Joint Call by 28 EU-level organisations: pan-European accident and injury data system needed

On the occasion of the European Consumer Day organised by the European Economic and Social Committee (EESC) on 14 March in Brussels, a coalition of twenty-eight European umbrella organisations issued a Joint Call urging European Institutions and the Member States to create an EU-funded accident & injury data system under the co-ordination of the European Commission. In the opening session, Wim Rogmans-secretary general EuroSafe, handed on behalf of the coalition the document over to Commissioner Borg, European Parliament-member Harbour and EESC President Nilsson.

In their joint statement these 28 organisations urge the European Institutions and the Member States to create an EU-funded accident and injury data system, embracing all Member States, under the co-ordination of the European Commission. This system should build upon the principles developed in several Member States, be similar to the US National Electronic Injury Surveillance System, and provide data from samples of national accident and emergency departments. It needs to be led and adequately funded by the European Commission.

All Member States should be required to contribute to the establishment of the database and regularly deliver injury data to the Commission that are comprehensive and in accordance with harmonised methodology and classification. The system should be readily accessible to all relevant stakeholders and allow analysis of injury risks, in particular those related to home and leisure accidents, and the potential effectiveness of various policy options and injury prevention measures.

Such a system is deemed to be critical in setting of priorities; development of policy; determination of preventive actions and public awareness campaigns; understanding of risk; design of safety into new products; and development of standards. The system would help create a level-playing field for European consumers and European businesses. Commissioner Borg announced in his response that data related to accidents and injuries related to unsafe products should feed into the market surveillance efforts. In the framework of the Multi-annual Market Surveillance Action Plan the Commission will launch an initiative to assess the feasibility of an EU-accident/ injury database.

Find the Joint Call at: http://www.eurosafe.eu.com/csi/eurosaf2006.nsf/
Accidents and injuries present a major health and consumer protection challenge.

EuroSafe’s the fourth edition of ‘Injuries in the European Union’ has now been released. The report reveals that an annual average of 40 million people within the EU need hospital treatment and 233,000 people die as a result of an injury event.

There are great differences between countries in the number of fatal and hospital treated accidental injuries per 100,000 inhabitants. This clearly indicates that there exists ample opportunities for rolling out measures that will lower injury rates across the entire EU-region.

Data are the foundation for better policies

In the fields of work safety and road safety, the need for injury information has been acknowledged a while ago; dedicated reporting systems are in place which are also used at EU-level. This has resulted in increased political understanding and commitment to make roads and work places safer. Over the past five years road traffic and work related accidents are slowly but steadily declining. But for home and leisure accidents this is not the case. This despite of the fact that the majority of injuries (73%) are due to home and leisure accidents, particularly affecting vulnerable groups such as the less well-off, children and older people. Sport-related injuries and fall-injuries among older people are even on the rise. It is evident that many opportunities for preventing home and leisure accidents remain untapped.

Government leadership needed

Given the immense financial burden of injuries, we all will benefit from actions to improve home and leisure safety, not the least by a decrease in health and social expenditures related to injury.

It is the responsibility of governments to ensure proper arrangements within countries for implementing injury prevention programmes and monitoring their impact in terms of less injuries. The health sector is uniquely positioned to collect injury data and to generate multi-sector prevention efforts across a range of sectors.

Experience in a couple of EU-countries shows that it is possible to collect information on home and leisure injuries in a cost-effective manner. Emergency Departments at hospitals provide the best setting for collecting information as this information relates to severe cases, while less severe cases are treated by family doctors or school nurses for instance. Information can also be obtained easily in hospitals on a large number of cases and at low cost. Over the past few years, EU-countries and the European Commission have explored ways to encourage national and EU-level exchange of data on injuries. At the moment, 12 countries deliver information from selected emergency departments, which is taken into the European Injury Data Base.

However, this will end by early next year and a long term commitment from member states governments and the EC is still lacking. Therefore EuroSafe, being also one of the 28 coalition partners (page 1), calls on the European Commission and Member States to agree on a binding and long term arrangement for all countries to collect ED-based injury data and to ensure a continued EU-level exchange of vital injury data in 2014 and following years. This source of information should be used in a more systematic manner and data should be made available for health and consumer policies in countries and at EU-level. The cost of data collection in emergency departments is only marginally compared to the overall direct medical costs of treating these injuries, while the benefits will exceed this additional cost multiple times.

Find our report at:
EU news

Product Safety and Market Surveillance in the EU

On February 13, the European Commission proposed a package of new rules to improve the safety of consumer products circulating in the Single Market and to step up market surveillance concerning all non-food products. This is meant both to strengthening consumer protection and to creating a level playing field for businesses. Unsafe products should not reach consumers and their improved identification and traceability will be a key improvement that will help to take them quickly out of the market.

Two new regulations are proposed: a Consumer Product Safety Regulation and a new Market Surveillance Regulation. These two proposals are complemented by a multi-annual plan for market surveillance setting out 20 concrete actions to be undertaken from now to 2015 to improve market surveillance under the current regulatory framework and until the new rules come into effect.

Purpose

The new Consumer Product Safety Regulation aims at clarifying the regulatory framework for consumer products to make it fit for purpose to meet the challenges of a globalised market. More emphasis is put on enhanced product identification and traceability. Also the procedures to develop new or update existing standards are simplified, enhancing the role of standards in the field of consumer product safety.

The proposed new Market Surveillance Regulation aims at simplifying the current set of market surveillance rules which is fragmented and spread across several different pieces of EU legislation. The future Regulation will as far as possible the rules and procedures applicable to all non-food products.

