to be restricted to be achievable. However, enforcement of relevant legislation will be included in the programme scope 'Strategies to prevent unintentional injuries among under 15's (http://www.nice.org.uk/Guidance/PHPG/Wave17/12)
Royal College of Paediatrics and Child Health		4.2.2	Completed illogical to exclude National legislation/regulation – a powerful influence at local/regional level	The scope needs to be restricted to be achievable, however enforcement of relevant legislation will be included in the programme scope 'Strategies to prevent unintentional injuries among under 15's (http://www.nice.org.uk/Guidance/PHPG/Wave17/12)
Royal College of Paediatrics and Child Health		4.2.2	Far too restrictive to simply focus on road design without evaluating cofactors and a speed limitation of.	The scope needs to be restricted to be achievable
Royal College of Paediatrics and Child Health		4.2.2	Likewise, excluding efforts to change behaviour will mean that these results will be too narrow to be of any value.	The scope needs to be restricted to be achievable. The final scope indicates that we will undertake another piece of guidance to address injuries in this age group that will focus on education and equipment and other related work will be covered in NICE guidance ontransport policies that prioritise walking and cycling and reducing road injuries in 15 – 24 year olds. In particular, enforcement of legislation relevant to this scope will be covered in the associated programme guidance 'Strategies to prevent unintentional injuries among under 15's (see http://www.nice.org.uk/Guidance/PHPG/Wave17/12)

Royal College of Paediatrics and Child Health		General	If they exclude all know preventatives strategies around product design (e.g., seatbelt, cycle helmets) and impact of speeding restrictions and only focus on engineering, it is not a 'health' guidance'.	Speed restrictions using signage and road design are included in this scope. Related legislation and enforcement are included in the associated programme guidance 'Strategies to prevent unintentional injuries among under 15's (http://www.nice.org.uk/Guidance/PHPG/Wave17/12).
Royal Society for the Prevention of Accidents (RoSPA)		General	RoSPA welcomes NICE's Consultation on the Draft Scope for Consultation on the Draft Scope for Preventing unintentional road injuries among under 15's and thanks NICE for the opportunity to comment. Great Britain has made tremendous progress in reducing death and injury to children on our roads over the last 20 years. In 1987 466 children (under 16 years old) were killed, 9,087 seriously injured and 35,399 injured in reported road crashes. By 2007, these numbers had fallen to 121 deaths, 2,969 seriously injured and slightly 20,717 respectively. There are many reasons for this success, and one of the most important has been improvements in road designs, most especially speed management and local safety schemes, such as traffic calming and 20 mph zones. However, the fact that we still kill and injure almost 25,000 children and young people a year clearly demonstrates that much more can, and must, be done. It is also true to say that there are a significant number of child road casualties that are not recorded in the road casualty data.	Thank you.

Royal Society for the Prevention of Accidents (RoSPA)			Drivers travelling at higher speeds have less time to identify and react to what is happening around them. It takes longer for the vehicle to stop. Any resulting crash is more severe, causing greater injury to the occupants and to any pedestrian or rider hit by the vehicle. Driving too fast for the conditions is a major cause of crashes. Excessive speed contributes to 12% of all injury collisions, 18% of crashes resulting in a serious injury and 28% of all collisions which result in a fatality. This means that over 800 people are killed each year on Britain's roads because drivers and riders travel too fast. Approximately two-thirds of all crashes in which people are killed or injured happen on roads with a speed limit of 30 mph or less. At 30 mph vehicles are travelling at 44 feet (about 3 car lengths) each second. One blink and the driver may fail to see the early warning brake lights; one short glance away and the tell-tale movement of a child behind a parked car will be missed.	We agree.

Royal Society for the Prevention of Accidents (RoSPA)			Even in good conditions, the difference in stopping distance between 30 mph and 35 mph is an extra 21 feet, more than 2 car lengths. At 35 mph a driver is twice as likely to kill someone as they are at 30 mph. • Hit by a car at 20 mph, 1 out of 40 pedestrians will be killed 97% will survive • Hit by a car at 30 mph, 2 out of 10 pedestrians will be killed 80% will survive • Hit by a car at 35 mph, 5 out of 10 pedestrians will be killed 50% will survive • Hit by a car at 40 mph, 9 out of 10 pedestrians will be killed 10% will survive Even a small amount above the limit makes a big difference.	We agree.
Royal Society for the Prevention of Accidents (RoSPA)		General	It is particularly good to see NICE showing interest in this topic.	Thank you.
Royal Society for the Prevention of Accidents (RoSPA)		General	However, given that there is so much knowledge and good practice about the role of road design and road engineering in preventing death and injury to children, it is important that NICE's guidance complements and supports existing guidelines and practice.	Agreed.

