training for health care and social care staff. When IT-professionals and computer and mobile phone service staff identify the phenomenon of domestic violence and technological-facilitated stalking, better service and more privacy is enabled for the victims.

42 WOUNDED INTEGRITIES: FINNISH WOMEN'S AND CHILDREN'S EXPERIENCES OF POST-SEPARATION STALKING

Anna Nikupeteri, Merja Laitinen. University of Lapland, Finland

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Background In this study, we examined the under-researched area of Finnish women's and children's experiences of post-separation stalking to learn how they experience it in their everyday lives and the impact it has on their wellbeing. In particular, we looked at how post-separation stalking threatens women's and children's integrity and how it should be acknowledged in the prevention of stalking and the promotion of victims' safety.

Methods The data consist of narratives of 20 Finnish women and 13 children who were exposed to post-separation stalking. The women were interviewed individually. The data was collected from children through therapeutic group sessions, thematic interviews and one mother-and-child therapy session.

Results Although women/mothers are the main targets of stalking, it also threatens children's wellbeing. The latter are used to carry out stalking, as targets of revenge or as abused informants. The data analysis shows that stalking threatens women and children's integrity socially, psychologically, emotionally, physically, ontologically and morally. As a consequence of these different dimensions of wounding, women's and children's safety and security are severely threatened. Wounded integrity reflects on victims' identities, social relations and everyday activities and is visible in help-seeking processes. Wounded integrity takes on different meanings in the aspects of wellbeing, safety and security.

Conclusions The findings highlight the need for professionals in social and health services, law enforcement and criminal justice to consider the different dimension of how stalking wounds women's and children's integrity. Taking these different dimensions of wounding into account will enable the implementation of more effective means to prevent post-separation stalking and promote victims' safety, security and wellbeing.

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43 ICECI: INJURY SURVEILLANCE IN SOUTH AFRICA

Richard Matzopoulos. University of Cape School of Public Health/South African Medical Research Council Burden of Disease Research Unit

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Background South Africa is a middle income country with large disparities in wealth and has one of the world's highest rates of injury mortality; more than half are from intentional injuries, particularly violence a major problem in the Western Cape Province.

Injuries claim 450 lives each month. Homicide was the third leading contributor to premature mortality in 2010.

Description of the problem Reliable mortality and morbidity data are vital for estimating Burden of Disease accurately and directing resources for injury prevention and control. This poses a particular challenge in low-income countries, which experience high rates of injury, particularly if these injuries are concentrated at peak times, overwhelming emergency treatment centres and displacing patients seeking treatment for other conditions.

Results The Western Cape has implemented a province-wide mortality surveillance system, the Provincial Injury Mortality Surveillance System that provides complete coverage of injury-related deaths. There are several trauma registries in tertiary hospitals and intermittent cross-sectional studies in all facilities serving selected high-risk areas.

This overview describes methodological aspects, including the use of separate coding axes for key variables akin to an ICECI structure, which simplifies data capture, before data are coded to either ICD-10 or Burden of Disease categories.

The results demonstrate the utility of the surveillance data in identifying high-risk areas and groups at-risk. Data collection has been co-ordinated by the Health Department in collaboration with injury prevention researchers and the institutionalisation of all except the mortality component represents a key challenge for ongoing surveillance.

Conclusions The data have been instrumental in providing ongoing burden of disease estimates for the province and complementing national burden of disease studies, evaluating interventions such as alcohol and gun control, and influencing prevention and interpersonal violence and alcohol harm reduction policies.

44 INJURY AND EXTERNAL CAUSES IN THE 11TH REVISION OF THE INTERNATIONAL CLASSIFICATION OF DISEASES

¹James Harrison, ²Kirsten Vallmuur. ¹Flinders University, Australia; ²Queensland University of Technology, Australia

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Background The International Classification of Diseases (ICD) is the most widely used classification of injuries and their external causes, particularly in vital registers of deaths and systems to report on cases admitted to hospitals. The ICD has been revised 10 times, most recently in the late 1980s. The World Health Organisation (WHO) is conducting the 11th revision.

Description of the problem Potential reasons to revise the classification include: the emergence of new knowledge; changing priorities and conceptualization of injuries and external causes; and matters unresolved in earlier revisions. National clinical modifications of earlier revisions (ICD-9 and ICD-10) have developed numerous, useful but sometimes non-comparable extensions to the international version. Dissatisfaction with aspects of the ICD external causes chapter prompted development of the International Classification of External Causes of Injuries (ICECI) and the revision provides an opportunity to integrate the ICECI with a new edition of the ICD.

Results In the first phase of the revision, advice was provided to the WHO on proposed changes, largely by Topic Advisory Groups, one of which has focused on the injury and external causes chapters. Also, the ICD was converted from a manually-curated list to a formal database of numerous potentially codeable entities, from which well-specified versions of ICD-11 (called 'linearizations') can be derived for particular purposes. In

the second phase of revision, linearizations are being developed, with highest priority being given to the Joint Linearization for Mortality and Morbidity Statistics (JLMMS). A special linearization based on ICECI is envisaged.

Conclusions The form and content of the JLMMS are still in flux, but are expected to be in largely final draft by mid-2016. Injury researchers need to be aware of the forthcoming changes to the ICD, which will impact on injury statistics worldwide.