Main change in a nutshell

The two set of rules will enable better coordination of how authorities check products and enforce the product safety rules across the EU, as it:

- Makes it easier to remove dangerous products from the market across the EU in a timely and consistent manner.
- It aligns the general market surveillance and consumer safety rules for all consumer products.
- Defines clearer the responsibilities for manufacturers, importers and distributors when they sell consumer products.
- Improves traceability of consumer products throughout the supply chain – enabling a swift and effective response to safety problems (e.g. recalls).
- Applies across the Union. Where products are unsafe, it will be easier to impose marketing restrictions, including their ban.
- Creates a more collaborative system of market surveillance across the EU, laid down in a single set of coherent rules.
- Streamlines procedures concerning the notification of dangerous products, based on the synergy between the Rapid Alert Information System (RAPEX) and the Information and Communication System for Market Surveillance (ICSMS).

The aim of the Commission is to develop common practices regarding the identification and assessment of risk which should be followed across the Union. Market surveillance activities will be better coordinated and joint actions will improve their effectiveness. The pooling of resources will help to eliminate the duplication of work and maximise the efficiency of market surveillance. Exchange of experience and information will lead to ‘best practices’ for the benefit of consumers, businesses and national authorities.

Action plan

A multi-annual market surveillance action plan has been presented in conjunction with the two legislative proposals. The plan outlines the immediate non-legislative actions that the Commission will take this and next year with a view to reduce the number of unsafe or non-compliant products and ensure the efficiency and effectiveness of the surveillance of products both within the Union and on entry into the Union. This includes actions to facilitate:
Investing in Health

- Pooling of information from investigations, results of joint actions, guidance for market surveillance, case studies, statistics and overall information on market surveillance;
- A common approach to risk assessment methodologies and their application;
- The improvement of information on market surveillance activities of member states in order to allow more accurate benchmarking and performance assessment; and
- Closer cooperation throughout the Union by cross-border surveillance and joint enforcement actions.

Under the heading “pooling of information”, it is stressed that data related to accidents and injuries related to unsafe products should feed into the market surveillance efforts. One of the twenty actions aims to assess the cost/benefit of an EU-accident/injury database.

By the end of 2015, the Commission will look into the need to launch a new multi-annual market surveillance plan which could draw inspiration and benefit from the experiences triggered by the implementation of EU programmes for consumers and customs.


Investing in Health

Health is a value in itself, but it is also a precondition for economic prosperity. Health spending is ‘growth friendly’ expenditure. The European Commission recently issued a strategic paper on investing in health which establishes the role of health as integral to the Europe 2020 strategy. It also links EU health policies and national health system reforms and presents the case for:

- Smart investments for sustainable health systems:
  According to the OECD, reforms in healthcare could lead to savings of, on average, 2% of GDP by 2017. Getting more value for money through reforms and investments is crucial. EU countries are responsible for the organisation and delivery of their own health services and care. They are invited to spend smarter - not necessarily more, to make their healthcare systems more efficient. Efficiency gains can be made by, for example, reducing unnecessary hospitalization and use of specialists, strengthening primary care, encouraging the use of less expensive equivalent (generic) drugs, and using health technology assessment to evaluate the cost-effectiveness of health technologies as a basis for decision making. The Commission says it will continue to foster the cooperation among the Member States and efforts to improve the knowledge and evidence at EU level.

- Investing in people’s health:
  A person’s health status influences how much they can participate in social and work life and how productive they are in the workplace. On a larger scale, it influences the financial impact on national healthcare systems. Investments in health can support economic growth by enabling people to remain in good health and be active in the workplace for longer. Investing in health promotion for children and young people, for instance, supports their physical and social development and ultimately equips them to play a full role in society. Another avenue is to invest in the health workforce, as the Commission suggested in an Action Plan of 2012.

- Investing in reducing inequalities in health:
  The on average improved levels of health hide major health inequalities that still exist both between and within Member States. Differences in life expectancy at age 30 between people with higher education and those with basic secondary education or less exceed 10 years in many Member States. Avoidable diseases and deaths attributable to inequalities in health are a waste of human capital and must be reduced. Universal access to safe, high quality, efficient healthcare services and better cooperation between social and healthcare services, and effective action on risk factors can all help break the vicious circle of poor health/poverty/exclusion. The Commission an-
nounces that it will report in 2013 on the implementation of its 2009 Communication on inequalities in health.

As to resources for implementing the Health strategy for 2020, the Commission refers the EU Health Program, the Cohesion and Structural Funds, as well as the Research and Innovation Funds (Horizon 2020) which can support investment in health all across the European Union.


### WHO news

#### People with disability

At its 132nd session, WHO's Executive Board adopted a draft resolution on disability, to be debated at the World Health Assembly in May this year. The resolution endorses the recommendations of the World report on disability and calls for WHO and Member States to ensure equal access to health services for persons with disabilities.

Across the world, more often than their non-disabled peers, people with disabilities have poorer health and do not receive the care they need. People with disabilities are more than twice as likely to find healthcare provider skills inadequate; nearly three times more likely to be denied care; and four times more likely to be treated badly.

The draft resolution urges States Parties to implement the Convention on the Rights of Persons with Disabilities, develop plans of action, and ensure that mainstream health services address the needs of people with disabilities. WHO is asked to support Member States to implement the recommendations of the World report on disability and the Convention, as well as ensure that the health needs of children and adults with disabilities are included in WHO's technical work.

The resolution also requests further action on improving disability data, strengthening health systems for the provision of rehabilitation and assistive technologies, and enhancing community-based rehabilitation.

