Response to the Australian Commission for Safety and Quality in Health Care on the

‘Australian Safety and Quality Goals for Health Care – Consultation Paper’

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Compiled by the Australian Trauma Quality Improvement Program (AusTQIP)

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- Queensland Trauma Registry
- South Australian Trauma Registry
- Victorian State Trauma Registry

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Executive Summary

Traumatic injury is a significant public health problem in Australia - it is a major cause of death and disability, it particularly affects young people, and many survivors have long-lasting disabilities. It has huge human, social and economic costs - the annual health care costs (more than $3.4 billion) outweigh cardiovascular disease ($2.2 billion) and type 2 diabetes ($989 million) combined.¹

Care of the severely injured presents a unique combination of characteristics:

- needing time-critical care
- occurring often in rural or regional areas and after hours
- necessitating transfer between facilities
- presenting diagnostic uncertainty
- requiring immediate and timely involvement of many disciplines
- involving complex hospital stays and multiple interventions, and
- leading to often prolonged rehabilitation, without certainty of full recovery.

More than any other condition, traumatic injury relies on integrated systems of care to allow the best chance of survival and recovery. These systems inevitably involve a range of Commonwealth, state and private sector funded providers. Such systems are complex, and present many possibilities for poor performance.

Australia has internationally-recognised expertise in trauma care and trauma system development, especially in Victoria, but as a nation continues to face major challenges in developing and sustaining high quality trauma systems.

In recognition of these difficulties and the need to share experiences and lessons about what works, to base improvement activities on meaningful comparisons of performance, and to move towards sustainable high quality trauma systems for injured people everywhere in Australia, all of Australia’s 26 designated trauma centres and 4 established state-based trauma registries in 2011 joined in partnership to develop an Australian Trauma Quality Improvement Program (AusTQIP) underpinned by an Australian Trauma Registry (ATR). The ATR will enable benchmarking between centres in different states, which is otherwise impossible using state or institution-based registries alone, and which is essential for understanding the causes of good and poor performance.

There currently exists an opportunity for the Australian Commission for Safety and Quality in Health Care (ACSQHC) to:

1. help to substantially improve the quality of trauma care received by injured Australians
2. promote better trauma systems through focus on quality and integration of systems which is not well covered elsewhere in the Goals, and
3. capitalise on an established partnership between major centres with history of quality improvement activities and a commitment to a national undertaking.

In light of the importance of traumatic injury to Australians, the need to promote national support for trauma system improvement, and the potential for the ACQSHC to promote a valuable aspect of quality and ultimately achieve these goals in the foreseeable future, we recommend ‘people sustaining serious injury’ is included as a third priority area for ‘Goal 2 - Appropriateness of care.’
Introduction

The Australian Trauma Quality Improvement Program (AusTQIP) is a collaboration of Australia’s 26 major trauma centres (MTCs) and 4 established state trauma registries, supported by the National Trauma Research Institute (NTRI) and the National Critical Care and Trauma Response Centre (NCCTRC). AusTQIP congratulates the Australian Commission for Safety and Quality in Health Care (ACSQHC) on a robust body of work and thank them for the opportunity to respond and contribute to the ‘Australian Safety and Quality Goals for Health Care – Consultation Paper’. We are confident that the following response adds strong support to achieving the objective of developing safety and quality goals for Australian health care (the Goals).

This submission is a response to the 2nd consultation question - ‘Do you agree with the topics that have been included as Goals and priority areas? Are there other areas that should be considered?’

Under ‘Goal 2 – Appropriateness of care’, we recommend a third priority area – people sustaining serious injury.

Australia has internationally-recognised expertise in trauma care and trauma system development, especially in Victoria, but as a nation continues to face major challenges in developing and sustaining high quality trauma systems.

State- and territory-based trauma systems operate at varying levels of maturity and all have seen a steady rise in demand for trauma services due to population growth and improvements in pre-hospital trauma triage and transport.2–6

Within this context, the vision that saw the establishment of AusTQIP was based on three premises:

1. The need for strong investment in safety and quality systems in trauma is important to manage the high degree of risk, contain the cost of providing care and ultimately to improve the outcome and quality of life for injured patients.