Royal Society for the Prevention of Accidents (RoSPA)		General	NICE defines children as under 15 years of age, whereas in road casualty statistics the DfT and the Police define children as under 16 years. Given the main data for road injuries involving children is that recorded by the Police and used by the DfT, local authorities and organisations such as RoSPA, we recommend that NICE amend its definition of children to 'under 16 years' for the purposes of these guidelines.	The age range is taken from the DH referral.

Royal Society for the Prevention of Accidents (RoSPA)		General	Although we recognise that these NICE guidelines will focus on road design, it is essential to note that road engineering is one part of a wider road safety strategy. Almost all road crashes are caused by, or involve, human error. Therefore, to reduce this appalling toll of loss and injury, it is necessary to influence the way drivers, riders and walkers behave when using the road. There are many ways of influencing behaviour and it is well recognised that the most effective approach is a co-ordinated strategy of:- **Education** (including training and publicity) to provide road users with **appropriate** knowledge, skills and, importantly, attitudes so that they choose to use the roads in a safe and responsible manner. So for example you would think that engineering would affect all groups equally, but it seems that Asian and Black African groups benefit less from improvements in road safety. **Engineering** (both road and vehicle) to physically affect the way road users behave (for example, through speed reduction measures). **Enforcement** to support and complement education and engineering measures, to specifically target irresponsible, dangerous and unlawful behaviour that puts other road users at risk, and to investigate, and where appropriate take enforcement action. Without the other two strands of this strategy, road safety engineering will be much less effective.	We agree that engineering is one part of a wider strategy and that education and enforcement are both important. Legislation and enforcement related to the topics within this intervention guidance will be included in the programme guidance 'Strategies to prevent unintentional injuries among under 15's (see http://www.nice.org.uk/Guidance/PHPG/Wave17/12) The final scope indicates that we will undertake another piece of guidance to address injuries in this age group that will focus on education and equipment We intend to address additional topics within other NICE guidance. This includes 'transport policies that prioritise walking and cycling' and 'reducing road injuries in 15 – 24 year olds'.

Royal Society for the Prevention of Accidents (RoSPA)		2 c, Background	In addition to the two PSA's listed, the guidance should also aim to support the DfT's public service agreement: "To reduce the number of people killed or seriously injured in Great Britain in road accidents by 40% and the number of children killed or seriously injured by 50% by 2010 compared with the average for 1994-98, tackling the significantly higher incidence in disadvantaged communities". It should also support the new road casualty reduction strategies and targets which DfT are currently developing for beyond 2010.	Thank you. This has been included in the final scope.

Royal Society for the Prevention of Accidents (RoSPA)		2d and 2e, Background	Other policy documents and good practice guidelines NICE should consider when drafting its guidelines, are: **Department for Transport** Child Road Safety Strategy 2007 Local Transport Note 1/07 Traffic Calming Circular 1/06 Setting Local Speed Limits Road Safety Good Practice Guide Manual for Streets Traffic Advisory Leaflets on road engineering measures **The Neighbourhood Road Safety Initiative (NRSI)** A DfT project to find new ways to reduce road casualties, particularly involving children, in deprived areas. Three reports are at www.dft.gov.uk/pgr/roadsafety/dpp/neighbourhoodroadsafety/ Neighbourhood Road Safety Initiative Central Team: Final Report Neighbourhood Road Safety Initiative, Project Management Consultancy Services: Final Report Widening the Reach of Road Safety – Emerging Practice in Road Safety in Disadvantaged Communities: Practitioners' Guide More details can be found at http://www.nrsi.org.uk/index.php	Thank you for these. While it is not possible to produce a comprehensive list in the final scope, these will be useful in informing the production of the guidance.