Twenty Member States, some speaking on behalf of regional groupings such as the European Union and the WHO African Region, voiced strong support for the resolution, proposed by Ecuador. Five nongovernmental organizations also backed the draft: CBM, International Society of Physical and Rehabilitation Medicine, Rehabilitation International, World Blind Union and World Federation of Occupational Therapists.

The resolution constitutes an important step in preparations for the United Nations High-Level Meeting on Disability and Development on 23 September.

WHO status report on road safety 2013

On 14 March, WHO launched the Global status report on road safety 2013 at WHO headquarters in Geneva, Switzerland. The launch event involved around 200 participants and was opened by the WHO Director-General.

The report, made possible by a grant from Bloomberg Philanthropies, presents information on road safety from 182 countries. Its purpose is to identify gaps and generate action in road safety at national level. It also serves as a baseline for the Decade of Action for Road Safety 2011-2020. The report indicates that worldwide the total number of road traffic deaths remains high at 1.24 million per year, legislation and enforcement are still inadequate, and pedestrians and cyclists need to be better protected.

Main findings

- In 2010, there were 1.24 million deaths worldwide from road traffic crashes, roughly the same number as in 2007. The report shows that while 88 Member States were able to reduce the number of road traffic fatalities, that number increased in 87 countries.
- Only 28 countries, covering 7% of the world's population, have comprehensive road safety laws on all five key risk factors: drinking and driving, speeding, and failing to use motorcycle helmets, seat-belts, and child restraints.
- Key to reducing road traffic mortality will be ensuring that as many Member States as possible have in place laws covering the five key risk factors listed above.
- The pace of legislative change needs to rapidly accelerate if the number of deaths from road traffic crashes is to be substantially reduced, according to the Global status report on road safety 2013: supporting a decade of action, published today by the World Health Organization (WHO).

Decade of Action

Mandated by the United Nations General Assembly, the Decade of Action is a historic opportunity for countries to stop and reverse the trend which - without action - has been predicted to lead to the loss of around 1.9 million lives on the roads each year by 2020. Launched on 11 May 2011 by governments across the world, the Decade of Action seeks to build road safety management capacity in countries; improve the safety of roads and vehicles; enhance the behaviour of all road users; and strengthen post-crash care.

In the context of the Decade of Action, WHO supports efforts in these areas, in particular through the "Road Safety in 10 Countries (RS10) Project", which in collaboration with partners provides technical guidance on legislation, enforcement, mass media campaigns, data collection and trauma care.

"The Decade of Action for Road Safety 2011-2020 is a fantastic not-to-be-missed opportunity," says Dr Etienne Krug, Director of WHO's Department of Violence and Injury Prevention and Disability. "With the Global status report on road safety 2013 we have the information we need to track progress. We need now to join forces to ensure that the Decade of Action's goal of saving five million lives is realized."

For further information, visit: www.who.int/violence_injury_prevention/road_safety_status/2013/en/index.html
WHO injury courses

The Violence and Injury Prevention (VIP short courses provide a complete training resource, each addressing a specific injury or violence area. They have been designed to provide facilitators around the world with everything they need to conduct a short course of 2-5 days on various topics. These "trainings in a box" can be downloaded from our website free of charge.

Each short course follows the same modular format and contains:
- a facilitator's guide to orient the facilitator to the material; and
- a series of training modules which include PowerPoint presentations and notes for facilitators supporting resources such as hand-outs and case studies.

The facilitators should take the time to read and study the facilitator's guide carefully. The training material and case examples can be adapted to the local injury context. The courses have been developed on the basis of a wide range of WHO materials and more courses will be developed in the future. In order to make downloading the courses easier the components of each course have been grouped into various parts and zipped. It is important to download all parts of a given course to have the entire set of modules needed:
- Child injury prevention;
- Data collection;
- Child maltreatment prevention;
- Intimate partner and sexual violence prevention;
- Trauma care system planning and management; and
- Trauma care quality improvement.

Further information: David Meddings
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Injury Data

IDB website update

Simultaneous with the publication of the fourth edition of the report 'Injuries in the European Union 2008-2010', IDB-webpages have been updated and the data-set up to and including 2010 made available for public access.

The web pages now give extensive information on the IDB-methodology and its implementation in the participating countries, the members of the IDB-network and the procedures established for offering public access to the data base as well the rules for receiving authorisation to access case data for research purposes. It also contains an overview of relevant publications and newsletters produced over the past few years, including links to these documents. Main feature is the page that provides access to the data base (see screenshot):


Public access

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The website is now part of the DG Health and Consumers’ website. Formally it was hosted as part of the Commission’s Heidi-wiki, but due to a general restructuring of the EC-DG Health and Consumers’ web presence it was decided to close down the Heidi-wiki

See also: http://ec.europa.eu/health/data_collection/databases/idb/index_en.htm

-country update on injury surveillance-

In the framework of the Joint Action on Injury Monitoring in Europe (JAMIE) we are regularly informing the Alert-readers on current activities of our JAMIE-partners in injury surveillance.

The objective of JAMIE, co-funded by the EU and its Executive Agency for Health and Consumers (EAHC) is to work towards one common hospital-based surveillance system for injury prevention in operation in all Member States (MSs) by 2015, that is integrated within the Community Statistics on Public Health (see also http://www.eurosafe.eu.com/csi/eurosafe2006.nsf/wwwVwContent/32injurydata.htm).

In this issue of the Alert our colleagues from Denmark and Romania share with us their latest experiences in injury surveillance and reporting.

