Implementation of the
Minimum Data Sets on Injuries (MDS-Is)

Background Report

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Funding:
European Commission, Directorate General for Health and Consumer Protection
Agreement number SI2 324865
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SUMMARY

There is a strong wish of European countries and the European Commission to record information on injuries in different health care settings (fatalities, hospital admissions, Emergency Departments, General Practitioners, household surveys). An instrument for monitoring injuries in settings that have limited resources (time, money, and/or information) and/or who start recording injuries would be a valuable development in the field of injury research and prevention. This was the reason for developing Minimum Data Sets for Injuries (MDS-Is) in Europe (financed by the Injury Prevention Programme of the European Commission), which resulted in five MDS-Is subject to aim and target group of injury monitoring activities. These MDS-Is are compatible to the most relevant existing classification systems including injuries/accidents. Depending on the setting and the objective to be met for recording accident/injury information, five MDS-Is were drafted (to be used for different settings and objectives). They are not developed to replace existing injury monitoring systems and certainly not the Injury Surveillance System (the former European Home and Leisure Accident Surveillance System, EHLASS). The MDS-Is represent a minimal necessary data set for monitoring injuries in yet a meaningful way, while securing comparability of data with international classifications like the International Classification of External Causes of Injuries (ICECI).

In follow-up of the development of the MDS-Is, tools for the implementation and promotion of these registrations were needed. These tools are necessary at three levels: as a reporting format; as a tool for improving the informative values of existing injury monitoring systems; and as a new injury surveillance system. An inventory was made among European organisations involved in current surveillance systems including injury/accident data: questions were asked about the possibilities to implement MDS-Is and the difficulties anticipated for the implementation. Two thirds of the respondents indicate that it is possible to introduce MDS-Is in their country, although the level of MDS-Is varies. Based on the results of this inventory, tools were developed to introduce the MDS-Is. This starters kit is available on cd-rom, and will be distributed to people who are willing to promote the MDS-Is in their country or region: the intermediates. For each MDS-I the cd-rom includes the data dictionary, a coding form, conversion tables with the most relevant classifications, reporting tables and graphs, and guidelines for using these items. Furthermore, information for the intermediates, a summary of the MDS-Is and a Power-point presentation are included for the promotion of the MDS-Is. A group of European experts was involved in all phases of the project. They formulated a promotion and communication plan, to get insight in the planned activities to give publicity to the MDS-Is.

The overall recommendation is to promote the MDS-Is:
- as a uniform way of reporting data in injuries at national and European level (reporting tables)
- as a standardised tool for injury data collection through standard health statistics which usually record only limited information on injuries/accidents, like fatality statistics and hospital discharges.
- as a basis for starting injury data collection in settings in which the ISS coding manual is (yet) too detailed.

Since it is important that the MDS-Is will become the European standard for injury/accident data collection, recommendations were formulated for the actual promotion and implementation of the MDS-Is:
- It is essential that the information on the MDS-Is is available for everyone. So it is recommended to publish the starters kit on the website of the European Commission and the website of ICECI.
- The actual implementation of the MDS-Is should be actively promoted in potentially interested countries/setting/target groups by means of journals, education sessions, seminars, conferences, newsletters, etceteras.

- The maintenance of the MDS-Is should be incorporated as much as possible in the process of ICECI, but co-ordination at European level is inevitable. It is advised to combine the maintenance of the MDS-Is and the ISS coding manual.

- It is recommended to establish a Task Force being responsible for the overall maintenance and promotion of the MDS-Is. This Task Force should have a clearinghouse function and combine the tasks for maintaining the MDS-IS with other tasks that are linked, like advising organisations on injury surveillance. The Task Force should be closely linked to the Working Party on Injuries (part of the Public Health Programme of the European Commission).
1 INTRODUCTION

1.1 Background

Since injuries are a major health problem, European countries are interested in injury information from different health care settings (e.g. fatalities, Emergency Departments, hospital admissions, General Practitioner attendances, household surveys). This kind of information is essential for priority setting (for injuries versus other health problems, but also between different accident categories) and for designing effective preventive interventions (like campaigns, legislation). To prevent organisations from re-inventing the wheel and ending up with incomparable databases, an instrument was needed for monitoring injuries, either at a national, regional, or local level. This instrument should take into account the variety in objectives and settings and the availability of resources, and should be compatible to the most relevant existing classification systems. This was the reason for developing Minimum Data Sets on Injuries (MDS-Is) in the European Union. These MDS-Is represent a minimal necessary data-set for monitoring injuries in yet a meaningful way, while securing comparability of data with international classifications like International Classification of External Causes of Injuries (ICECI) and the possibility for monitoring systems like the former EHLASS. The Consumer Safety Institute published two reports: on the development of the MDS-Is and a Data Dictionary that presents all the data elements of the MDS-Is.1,2

The development of the MDS-Is needed a follow-up: the preparation of the implementation and promotion of the MDS-Is for injury surveillance in Europe. This report describes the results of an inventory among European organisations of current surveillance systems including injury data, and wishes and possibilities/difficulties of implementing the MDS-Is. Based on the results of this inventory, tools were developed to introduce injury monitoring in settings with no monitoring history and to compare injury data from existing sources: a starters kit. In addition, necessary activities were formulated for the promotion of the MDS-Is.

1.2 Aim

The aim of this project is to co-ordinate the implementation and promotion of MDS-Is in settings which could monitor injuries throughout the European Union and its applicant countries. The project aims at three levels of implementation of MDS-Is:

a. As a reporting format: enabling the comparison and exchange of data between settings equipped with detailed injury monitoring systems. The main target groups will be injuries resulting in death, hospital admission or Emergency Department attendances.

b. As a tool for improving the informative value of existing injury monitoring systems. The main target groups will be injuries resulting in death and those resulting in hospital admission.

c. As a registration system: providing settings with limited resources or with no experience in injury monitoring with a tool for collecting injury data. The main target group will be injuries resulting in Emergency Department attendance and other, small-scale health care attendance.
1.3 Outline

The results of the questionnaire about the current surveillance systems including the wishes and possibilities of implementing the MDS-Is are described in Chapter 2. Chapter 3 provides an overview of the contents of the starters kit, which includes tools for the implementation and promotion of the MDS-Is. The short-term promotion plans for implementing the MDS-Is in the European Union by a team of European experts (i.e. the reference group; see Annex 1) is formulated in Chapter 4. Finally, the conclusions and recommendations including activities for the long-term promotion of the MDS-Is are described in Chapter 5.

The contents of the starters kit is published in a separate report: Starters Kit for the Implementation and Promotion of the Minimum Data Sets on Injuries (MDS-Is).³
In May 2002 an inventory was made in order get insight in the existing surveillance systems including injuries/accidents and relevant contact persons. We also wanted to get knowledge about the possibilities to implement the Minimum Data Sets on Injuries (MDS-Is) in the European countries and expected difficulties for the implementation. Key persons in the field of injury monitoring and injury prevention were interviewed. We collected information about:
- European and national associations concerning health settings involved in injury monitoring;
- Available injury data relating to deaths, hospital admissions, Emergency Department attendances and other health care attendances;
- Wishes and possibilities regarding the level of implementation of MDS-Is.

2.1 Overview of injury surveillance systems in European countries

In May 2002 we have sent questionnaires (see Annex 2) to organisations in 27 European countries. We received 23 questionnaires from 19 countries.

Table 1 provides an overview of the countries that responded, the existing injury surveillance systems, the classifications used, and the owners of the surveillance system. Similar inventories have been made for other projects carried out within the Injury Prevention Programme (e.g. the project on the calculation of the costs of injuries), so additional information could be obtained from these projects. This information is shown in Italics and has not been up-dated.
<table>
<thead>
<tr>
<th>Country</th>
<th>Injury surveillance systems</th>
<th>Classification</th>
<th>Owner of surveillance system</th>
</tr>
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<tbody>
<tr>
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<td>ICD-10</td>
<td>Statistics Austria</td>
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<td>Other</td>
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<td>GPs, no centralised system exists</td>
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### Possibilities for implementation MDS-Is in European countries

Table 2 shows an overview of the respondents in the countries, the possibilities they see regarding the level of implementation of MDS-Is, difficulties they expect to encounter and their willingness to promote the MDS-Is in their country.

About two thirds of the respondents see possibilities to implement the MDS-Is in their country. The level of the MDS-I varies, but most of the respondents expect to implement the more detailed MDS-Is (MDS-I-4 and MDS-I-5). Reasons for not implementing an MDS-I were:

- data not available (for settings which should use the MDS-I as a reporting format; 3x)
- coding burden on the administrators
- items allowed to collect is regulated by law
- injury data is already recorded in most detailed level

Almost all of the respondents expect some difficulties when they will implement one or more MDS-Is in their country. The most frequently mentioned difficulties are 'limited resources' (15x), the extra time
and expenditures that are needed for the implementation (17x), the mapping between data from existing systems and the MDS-Is (7x), and the guarantee of the quality of the registrations (5x).

In the questionnaire we listed some tools that might be helpful for the promotion and implementation of the MDS-Is: a Power-point presentation, conversion tables, guidelines, data dictionary, coding forms. The respondents welcome all these tools to help facilitate the implementation of the MDS-Is. Other tools that would help the implementation according to the respondents:

- reporting tables
- workshops about MDS-Is implementation for interested organisations;
- a European recommendation;
- Training and quality control;
- Translation of the data dictionary in other European languages.

Besides an overview of the possibilities to implement the MDS-Is, the inventory also produced a list of persons who are willing to promote the MDS-I in their country or region.

Annex 3 includes the answers per respondent.
Table 2: An overview of contact persons, the possibilities to implement the MDS-Is, expected difficulties and the willingness to promote the MDS-Is, by country

<table>
<thead>
<tr>
<th>Country/responder</th>
<th>Organisation</th>
<th>Possibility for implementation*</th>
<th>Expected difficulties*</th>
<th>MDS-I promotion</th>
<th>Promotion MDS-I by somebody else</th>
</tr>
</thead>
<tbody>
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3 STARTERS KIT

Based on the results of the questionnaire about the wishes and possibilities regarding the implementation of the Minimum Data Sets on Injuries (MDS-Is) among European experts, tools were developed for the implementation and promotion of the MDS-Is. These tools were discussed in an expert meeting of the reference group in November 2002 in Amsterdam (see Annex 4), and their comments were incorporated. All materials were included in the starters kit. This starters kit can be distributed to persons who are willing to promote the MDS-Is in their country or regions: the intermediates.

3.1 Overview of the contents

The contents of the starters kit for all MDS-Is is included in a separate report: Starters kit for the Implementation and Promotion of the MDS-Is. This starters kit is also available on cd-rom and is meant to be distributed to potential intermediates. On this cd-rom, the different levels of MDS-Is are worked out in different folders. The intermediates will be able to create their own manual by selecting and printing the sections needed for a specific setting in their country (i.e. specific level of MDS-I, coding form, reporting guidelines, etc.). The text box below gives an overview of the contents of this manual: the titles of the different parts in the text box correspond with the names of the files on the cd-rom.

Besides the manual, also information for the intermediates about the MDS-Is and guidelines for promotion and implementation of the MDS-Is are inserted on the cd-rom. A summary of the MDS-Is and a Power-point presentation are included for the promotion of the MDS-Is.