Royal Society for the Prevention of Accidents (RoSPA)		2d and 2e, Background	**The Mixed Priority Routes Demonstration Project** Shows how roads can be made safer and more pleasant for pedestrians, cyclists and motorists. Two reports are available at http://www.dft.gov.uk/pgr/roadsafety/dpp/mpr/ : High street renaissance LTN 3/08 Mixed Priority Routes: Practitioners Guide	Thank you for these. While it is not possible to produce a comprehensive list in the final scope, these will be useful in informing the production of the guidance.
Royal Society for the Prevention of Accidents (RoSPA)		2d and 2e, Background	**Rural Road Safety Demonstration Project** This on-going project is intended to demonstrate good practice for local highway authorities in developing and implementing an evidence and data-led strategy to address rural road casualty reduction. Details can be found at http://www.dft.gov.uk/pgr/roadsafety/dpp/rural/ Other publications that NICE should consider when drafting its guidelines are: **Highways Agency** Safety Action Plan **Institution of Highways and Transportation Guidelines** Collision Prevention & Reduction Rural Safety Management Urban Safety Management Traffic Calming Techniques Cycle-Friendly Infrastructure **RoSPA** Road Safety Engineering Manual	Thank you for these. While it is not possible to produce a comprehensive list in the final scope, these will be useful in informing the production of the guidance.

Royal Society for the Prevention of Accidents (RoSPA)		4.1.2 Groups that will not be covered	We presume that the definition of road will include pavements and footpaths. We also recommend that NICE consider the fact that many cycle networks, routes and facilities include both on and off road sections. For many cyclists, a journey will include riding on the road and also on off-road cycle paths. The guidance should also consider the points at which off-road facilities join roads.	Agreed. The final scope has been widened to include other road design or environmental change to promote safety. This includes walking and cycling networks. The final scope indicates that we will undertake another piece of guidance to address injuries in this age group that will focus on education and equipment
Royal Society for the Prevention of Accidents (RoSPA)		4.2 Activities	In our view, the guidance should encompass both urban and rural environments. The road safety dangers to children, and the ways in which road design can reduce those dangers, differ significantly between these environments.	Agreed
Royal Society for the Prevention of Accidents (RoSPA)		Question 1	The road engineering measures that are most effective in reducing vehicle speeds, and reducing road injuries among children and young people under the age of 15 years, are traffic calming measures, especially in area-wide schemes or 20 mph zones. A review[1] of accident data in seventy-two 20 mph zones found that average mean speeds were reduced by 9 mph, from 25 mph to 16 mph in the zones. On average, for every 1 mph speed reduction, there was a 6.2% accident reduction. [1] "A Review of Traffic Calming Schemes in 20 mph Zones, TRL Report 215, 1996"	Thank you for these links.

Royal Society for the Prevention of Accidents (RoSPA)		Question 1 Cont'd	All road accidents in the zones fell by 61%, and there was no evidence of accident migration onto surrounding roads. Traffic flows in the zones reduced by 27%. The effects were particularly significant for child road casualties: • Child accidents down by 67% • Child pedestrian accidents down by 70% • Child cyclist accidents down by 48% Hull City Council have been especially proactive in installing 20 mph zones and reported that in the zones speeds were down from 30 mph to 17 mph. This resulted in child casualties falling by 64%, and child pedestrians casualties by 74%.	

Royal Society for the Prevention of Accidents (RoSPA)		Question 1 cont'd	A review of over one hundred 20 mph zones in London[2] also found that they were very effective in reducing road injuries to children. In the zones, speeds were reduced by 9 mph and traffic flows by about 15%. Overall, road user casualties in the zones were reduced by 45% and fatal or seriously injured casualties by 57%. Again, significant protection was provided to children: • Child pedestrian casualties down by 48% • Child pedestrians killed or seriously injured down by 61% • Child cyclist casualties down by 59% • Child cyclists killed or seriously injured down by 60% • Child car occupant casualties down by 51% • Child car occupants killed or seriously injured down by 47% [2] "Review of 20 mph Zones in London Boroughs TfL Safety Research Report 2, 2003"	

Royal Society for the Prevention of Accidents (RoSPA)		Question 1 cont'd	Using 'Before and After' data from traffic calming schemes, the DfT's Local Transport Note 1/07 "Traffic Calming" summarises the accident reduction effectiveness of different traffic calming measures: • Road Humps about 60% (up to 89% in some cases) • Speed cushions up to 86% • Rumble devices between 35% to 60% • Chicanes and road narrowings about 50% • Roundabouts (new ones and mini-ones) 40% in urban areas and 54% in rural areas. There is considerable good practice guidance published about the designs of traffic calming schemes and 20 mph zones.	Thank you.