Injury data collection in Denmark

History

Denmark has a long tradition of injury registration in a hospital setting. The first systematic registration was of traffic injuries at Odense Hospital in 1971. This was extended to all accidents in 1976. In 1988, registration of Home and leisure injuries started at five hospitals as part of the European Home and leisure Accident surveillance system (EHLASS). From 1990 onwards, this registration was extended to all accidents (including road and work related accidents), and from 2008 to all injuries (by including violence and self-harm). All these registrations are quite detailed, including information on e.g. products involved. While the registration in Odense was part of the routine registration to the national Patient register, the injury register at the five EHLASS hospitals was run parallel to the mandatory registration to the National Patient Register. The National Patient Register includes information on all admissions since 1977, and from 1995 onwards, it includes emergency department registrations at all Danish hospitals using a minimum data set containing data on injury mechanism, activity, place, and mode of transport and counterpart for traffic injuries.

The information is obtained by interviews made by secretaries when the patient arrives, and coded afterwards. Different classifications have been used for these registrations. Therefore, the data are not always directly compatible. The classifications used are EHLASS and NOMESCO classifications of external cause of injury versions 2, 3, and 4. When introducing the version 4 of the NOMESCO classification in 2008, this classification was implemented at national level allowing for registration of both a minimum dataset and an extended dataset including e.g. products.

In 2010, the Injury register was closed and replaced by a pilot registration at three hospitals, including Odense Hospital. This registration used the extended dataset, while the minimum dataset continued to be used at all other hospitals in Denmark. Due to the lack of funding and budget cuts the pilot study was not continued and ended in 2012.

Current situation

Only two hospitals are continuing to register injury patients at detailed level at present: the Odense Hospital and the Aarhus Hospital. The routine registration of the minimum dataset continues to be collected at all hospitals.

An evaluation of the pilot study in 2010-2012 resulted in recommendations for future registrations. One of the recommendations is that all hospitals should register a minimum dataset that is much simpler than the present dataset and that should be more in line with the JAMIE minimum dataset. In addition to this the evaluation study recommended that the extended registration should be implemented in at least five hospitals to ensure a representative sample.
The current status is that the new minimum dataset is expected to be implemented from 2014 onwards. The continuation of a detailed registration is still uncertain.

**Use of data**

The main purpose of injury registration in Denmark is surveillance (see figure). Both the National Institute of Public health and the Accident Analysis Group in Odense have published annual reports as well as study reports on injury trends. These have been used by both governmental institutions, NGOs, and the media to put injury prevention on the agenda. One of the successful intervention actions is the action on injuries due to firework – the number of injuries has been reduced significantly during the last decade. Data on traffic injuries have been used to change road crossings to become safer.

**Incidence of emergency department contacts due to home and leisure injuries 1990 and 2009, by age and sex.**

By being based on person numbers from 1995 onwards, injury registration can be linked to other register information like socioeconomics, use of medicine, type of dwelling etc. This has been used in several research projects, e.g. on risk factors for childhood injuries and long-term consequences of injury.

The main political interest in injury registration at hospitals has been in the registration of traffic injuries, because these are under-reported by the police. The governmental involvement in injury registration and injury prevention for home and leisure injuries has generally been relatively low; this registration has sometimes been a “by-product” of the registration of traffic injuries. The most frequent user of home and leisure injury data is the Danish Safety Technology Authority, which has the responsibility of product safety; they have used the injury data to set priorities.

The National Board of Health is now beginning to set focus on injury prevention and is working on the clarification of the responsibilities between the different ministries. But still, the funding of the collection of a detailed data set from a sample of hospitals remains uncertain for the time being.

More information: Bjarne Laursen
E-mail: bla@si-folkesundhed.dk

A report on injury registration in Denmark 1990-2009 (in Danish, but including an English summary) can be found at: http://www.si-folkesundhed.dk/upload/ulykker_i_danmark1990-2009(rettet)-.pdf
Data injury collection in Romania

Introduction

In Romania injuries are the fourth leading cause of death for all age groups and the leading cause of death in children and adolescents aged 0-19 years. As stated in the hospital discharge statistics, at national level around 30,000 people received advanced care due to an injury in 2010. The death rate for all types of injuries is 57.2/100 000 inhabitants in Romania, while the EU average rate is of 40.0/100 000.

Romania still lacks a well-established national injury monitoring and surveillance system, therefore, we expect that the real burden of injuries is underestimated. Moreover, there is no national policy ensuring that injury prevention strategies are adopted and implemented. Considering the high costs of injury treatment and care, continuous collection of data on injuries at national level is desperately needed. Providing evidence for policies and prevention strategies and programs would also contribute to the decrease of the financial and social costs associated with injuries.

In this context, the government has the responsibility to ensure a stronger leadership dealing with this issue as well as support the control and monitoring of injuries.

Methodology

Over the years, Romania has been member of the joint actions on injury monitoring and control piloting the IDB surveillance system. Centre for Health Policy and Public Health is the National Data Administrator (NDA) endorsed by the National Ministry of Health. Currently, the efforts are concentrating in collecting minimum data sets (MDS) from four emergency departments (EDs) and in one hospital the full data set (FDS) as part of the Joint Action for Monitoring Injuries in Europe (JAMIE) project.

- **MDS collection**
  Currently, MDS is collected in four EDs that are regionally distributed. Each month, around 300 cases are collected in each partner ED, starting with September 2012, when one emergency unit accepted our initiative, while the other three units were enrolled in February 2013. Data is collected in voluntary participation, but incentives for data collectors are provided.

  Each emergency unit has a data collection manager, who has been trained as part of JAMIE to coordinate the data collection at ED level and provide a short monthly report regarding the data collection process. At the start, ED data managers were required to identify the most efficient way to collect data in their unit in order not to burden their staff. Contact with this manager is being maintained on a regular basis by the NDA. Data is being collected on a paper format, extracted from the current patient medical chart, followed by the electronically upload of data using an online format.