<table>
<thead>
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<td>- Introduction Minimum Data Sets on injuries (MDS-Is)</td>
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CONTENTS OF THE STARTERS KIT (CD-ROM), continued

2. Data Collection
   - Titlepage
   - Guidelines for data collection: the data dictionary and coding form
   - Data dictionary
   - Coding form

3. Conversion tables
   - Titlepage
   - Guidelines for conversion tables
   - Conversion tables: MDS-I to ICD-9
     MDS-I to ICD-10
     ICD-9 to MDS-I
     ICD-10

4. Reporting tables
   - Titlepage
   - Guidelines for reporting tables
   - Quality of the data
   - Baseline reporting tables and figures

5. Annex
   Annex A  Contact addresses
   Annex B  Letter of recommendation from the EU

MDS-I-2  Contents is similar to the contents of MDS-I-1 (see above), but the information is adjusted for MDS-I-2

MDS-I-3  Contents is similar to the contents of MDS-I-1 (see above), but the information is adjusted for MDS-I-3

MDS-I-4  Contents is similar to the contents of MDS-I-1 (see above), but the information is adjusted for MDS-I-4

MDS-I-5  Contents is similar to the contents of MDS-I-1 (see above), but the information is adjusted for MDS-I-5
4 OVERVIEW OF SHORT-TERM PROMOTION PLANS

All participants of the reference group were invited to write a short-term promotion plan for their own country. The aim of these promotion plans was to get insight in the planned activities to give publicity to the MDS-Is, which may include activities like distributing written information, publishing articles in relevant media, submitting papers at symposia and organising individual meeting with relevant, national organisations in order to inform and motivate parties for additional elements from the MDS-Is. These short terms plans were very helpful to get knowledge on practical issues to be solved. The next paragraph shows the short-term promotions plans per country.

4.1 Austria

Preliminary considerations
Without pre-judging the results of the MDS-I questionnaire for Austria our (Sicher Leben) experience is that the health service sector as well as other institutions in the field of injury statistics are very reluctant to introduce changes or supplements to existing registration schemes. This experience is reflected by the history and current situation of injury registration in Austria:
- attempts of Sicher Leben in 1994 to extend the E-Codes for hospital admissions were blocked by the Central Statistical Office (ICD-9 linked E-Codes were and still are a special Austrian version, not comparable to official ICD-9 E-Codes)
- EHLASS was introduced in Austria in 1996 in six hospitals, however, without the involvement of hospital staff but with external Interviewers
- ICD-10 was introduced in Austria for hospital admission coding in 2001, however, without the chapter 20 on external causes
- until now no federal (national) system for the registration of diagnoses (and E-Codes) of out-patients (A&E) exists
- dedicated registration systems for occupational and traffic accidents each use their own classification systems (without any link to health care based registration systems)
- after a pilot of the MDS-I applied to death certificates, signals form the Central Statistical Office were on red for a permanent implementation. Mainly because of lack of personnel and lack of a legal obligation.

Even though this is not a very encouraging record the situation clearly calls for some improvements and changes - thus (hopefully) facilitating new developments:
- in view of increasing EU harmonisation pressure – asking for internationally compatible systems
- in view of limited resources, especially in the health care sector – asking for cutting down redundancy and increasing synergy
- in view of increasing demand for quality data - less (expensive) but better quality

Keeping both restrictions and chances in mind we tried to answer the following questions:.
- In which settings do you see possibilities to implement the MDS-Is? In general, most chances seen to be with interested doctors in
  - GPs
  - hospital based A&E dept.
- At which settings will you focus?
  - hospital based A&E dept.
- Which organisations can help you with the implementation of the MDS-Is?
  - The Austrian Society of Injury Surgeons
  - The Health Ministry / HDR Dept.
- Do you have any contacts within these organisations?
  - Yes, within the so-called "Austrian Safety Board", an umbrella for all institutions working in and around injury prevention

- What is the time path? We would try:
  - to launch a "call for interest" 2002/03
  - implement a voluntary MDS-I network of A&E dept. in 2003
  - demonstrate the network and results in 2004 (at the 7WoCO)

**Implementation scenario of MDS-I in ED attendance (combined with hospital admission in the respective hospital)**

The following scenario is based on the assumption that readiness for extra work in the hospital is very limited without having extra benefits. As injury surveillance as such is usually not considered a hospital duty, the benefits of the MDS-I data in this particular case might be more on the personal level of surgeons doing also medical / injury research. Thus, in the following scenario a central maintenance and data pool is offered (in parenthesis, as organisation and financing of this process is still unclear to us.

- Seeking aid and authorisation of the "The Austrian Society of Injury Surgeons", The Federal Ministry of Health / HDR Dept. and the EC DG SANCO (your letter)
- Presentation and promotion of the MDS-I network to the heads and seniors of all so-called "accident departments" in Austrian hospitals (and also other dept. relevant to the treatment of injuries)
- Proposing known and new key benefits ("selling propositions")
  - belonging to an international research network (MDS-I Europe ?!)
  - having access as core-user to unique data for research and local surveillance (Central national or EU-level MDS-I database?!)
  - data is comparable with "big brothers" ICD-10 and ICE-CI (and ISS)
  - the only task: data registration or conversion according to an MDS-I level and transmission to the national MDS-I centre(?!)
  - due to the modularity of the MDS-I the level (detail) of implementation can be individually chosen
  - further data processing up to making data available in the (Central national or EU-level MDS-I database?! is being taken care of by the national MDS-I centre(?!)

- Time path
  - "call for interest" 2002/03
  - implement a voluntary MDS-I network of A&E dept. in 2003
  - demonstrate the network and results in 2004 (at the 7WoCO)

**4.2 Denmark**

The situation in Denmark at the moment is characterised by the ongoing changes due to the change of government last November. Hopefully the current activities of preparing an update of the national
health promotion and prevention plan may pave the way for innovative thinking, including improvements of the databases on mortality etc. This might entail possibilities in the field of fatalities and other settings (e.g. general practices).

The MDS-I could be used as a reporting format for fatalities, hospital admissions and ED attendances to make international comparisons.

ED: There already exists a minimum data set for the registry of ED attendances. This minimum data set is similar to MDS-I-3 and mandatory.

Because injuries have priority in the prevention plans of the government, the authorities will provide resources for injury registry.

GPs: There are possibilities to implement the MDS-I-3.

Fatalities: MDS-I could be used as a reporting format. We have to convince the authorities to include enough information on death certificates.

4.3 Germany

In autumn 2002 we will have a meeting of the nation-wide working group “Epidemiology of childhood injuries “ (chair Ellsäßer), which is part of the “Bundesarbeitsgemeinschaft für Kindersicherheit” (BAK).

Relevant participating organisations:
- Federal statistic office
- Bundesanstalt für Arbeitsschutz und Arbeitsmedizin (responsible for the household survey on home and leisure accidents in 2002)
- Robert Koch Institut (responsible for the new child health survey)
- Public health centre of the city of Münster
- Bundesanstalt für gesundheitliche Aufklärung

I will give a presentation on the MDS-I and discuss possibilities of the implementation.

In former discussions on the lack of regarding thermal injuries we recommended to extend the hospital discharge register by “place”. But we have not received a positive answer by the Federal statistic office yet.

Hospital admission/ ED attendances

We have developed an electronic tool for MDS-I objective 4-5 linked with the doctor’s documentation of injuries (e.g. needed by the public accident insurance). The proposal of our surgeons was to combine the two systems together – data registering and injury documentation of injured patients, which we have piloted in two hospitals: Dortmund and Delmenhorst in May 2002. The results from this will be discussed in September under the leadership of the Forum Unfallprävention / German Green Cross (chair Ellsäßer).

In autumn 2003, there will be a conference by the association of child surgeons and paediatricians focussed on accidents in childhood. We will try to give a presentation on our established injury monitoring system based on MDS-I in Delmenhorst (experience of 4 years).
4.4 Greece

We will try to implement the MDS-I in hospitals or health centres that are not collecting any data for injuries at all.
Contacts have been made for implementing the MDS-I in the following settings:

- Hospitals: 4 Hospitals that collaborate with the Centre of Research and Prevention of Injuries (CEREPRI): General Hospital of Volos, General Hospital of Corfu, General Hospital “Asklipieion Voulas” from Athens, and the Children’s Hospital “Aglaiakou Kyriakou” from Athens. Also, we have contacted the General Hospital of Larissa and the General Hospital of Crete.

- Rural Health Centres: of Kalampaka, Corfu;

- Regional Health Care Centres: all over Greece;

- General Practitioners’ offices: in Corfu.

More specifically, we have contacted the managers of these centres and informed them about MDS-I. We sent them all the materials concerning MDS-I. We have sent them all the materials concerning MDS-I, after performing the translation of these documents in Greek and tried to convince them about the importance of injury surveillance and about the MDS-I.

As we had a positive feedback from the manager of the Regional Health Care System of Thessaly (they agreed to implement MDS-I in all rural health centres that are situated in the region of Thessaly) we then trained some of the personnel that is going to get involved in the implementation of the MDS-I. We provided them training on how to collect the appropriate injury data and about the coding system of the questionnaire. They are going to educate all the other doctors who are going to get involved further.

The Health Centre of Kalampakas has agreed to use the MDS-I after the summer and will keep us informed about the results.

Currently, we are waiting for the decision concerning the application of MDS-I of all other managers from the health systems that have been listed above.

4.5 The Netherlands

Fatalities
In 2002 we will contact relevant organisations and try to join forces to implement the MDS-I in the death certificate register.
Relevant organisations:
CBS (Statistics Netherlands)
SWOV (Institute for Road Safety Research)
TNO Arbeid en Gezondheid (TNO Work and Employment)
Hospital admissions
The Registration of Hospital Admissions in the Netherlands will be reorganised in the coming years. In 2002, together with other relevant parties we will try to implement the MDS-I in the renewed Registration of Hospital Admissions.
Relevant organisations:
Prismant (Registration of Hospital Admissions)
SWOV (Institute for Road Safety Research)
TNO Arbeid en Gezondheid (TNO Work and Employment)

ED attendances
In hospitals that do not participate in LIS, we will try to implement MDS-I-5. Recently, a software company included MDS-I-5 in the new release of their ED-module (part of a hospital information system). We will now try to convince the participating hospitals to use the MDS-I-5 permissible values and to supply us with the data they collect.

Other health settings
At this moment we have no plans to implement the MDS-Is in other health settings.

4.6 Norway
There are at least 25 years of experience with registration of injury data from patients treated in the health system, and with injury prevention of all injury types in Norway. Due to this experience, four important prerequisites are found with regard to the possibilities to implement MDS-Is in health settings:

1) In the National Injury Register at the National Institute of Public Health, data from about 40 000 injuries treated at hospitals and accident and emergency departments (AED) in four towns have annually been collected since 1985 according to the NOMESCO classification; covering about 10% of the Norwegian population. This comprehensive classification requires extra registration resources, about 5-6 EUR per injury. The National Injury Register will no longer produce statistics according to the NOMESCO-level, but will aim at collecting data more or less on the same level as the European MDS-I-3 from the National In-Patient Register (NPR) and from the Death Register.

2) A National Plan for the Prevention of Home and Leisure Accidents during 1997-2002 was put forward by nine ministries, co-ordinated by the Ministry of Health. One important aim in this plan is to improve the injury statistics on all levels. One accomplishment has been that a Norwegian MDS (almost compatible with the European MDS-I-3) was developed in 1999, and has been introduced as an extra window in the electronic record system for general practitioners in Norway by two of the three leading manufacturers of software. More or less all GPs in Norway use electronic records. This means that 50-60% of the Norwegian GPs have this additional window available in their computer. The window is displayed whenever an injury diagnosis is registered, and about 1 minute is needed to complete the necessary information. The system has been tested for about 2 years by about 20 GPs in Norway, and the system functions technically. The coverage rate is 100% when dedicated physicians concerned with injury registration and prevention are involved, but only a 50% rate is reached among other GPs, indicating that some motivating factors are
needed in order to get an overall high coverage rate. Maybe something in the software can be installed which makes it impossible to continue the record without completing the injury window.