Royal Society for the Prevention of Accidents (RoSPA)		Question 1 cont'd	***What More Can Be Done on the Roadside?*** It needs to be much, much easier for drivers to choose to drive at safe speeds. This requires education, training and publicity, better and more consistent roadside information about the posted speed limits and improved vehicle design so that drivers are more aware of the speed at which they are travelling. **Speed Limits** Drivers' choice of speed is partly dependent on the characteristics of the road on which they are driving, and their perception of what is a safe speed on a particular road will often differ from other road users, such as pedestrians, pedal cyclists and horse riders. Therefore, it is important that road design gives drivers the right messages about the maximum safe speed. Speed limits need to be appropriate for the road on which they are posted, otherwise drivers are less likely to respect them. However, the reasons for a particular speed limit may not be apparent to motorists and consideration needs to be given to ways of making the reasons for speed limits on particular roads, especially roads which have a speeding problem, more obvious to the road users. This could be by providing information at the roadside or through local publicity campaigns.	Thank you. Speed limit signing will be included in the scope.

Royal Society for the Prevention of Accidents (RoSPA)		Question 1 cont'd	***Speed Limit Signing*** The over-riding principle of speed limit signing should be to ensure that the limit is always as clear and obvious as possible. Drivers should not be expected to work out the speed limit. In many cases, the nature of the road does not indicate the speed limit. In urban areas, for example, dual carriageways can have limits of 30 mph, 40 mph, 50 mph, 60 mph or 70 mph. Drivers who claim they do not know the limit may be genuinely unsure, or may be making excuses. Making the limit obvious would help those drivers who are genuinely unclear, and would remove the excuse from those drivers who really did know the limit but exceeded it anyway.	Thank you. Speed limit signing will be included in the final scope

Royal Society for the Prevention of Accidents (RoSPA)		Question 1 cont'd	Repeater signs help to solve this problem, but only if they are in place and at regular intervals. This is not always the case, and when repeater signs are present, the first one may be some considerable distance from the junction or the point at which the limit changed. Speed limit signing is not always consistent. Motorists often claim that it is difficult to know what the speed limit is on a particular stretch of road. Sometimes this is because they have not noticed the speed limit signs, but sometimes the signs are not present. Most drivers will have had the experience of driving on a stretch of road and not being sure of the limit. Speed limit signs tend to be placed at junctions because this is often the point at which the limit changes. However, junctions are also where drivers need to absorb a wide range of different information and it is easy to miss a speed limit sign when concentrating on one or more other things (e.g., which way am I going, is that driver going to pull out, etc).	As above

Royal Society for the Prevention of Accidents (RoSPA)		Question 1 cont'd	Drivers can also be made aware of a change in speed limit by more marked changes on the road and roadside. Strips of coloured tarmac and a roundel painted on the road would emphasise the change and alert drivers to the new speed limit. In rural areas, the use of 'Gateways' to mark the start of a lower speed limit in a village are particularly useful. Speed limits should always be clearly and consistently marked, and this requires greater use of speed limit repeater signs and speed limit road markings.	Speed limit signing will be included in the final scope. Gateway changes will also be included as examples of environmental changes.
Royal Society for the Prevention of Accidents (RoSPA)		Question 1 cont'd	**Speed Limit Signs and Cameras** A common complaint from car drivers about cameras is that speed limits at camera sites are not always made obvious. RoSPA believes that the speed limit should always be shown at camera sites. **30 mph Speed Limit Repeater Signs** 30 mph speed limit repeater signs are prohibited on 30 mph roads which have street lamps. Even if a local authority wished to place 30 mph repeater signs on these roads to address a speeding or accident problem it is not able to do so. Paragraph 103 of the Highway Code tells drivers *"Street lights usually mean that there is a 30 mph speed limit unless there are signs showing another limit".*	As indicated above speed limit signing will be included in the scope for this work, and enforcement of relevant legislation will be considered by the associated programme guidance 'Strategies to prevent unintentional injuries among under 15's (http://www.nice.org.uk/Guidance/PHPG/Wave17/12).