- **FDS collection**
  FDS is collected in one of the partner emergency departments that the Centre worked with during previous IDB pilots: the Mobile Service for Extrication and Resuscitation (SMURD) Tirgu-Mures.

  FDS is collected by the medical personnel trained in data collection and coding procedures as part of the previous IDB pilot. Around 80% of the total injury and violence cases treated within the emergency unit are collected and coded using the IDB software.

  Firstly, data is collected using a paper-based form that contains open-ended questions, followed by multiple choice items related to the specific IDB modules. The paper-based forms are completed during or just after the patient visit, usually when every-day medical patients’ cards are filled by attending physicians. IDB software is used to electronically collect information. Close contact with the ED data collection manager is maintained.

Preliminary results

In data presentations at minimum data set-level (N=2303), falls are by far the leading mechanism of injury, accounting for more than 60% of all injuries. 61% of the injured individuals are males, while 10% of injuries were work related. Home still remains the main place of injury:
Moreover, injury surveillance systems provide evidence as to the need for prevention strategies and policies aimed to reduce the number and severity of injuries through specific interventions for vulnerable and high-risks groups. They help to raise awareness on the burden of injuries on the health-care system and society, and contribute to the development of strategic plan with specific action steps for to prevent injury and increase safety.

More information: diana.rus@publichealth.ro

**Use of data**

Although, a more detailed injury monitoring and control surveillance system would be more appropriate, the MDS data helps us identify the leading mechanism of injury, the number of work related injuries that are treated by emergency departments as well as the primary type of injuries. These data are most valuable for multiple stakeholders. Some of the specific actions that the data could provide evidence for are actions to:

- Advocate for safe playgrounds as well as safe environments for elderly (falls being the leading mechanism of injury);
- Evaluate the injury burden on the emergency departments;
- Educate youth on injury sport prevention (10 per cent of injuries in Romania are sport related); and
- Encourage data collection on multiple emergency units to provide evidence for community based programs.

Moreover, injury surveillance systems provide evidence as to the need for prevention strategies and policies aimed to reduce the number and severity of injuries through specific interventions for vulnerable and high-risks groups. They help to raise awareness on the burden of injuries on the health-care system and society, and contribute to the development of strategic plan with specific action steps for to prevent injury and increase safety.

More information: diana.rus@publichealth.ro

**EuroSafe, the European Association for Injury Prevention and Safety Promotion**

is the network of injury prevention champions dedicated
to making Europe a safer place

Together we can make a difference!

CONTACT US!

http://www.eurosafe.eu.com/csi/eurosafe2006.nsf/wwwVwContent/12membership.htm
Parenting programmes

A recently updated Cochrane-review looked at whether parent education and training programmes (called parenting programmes) help parents to provide a safer home environment and to reduce injuries in children. Several factors can increase the risk of unintentional injury to children but that may be helped by parents attending parenting programmes, such as mothers’ mental health and child behaviour problems. In addition, injuries are more likely to occur when parents are unable to predict a child’s ability to perform tasks such as climbing furniture or opening locks. Parenting programmes may help parents develop realistic expectations of their child’s behaviour for their age and stage of development. Therefore, the review aimed to assess if parenting programmes reduced the risk of unintentional injuries in children and whether parents provided a safer home environment by using more safety equipment, such as stair gates, and adopted safe practices such as keeping medicines out of reach.

From searches of databases and web sites the reviewers found 22 randomised and non-randomised studies that evaluated the effect of parenting programmes on childhood injuries or home safety. Overall, the quality of the studies was reasonable. Fifteen of these were home visiting programmes which provided a range of support services as well as parent education or training. These were usually provided to families who were disadvantaged, whose children were considered to be at risk of poor health or those who may benefit from extra support. The results from 10 randomised controlled trials which included a total of 5074 children were pooled together and it was found that children from families who had received the parenting programmes had fewer injuries than those from families who had not had the programmes. However, the results from 3 randomized controlled trials which measured home safety using the Home Observation for Measurement of the Environment (HOME) tool did not show any difference in HOME scores between families receiving parenting programmes and those not receiving the programme.

It is concluded that parenting programmes are effective in reducing unintentional injury in children and can improve home safety, particularly in families who may be considered ‘at risk’, such as some teenage or single mothers. It would be therefore worthwhile for health and social care providers to provide parenting programmes to families.

Late last year the Cochrane Collaboration published a review on interventions addressing falls among older people living in the community. The Cochrane Collaboration is an international, independent, not-for-profit organisation, funded by a variety of sources including governments, universities, hospital trusts, charities and personal donations. Cochrane Reviews are widely recognized and contain the most rigorous application of scientific methods.

As people get older, they may fall more often for a variety of reasons including problems with balance, poor vision, and dementia. Up to 30% may fall in a year. Although one in five falls may require medical attention, less than one in 10 results in a fracture. The review looked at the healthcare literature to establish which fall prevention interventions are effective for older people living in the community, and included 159 randomised controlled trials with 79,193 participants:

- **Group and home-based exercise programmes**, usually containing some balance and strength training exercises, effectively reduced falls, as did Tai Chi. Overall, exercise programmes aimed at reducing falls appear to reduce fractures.

- **Multifactorial interventions** assess an individual's risk of falling, and then carry out treatment or arrange referrals to reduce the identified risks. Overall, current evidence shows that this type of intervention reduces the number of falls in older people living in the community but not the number of people falling during follow-up. These are complex interventions, and their effectiveness may be dependent on factors yet to be determined.