3) Norwegian Safety Forum is a co-ordinating body outside the governmental area financed by the insurance association. It consists of 60 members, the most important injury prevention organisations in Norway. This Forum also has a watchdog function, and has over the years worked for improving injury statistics in Norway. It also has some influencing power to put pressure on establishing MDS-Is in Norway.

4) A new strategy with regard to injury statistics seems now to emerge in Norway: to collect a MDS-I-3 with good quality as part of the routines for fatalities, in-patients, some AEDs and GPs in order to obtain a high quality priority setting, resource allocation for prevention and trend analyses. This will require some resources for quality control, and maybe economic resources to the GPs. In addition, periodic specially designed in-depth investigations on selected injury/accident groups have been done (and should be continued) to determine contributing factors to the accidents/injuries, in order to identify prevention measures.

MDS-I-3 should be established for registering injury data comprising all severity levels in Norway. Necessary activities could entail:

1) Fatalities (about 2 500 annually). The Norwegian version of ICD-X, chapter XX includes 4. and 5. digits which are more or less compatible with the place of occurrence and activity of the European MDS-I-3. Currently physicians do not record these digits in a satisfactory manner, especially not for persons above 80 years of age (falls). Statistics Norway/ National Institute of Public Health ought to instruct physicians to record these data more accurately on the death certificate, and/or establish a quality control system to return forms when data are missing.

2) In-patients (about 50 000 annually). The National In-Patient Register can provide information on the total number of injured persons treated annually at all hospitals, also summarising different departments stays for one injury into one stay, thus enabling counting persons with one or multiple injuries. Projects might now be launched in order to improve the registration of the 4. and 5. digit (ICD-10, Ch. XX). Some additional training resources in the hospitals are required to obtain sufficient high quality of the registered data. The data should be collected when the patients arrive at the hospital or in the ambulance. In the existing systems, physicians code Ch. XX when the patient has left the hospital, and consequently will have no or little information about the external causes of the injuries present. It is anticipated that a working group will be established in the Ministry of Health to decide the contents of a MDS-I to be included in the electronic registration system for the in-patients, enabling the necessary data to be registered on arrival.

3) AEDs (about 300 000 annually). In the AED in Oslo with about 40 000 out-patients annually, a MDS-I-3 is installed in the electronic data system, trigged when the physician registeres an injury code from ICD-10. The physician then completes the necessary data (1 minute). In the future and/or at other AEDS, these data might be collected by the receiving personnel. Some resources for information and motivation of registration personnel and for quality control are necessary. At the Oslo AED 20% of one physician time is allocated to information and feedback about data quality to the 50 doctors working there (with high turn over). There is no national data system.
comprising the AEDs. In Norway 12 municipalities are now designated as a “Safe Community” by WHO. In addition 40 more of the 450 municipalities are working for fulfilling the requirements to be a Safe Community. Safe Community municipalities should install a registration system in order to have an overview of the local injuries (one of the indicators of being a “Safe Community”).

4) GPs and Occupational Health Practitioners (OHP) (100 – 150 000 annually). As mentioned above, a MDS-I-3 with a narrative of the accident is included by two of the three main suppliers of electronic records now in use by the GPs. The Ministry of Health should make the MDS-I-3 a national recommendation for injury registration by the GPs and OHPs, to put pressure also on the third supplier of electronic records. If so, then almost 100% of GPs and OHPs in Norway will have an electronic tool for injury registration available.

During winter/spring 2003, a meeting should be held between health and statistical authorities together with the national association of medical doctors. In this meeting, information about the European MDS-Is should be given, the experiences in Norway about MDS should be summed up, and finally a conclusion on how to get injury data for fatalities, in-patients, AEDs and GPs in a systematic way in Norway should be discussed.

4.7 UK/Wales

Death certification
We will translate ICD10 to MDS-I codes when the translation tables are available. The death certificates cannot be changed. The MDS-I can be used as a reporting format.

Hospital admissions
We will translate ICD10 to MDS-I-2 hospital admission data for Wales when the translation tables are available.

ED data
Again we will translate AWISS codes to MDS-I-2 codes. However, this is consequent on AWISS continuing which is dependant on confidentiality issues being sorted- currently under discussion. Translations are only made if other countries also make translations, so comparisons can be made.

Other settings
We have no plans for the introduction of MDS-Is in other settings at this point in time.
5 CONCLUSIONS AND RECOMMENDATIONS

5.1 Conclusions

In a previous project we have developed five Minimum Data Sets on Injuries (MDS-Is), which can be used for recording accident/injury information in different settings and objectives. These MDS-Is were based on relevant existing classifications: International Classification of External Causes of Injuries version 1.0 (ICECI 1.0), the International Classification of Diseases and Related Health Problems (ICD, tenth revision), and the classification of the European Home and Leisure Accident Surveillance System (EHLASS) which has been input for ICECI. In 2003, the five MDS-Is were adapted to the updated version of ICECI (ICECI 1.1a) and to HLA V2000 (former EHLASS). There is certain flexibility in the use of the different MDS-Is. It is possible to replace a data element of an MDS-I by a data element of a more detailed MDS-I.

The aim of the present project was to develop tools for the implementation and promotion of the MDS-Is for injury surveillance in the European Union (EU) and its applicant countries.

First of all, we have made an inventory of the possibilities to implement MDS-Is and the difficulties anticipated for the implementation. A questionnaire was sent to organisations/people in all EU member states and the accession countries (a total of 27 countries). Two thirds of the respondents (total: 23 respondents from 19 countries) indicate that it is possible to introduce MDS-Is in their country, although the level of MDS-Is varies. However, almost all of these respondents expect difficulties when implementing MDS-Is. Major concerns are the limited resources and mapping the data with existing systems.

Based on the results of the inventory among potential interested organisations and the knowledge of the reference group, we have determined the contents of the starters kit (See Chapter 3 and the cd-rom with corresponding report ‘Starters kit for the implementation and promotion of the MDS-Is’). The starters kit is meant to provide information and material to organisations who want to implement one or more MDS-Is and is ready for immediate use. The kit includes per MDS-I:
- guidelines for data collection, i.e. general information on how to set up and maintain a surveillance system
- data dictionary, including the data elements, their permissible values and the in- and exclusion criteria
- coding forms, a tool for the actual data collection (optional)
- conversion tables on MDS-Is with ICD-9 and ICD-10 and visa versa.
- reporting tables, including guidelines and information on the quality of the data
- promotion materials: a summary of the MDS-Is and a Power-point presentation, a letter of recommendation from the European Commission.

5.2 Recommendations

It is important that the MDS-Is and the reporting tables that were drafted will become the European standard for injury/accident data collection. However, it should be stressed that the MDS-Is are not meant to replace the new ISS coding manual. This coding manual is meant to record injuries/accidents at Emergency Departments in the European Union. Only if the level of detail is too much for a setting, one might implement the MDS-Is relevant for Emergency Departments.

The overall recommendation is to promote the MDS-Is:
- as a uniform way of reporting data in injuries at national and EU-level (reporting tables)
- as a standardised tool for injury data collection through standard health statistics which usually record only limited information on injuries/accidents, like fatality statistics and hospital discharges.
- as a basis for starting injury data collection in settings in which the ISS coding manual is (yet) too detailed.

Therefore attention should be paid at the accessibility of information on MDS-Is, ‘spreading the news’, and maintenance.

In order to give a thorough basis for the implementation, we recommend the following.

**Accessibility of information about MDS-I**

In order to stimulate the use of the MDS-Is as much as possible, it is essential that the information on the MDS-Is is available for everyone.

The data dictionary, reporting tables, and other relevant information on the implementation of the MDS-Is (e.g. guidelines, conversion tables) should be published at the website of the European Commission ([http://www.europa.eu.int/comm/health/ph_projects/injury_project_en.htm](http://www.europa.eu.int/comm/health/ph_projects/injury_project_en.htm)). A specific warning should be added that for Emergency Department surveillance the ISS coding manual is preferred.

Since the MDS-Is are partly based on the International Classification of External Causes of Injuries (ICECI), they can be regarded as a derivative of ICECI. The data dictionary of the MDS-Is is already published on the ICECI website (www.iceci.org). The rest of the starters kit should also be published at the ICECI website.

**Promoting MDS-Is**

Some of the promotion activities apply for all three elements of implementation (reporting, improving existing systems, starting injury/accident data collection), and some are specially meant for promoting one element. Another distinction is the implementation at EU-level and at national level. The overall recommendation is to seize every opportunity to promote the MDS-Is and to share experiences.

Because many stakeholders (e.g. organisations responsible for mortality statistics, public health workers) are involved in actually implementing and reporting on the MDS-Is, the target group for the promotion of the MDS-Is is not limited to people from the ‘injury community’. Also conferences, journals etceteras addressed to public health workers, medical doctors, and health administrators should be taken into account. Since nowadays injury prevention is embedded in the Public Health Programme of the European Commission, many opportunities for information exchange are possible.

For the general promotion of the MDS-Is, it is at least recommended to:

- organise seminars at national and international level to teach on the MDS-Is. It is suggested to combine the education on MDS-Is with information such as developing accident/injury surveillance systems, and strengthen policy involvement.
- promote MDS-Is at national and international conferences. The World Conferences on Injury Prevention and Control (next one in Vienna in 2004) give an excellent opportunity.
- publish experiences and results of international comparisons in journals and newsletters (for instance a column in the newsletter of the EU Injury Prevention Programme, and the newsletter of the WHO Family of International Classifications)

The tables and figures designed for reporting can be the basis for international comparisons. This should be stimulated and can be the basis for the ISS database.

For improving existing systems by adding MDS-Is all the promotion activities mentioned above are relevant. Emphasis should be on improving the information for fatalities and hospital discharge registers. Explicit lobbying is needed, as well bottom-up (from a national level, f.i. national statistical
offices) as top-down (from the EU-level, f.i. Eurostat). Since many of the pitfalls for improving the value of existing collection systems for accident and injury prevention are similar in countries, sharing experiences is indispensable.

**Maintenance**

Of course the MDS-Is aren’t static: it should take into account practical experiences, including new types of accidents that occur. However, one should always be very careful, since a minor change might have major consequences for historic comparisons. Organising the maintenance of the MDS-Is in an efficient way is important.

The maintenance of part of the MDS-Is should be directly linked to the ICECI Co-ordination and Maintenance group, since ICECI is the basis. Changes in ICECI should be incorporated in the MDS-Is (if applicable). On the other hand, any suggestions for improving ICECI based on experiences with the MDS-Is should be discussed within the ICECI maintenance procedure.

Changes in the ICD External Causes chapter should be monitored for its effects on the MDS-Is. It is recommended to incorporate the maintenance of the MDS-Is as much as possible in the process of ICECI, but co-ordination at EU-level is inevitable. It is advised to combine the maintenance of the MDS-Is and the ISS coding manual.

The MDS-Is are currently only available in English (a previous version has been translated into German), but translations into the European languages are needed. It is recommended to at least co-ordinate the translation at EU-level (since some countries share their language) and maybe actually translate within the European Commission.

**Task Forces**

It is recommended to have a dedicated group of experts (a task force) being responsible for the overall maintenance and promotion of the MDS-Is. The group should have a clear link with other working groups, committees within the European Commission related to accident prevention, preferably with the Injury Working Party of the Programme of Public Health of the European Commission. It is recommended to combine the tasks for maintaining the MDS-Is with other tasks that are linked, like training staff in coding, advising organisations on injury surveillance, developing software, etc.