Royal Society for the Prevention of Accidents (RoSPA)		Question 1 cont'd	This requires drivers to work out what the limit is. It is worth repeating that approximately two-thirds of all crashes in which people are killed or injured happen on roads with a speed limit of 30 mph or less. Therefore, doing everything possible to make the speed limit as clear and obvious as possible would be a logical step. It is not feasible to put repeater signs or roundels on the road on all 30 mph roads, because it would lead to a massive proliferation of signs and create considerable resource problems. However, Highway Authorities should have the ability to do so. This would enable them to place repeater signs or markings on roads which speed surveys showed there is a speeding problem, or accident data showed a speed-related crash problem. A trial should be conducted to examine the effectiveness of 30mph repeater signs on driver speed. If it found that such signs are effective, then the prohibition against repeater signs in 30 mph zones should be rescinded.	Please see comments above
Royal Society for the Prevention of Accidents (RoSPA)		Question 1 cont'd	Repeater signs are not the only way of informing drivers of the prevailing speed limit. Wider use of speed limit markings on the road surface can also be employed, although care must be taken to ensure that this does not adversely affect two-wheelers, especially in wet road conditions.	Signage relating to speed limits, including road surface marking, will be included. We would be interested in any relevant evidence you may have on these topics.

Royal Society for the Prevention of Accidents (RoSPA)		Question 1 cont'd	**National Speed Limit Sign** Some drivers are confused about the meaning of the national speed limit sign (white circle with diagonal black bar) which means different speed limits on different types of road and for different vehicles. The Transport Select Committee in its report, "Road Traffic Speed", recommended that "The 'derestricted' sign should be replaced by a sign indicating what the speed limit is". RoSPA agrees.	National legislation and its enforcement will be considered in the associated programme guidance 'Strategies to prevent unintentional injuries among under 15's (http://www.nice.org.uk/Guidance/PHPG/Wave17/12).
Royal Society for the Prevention of Accidents (RoSPA)		Question 1 cont'd	**Sign Visibility** Road signs are only useful if drivers can see them. It is important that Highway Authorities ensure that signs are kept visible, and in particular, that hedges, trees and vegetation do not obscure them.	Thank you.

Royal Society for the Prevention of Accidents (RoSPA)		Question 1 cont'd	**Vehicle Activated Signs (VAS)** Vehicle activated signs detect the speed of oncoming vehicles and, if above the speed limit, flashes the speed the driver is doing or the speed limit of the road, sometimes with warning messages such as 'slow down'. They can also display junction or bend warning signs or the safety camera sign, and are also particularly effective on approaches to isolated hazards, such as junctions and bends in rural areas. A large-scale evaluation was conducted into the effectiveness of VAS by TRL in 2002. It found that junction and bend warning signs reduced the mean speed by up to 7mph. Safety camera repeater signs, used in conjunction with enforcement, reduced the mean speed by up to 4mph, and their use with cameras reduced accidents more than cameras alone. The evaluation also measured public opinion and found that there was "overwhelming approval" of the signs.	Thank you. Speed limit signage will be included in the final scope. Thank you for the pointer towards this relevant evidence.

Royal Society for the Prevention of Accidents (RoSPA)		Question 1 cont'd	**Intelligent Speed Adaptation** Technology which can prevent drivers from exceeding the speed limit on any particular road is being developed and tested. The latest field tests[3] show that this "*is now a mature technology which is capable of delivering substantial reductions in excessive speed and thereby considerable benefits in terms of safety."* Depending on how the technology is implemented, over the 60 year period from 2010 to 2070, it would be expected to reduce fatal accidents by between 10% (approximately 15,400 fatal accidents) and 26% (approximately 43,300 fatal accidents), serious injury accidents between 6% (96,000 accidents and 21% (330,000 accidents), and slight injury accidents by between 3% (336,000 accidents and 12% (1.3 million accidents). One of the requirements for the widespread implementation of this technology is a digital map showing the speed limit on every road in the country, which can easily and regularly be updated, including taking account of speed limit changes due to road works. The Government needs to create or commission this. [3] "***Isa***- ***UK i****ntelligent* ***s****peed* ***a****daptation:* Final Report, the University of Leeds and MIRA Ltd, June 2008"	Thank you for raising this important issue. Unfortunately changes to vehicle technology are outside the scope of this work

Royal Society for the Prevention of Accidents (RoSPA)		Question 2	A shortage of funds and qualified staff, especially in local highway authorities, is often cited as a barrier. There can also be opposition to traffic calming schemes, in particular from Ambulance Services. It is common for Ambulance Services to object to traffic calming schemes and 20 mph zones because they are concerned that they slow down their response times, and thereby put people at risk. They often state that heart attack victims are put at additional risk because traffic calming measures slow down ambulances.	Thank you. We would be interested if you know of any research where these issues have been examined.
Royal Society for the Prevention of Accidents (RoSPA)		Question 2 Cont'd	However, we are not aware of any research that has attempted to properly assess these or quantify these concerns. It would seem fairly straightforward to assess: What proportion of ambulance journeys take place on traffic calmed roads • How their response times are affected • How their response times compare to similar journey on non-traffic-calmed roads • How many patients have genuinely suffered or been put at risk because ambulances have had to use traffic-calmed roads • What more can be done to design traffic calming schemes and 20 mph zones to continue to provide the level of road safety and to meet the concerns and needs of the ambulance service.	Thank you.