- **Interventions to improve home safety** appear to be effective, especially in people at higher risk of falling and when carried out by occupational therapists. An anti-slip shoe device worn in icy conditions can also reduce falls.

- **Taking vitamin D supplements** does not appear to reduce falls in most community-dwelling older people, but may do so in those who have lower vitamin D levels in the blood before treatment.

- **Some medications** increase the risk of falling. Three trials in this review failed to reduce the number of falls by reviewing and adjusting medications. A fourth trial involving family physicians and their patients in medication review was effective in reducing falls. Gradual withdrawal of a particular type of drug for improving sleep, reducing anxiety, and treating depression (psychotropic medication) has been shown to reduce falls.

- **Cataract surgery** reduces falls in women having the operation on the first affected eye. Insertion of a pacemaker can reduce falls in people with frequent falls associated with carotid sinus hypersensitivity, a condition which causes sudden changes in heart rate and blood pressure.

In people with disabling foot pain, the addition of footwear assessment, customised insoles, and foot and ankle exercises to regular podiatry reduced the number of falls but not the number of people falling.

The evidence relating to the provision of educational materials alone for preventing falls is inconclusive.

Safety of outdoor leisure activities

Safety of outdoor leisure activities in the EU is receiving increasing interest from Member States, consumer authorities and service providers due to the fact that outdoor leisure activities can involve risks of fatalities and severe injuries. As these services are provided throughout the EU there is a clear cross-border dimension involved. In order to obtain a more profound and overall picture of ‘non-regulatory safety measures in outdoor leisure activities’ DG SANCO commissioned a study to the European Confederation of Outdoor Employers (EC-OE).

The aim of the study was to gather information on existing non-regulatory measures with regards to safety in outdoor leisure activities across the EU and to analyse the effectiveness of these safety measures. Based on these findings, this report attempts to identify gaps and, if possible also identify the optimal level of the effectiveness of self-regulatory measures at local, regional or national level.

The study focused on mapping and defining the outdoor sector as well as unravel the labyrinth of safety measures that have been developed over the past decade.

In the study ‘Outdoor leisure activities’ are taken into account that are organised and offered by commercial outdoor companies to their customers. In general, a common feature of outdoor leisure activities is that they are delivered in a natural environment. These activities are extensive, ranging from hiking, canoeing, sailing, skiing, canyoning, etc.

From a safety perspective five main interrelated aspects of outdoor leisure activities are being addressed in order to ensure an appropriate level of safety for both the customers and the members of staff involved. The five aspects of outdoor leisure activities are as follows:

1. Management;
2. Animator – the professional delivering the service;
3. Client;
4. Environment;
5. Tool - equipment used during the service delivery.

Safety of outdoor activities is directly linked to the fact that each of the five aspects has to be taken care of according to professional, recognised or accepted standards. This means that as far as outdoor leisure activities are concerned, safety is dependent on the factors management AND staff AND clients AND environment AND equipment as being controlled, checked, adapted and appropriate.

In total 223 safety measures were identified in twelve EU countries plus Norway and Switzerland, ranging from simple ‘best practices’ to ‘regulatory measures’. The majority of these measures is in force only in one of these countries and often only addressing one form of activity, e.g. hiking but not on mountain biking. In other words, there is no EU wide structural link between all the measures identified neither at activity level, neither at sectoral level.

The multitude of issues relating to the type and content of the identified safety measures makes it very difficult to oversee the whole picture and to map the totality of measures covering all outdoor activities throughout the EU.

One of the main findings of the study with regards to the ‘five aspects of outdoor leisure activities’ is that not one single outdoor leisure activity is fully and adequately covered at country level nor at EU-level.

The authors conclude that an EU programme for outdoor-safety schemes is much needed and recommend that stakeholders in the outdoor leisure industry be strongly involved in setting up any kind of (sectoral) EU programme for safety schemes. The major feature of such a programme for safety schemes should be that it focuses on the complete management cycle of the provider offering outdoor leisure activities. Instead of focussing on the safety of specific activities, programme safety measures should cover a wider range of similar activities and also function as a audit system for quality control.

The final conclusion is that the most effective approach to promote safety in outdoor leisure activities consists of a combination of a regulatory measure at EU level with a certification scheme.

More information: E-mail: info@ec-oe.eu/ or http://www.ec-oe.eu/
Cardiac arrests in sports: US-Athletic Trainers’ Association statement

Of all the possible injuries and illnesses that can occur among the physically active population, cardiovascular emergencies can be the most devastating. For decades, the concerns for cardiovascular emergencies and sudden cardiac arrest in the physically active were generally limited to those with known risk factors such as age, obesity, lifestyle habits, diet, and pre-existing cardiovascular disease or congenital abnormalities. In fact, complications of coronary heart disease resulting in myocardial ischemia or myocardial infarction account for over 80% of sudden cardiac deaths in athletes older than 35 years of age.

The concern over sudden cardiac arrest, especially in young athletes, has prompted many to call for mandatory screenings during pre-participation physical exams through the use of an electrocardiogram (ECG or EKG). Such screenings are in use in a number of countries. However, while some experts believe such screenings may be able to detect heart abnormalities and possibly prevent sudden cardiac arrest, there currently exists no standardized interpretation of such tests, and other experts believe that tests can lead to false-positive results, causing undue concern by athletes and their parents.

Additionally, some studies suggest that mandatory screening programs using electrocardiograms do not decrease the incidence of sudden cardiac death in athletes. For instance, the American Heart Association does not endorse mandatory screening of athletes using electrocardiograms, but does recommend a 12-point screening process that addresses an athlete’s personal and family history, as well as physical examination.