2. There is a growing impetus to combine trauma data and use it to collaborate more effectively in trauma quality improvement.

3. The establishment of a sustainable national clinical quality register for trauma has been revived in response to ever increasing demands for trauma services and the concurrent need for trauma systems improvement in Australia.

Support provided by the NTRI means that AusTQIP is linked to the Monash University School of Population Health and Preventative Medicine; the Institute of Safety, Compensation and Recovery Research; Australia’s busiest trauma centre, The Alfred; and a wide network of international collaborators.

Support provided by the NCCTRC means that AusTQIP has direct links to disaster response networks in Australia and the Asia-Pacific region.
Recommendation for a third priority area under Goal 2 – ‘Appropriateness of care’

The initial priority areas listed under ‘Goal 2 – Appropriateness of care’ are limited and do not reflect the relative cost of traumatic injury, its burden of disease, and the impact on the injured and their families. To ensure traumatic injury is appropriately addressed at a national level, we recommend ‘people sustaining serious injury’ is included as a third priority area for this Goal. Our supporting information follows.

Impact on the health system

Burden of disease

Traumatic injury is the leading cause of death in people under 45, a leading cause of morbidity, mortality and permanent disability, and a major source of health costs in Australia. Approximately 27 people die as a result of injury every day – almost 10,000 lives are lost each year.\(^1\)

With almost 426,000 hospitalisations due to injury in 2007-08, trauma accounted for 1 in 20 admissions to hospitals – on average, over 1000 injured people are admitted to hospital every 24 hours.\(^5\)

Each year over 1000 Australians sustain a severe traumatic brain injury, 136 become quadriplegic and another 137 are left paraplegic.\(^8\) The Survey of Disability, Ageing and Carers reported that injuries were the reason for nearly 1 in 10 of all physical disabilities.\(^9\) Over 96,000 Australians report having a disability due to diabetes. By comparison, 600,000 are living with a disability due to traumatic injury. Of these 10% had a profound limitation of core-activity (communication, mobility and self care), 28% had a mild core-activity limitation and nearly half (45%) reported having a schooling or employment restriction.\(^9\)

Overall, traumatic injury accounts for 7% of the burden of disease in Australia.\(^10\) However, a third of Australia’s population live in regional and remote areas in which traumatic injury is the greatest cause of disease burden (29.1% for intentional and unintentional injury combined, followed by diabetes 19.5%, and cardiovascular disease 9.1%).\(^10\)

The status of trauma as a leading burden of disease in Australia has driven the development of injury prevention and control programs which have been a National Health Priority Area since 1996, and trauma is the subject of three national prevention plans: the National Injury Prevention and Safety Promotion Plan: 2004-2014\(^11\); the National Falls Prevention for Older People Plan: 2004 Onwards\(^12\); and the National Aboriginal and Torres Strait Islander Safety Promotion Strategy.\(^13\) While injury surveillance is essential, implementation of the majority of these plans is yet to be realised.\(^14\)

Cost to the health care system

The annual cost for traumatic injury related health care in Australia exceeds $3.4 billion, over 7% of total health costs, and it is likely these costs are underestimated.\(^15,16\) This outweighs cardiovascular disease ($2.2 billion) and type 2 diabetes ($989 million) combined.\(^1\)

The cost of traumatic injury is not limited to the health system alone. The annual cost of traumatic injury to the Australian economy has been estimated to be $18 billion.\(^3\) For the more than 1220
people who suffer traumatic brain or spinal cord injuries in Australia every year, the overall cost (including health care, equipment and life-time care) exceeds $3 billion per year. The disproportionate impact on younger people means that traumatic injury is also the leading cause of loss of economically productive years of life.¹

**Significant safety and quality problems**

Trauma systems and approaches to their development, management and quality improvement vary widely by state and territory. Quality and safety activities are largely restricted to the efforts of individual organisations or trauma services. This leads to significant limitations:

1. Evidence-based approaches to trauma care save lives.¹⁸⁻²⁰ The Victorian State Trauma System, an international leader, has halved the odds of dying after serious injury since its inception in 2001, and the odds of good functional outcomes have increased.⁵⁰ Other states and territories have not yet reaped such benefits. For most, geographic and service organisation differences, and data and reporting limitations have thus far hindered the effective use of data to improve care quality, and the ability to capitalise on the Victorian experience in states that face a range of other challenges.