The group of experts should at least meet once a year (at a time when changes can still be incorporated for the next year).

It is important that organisations that need information on the MDS-Is, can get in fast. Therefore, it is recommended to select one contact organisation, which also participates in the task force. Until the formal procedures have been decided upon, the Consumer Safety Institute (Amsterdam, the Netherlands) is willing to be the contact organisation.

The recommended main tasks for maintaining and promoting the MDS-Is should be:
- a clearinghouse function: answering questions
- determining the overall policy on accident data collection within Europe
- document best and good practices on injury/accident surveillance: focal point for sharing experiences
- active promotion the use of the MDS-Is
- communication with the national task force and/or contact persons
- organise educational workshops
- develop new promotion materials, if necessary
- actively collect suggestions for improving the MDS-Is
- communication with the Co-ordination and Maintenance group of ICECI
- decide on any changes to be made (and keep records for historic analysis)
- distribute new releases of the MDS-Is
- maintain conversion tables
- follow new developments in the field of injury surveillance
- stimulate the use of reporting tables and figures at EU-level.
- stimulate the improvement of mortality statistics and hospital discharge registers concerning information on accidents at EU-level: for instance by formal recommendations.

Besides an European task force, it is recommended to create national task forces with experts on injury classifications and surveillance, who can train staff and promote the MDS-Is. The organisation, members and tasks of these groups should be integrated in relevant national structures.
REFERENCES


Annex 1  Reference group

_Austria_
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Robert.Bauer@sicherleben.at

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dalexe@med.uoa.gr

Eleni Petridou  
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_Norway_
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johan.lund@fnh.no

_United Kingdom_
Ronan Lyons  
University of Wales  
r.a.lyons@swansea.ac.uk
Annex 2 Questionnaire about the implementation of the Minimum Data Set on Injuries (MDS-I)

Name : 
Organisation : 
Country : 
E-mail address : 

1. Which surveillance systems for collecting and recording data on injuries do already exist (and are running) in your country? (multiple answers are possible)
   - none (go to question 3)
   - specific injury surveillance system(s) (like EHLASS, LIS, etc)
   - mortality surveillance system(s)
   - morbidity surveillance system(s)
   - I do not know (go to question 3)

2. Which coding systems are being used in these surveillance system(s)?
   (please fill in the name of the registration and mark with a cross the corresponding coding systems)

<table>
<thead>
<tr>
<th></th>
<th>ICD-9</th>
<th>ICD-10</th>
<th>ICECI</th>
<th>EHLASS</th>
<th>NOMESCO</th>
<th>Other*</th>
<th>Unknown</th>
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39
If another coding system is being used, please indicate that specific system.

3.a. Who is/are the owner(s)/administrator(s) of the injury surveillance system(s)?

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<tr>
<td>Organisation:</td>
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<td>E-mail address:</td>
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b. Who is/are the owner(s)/administrator(s) of the mortality surveillance system(s)?

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<td>E-mail address:</td>
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c. Who is/are the owner(s)/administrator(s) of the morbidity surveillance system(s)?

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<tr>
<td>Organisation:</td>
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<td>E-mail address:</td>
<td>E-mail address:</td>
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</table>
4. For which settings the MDS-I could be useful in your country?
   (multiple answers are possible)
   - Hospitals
   - Emergency departments
   - General practitioners
   - Fatalities
   - Other settings, like ...............................................................

5. Do you see possibilities for implementation the MDS-I within one or more settings?
   - yes
   - no, because...........................................................................

If yes, which level of MDS-I is the most useful instrument for the specific setting?
   (mark with a cross the most useful instrument for each relevant setting)

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<thead>
<tr>
<th></th>
<th>MDS-I-1</th>
<th>MDS-I-2</th>
<th>MDS-I-3</th>
<th>MDS-I-4</th>
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</thead>
<tbody>
<tr>
<td>Hospitals</td>
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<td>Emergency Departments</td>
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<td>General Practitioners</td>
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<td>Fatalities</td>
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<td>Other settings like:</td>
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6. Do you expect difficulties for implementation the MDS-I within one or more settings?
   - yes
   - no

   If yes, which difficulties do you expect?
   (please indicate for each relevant setting separately)

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<th>Expected difficulties</th>
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<tr>
<td>Hospitals</td>
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<tr>
<td>Emergency Departments</td>
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<td>General Practitioners</td>
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<td>Fatalities</td>
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<td>Other settings like:</td>
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</table>

7.a. Are you willing to promote the MDS-I to relevant settings in your country?
   - yes (go to question 8)
   - no

   b. Do you know somebody else who is willing to promote the MDS-I in your country?
      - yes, namely:
        Name: ............................................................................................................
        Organisation: ..................................................................................................
        Address: ..........................................................................................................
        Town: .............................................................................................................
        Country: .......................................................................................................  
        Telephone no.: ............................................................................................
        Fax no.: .....................................................................................................
        E-mail address : .........................................................................................
      - no
8. Which tools and information do you need to promote and implement the MDS-I in your country?
(multiple answers are possible)

- Power Point presentation
- conversion tables
- guidelines
- data dictionary
- coding form
- other tools/information, like ....................................................................................
  ...................................................................................................................................

............................................................................................................................................
Annex 3 Overview of answers per respondent

Austria
Jeannette Klimont
Statistics Austria
Jeannette.klimont@statistik.gv.at

1. Which surveillance systems for collecting and recording data on injuries do already exist (and are running) in your country?
Fatalities.

2. Which classifications are being used in this surveillance system(s)?
Fat.: ICD-10.

3. Who is the owner/administrator of the surveillance systems?
Fat.: Statistics Austria
Hintere Zollamtsstrasse 2b, 1033 Wien

4. For which settings the MDS-Is could be useful in your country?
-

5. Do you see possibilities for implementation of the MDS-Is within one or more setting? If yes, what is the most detailed MDS-I that can be implemented in each specific setting?
No, because on the death certificate there is only information on the cause of death and the circumstances of the accident or violence which produced the fatal injury.

6. Do you expect difficulties for implementation of the MDS-I within one or more setting? If yes, which difficulties do you expect?
Yes, because there is not more information available on the death certificate.

7. Are you willing to promote the MDS-I to relevant settings in your country?
No.

8. Which tools and information do you need to promote and implement the MDS-I in your country?
-
1. Which surveillance systems for collecting and recording data on injuries do already exist (and are running) in your country? Hosp.: Minimal Clinical Report.

2. Which classifications are being used in this surveillance system(s)? Hosp.: ICD-9

3. Who is the owner/administrator of the surveillance systems? Hosp.: Ministry of Public Health, Social Affairs and Environment Quartier Vésale – Cité administrative de l’Etat Rue Montagne de l’Oratoire 1010 Bruxelles anita.simoens@health.fgov.be

4. For which settings the MDS-Is could be useful in your country? Hospital admissions.

5. Do you see possibilities for implementation of the MDS-Is within one or more setting? If yes, what is the most detailed MDS-I that can be implemented in each specific setting? Yes, Hosp.: MDS-I-1.

6. Do you expect difficulties for implementation of the MDS-I within one or more setting? If yes, which difficulties do you expect? Hosp: No.

7. Are you willing to promote the MDS-I to relevant settings in your country? Yes.

8. Which tools and information do you need to promote and implement the MDS-I in your country?
Cyprus
Dr. P. Pavlou
Ministry of Health
pavlospavlou@cytanet.com.cy

1. Which surveillance systems for collecting and recording data on injuries do already exist (and are running) in your country?
Hospital admissions.

2. Which classifications are being used in this surveillance system(s)?
Hosp.: Other, coding system designed in-house

3. Who is the owner/administrator of the surveillance systems?
Hosp.: Dr. C. Antoniades
Accident and Emergency Department
Nicosia General Hospital
c.aniades.@cytanet.com.cy

4. For which settings the MDS-Is could be useful in your country?
Hospital admissions, Emergency departments and Fatalities.

5. Do you see possibilities for implementation of the MDS-Is within one or more setting? If yes, what is the most detailed MDS-I that can be implemented in each specific setting?
People in Cyprus recognise the importance of reliable information on injuries. Accession to the European Union acts as a strong stimulus to implementing Health Monitoring projects.

6. Do you expect difficulties for implementation of the MDS-I within one or more setting? If yes, which difficulties do you expect?
Yes, Hosp.: Medical and nursing staff will consider filling in the forms as an additional task. They are short of time. They may need clerical staff to do this job. ED: Difficulties in administrative work.
ED: As above, but the problem is more acute here. Some of the information may not be available in time.
Fat.: As above.

7a. Are you willing to promote the MDS-I to relevant settings in your country?
No.

7b. Do you know someone else who is willing to promote the MDS-I in your country?
Yes, namely: Dr. C. Antoniades
Accident and Emergency Department
Nicosia General Hospital
c.aniades.@cytanet.com.cy

8. Which tools and information do you need to promote and implement the MDS-I in your country?
Power Point presentation, conversion tables, guidelines, Data Dictionary, coding form, other tools like official translations of data dictionaries may be needed in some cases.
Czech Republic
M. Grivna, MD, PhD, MPH
Centre of Childhood Injury Epidemiology and Prevention
Michal.grivna@lfmotol.cuni.cz

1. Which surveillance systems for collecting and recording data on injuries do already exist (and are running) in your country?
ED: Pilot Study - Center
Hosp.: National Health Statistics
Fat.: Pilot Study - Center

2. Which classifications are being used in this surveillance system(s)?
ED: ICD-10
Hosp.: ICD-10
Fat.: ICD-10

3. Who is the owner/administrator of the surveillance systems?
ED: Centre of Childhood Injury Epidemiology and Prevention
Hosp.: National Health Statistics
Ministry of Health
Fat.: Centre of Childhood Injury Epidemiology and Prevention

4. For which settings the MDS-Is could be useful in your country?
Hospital admissions, emergency departments, fatalities and other settings like traumacenters.

5. Do you see possibilities for implementation of the MDS-Is within one or more setting? If yes, what is the most detailed MDS-I that can be implemented in each specific setting?

6. Do you expect difficulties for implementation of the MDS-I within one or more setting? If yes, which difficulties do you expect?
Yes, Hosp.: No complete data and data collection finance.
ED: Differences in database systems and low compliance of staff.
Fat.: Data not complete and not unified data collection system.
Other: Data collection finance and data processing.

7a. Are you willing to promote the MDS-I to relevant settings in your country?
Yes.

8. Which tools and information do you need to promote and implement the MDS-I in your country?
Power Point presentation, conversion tables, guidelines, Data Dictionary, coding form, other tools like workshop.
1. Which surveillance systems for collecting and recording data on injuries do already exist (and are running) in your country?

ED: 1) Injury Register, 2) National Patient Register, 3) Injury database at Odense University Hospital.
Hosp.: National Patient Register
Fat.: Danish Mortality Register
Other: General Practice

2. Which classifications are being used in this surveillance system(s)?

ED: 1) EHLASS 2000, NOMESCO, 2) ICD-10, NOMESCO, 3) NOMESCO.
Hosp.: ICD-10, NOMESCO
Fat.: ICD-10
Other: ICPC

3. Who is the owner/administrator of the surveillance systems?

ED: 1) Anne Mette Johansen 2) Jorgen Jorgensen
   National Institute of Public Health National Board of Health
   .25 Svanemollevej, DK-2100 Copenhagen Islands Brygge 67, DK-2300 Copenhagen S
   amt@niph.dk ji@sst.dk

3) The Accident Analysis Group
   Odense University Hospital
   DK-5000 Odense C
   Ulykkes.analyse.gruppen@ouh.dk

Fat.: Morten Hjulsager Hosp.: Jorgen Jorgensen
   National Board of Health National Board of Health
   Islands Brygge 67, DK-2300 Copenhagen S Islands Brygge 67, DK-2300 Copenhagen S
   Mhj@sst.dk jj@sst.dk

4. For which settings the MDS-Is could be useful in your country?

Fatalities, other settings like General Practice.