The National Athletic Trainers’ Association (NATA) recently released a position statement on Preventing Sudden Death in Sport published in the February issue of the Journal of Athletic Training, which offers recommendations for preventing sudden death resulting from several causes, including sudden cardiac arrest.

These recommendations include:

• Unlike professional teams, which usually have athletic trainers, numerous athletic settings lack appropriate medical personnel. Authors of the position statement urge that athletic trainers be available to promptly take charge of a medical emergency. Additionally, training in first aid and cardiopulmonary resuscitation (CPR) is strongly advocated for all coaches, so that they may provide treatment until medical professionals arrive.

• Organizations that sponsor athletic activities should have a written, structured emergency action plan (EAP). The EAP should be venue specific, and should be developed in coordination with all stakeholders (such as school staff and administrators, medical staff, and EMS personnel). The plan should be practiced at least annually with all individuals who may be involved in an emergency response.

• Access to early defibrillation is essential for reversing sudden cardiac death. A collapse to first shock time of three to five minutes is strongly recommended.

• Pre-participation physical examinations should include the completion of a standardized history form and attention to episodes of exertional syncope or pre-syncope, chest pain, a personal or family history of sudden cardiac arrest or a family history of sudden death, and exercise intolerance.

• Sudden cardiac arrest should be suspected in any athlete who has collapsed and is unresponsive. Airway, breathing and circulation should be assessed, and automated external defibrillator (AED) should be applied as soon as possible.

• Cardiopulmonary resuscitation (CPR) should be provided while the AED is being retrieved, and interruptions in chest compressions should be minimized by stopping only for rhythm analysis and defibrillation. Treatment should be administered in accordance with the updated American Heart Association guidelines, which recommend that health care professionals follow a sequence of chest compressions, airway, and breathing.

Perhaps not every death from sudden cardiac arrest in the physically active can be prevented. However, proper planning, preventive measures, and appropriate management can have a significant impact on the prevention of sudden cardiac arrest, and result in lives saved.

Vulnerable road users

Road traffic injuries

Road fatalities across the EU have decreased by 9% in 2012. According to new figures published by the European Commission, 2012 saw the lowest number of people killed in road traffic in EU countries since the first data were collected. Country by country statistics show that the number of road deaths still varies greatly across the EU. The countries with the lowest number of road fatalities remain the UK, Sweden, the Netherlands and Denmark, reporting around 30 deaths per million inhabitants.

Current estimates indicate:

- Every year, about 250 000 people are seriously injured in road accidents in the EU – compared to the 28 000 road fatalities in 2012.
- While the number of road deaths decreased by 43% during the last decade, the number of seriously injured people decreased by only 36%.
- The most common serious road injuries are head and brain injuries, followed by injuries to the legs and spine.
- Vulnerable road users, for example pedestrians, cyclists, motorcyclists or users in certain age groups – notably the elderly – are especially affected by serious road injuries. Serious road traffic injuries more often occur in urban areas than on rural roads.

EU Road safety action programme 2011–2020

The European Road Safety Action Programme 2011-2020 sets out challenging plans to reduce the number of road deaths on Europe’s roads by half in the next 10 years. It contains ambitious proposals focusing on making improvements to vehicles, infrastructure and road users’ behaviour. For example, key recent initiatives include:

- A new EU Driving Licence, since January 2013, with tighter rules for the access of young people to powerful motorbikes;
- National enforcement plans- submitted by Member States providing a rich source of best practices;
- Cross border enforcement rules to crack-down on traffic offences committed abroad (drink driving, speeding etc.) in force since November 2012;
- Work towards the development of an injuries strategy.

Towards an injuries strategy

It is estimated that for every death on Europe’s roads there are 10 serious injuries and 40 more slightly injured. A key factor contributing to success in tackling road fatalities has been the results-based approach adopted in two consecutive ten-year EU road safety strategies.

Much could be gained by applying a similar focus to serious but non-fatal road injuries. The problem is that current figures on serious injuries are general and they are estimates. There are problems with misreporting and underreporting of serious injuries and the figures are not comparable across the EU.

For these reasons, the European Commission has recently published a document on serious road traffic injuries outlining the next steps towards a comprehensive EU strategy on serious road injuries, notably: a common definition of serious road traffic injury (applicable from 2013); a way forward for Member States to improve data collection on serious road accidents, (first reporting using comparable EU wide data collection methods and using new definition, 2014); the principle of adopting an EU-level target for the reduction of serious road traffic injuries, for example for the period 2015-2020.

A step forwards was already taken in 2012 with the agreement on an EU wide system for the definition of serious road injuries. The European Commission has worked with Member States in the High Level Road Safety Group to agree on the use of the MAIS trauma scale – the Maximum Abbreviated Injury Score- for the definition of serious road traffic injuries.

More information:
Second UN Global Road Safety Week

The Second UN Global Road Safety Week to be held 6-12 May 2013 is dedicated to pedestrian safety. Requested by the UN General Assembly, the Week will draw attention to the urgent need to better protect pedestrians worldwide, generate action on the measures needed to do so, and contribute to achieving the goal of the Decade of Action for Road Safety 2011-2020 to save 5 million lives.

The Second UN Global Road Safety Week will draw attention to the need for pedestrian safety, generate action on measures which work to protect pedestrians, and contribute to achieving the goal of the Decade of Action for Road Safety 2011-2020 to save 5 million lives. More specifically, the Week will contribute to:

- drawing attention to the need for pedestrian safety; and
- generating action on measures which work to increase pedestrian safety.