Royal Society for the Prevention of Accidents (RoSPA)		Question 2 Cont'd	We are also aware that local authorities say that when they consult ambulance services on traffic calming proposals, they will often receive blanket objections, without any real attempt to discuss alternative measures or how the specific design of schemes can seek to accommodate the needs of the ambulance service. It would be particularly useful if the NICE guidelines could seek to resolve these issues, which are in danger of becoming an impasse.	We agree that this is an important area to address. We would be interested if you know of any research which considers these issues.
Sandwell PCT		4.2.1	We support the emphasis on danger reduction, in particular the emphasis on traffic calming measures. We agree that intervention guidance dedicated to this particular area will be valuable, and that it should not attempt to cover behavioural measures which can be captured in the programme guidance.	Thank you
Sandwell PCT		General	Traffic calming design guidance already exists. Evidence to support particular types may be valuable. More importantly, the guidance should offer evidence why decision makers should support the adoption of more widespread traffic calming. In the real world decisions about whether to adopt traffic calming will always be made in the context of many factors, not just child injury alone. Any convincing arguments to adopt traffic calming would therefore need to cover its overall effect. From a health perspective, it would be good if this could be expressed in net QALYS, although some other quantification measure would also be welcome, especially any more familiar to local councillors. Such a measure should try to include the effect of trips foregone.	Thank you. The aim of the guidance will be provide evidence based recommendations for action. We anticipate that this will include calculations of benefits in terms of cost per QALY as well as potentially other calculations designed to reflect the interests of other professional groups.

Public Health Intervention Guidance

Preventing unintentional road injuries among under 15s - Consultation on the Draft Scope: Stakeholder Comments and Response Table

Monday 3rd November – Monday 1st December 2008

Sandwell PCT		General	We would like the programme guidance to cover any evidence for making Level 2 National Standard cycle training part of the National Curriculum, delivered by instructors external to schools.	The programme guidance 'Strategies to prevent unintentional injuries among under 15's (http://www.nice.org.uk/Guidance/PHPG/Wave17/12) will address policy and legislative approaches to related issues. You may be interested to hear that NICE has been referred a topic on 'transport policies that prioritise walking and cycling'
Sandwell PCT		4.2.1	Please look for any evidence regarding the effect of dropped kerbs. Anecdotally it would appear that these facilitate pavement cycling/skating and may increase the risk of cyclists/rollerbladers etc. being hit by cars turning into side roads.	Thank you.
Telford & Wrekin PCT		General	The document's aim of identifying approaches to traffic management design that are effective and ineffective is welcomed by both the road safety officers and traffic engineers at Telford & Wrekin Council. This piece of work should have some positive outcomes that we can learn from and go on to implement. We strongly feel that NICE should involve professionals with knowledge of road safety engineering in the study. Consideration should be given to how the guidance will be disseminated, particularly to traffic engineers. Most road safety officers have good working links with health professionals and are used to learning from the health sector. On the whole, engineers do not have these links with the health agenda and if dissemination is not given careful consideration it could be met with a degree of resistance. The best way of overcoming this is to involve traffic engineering professionals in the development of the guidance.	Thank you. We aim to involve relevant professionals through a variety of methods, including as stakeholders and through our fieldwork processes. We agree that consideration of dissemination routes will be very significant and will address this with our communications colleagues.

Telford & Wrekin PCT		General	Shropshire Fire and Rescue Service welcome this draft guidance and are fully supportive of any guidance designed to reduce road accidents, and as such will willingly contribute to any programmes that will support the accident reduction agenda.	Thank you. We look forward to your continued involvement through stakeholder comments and other routes.
Telford & Wrekin PCT		General	Telford and Wrekin Primary Care Trust – School Nurse Team support this document but have raised that the document lacks emphasis on the need to introduce compulsory wearing of cycle helmets. Can NICE influence future policy? There are also concerns regarding there being no mention of street lighting in more rural areas?	Thank you. Cycle helmets are not part of the current scope, however this issue could be considered in additional guidance to address this referral. The final scope indicates that we will undertake another piece of guidance to address injuries in this age group that will focus on education and equipment