5. Do you see possibilities for implementation of the MDS-Is within one or more setting? If yes, what is the most detailed MDS-I that can be implemented in each specific setting?

6. Do you expect difficulties for implementation of the MDS-I within one or more setting? If yes, which difficulties do you expect?

Yes, Hosp.: The National Patient Register already uses an MDS, which is similar to MDS-I-4.
ED: The MDS used in the National Patient Register is supplemented by the injury registers at NIPH and Odense University Hospital. The latter contain data at more detail than MDS-I-5. The present surveillance system in Denmark benefits from the national monitoring system and the nationally representative detailed registers, which facilitate research. This system will be preserved.
Fat.: Mortality coding follows WHO’s conventions and rules. It is unlikely that changes to the mortality registration system will be made without WHO’s formal adoption of such changes. If an MDS-I were implemented, it would incur extra resources, as it would be a national project parallel to the conventional coding.
Other: For General Practice, the implementation of an MDS-I needs negotiations with the relevant bodies concerned with this setting. Such negotiations will take a long time! So far, it has not been possible to establish a morbidity register for General Practice. However, pilot projects may be feasible within this setting, depending on availability of motivation, resources, and time.

7. Are you willing to promote the MDS-I to relevant settings in your country?

Yes.

8. Which tools and information do you need to promote and implement the MDS-I in your country?

Power Point presentation, conversion tables, guidelines, Data Dictionary, coding form.
The above might serve as inspiration for tools/information which may have to be developed at national level. At this time it is uncertain which other tools/information might be useful.
1. Which surveillance systems for collecting and recording data on injuries do already exist (and are running) in your country?
Hosp.: Hospital Episode Statistics

2. Which classifications are being used in this surveillance system(s)?
Hosp.: ICD-10

Who is the owner/administrator of the surveillance systems?
Hosp.: Section SD2HES, Statistics Division
Department of Health
Skipton House, 80 London Road, London, SE1 6LH
Sd2hes@doh.gsi.gov.uk

4. For which settings the MDS-Is could be useful in your country?
Hospital admissions.

5. Do you see possibilities for implementation of the MDS-Is within one or more setting? If yes, what is the most detailed MDS-I that can be implemented in each specific setting?

6. Do you expect difficulties for implementation of the MDS-I within one or more setting? If yes, which difficulties do you expect?
Yes, Hosp.: information is not held in HES in the MDS-I format. The ability to complete the MDS-I data items is dependent on a mapping from ICD-10 tot the MDS-I codes being available. Potential difficulties are the availability of such a mapping, and also the availability of resources to produce reports in the MDS-I formats based on HES data.

7. Are you willing to promote the MDS-I to relevant settings in your country?
No.

8. Which tools and information do you need to promote and implement the MDS-I in your country?
Conversion tables, guidelines, Data Dictionary, coding form.
1. Which surveillance systems for collecting and recording data on injuries do already exist (and are running) in your country?
ED, Hospital admissions, Fatalities, Other.

2. Which classifications are being used in this surveillance system(s)?
ED: ICD-10
Hosp.: ICD-10
Fat.: ICD-10
Other: ICD-10.

3. Who is the owner/administrator of the surveillance systems?
ED: Statistical Office of Estonia
Endla 15, 15174 Tallinn, Estonia
Stat@stat.ee
Ministry of Social Affairs
Gonsiori 29, 15027 Tallinn, Estonia
smin@sm.ee
Hosp.: Statistical Office of Estonia
Other: Departments of statistics in hospitals over the Estonia

4. For which settings the MDS-Is could be useful in your country?
ED departments, hospital admissions, other settings like Department of Statistics at the Ministry of Social Affairs.

5. Do you see possibilities for implementation of the MDS-Is within one or more setting? If yes, what is the most detailed MDS-I that can be implemented in each specific setting?
Yes. Everywhere should be the most developed and the same instrument.

6. Do you expect difficulties for implementation of the MDS-I within one or more setting? If yes, which difficulties do you expect?
Yes, because this needs more work.

7. Are you willing to promote the MDS-I to relevant settings in your country?
No, this is not among my job, if this was, then of course.

8. Which tools and information do you need to promote and implement the MDS-I in your country?
-
Finland
Hilkka Ahonen
Cause of Death Statistics, Statistics Finland
Hilkka.ahonen@stat.fi

1. Which surveillance systems for collecting and recording data on injuries do already exist (and are running) in your country?
Fat.: Cause of Death Statistics

2. Which classifications are being used in this surveillance system(s)?
Fat.: ICD-10.

3. Who is the owner/administrator of the surveillance systems?
Fat.: Statistics Finland

4. For which settings the MDS-Is could be useful in your country?
Fat.: Fatalities.

5. Do you see possibilities for implementation of the MDS-Is within one or more setting? If yes, what is the most detailed MDS-I that can be implemented in each specific setting?
Yes, Fat.: if possible with conversion from ICD-10 data.

6. Do you expect difficulties for implementation of the MDS-I within one or more setting? If yes, which difficulties do you expect?
Yes, Fat.: There are some useless place-codes for mortality (f.e. school). All mortality statistics should be compiled on the basis by conversion from the mortality data sent from MC to EURSTAT. National statistical data should be converted centralised by the collector of the injury statistical office on the basis of EUROSTAT-database.

7. Are you willing to promote the MDS-I to relevant settings in your country?
Yes, with co-ordination with EUROSTAT.

8. Which tools and information do you need to promote and implement the MDS-I in your country?
Other tools/information, statistical tables based on the conversion tables on the basis of ICD-10-data.
1. Which surveillance systems for collecting and recording data on injuries do already exist (and are running) in your country?
Fat.: Cause of Death Statistics
Hosp.: discharge register

2. Which classifications are being used in this surveillance system(s)?
Fat.: ICD-10
Hosp.: ICD-10

3. Who is the owner/administrator of the surveillance systems?
Fat.: Helena Korpi
Hosp.: Hannu Rintanen
Statistics Finland
00022 Tilastokeskus
hanna.korpi@stat.fi

STAKES
P.O. Box 220, 00531 Helsinki
hannu.rintanen@stakes.fi

4. For which settings the MDS-Is could be useful in your country?
Hospital admissions and Emergency departments.

5. Do you see possibilities for implementation of the MDS-Is within one or more setting? If yes, what is the most detailed MDS-I that can be implemented in each specific setting?
Yes, to test conversion tables between MDS-I and ICD-10.
Hosp.: MDS-I-3 for testing purposes, MDS-I-5 partly
ED: MDS-I-3 for testing purposes, MDS-I-5 partly

6. Do you expect difficulties for implementation of the MDS-I within one or more setting? If yes, which difficulties do you expect?
-

7. Are you willing to promote the MDS-I to relevant settings in your country?
Yes.

8. Which tools and information do you need to promote and implement the MDS-I in your country?
Conversion tables.
Germany
Stefan Dittrich
Statistisches Bundesamt
Stefan.dittrich@destatis.de

1. Which surveillance systems for collecting and recording data on injuries do already exist (and are running) in your country?
Hosp.: Hospital Discharge Register
Fat.: Cause of Death Statistics

2. Which classifications are being used in this surveillance system(s)?
Hosp.: ICD-10
Fat.: ICD-10

3. Who is the owner/administrator of the surveillance systems?
Hosp.: Stefan Dittrich
      Federal Statistics Office
      Graurheindorferstr. 198, D-53029 Bonn
      Stefan.dittrich@destatis.de
Fat.: Christiane Rosenow
      Federal Statistics Office
      Graurheindorferstr. 198, D-53029 Bonn
      christiane.rosenow@destatis.de

4. For which settings the MDS-Is could be useful in your country?

5. Do you see possibilities for implementation of the MDS-Is within one or more setting? If yes, what is the most detailed MDS-I that can be implemented in each specific setting?
No, the items we are allowed to collect are regulated by law. There is no information about injuries in the diagnosis statistic of inpatient dismissed from hospital. In the cause of death statistic (number of death classified by ICD-10) we have a few accident categories (work, school, traffic, sports, other) and information about sex and age.

6. Do you expect difficulties for implementation of the MDS-I within one or more setting? If yes, which difficulties do you expect?

7. Are you willing to promote the MDS-I to relevant settings in your country?

8. Which tools and information do you need to promote and implement the MDS-I in your country?


1. Which surveillance systems for collecting and recording data on injuries do already exist (and are running) in your country?

ED: Emergency Department Injury Surveillance System
Hosp.: In-patient Information Surveillance Systems
Fat.: Registration of Mortality Data
Other: Statistics on Road Traffic Accidents

2. Which classifications are being used in this surveillance system(s)?

ED: ICD-9, ICD-10, EHLASS 86, EHLASS 2000, NOMESCO.
Hosp.: ICD-9
Fat.: ICD-9
Other: Unknown

3. Who is the owner/administrator of the surveillance systems?

ED: Dr. Eleni Petridou
    CEREPRI
    M. Asias 75, Athens, 11527, Greece
    Epetrid@med.uoa.gr

Hosp.: Mrs. Hondrou Evangelia
    Mr. Karavitis Nikos, General Secretariat
    Makedonias 6-8, Athens, Greece

Fat.: National Statistics Services of Greece
    National Statistics Services of Greece
    Makedonias 6-8, Athens, Greece

Other: Mrs. Hondrou Evangelia
    National Statistics Services of Greece
    Makedonias 6-8, Athens, Greece

4. For which settings the MDS-Is could be useful in your country?

ED departments, hospital admissions, fatalities, other settings like Health Centres.

5. Do you see possibilities for implementation of the MDS-Is within one or more setting? If yes, what is the most detailed MDS-I that can be implemented in each specific setting?

Yes, we have contacted the health Centre of Kalampakas. The doctors of the health centre and the administration have agreed to ask the necessary questions and complete the questionnaires for MDS-I with our guidance and supervision. Concerning the rest of the settings, we do not know whether the doctors will agree to collaborate and what information they select in their database.
6. Do you expect difficulties for implementation of the MDS-I within one or more setting? If yes, which difficulties do you expect?
Yes, Hosp.: The time of the doctors is very limited, no time to ask and write the information needed.
Fat.: ESYE, the Organisation who is responsible for data collection, has a certain way of receiving the data from all around Greece and coding each field. We find it very difficult to change the way of collection.
Other: Health Centres: There is no person available for interpreting the questionnaires in a PC or a person to analyse the data. In some cases there is no computer available.

7. Are you willing to promote the MDS-I to relevant settings in your country?
Yes.

8. Which tools and information do you need to promote and implement the MDS-I in your country?
Power Point presentation, conversion tables, guidelines, Data Dictionary, coding form, all relative documents translated in order to better promote them.
1. Which surveillance systems for collecting and recording data on injuries do already exist (and are running) in your country?
ED, Hospital admissions, Fatalities, Other.