Short-term goal: a fatality-free week

The short-term goal for the Week is to prevent even a single pedestrian fatality during the period 6-12 May 2013. There are relatively simple actions that could be taken in advance of the Week to save pedestrian lives. With the support of technical experts, the following interventions could be initiated in communities around the world in the hope of making the Week fatality free:

- raising awareness of existing traffic laws on speeding, drinking and driving, distracted driving and walking, and pedestrian-right-of-way;
- increasing enforcement of the above traffic laws;
- making “quick wins” to improve road infrastructure:
  - improving lighting around facilities used by pedestrians;
  - removing objects from streets which block facilities used by pedestrians;
- improving the safety of routes to and from schools and in school zones, including by establishing “walking school bus” programmes;
- enhancing the visibility of pedestrians by encouraging the use of reflective materials.

Long-term goal: safe walking

The ultimate goal of the Second UN Global Road Safety Week is to make a significant and long-lasting contribution towards making walking safe for the world’s pedestrians. This could be achieved through a number of measures which are known to save pedestrian lives. Although not an exhaustive list, some of the measures which could be put in place over the long-term include:

- installing and/or upgrading crosswalks, sidewalks, overpasses, underpasses, raised medians, and road signs and signals;
- lowering vehicle speed limits and otherwise “calming” streets with speed bumps, rumble strips and chicanes;
- developing and enforcing new and existing traffic laws on speeding, drinking and driving, distracted driving and walking, and pedestrian-right-of-way;
- restricting or diverting vehicles from pedestrian zones;
- establishing and ensuring vehicle safety standards which protect pedestrians;
- improving mass transit route design;
- organizing and/or further enhancing trauma care systems and timely rehabilitation services;
- providing education and training to all road users and the public generally.

See also: http://www.who.int/roadsafety/week/2013/about/en/index.html
Increasingly, businesses are outsourcing their activities and processes. But what implications does the growing importance of supply chains have for working conditions? A new report from the European Agency for Safety and Health at Work (EU-OSHA) sheds light on occupational safety and health (OSH) within these complex networks of suppliers and service providers.

The report ‘Promoting occupational safety and health through the supply chain’, analyses existing literature on the subject, as well as government policies and case studies, to provide an overview of how OSH can be managed and promoted through the supply chain, and which incentives and instruments exist for companies to encourage good OSH practices among their suppliers and contractors.

Promoting occupational safety and health through supply chains is a good example of how workers can be safeguarded when organisations co-operate – this is the subject of EU-OSHA’s current Healthy Workplaces Campaign.

The report shows that companies are affected by many different pressures in working with their supply chains to improve OSH: as well as market-based business considerations and sustainability and corporate social responsibility agendas, there are also external pressures, such as legal demands and the concerns of stakeholders, consumer groups and other pressure groups. Though there are considerable differences between sectors and between companies of different sizes, the report shows that successful attempts to influence businesses in promoting OSH throughout their supply chains often involve a mixture of regulation and market-based measures and initiatives.

Companies who are looking to hold their suppliers to high OSH standards need to be involved at many different stages of the contracting process, from choosing safe contractors at the pre-contract stage, to supervising work as it is being carried out, and reviewing the OSH performance of contractors when the contract ends. The report shows that the most successful initiatives use a combination of approaches, with clear rewards for environmental and socially responsible behaviour.

The report highlights the importance of safety certification schemes, in particular, as a way of promoting OSH in the supply chain: the national governing bodies of the different national schemes are currently examining how they could adopt a common, EU-wide approach, which would help in working with contractors from outside Europe.

Apart from procurement strategies and safety certification schemes, the report also looks at other approaches that can be used to diminish work accidents and ill health in the supply chain, and which could be taken up more widely in Europe. These approaches focus on issues such as clarifying contractual responsibilities, improving communication, cooperation and training, and putting in place joint control procedures.

Mark the date: Conference in Brussels, 13 November 2013 on:

The use of injury data for driving health and consumer policies and actions at local, national and EU-level.

On 13 November, EuroSafe and the Injury Section of the European Public Health Association will jointly organise a one day conference which precedes the 6th European Public Health Conference (14-16 November).

The theme of the EuroSafe/ EPHA-Injury Section pre-conference is: use of injury data for driving health and consumer policies and actions at local, national and EU-level.

Injury experts will demonstrate the value of ED-based injury information both for health initiated policies and actions and for consumer product safety policies and implementation practices. The pre-conference will showcase local and national level initiatives that are geared by data from accident and emergency departments at hospitals.

Further information on programme and registration will be provided in the July issue of the Alert magazine.

More information: secretariat@eurosafe.eu.com
AGENDA

2013

6-12 May: Second UN Global Road Safety Week

3-5 June in Jerusalem, Israel
5th International Jerusalem Conference on Health Policy

East Midlands & Trent Falls Symposium
7 June in Nottingham, United Kingdom
http://www.nos.org.uk/document.doc?id=1031

19-20 June in Vienna, Austria
Mobility and Road Safety in an Ageing Society
http://www.kfv.at/congress2013

International Conference on Pedestrian and Cyclist Safety
19-22 June in Kyiv, Ukraine
http://www.pri.kiev.ua/index.php/ru/

14th International Falls & Postural Stability Conference
9th September in Bristol, United Kingdom
http://profane.co/event/

2nd TBI-Challenge 2013 Conference
19-21 September in Vienna, Austria
http://www.tbi-challenge.eu/2013/

19-20 September in Columbus, Ohio, USA
Global Summit on Child Injury Prevention

20-22 October in Potsdam, Germany
World Conference on Drowning Prevention
http://www.wcdp2013.org/home/

13-16 November in Brussels
6th European Public Health Conference
http://www.eupha.org/site/upcoming_conference.php