2. There is currently no formal system of performance benchmarking and sharing of information amongst Australia’s 26 MTCs.

3. Attention to quality and safety issues in trauma varies between MTCs.

4. Trauma quality improvement efforts often occur in relative isolation, due in part to Australia’s geographically disparate population combined with local resource limitations. A recent audit of trauma quality systems in MTCs revealed significant duplication of trauma quality improvement efforts.¹⁷ Substantial potential exists to standardise systems and gain efficiencies through information sharing and collaboration.

5. Consumer participation in trauma service development, quality improvement and patient safety systems has been limited. Evidence that links consumer involvement to patient-centred, high quality health care has not yet been translated to the trauma service sector.⁴⁶⁻⁵⁰

To effectively address these limitations, a national approach is required. The United States has successfully initiated a similar pathway. The Trauma Quality Improvement Program (TQIP) run by the American College of Surgeons, has demonstrated that a national approach relies on agreed principles, data standards and coordinated effort. As a result, TQIP utilises the infrastructure of the National Trauma Data Bank to provide risk-adjusted benchmarking of designated/verified trauma centres; track performance; improve patient care processes and identify institutional characteristics associated with improved outcomes.²⁶

**Number of adverse events**

The impact of sub-optimal systems of care in traumatic injury has been well documented. In Victoria, the Consultative Committee on Road Traffic Fatalities identified potentially preventable outcomes contributing to death in up to 38% of road traffic fatalities.²⁷ Similarly, the Major Trauma Management Study identified potentially preventable outcomes from all aetiologies of trauma, as well as potentially preventable complications in survivors.²⁸ In New South Wales, severely injured
patients treated at level III (smaller) trauma centres had higher mortality rates than those treated at a level I centre (MTC).\textsuperscript{29}

Care of the severely injured presents a unique combination of characteristics:

- needing time-critical care
- occurring often in rural or regional areas and after hours
- necessitating transfer between facilities
- presenting diagnostic uncertainty
- requiring immediate and timely involvement of many disciplines
- involving complex hospital stays and multiple interventions, and
- leading to often prolonged rehabilitation, without certainty of full recovery.

Within this high-risk context, errors are common. Australian studies have found critical decisions in trauma resuscitation are made every 72 seconds and, on average, 2.5 errors are made in the treatment of severely injured patients.\textsuperscript{30} Similar problems with adverse events have been found in trauma research internationally. A review of 2594 deaths in a leading level I trauma centre in the United States identified multiple error patterns contributing to death. These include failure to secure an airway; delayed haemorrhage control; inadequate prevention of deep vein thrombosis; lengthy initial operative procedures rather than damage control surgery; excessive fluid resuscitation; and complications with feeding tubes. Missed injuries are also common, and have been reported to affect as much as 8% of severely injured patients.\textsuperscript{32}

There is growing evidence that quality improvement interventions to reduce error in trauma care are effective. Computerised decision support systems in trauma resuscitation have resulted in improved protocol compliance and reduced errors and morbidity.\textsuperscript{30} Changes to institutional and trauma systems policies have demonstrably reduced the incidence of error-associated death.\textsuperscript{31}

**Building on existing bodies of work**

Although early foundations for quality improvement exist in Australia’s trauma services, these efforts would be strengthened and consolidated if ‘people sustaining serious injury’ was made an initial priority under a national goal. AusTQIP is developing systems to support trauma quality improvements underway in Australia’s 26 MTCs and build on this work through:

- Facilitating benchmarking of trauma data to identify system and process characteristics that improve survival and longer term trauma patient outcomes.
- Aligning trauma data definitions and improving the statistical power and therefore usability of trauma data already being collected for quality improvement and patient safety.
- Developing a collaborative network to support all MTCs in improving the quality and safety of trauma care through sharing information, lessons learned and joint efforts in trauma quality improvement.
- Reducing duplication of effort, improving efficiency and expanding capacity for MTCs to monitor and further improve the quality of trauma care provided.
• Providing a platform from which consumers can have a greater voice in trauma system improvement and development by actively encouraging and seeking consumer participation.