45 TRAUMA CARE EVALUATION

^{1,2}Belinda Gabbe. ¹Monash University, Australia; ²Swansea University, UK

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Background While the global burden continues to rise, injury-related mortality rates have declined in many high-income countries. A key contributor to reduced mortality has been implementation of trauma systems with improved care of injured patients substantially enhancing the likelihood of surviving serious injury. The focus has now shifted to improving the quality of survival and reducing the burden of non-fatal injury. However, there is limited understanding of how well patients recover, how long this takes, and the proportion of the injured population who go on to experience lifelong disability.

Methods The state of Victoria, Australia, using the population-based Victorian State Trauma Registry as a data spine, is using coordinated data linkage, longitudinal qualitative studies, and routine long-term patient follow-up to evaluate trauma care through acute care, rehabilitation and community reintegration.

Results Key findings include: i) demonstrated reduced burden, measured in Disability Adjusted Life Years, of road traffic injury following implementation of an organised trauma system; ii) improved mortality and functional outcomes for patients following redesign of the state's retrieval system; iii) improvement in patient-reported outcomes to 2-years post-injury but variable recovery trajectories for key patient groups; and iv) profound issues with discharge planning, and post-discharge care coordination of trauma patients.

Conclusions Clinical data represents only a component of what we need to know to understand the impact of clinical practice and healthcare policy in trauma. Insight into patient experiences and pathways, healthcare and disability service needs, and factors that facilitate and impede recovery are needed to improve trauma system design and better meet the needs of injured patients.

46 THE NATIONAL EMERGENCY MEDICAL SERVICES INFORMATION SYSTEM (NEMSIS): PREHOSPITAL CARE DATA ON INJURY

¹Holly Hedegaard. ²N Clay Mann. ¹Centers for Disease Control and Prevention National Centre for Health Statistics, USA; ²University of Utah, USA

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Background The National Emergency Medical Services Information System (NEMSIS) is the repository for data on emergency medical services (EMS) in the United States (US). Standard data elements are collected by local EMS providers, then aggregated at the state level and submitted to the national database. Data from NEMSIS are used to evaluate care delivery, compare regional differences, inform EMS provider training and generate research hypotheses.

Methods Data were accessed using the NEMSIS on-line data cube. Nearly 25.5 million patient care reports were submitted in 2014. The subset of injury events were selected using Type of service = 911 response and Possible injury = Yes.

Results More than 3.3 million records for possible injury events were reported in 2014, with 50% involving females and with 13% involving patients aged 0–19, 50% aged 20–59 and 36% aged 60+. Cause of injury was reported for 72%. Of events with a known cause, falls accounted for 46%, land transport 33%, struck by blunt object 11% and drug poisoning 4%. Age and sex distribution varied by cause of injury. Treatment was provided in 85% of events. Procedures were reported as being performed on 60% of patients. Common procedures included venous access (33%), spinal immobilisation (28%), cardiac monitoring (21%), pulse oximetry (20%), wound care (14%) and splinting (6%). Medications were reported as being given to 19% of patients. For those receiving medications, the most common medications were fentanyl (17%), morphine (10%), ondansetron (10%) and naloxone (2%). Nearly 90% of the treated patients were transported from the scene to a facility.

Conclusions Analysis of NEMSIS data provides insight into the provision of EMS care to injured patients in the US. This data system may serve as a model for other countries in how to capture standard information from prehospital providers. Continued efforts to improve completeness of reporting will enhance the utility of these data for injury research.

47 DISABILITY WEIGHTS FROM THE INJURY VIBES COLLABORATION

^{1,2}Ronan A Lyons, ²Belinda J Gabbe, ²Pam M Simpson, ³James E Harrison, ⁴Shanthi Ameratunga, ⁵Sarah Derrett, ⁶Suzanne Polinder, ⁷Frederick P Rivara. ¹Farr Institute, Swansea University Medical School, UK; ²Department of Epidemiology and Preventive Medicine, Monash University, Melbourne, Australia; ³Research Centre for Injury Studies, Flinders University, Adelaide, South Australia; ⁴Section of Epidemiology and Biostatistics, School of Population Health, University of Auckland, Auckland, New Zealand; ⁵Injury Prevention Research Unit, Department of Preventive and Social Medicine, Dunedin School of Medicine, University of Otago, Dunedin, New Zealand; ⁶Department of Public Health, Erasmus MC, Rotterdam, The Netherlands; ⁷Departments of Paediatrics and Epidemiology, University of Washington, Seattle, USA

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Background Disability weights (DWs) are an integral part of deriving the years lived with disability (YLD) component of disability adjusted life years (DALYs). DWs can be derived through different methods including panels comprising of experts, the general population judging the impact of conditions on loss of health, or through follow-up data on the health-related quality of life of groups of injured patients. The Validating and Improving injury Burden Estimates Study (Injury-VIBES) sought to create new injury DWs by combining data from six of the largest injury outcome studies, that were conducted in Australia, New Zealand, United Kingdom, Netherlands and USA.

Methods Data were combined in an individual level meta-analysis from the Victorian State Trauma Registry, Victorian Orthopaedic Trauma Outcomes Registry, Dutch Injury Patient Survey, UK Burden of Injury Study, Prospective Outcomes of Injury Study, and the National Study on Costs and Outcomes of Trauma. DWs were calculated for individual and grouped ICD10 diagnosis codes and established nature of injury classifications. Twelve month annualised DWs (assumed to be indicative of permanent health loss) were calculated separately for cases discharged