2. Which classifications are being used in this surveillance system(s)?
ED: ICD-10, ICECI
Hosp.: ICD-10, ICECI
Other: ICD-10

3. Who is the owner/administrator of the surveillance systems?
ED: Information Centre for Health Care National Health Insurance Fund
Ministrial State Budget Institution Hungary, Budapest, Váci út 73/a
Szekszárd, Arany J. 23-25 Titkar@gyogyinfok.hu
www.oep.hu

Hosp.: Information Centre for Health Care National Health Insurance Fund
Ministrial State Budget Institution Hungary, Budapest, Váci út 73/a
Szekszárd, Arany J. 23-25 Titkar@gyogyinfok.hu
www.oep.hu

Fat.: National Statistical Office Other: National Health Insurance Func
Hungary, Budapest, Keleti Károly u. 5-7 Hungary, Budapest, Váci út 73/a
Ksh@office.ksh.hu www.oep.hu

4. For which settings the MDS-Is could be useful in your country?
Hospital admissions, ED, Fatalities, Other.

5. Do you see possibilities for implementation of the MDS-Is within one or more setting? If yes, what is the most detailed MDS-I that can be implemented in each specific setting?

6. Do you expect difficulties for implementation of the MDS-I within one or more setting? If yes, which difficulties do you expect?
Yes.

7. Are you willing to promote the MDS-I to relevant settings in your country?
Yes.

8. Which tools and information do you need to promote and implement the MDS-I in your country?
Conversion tables, guidelines, Data Dictionary.
Hungary
Éva Gárdos
Hungarian Central Statistics Office, Department of Population, Health and Social Statistics
judit.gyorke@office.ksh.hu

1. Which surveillance systems for collecting and recording data on injuries do already exist (and are running) in your country?
Hospital admissions, fatalities.

2. Which classifications are being used in this surveillance system(s)?
Hosp.: ICD-10, Other (ESAW)
Fat.: ICD-10

3. Who is the owner/administrator of the surveillance systems?
Hosp.: Hungarian Central Statistical Office
Dr. István Bordás
Center of Health Care Information
Hungary, 7101 Szekszárd, AranyJu 23-25

Fat.: Department of Population, Health and Social Statistics
János Gádor
Hungarian Central Statistics Office
National Labour Safety and Labour Inspectorate
Hungary, 1024 Budapest, Keleti K. u. 5-7

4. For which settings the MDS-Is could be useful in your country?
All settings could be useful

5. Do you see possibilities for implementation of the MDS-Is within one or more setting? If yes, what is the most detailed MDS-I that can be implemented in each specific setting?
Yes, Hospitals: MDS-I-1, Fatalities: MDS-I-3

6. Do you expect difficulties for implementation of the MDS-I within one or more setting? If yes, which difficulties do you expect?
No.

7. Are you willing to promote the MDS-I to relevant settings in your country?
Yes.

8. Which tools and information do you need to promote and implement the MDS-I in your country?
Power Point presentation, conversion tables, guidelines, Data Dictionary, coding form, other information.
Hungary
Dr. G. Göbl
Hungarian National Emergency and Ambulance Service
gobl@bp.mentok.hu

1. Which surveillance systems for collecting and recording data on injuries do already exist (and are running) in your country?

2. Which classifications are being used in this surveillance system(s)?
Hosp.: Other

3. Who is the owner/administrator of the surveillance systems?
-

4. For which settings the MDS-Is could be useful in your country?
Emergency departments of Traumatology

5. Do you see possibilities for implementation of the MDS-Is within one or more setting? If yes, what is the most detailed MDS-I that can be implemented in each specific setting?
Yes, ED: MDS-I-5

6. Do you expect difficulties for implementation of the MDS-I within one or more setting? If yes, which difficulties do you expect?
Yes, ED: Difficulties in administrative work.

7. Are you willing to promote the MDS-I to relevant settings in your country?
Yes.

8. Which tools and information do you need to promote and implement the MDS-I in your country?
Implementation should happen under the co-ordination of Ministry of Health, Social and Family Affairs.
Ireland
Tim McCarthy
Department of Health and Children
Tim_mccarthy@health.irlgov.ie

1. Which surveillance systems for collecting and recording data on injuries do already exist (and are running) in your country?
ED: EHLASS Ireland
Hosp.: Hospital In-patient Enquiry (HIPE)
Fat.: Vital Statistics Mortality Data
Other: 1) National Roads Authority Database, 2) SAFE Database (occupational injuries)

2. Which classifications are being used in this surveillance system(s)?
ED: EHLASS 86
Hosp.: ICD-9
Fat.: ICD-9
Other: 1) Unknown, 2) Unknown

3. Who is the owner/administrator of the surveillance systems?
ED: Tim McCarthy
Department of Health and Children
Hawkins House, Dublin 2
Tim_mccarthy@health.irlgov.ie

Hosp.: Mary Heanu
Central Statistics Office
Skehard Road, Cork House, Dublin 2
Mary.heanue@cso.ie

Hugh Magee
Department of Health and Children
Hawkins Road, Dublin 2
hugh_magee@health.irlgov.ie

Fat.: Hugh Magee
Department of Health and Children
Hawkins Road, Dublin 2
hugh_magee@health.irlgov.ie

Prof. Miriam Wiley
Economic and Social Research Institute (ESRI)
4 Burlington Road, Dublin 4
miriam.wiley@esri.ie

Other: 1) Mr. Cyril Connolly
National Roads Institute
St. Martin’s House, Waterloo Road, Dublin 4
2) Ms. Carmel Kearns
Health and Safety Authority
10 Hogan Place, Dublin 2

4. For which settings the MDS-Is could be useful in your country?
ED, Hospital admission, Fatalities.

5. Do you see possibilities for implementation of the MDS-Is within one or more setting? If yes, what is the most detailed MDS-I that can be implemented in each specific setting?
No, not likely at present but maybe in the future if the system proves itself since there is already a coding burden on the administrators.
6. Do you expect difficulties for implementation of the MDS-I within one or more setting? If yes, which difficulties do you expect?
   In all settings: existing systems already apply a burden to administrators.

7. Are you willing to promote the MDS-I to relevant settings in your country?
   No.

8. Which tools and information do you need to promote and implement the MDS-I in your country?
   -
Italy
Bruzzone Silvia
Italian National Institute of Statistics
Bruzzone@istat.it

1. Which surveillance systems for collecting and recording data on injuries do already exist (and are running) in your country?
   Fatalities.

2. Which classifications are being used in this surveillance system(s)?
   Fat.: ICD-9

3. Who is the owner/administrator of the surveillance systems?
   Fat.: Italian National Institute of Statistics

4. For which settings the MDS-Is could be useful in your country?
   Fatalities.

5. Do you see possibilities for implementation of the MDS-Is within one or more setting? If yes, what is the most detailed MDS-I that can be implemented in each specific setting?
   Yes, Fat.: MDS-I3.

6. Do you expect difficulties for implementation of the MDS-I within one or more setting? If yes, which difficulties do you expect?
   Fat.: No.

7. Are you willing to promote the MDS-I to relevant settings in your country?
   Yes.

8. Which tools and information do you need to promote and implement the MDS-I in your country?
   Guidelines, Data Dictionary, coding form.
Latvia
Dr. Jautrite Karaskevica
Health Statistics and Medical Technology Agency
Jautrite@vsmta.lv

1. Which surveillance systems for collecting and recording data on injuries do already exist (and are running) in your country?
Hospital admissions: National Databases based on: 1) Branch Statistical Reports 2) Primary medical documents
Fatalities: National Death Cause Database

2. Which classifications are being used in this surveillance system(s)?
Hosp.: ICD-10
Fat.: ICD-10

3. Who is the owner/administrator of the surveillance systems?
Hosp./Fat.: Dr. J. Karaskevica
Health Statistics and Medical Technology Agency
12/22 Duntes Street, LV-1005, Riga, Latvia

Fat.: I. Bluke
State Compulsory Health Insurance Agency
25 Baznicas Street, LV-1010, Riga, Latvia

4. For which settings the MDS-Is could be useful in your country?
Hospital admissions, ED, Fatalities.

5. Do you see possibilities for implementation of the MDS-Is within one or more setting? If yes, what is the most detailed MDS-I that can be implemented in each specific setting?

6. Do you expect difficulties for implementation of the MDS-I within one or more setting? If yes, which difficulties do you expect?
Yes, in all settings: financing, development of new standard forms and personnel training.

7. Are you willing to promote the MDS-I to relevant settings in your country?
Yes.

8. Which tools and information do you need to promote and implement the MDS-I in your country?
Power Point Presentation, conversion tables, guidelines, Data Dictionary, coding form.
1. Which surveillance systems for collecting and recording data on injuries do already exist (and are running) in your country?

Hosp.: 1) Health Information System, 2) DB from Health Insurance System

Fat.: 1) Mortality Register, 2) Health Information System

Other: 1) Disability Surveillance System, 2) Poisoning Surveillance System

2. Which classifications are being used in this surveillance system(s)?

Hosp.: 1) ICD-10, 2) ICD-10

Fat.: 1) ICD-10, 2) ICD-10

Other: 1) ICD-10, 2) ICD-10

3. Who is the owner/administrator of the surveillance systems?

Hosp.: 1) Aldona Gaiauskieni, PhD, MD
Lithuanian Health Information Centre
Kalverijų st. 153, LT 2042 Vilnius
Lsic@lsic.lt

2) Mr. Sauliva Julius Janonis
State Patients Fund
Gerosios Viltus st. 1A, LT 2009 Vilnius
vlk@vlk.lt

Fat.: 1) Statistical Department
Gedimino av. 29, LT 2600 Vilnius
Statistika@mail.std.lt

2) Aldona Gaiauskieni, PhD, MD
Lithuanian Health Information Centre
Kalverijų st. 153, LT 2042 Vilnius
Lsic@lsic.lt

Other: 1) Mr. Vytautas Brurga
State Commission of Medical Social Ex.
Saltoniskuj st. 29/3, LT 2677 Vilnius
RIKTC@is.lt

2) Mr. Tomas Jovaisa
Poisoning Control and Information Office
Kalvarijų st. 153, LT 2042 Vilnius
jovaisa@tox.lt

4. For which settings the MDS-I could be useful in your country?

Hospital admissions, Fatalities, Other.

5. Do you see possibilities for implementation of the MDS-I within one or more setting? If yes, what is the most detailed MDS-I that can be implemented in each specific setting?


6. Do you expect difficulties for implementation of the MDS-I within one or more setting? If yes, which difficulties do you expect?

Yes, in all settings additional time and work expenditures, data grouping differences.

7. Are you willing to promote the MDS-I to relevant settings in your country?

Yes.
8. Which tools and information do you need to promote and implement the MDS-I in your country?
Power Point presentation, conversion tables, guidelines, Data Dictionary, coding form, other tools/information, like workshops on MDS-I for interested bodies and selected settings.
Malta
Dr. M.A. Borg
St. Luke’s Hospital
Infection.control@gov.mt

1. Which surveillance systems for collecting and recording data on injuries do already exist (and are running) in your country?
Fat.: National Mortality Register
Other: 1) Social Security, 2) Occupational Health and Safety Unit

2. Which classifications are being used in this surveillance system(s)?
ED: ICD-10
Fat: ICD-10
Other: 1) Other: NACE, 2) Unknown

3. Who is the owner/administrator of the surveillance systems?
Fat.: Dr. R. Pace Asciak
Other: 2) Dr. Mark Gauci
Health Information
95, G’Mangia Hill – G’Mangia MSD 08
renzo.pace-asciak@gov.mt
Occupational Health and Safety Unit
st. Ursola Street; Valletta
mark.gauci@gov.mt

4. For which settings the MDS-Is could be useful in your country?
Hospital admissions, Fatalities, ED departments.

5. Do you see possibilities for implementation of the MDS-Is within one or more setting? If yes, what is the most detailed MDS-I that can be implemented in each specific setting?
Yes, ED: MDS-I-2, MDS-I-3 partly.
In the ED the ED module has sufficient information to fulfil the requirements of level 2 and partly level 3 of MDS-I-3.

6. Do you expect difficulties for implementation of the MDS-I within one or more setting? If yes, which difficulties do you expect?
Yes, In general, problems likely to arise is getting doctors to enter clinical diagnosis.

7. Are you willing to promote the MDS-I to relevant settings in your country?
- 

8. Which tools and information do you need to promote and implement the MDS-I in your country?
Power Point presentation, guidelines, Data Dictionary, coding form, other tools/information, like finance is needed to promote and implement the MDS-I.
1. Which surveillance systems for collecting and recording data on injuries do already exist (and are running) in your country?

ED: 1) National Injury Register, 2) Oslo Injury Register
Fat.: Statistics Norway
Hosp.: Norwegian Patient Register
Other: About 20 General Practitioners

2. Which classifications are being used in this surveillance system(s)?

ED: 1) ICD-10, NOMESCO, 2) Norwegian Minimum Data Set
Hosp.: ICD-10
Fat.: ICD-10
Other: Norwegian Minimum Data Set

3. Who is the owner/administrator of the surveillance systems?

ED: 1) National Institute of Public Health 2) Oslo Municipality Public Health Authority
   PO Box 4404, Nydalen, 0403 Oslo Maridalsveien 3, 0178 Oslo
   Johns.wiik@folkehelsa.no kostas.vilimas@helsevernetaten.oslo.kommune.no

Fat.: Statistics Norway Hosp.: SINTEF Unimed Norsk Pasientregister
   PO Box 8131, Dep, 0033 Oslo Olav Kyrresgt. 3, NO-7465 Trondheim
   Finn.gjertsen@ssb.no npr@sintef.no

Other: Helge Lund Oslo municipality Public Health Authority
   General Practitioner Maridalsveien 3, 0178 Oslo
   NO-2550 Os i Osterdale kostas.vilimas@helsevernetaten.oslo.kommune.no
   Helge.lund@os.kommune.no

4. For which settings the MDS-Is could be useful in your country?

ED, Hospital admission, Fatalities, other.

5. Do you see possibilities for implementation of the MDS-Is within one or more setting? If yes, what is the most detailed MDS-I that can be implemented in each specific setting?

6. Do you expect difficulties for implementation of the MDS-I within one or more setting? If yes, which difficulties do you expect?

ED: MDS is running ok in Oslo due to having invested in information and quality control.
Hosp.: Data have now too low quality and completeness need resources for information, training and quality control.
Fat.: Need resources for improving data quality and completeness on death certificates.
Other: Need a standardised MDS in my country to be approved by health authorities in order to press the data system suppliers to equip their electronic medical journals with automatic screens for registering the data, screens which are activated when doctor puts an injury diagnosis into the journal.

7. Are you willing to promote the MDS-I to relevant settings in your country?

Yes.

8. Which tools and information do you need to promote and implement the MDS-I in your country?

Other tools/information, like 1) European recommendation that MDS is important and necessary to get statistics, 2) Necessary to convince authorities to invest in information, training and quality control, i.e. money!
1. Which surveillance systems for collecting and recording data on injuries do already exist (and are running) in your country?
ED, Hospital admission, Fatalities, other.

2. Which classifications are being used in this surveillance system(s)?
ED: ICD-10
Hosp.: ICD-10
Fat.: ICD-10
Other: ICD-10

3. Who is the owner/administrator of the surveillance systems?
ED: Mrs. Aleksandra Rypinska
Ministry of Health
PL 00-952 Warsaw, Miodowa str. 15
a.rypinska@mz.gov.pl
Hosp.: Dr. Pawel Gorynski
National Institute of Hygiene
PL 00-791 Warsaw, Chocimska str. 24
pawel@medstat.waw.pl

Other: Dr. Jerzy B. Karski
National Centre of Health Information Systems
PL 02-326 Warsaw, al. Jerozolimskie 155
j.karski@csioz.gov.pl

4. For which settings the MDS-Is could be useful in your country?
ED, Hospital admission, Fatalities, other.

5. Do you see possibilities for implementation of the MDS-Is within one or more setting? If yes, what is the most detailed MDS-I that can be implemented in each specific setting?

6. Do you expect difficulties for implementation of the MDS-I within one or more setting? If yes, which difficulties do you expect?
Yes, in all settings administrative difficulties.

7. Are you willing to promote the MDS-I to relevant settings in your country?
Yes.

8. Which tools and information do you need to promote and implement the MDS-I in your country?
Power Point presentation, guidelines, other tools/information, like updated information sets.
1. Which surveillance systems for collecting and recording data on injuries do already exist (and are running) in your country?
Hospital admissions.

2. Which classifications are being used in this surveillance system(s)?
Hosp.: 1) ICD-9.

3. Who is the owner/administrator of the surveillance systems?
Direcção-Geral da Saúde

4. For which settings the MDS-Is could be useful in your country?
Hospital admissions.

5. Do you see possibilities for implementation of the MDS-Is within one or more setting? If yes, what is the most detailed MDS-I that can be implemented in each specific setting?
Yes, Hosp.: MDS-I-3.

6. Do you expect difficulties for implementation of the MDS-I within one or more setting? If yes, which difficulties do you expect?
Hosp.: Yes, to fulfill correctness the registries.

7. Are you willing to promote the MDS-I to relevant settings in your country?
Yes.

8. Which tools and information do you need to promote and implement the MDS-I in your country?
Power Point presentation, conversion tables, guidelines, Data Dictionary, coding form.
Spain
Margarita Garcia Ferruelo
National Institute of Statistics
Ferruelo@ine.es

1. Which surveillance systems for collecting and recording data on injuries do already exist (and are running) in your country?
Fat.: Mortality Register

2. Which classifications are being used in this surveillance system(s)?
Fat.: ICD-10

3. Who is the owner/administrator of the surveillance systems?
Fat.: Margarita Garcia Ferruelo
National Institute of Statistics
Paseo Castellana 183, Despacho 801
Ferruelo@ine.es

4. For which settings the MDS-Is could be useful in your country?
-

5. Do you see possibilities for implementation of the MDS-Is within one or more setting? If yes, what is the most detailed MDS-I that can be implemented in each specific setting?
Fat.: No, in mortality data the nature of injury and body part injured are not available.

6. Do you expect difficulties for implementation of the MDS-I within one or more setting? If yes, which difficulties do you expect?
-

7. Are you willing to promote the MDS-I to relevant settings in your country?
-

8. Which tools and information do you need to promote and implement the MDS-I in your country?
-
Sweden
Henrik Nordin
Swedish Consumer Agency
Henrik.nordin@konsumentverket.se

1. Which surveillance systems for collecting and recording data on injuries do already exist (and are running) in your country?
ED: EHLASS extended.

2. Which classifications are being used in this surveillance system(s)?
ED: EHLASS 96.

Who is the owner/administrator of the surveillance systems?
ED: Mr. Anders Aberg
National Board of Health and Welfare
Centre for Epidemiology

4. For which settings the MDS-Is could be useful in your country?
ED.

5. Do you see possibilities for implementation of the MDS-Is within one or more setting? If yes, what is the most detailed MDS-I that can be implemented in each specific setting?
No, because the Swedish Consumer Agency is a user, not a supplier, of injury data.

6. Do you expect difficulties for implementation of the MDS-I within one or more setting? If yes, which difficulties do you expect?
-

7. Are you willing to promote the MDS-I to relevant settings in your country?
No.

8. Which tools and information do you need to promote and implement the MDS-I in your country?
-
Sweden
Anders Aberg
Centre for Epidemiology, National Board of Health and Welfare
Anders.aberg@sos.se

1. Which surveillance systems for collecting and recording data on injuries do already exist (and are running) in your country?
ED: EHLASS extended,
Hosp.: 1) Hospital Discharge Register, 2) Outpatient Registry
Fat.: Cause of Death Register

2. Which classifications are being used in this surveillance system(s)?
ED: EHLASS 96, NOMESCO
Hosp.: 1) ICD-10, 2) ICD-10
Fat.: ICD-10

Who is the owner/administrator of the surveillance systems?
ED: Centre for Epidemiology
National Board of Health and Welfare
Anders.aberg@sos.se

Hosp.: 1) Curt-Lennart Spetz
National Board of Health and Welfare
SE-10630 Stockholm
Curt-lennart.spetz@sos.se
2) Mr. Anders Aberg
National Board of Health and Welfare
SE-10630 Stockholm
Anders.aberg@sos.se

Fat.: Annika Edberg (Cause of Death registry)
National Board of Health and Welfare
SE-10630 Stockholm
Annika.edberg@sos.se
Mr. Anders Aberg
National Board of Health and Welfare
SE-10630 Stockholm
Anders.aberg@sos.se

4. For which settings the MDS-Is could be useful in your country?
-

5. Do you see possibilities for implementation of the MDS-Is within one or more setting? If yes, what is the most detailed MDS-I that can be implemented in each specific setting?
No, because injury data already are recorded on the most detailed level. This means that we don’t intend to implement MDS-Is as a tool for registration. MDS-Is could however be used for analyses and as a report format.

6. Do you expect difficulties for implementation of the MDS-I within one or more setting? If yes, which difficulties do you expect?
-
7. Are you willing to promote the MDS-I to relevant settings in your country?
No.

8. Which tools and information do you need to promote and implement the MDS-I in your country?
-
1. Which surveillance systems for collecting and recording data on injuries do already exist (and are running) in your country?
ED: 1) AWISS, 2) HASS, 3) LASS
Hosp.: HADD
Fat.: 1) Patient Episode Database for Wales, 2) Hospital Episode Statistics
Other: 1) Welsh Health Survey, 2) General Practice Morbidity Database for Wales, 3) Health Survey for England

2. Which classifications are being used in this surveillance system(s)?
ED: 1) Local, 2) Local, 3) Local
Hosp.: -
Fat.: 1) ICD-10, 2) ICD-10
Other: -

3. Who is the owner/administrator of the surveillance systems?
ED: 1) University of Wales 2) UK department of Trade and Industry
    Singleton Park, Swansea SA2 8PP, Wales 3) UK department of Trade and Industry
    r.a.lyons@swansea.ac.uk
Fat.: 1) National Assembly for Wales 2) National Board of Health and Welfare
Hosp.: Office for National Statistics Other: National Assembly for Wales

4. For which settings the MDS-Is could be useful in your country?
Hospital admissions, ED, Fatalities.

5. Do you see possibilities for implementation of the MDS-Is within one or more setting? If yes, what is the most detailed MDS-I that can be implemented in each specific setting?

6. Do you expect difficulties for implementation of the MDS-I within one or more setting? If yes, which difficulties do you expect?
Yes, ED: x Two issues - one is current threat to database existence due to confidentiality regulation changes and the other is that some resource will be required to carry out the recording.

7. Are you willing to promote the MDS-I to relevant settings in your country?
Yes, am doing so.

8. Which tools and information do you need to promote and implement the MDS-I in your country?
-
Annex 4

Minutes of the meeting of the reference group

4 & 5 November 2002, Amsterdam

Present: Delia Alexe, Athens University; Medical School; Robert Bauer, Austrian Institute of Home and Leisure Safety; Rieneke Dekker, Consumer Safety Institute; Gabriele Ellsaesser, Landesgesundheitsamt für Soziales und Versorgung; Birthe Frimodt-Møller, National Institute of Public Health; Juanita Haagsma, Consumer Safety Institute; Jeanet Kemmeren, Consumer Safety Institute; Johan Lund, Norwegian Safety Forum; Ronan Lyons, University of Wales; Saakje Mulder, Consumer Safety Institute (chair)
Absent: -

1. Welcome
Saakje welcomes everyone to the meeting. Saakje gives a short presentation of the objectives of the project and its current status.

2. Results of the questionnaire about the implementation of the MDS-Is
   General remarks:
   - Information about injury surveillance systems should be limited to general health care settings. Sectoral systems like statistics on traffic accidents or occupational accidents will not be included. CSI will make a distinction between these types of settings in the tables.
   - Health surveys should be included in table 1 and table 2 of annex 2a.
   - We should be careful when interpreting the results because the level of information in the questionnaires differs per country and per respondent (hopes versus realistic answers).

2a. Overview of the results
   Objective: to get additional information, to fill gaps in the tables including an overview of injury surveillance systems and of the contactpersons of these injury surveillance systems.

   - Austria: no additions.
   - Belgium: no information available about fatalities and ED attendances.
   - Denmark: there is no centralised system for injury surveillance by GPs. A pilot study has started with MDS-I in GP injury surveillance. There is a Health Survey in Denmark, by the National Institute of Public Health.
   - Estonia: the classification of injury surveillance by GPs should be ICD-10 in stead of ICPC.
   - Finland: no information available about hospital admissions.
   - France: no response.
   - Germany: German Health Survey of the Robert Koch Institute. Survey on home and leisure injuries (instead of accidents). There is no central surveillance system on ED attendances and on GP attendances.
   - Greece: no additions.
   - Hungary: no additions.
   - Ireland: no additions.
- Italy: no additions.
- Lithuania: no information available about ED attendances. Poisoning Surveillance system will be removed from the table.
- Luxembourg: no additions.
- Malta: no information available about hospital admissions.
- The Netherlands: is missing in the table and will be included.
- Norway: no funding for ED injury surveillance system, therefore the future of National Injury System is unclear. There is a Health Survey in Norway, by Statistics Norway.
- Poland: not clear who is responsible for the mortality register.
- Portugal: no information available about fatalities. Not clear who is responsible for the hospital discharge register.
- Spain: no additions.
- Sweden: no additions.
- UK:
  - Wales, England, Scotland & North-Ireland: HASS, LASS (ED attendances)
  - Wales & England: HES (Hospital admissions)
  - Wales: AWISS (ED attendances), Patient Episode Database for Wales (hospital admissions), HADD (fatalities).
  - Scotland: no information available about hospital admissions and fatalities.
  - North-Ireland: no information available about hospital admissions and fatalities.

2b. Overview of contact persons who did not respond

Objective: to decide if further actions are necessary to increase the response.

For additional information on health care settings the following persons per country will be contacted:
- Belgium: we will contact Peter Hooft again about fatalities and ED attendances.
- Czech Republic: we will contact Michal Grivna again.
- Finland: we will contact Anne Lounamaa (National Research & Development Centre for Welfare and Health).
- France: we will contact Bertrand Thélot (Institut de Veille Sanitaire).
- Luxembourg: we will contact Jolande Wagener again for the missing information.
- Malta: we will contact Mariella Borg again about the hospital admissions.
- Portugal: we will contact Jose Alexandre Dinez from the Ministry of Health, he is a new member of the IPP network.
- Rumania: Delia will provide us with a name of a contactperson.

Ronan will provide CSI with names of contactpersons in Scotland and Northern Ireland.
The list of countries should be completed with all EU applicant-countries and Turkey according to the Public Health Programme.
Birthe will provide a list of contact persons for the EU applicant-countries and Turkey.

3. Starters kit

3a. Conversion tables MDS-I and ICD-9

Objective: to get agreement on the conversion tables.
In the conversion tables (annex 3a) several ICD-9 codes appear more than once in a table. To ensure uniformity, these codes are studied and put in the category in which they belong or the category in which they are decided to be by the reference group.

*Place (level 1):*
The 4th digit .5 appears twice in the table. This is a typing error.

*Place (level 2):*
You can not make the conversion from MDS-I to the second level of the Place data element. This table will be deleted.

*Vehicle involvement:*
E818, E825 -> Vehicle Involvement (1)
E806 (decision), E829 (decision) -> Unknown (9)

*Mechanism:*
E9068 (decision) -> Piercing or penetrating force (20)
E9249 (decision) -> Contact with hot liquid/gas/object (31)
E817 (decision), E824 (decision), E958 (decision), E9880 (decision) -> Unknown mechanism (99)

*Mode of transport of injured person:*
The conversion can only be made if the 4th digit is registered.

*Counterpart:*
The conversion can only be made when the 4th digit is registered.

*Nature of Injury:*
959 -> Unknown nature of injury (999)

*Body part injured (level 1):*
- The late effects (905-909) and complications of medical treatment (996-999) will be excluded from the conversion.
- We will also make a conversion table with the 3 digit ICD-9 codes.
- Pharynx should be included in the head (1) not in the neck (2). In de data dictionary of the MDS-I this should be adjusted.
9470 (decision) -> Head (1)
9471 -> Multiple body parts (7)
9008, 9009, 910, 920, 925, 941(decision), 9570 (decision), 9590 (decision), 9351 (decision) -> Body part, other and unknown (9)
9060, 9065, 9083, 9051 (late effects and complications) -> excluded

*Body part injured (level 2):*
- We will write out all the 4 digit ICD-9 codes.
8470 (decision) -> Cervical spine (21)
8740 -> Neck (29)
3b. Report Guidelines

Objective: to get agreement on the report guidelines.

- The main objective of the report guidelines is the European comparison. It can also be used for prevention and policy making.

- The reporting format should be comparable to the WHO (EUPHIN) reporting format.
- If possible there should also be population-based data (at least the age and sex distribution) in the reporting tables, so rates can be compared between countries.
- Basic information about quality of data should be added to the reporting guidelines (we will see if the quality indicators used in the Eurocost project can be used here).
- There should be separate reporting tables for MDS-I-1, MDS-I-2, MDS-I-3, MDS-I-4 and MDS-I-5 (in this order).
- There are different ways of presenting figures in tables: we prefer rates, but it can also be extrapolated numbers and if you cannot extrapolate you can use actual numbers. It should always be clear which numbers are presented in a table.
- A frequency table with all the age groups (as recommended in the data dictionary) will be added.
- In the crosstabs the age groups will be changed to: 0-14 yrs, 15-64 yrs and 65 yrs and older.
- In the recommendations it should be reported which patients are included in the analysis.
- The reporting tables 3a, 3b, 4a, 4b, 8a and 8b can be deleted from the reporting guidelines. A frequency table of ‘residency’ will be added.
- After table 5b a table or figure will be added with the different types of accidents (home and leisure, traffic, occupational, sports). Here after a couple of tables for the separate types of accidents will be added.
- The following crosstabs will be added: activity x place, counterpart x mode of transport injured person, type of injury x intent, type of lesion x body part.

3c. Manual concerning introduction MDS-Is

Objective: to decide upon the contents of the manual.

- It should be recommended in the final report to check whether the conversion tables can be provided electronically (in Excel/Access).
- In the introduction it will be stated that there is a certain flexibility in the use of the different MDS-Is. For example if a country can only record MDS-I-1, but they do have information about a data element in another MDS-I, they can record this information.
- In the introduction it will be made clear what the possibilities are for the different MDS-I-s. For example: if you record intent you can differentiate between accidents and non-accidents. If you record activity, place and vehicle involvement you can differentiate between the different types of accidents.
- The manual should not only be available on cd-rom but also on the internet.
- Table 2.2 in the data dictionary is not clear. The differences between the MDS-Is should be made ‘bold’.
- Discussion raised whether body part injured should be included in MDS-I level 1. Because all health care settings have information about body part injured, it should be included in MDS-I level 1.
- We should give short guidelines to people who want to use the MDS-Is in surveys.

3d. Contents of starters kit
*Objective: to decide upon the contents of the starters kit.*

This agenda item is discussed together with agenda item 4.

4. Extra wishes
*Objective: to brainstorm about usefulness of the tools that respondents mentioned in the questionnaire.*

- Several countries would like workshops about implementing MDS-I, including the East European countries. We cannot put a concept for a workshop in the starterskit, but we can give some recommendations on topics that should be covered. Saakje is working on a workshop for the Eastern European countries.
- For countries which start with setting up surveillance systems the reference group could function as an advisory board.
- It should be clearly stated in the introduction that the MDS-I is not a replacement of the existing injury surveillance system (EHLASS). The differences will be named and the advantages of both systems will be clarified.
- The promotion of the MDS-I should especially be directed to the EU applicant-countries.
- Several countries would like a formal recommendation from the EC in order to be sure about the status of the MDS-Is. We will recommend that a EC statement on the MDS-Is is important.
- Quality control: we will add a few tables to the report guidelines as a quality check, to see if the data is reliable.
- It is too early to write a promotion leaflet, also because it is not clear who the target group is. We will, however, give a brief summary on what the MDS-Is are about.
5. Promotion plans

5a. Short presentations of the (short-term) promotion plans by each member of the reference group.

Objective: to learn about the plans that each of you have and to learn from each other’s (expected and encountered) difficulties.

Any additions that came from the presentations will be to annex 5a.

Summary of recommendations for the promotion of the MDS-Is:
- Address relevant bodies/persons (for example the Society of Traumatologists or injury surgeons).
- Share experiences with promotion by means of a network.
- There should be bottom-up promotion as well as top-down promotion.
- Use local as well as national promotion to put injuries higher on the agenda.
- Join forces with other relevant organisations.
- Use results as soon as we get them, do not wait for perfection.

5b. Long term promotion plan

Objective: to discuss and brainstorm about the following items:
- maintenance of the MDS-Is (organisation, finance)
- data collection and analysis

We came up with some items to be included in the long-term promotion plan:
- Form a group of people for the maintenance of the MDS-Is, preferably linked to another coordinating body. The group should act low profile, but some budget is needed for an annual meeting. We might be able to join forces with the EHLASS maintenance group.
- Create national taskforces with experts, who can train staff and promote the MDS-Is. The organisation of such task forces can differ per country. On the internet you can find English task force reports: www.doh.gov.uk/accidents/.
- Create a network on European level for sharing experiences.
- Publish results of international comparisons.
- Contact politicians in the European Parliament.
- Promote MDS-I at international European conferences, for example the annual meeting of European Public Health organisations, or conferences where doctors or health administrators are present.
- Promote MDS-I at the World Conference in Vienna in 2004. There should be a round table discussion or business meeting about MDS-I at the World Conference, so experiences can be shared.
- Make strategic plans: how do we see data collection in the next 10 years.
- Keep filling the gaps in the overview of injury surveillance systems in the applicant countries.
- Write a proposal for EU Health Programme.
- Organise workshops for the EU candidate-countries.
- Develop promotion materials for use in for example stands.
6. Final report

6a. Contents
Objective: to decide upon the contents of the two reports.

Add the short-term promotion plans to the final report.

6b. Authors
Objective 1: to decide upon the authorship of the final reports.  
Objective 2: to decide upon the authorship of publications.

The members of the reference group should be listed alphabetically on the country names.

7. Future actions
Objective: discussion on the future activities.

Future actions of the project team:
- Make a report of the meeting.
- Finalise the overview of the injury surveillance systems, adding new information from the reference group.
- Readjust the reporting guidelines.
- Readjust the conversion tables.
- Write a long-term promotion plan.
- Make a time schedule for the coming months.
- Finalise the reports.

Future actions of the reference group:
- Delia: provide the project team with a name of a contactperson in Romania and Cyprus.
- Birthe: provide project team with a list of names of contactpersons in the applicant countries.
- Ronan: provide project team with names of contactpersons in Scotland and Northern Ireland.
- Ronan: make a decision about the elbow.
- All: comment the drafts sent to you by the project team
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