• Developing a ‘next-generation’ clinical quality registry for trauma (the ATR) to provide an accessible evidence-base for quality improvement for trauma service leaders, clinicians and health service managers alike.

• Contributing to all three proposed national safety and quality goals for health care.

The development of the ATR is being based on the work of the previous National Trauma Registry Consortium (NTRC), which evolved into the new arrangement with new funding. The Bi-National Trauma Minimum Data Set (Australia and New Zealand) developed by the NTRC has been refined by an AusTQIP working group (with participation from all states and territories) into a standardised data dictionary to support MTCs in aligning their data collection processes. This means that the data provided for the ATR will be reliable, high quality and ready to use for performance benchmarking and measuring quality of care for Australians with traumatic injury.

Although the principal strength of AusTQIP lies in the collaborative effort of the 26 MTCs, it is predicated (primarily) on the professional commitment and mutual intentions of MTCs and state trauma registries. It is not yet explicitly grounded by national policy or quality and safety strategy. Consequently, its capacity to impact on wider trauma systems (regional and rural / remote, pre-hospital providers, rehabilitation services), and add value to the national safety and quality agenda, is limited. The National Goals for Safety and Quality in Health Care have the potential to unify and focus efforts of policy makers, health service leadership and clinicians. To be effectively addressed as a national health priority area, consolidate quality improvement efforts of Australia’s MTCs and improve trauma patient outcomes, ‘people sustaining serious injury’ need to be given priority under a national goal.

Trauma systems improvement – amenable to multi-level national action

AusTQIP’s collaborative network has the potential to stimulate quality improvements at all levels of the health system.

At a local health service level, individual trauma services can be assisted in developing clinical trauma guidelines through linking them with existing bodies of evidence and facilitating benchmarking / sharing of clinical guidelines from other trauma centres.

At a state level, MTCs will be supported in working with pre-hospital care providers such as ambulance and retrieval services to update or standardise pre-hospital triage guidelines. This will ensure trauma patients are taken to the appropriate level of trauma services within the shortest timeframe possible.

At a national level, AusTQIP has already collaborated with the Royal Australasian College of Surgeons to deliver a national workshop on Trauma Quality Improvement in November 2011. Outcomes of this workshop included identification of 10 priority areas for trauma quality improvement in Australia, and identification of 5 trauma clinical indicators as an initial measure for trauma systems performance and validation by the ATR. It also served to gather considerable momentum for AusTQIP from stakeholders involved in trauma care throughout Australia.
Expected improvements within three to five years

- Governance arrangements for AusTQIP are well established and a detailed program plan is in place.
- A network amongst MTCs and other providers of trauma care has been established through AusTQIP. This network will continue to grow to include pre-hospital and rehabilitation sectors and non-MTC trauma service providers.
- A baseline audit of trauma quality systems in Australia and a comprehensive survey of trauma data capability are complete and a report has been distributed for consultation to the wider trauma community.17
- Development of an ATR is in progress and will be available by the end of 2012.
- Regular reports of ATR data will be available from 2013 which will inform trauma quality improvement efforts and measure their success at different levels within Australia’s trauma systems.
- Development of an electronic platform for sharing of information amongst MTCs, including clinical practice guidelines and quality improvement projects, will be launched before the end of 2012 and expanded to the wider trauma community over time.
- Processes to better engage consumers in trauma service delivery and trauma systems development will be created.

Relevance to other national priorities / activities

The inclusion of people sustaining serious injury as an initial priority area would reflect other national priorities and policy as follows.

Injury prevention and control as a National Health Priority Area since 1996

National Injury Insurance Scheme (NIIS)

A National Injury Insurance Scheme has been proposed to provide no-fault lifetime care and support for all catastrophic injuries. This proposal has recommended that governance for the NIIS should be built around coordinated services with specialist centres of excellence such as trauma centres.33

In the context of the proposed scheme, people sustaining serious injury is an important initial priority for the Goals because:

- MTCs will have a significant role in the NIIS. Collaborative relationships and a culture of benchmarking and performance improvement will already be in place under AusTQIP.
- AusTQIP and the ATR hold the potential to limit the liability of the NIIS by providing
  - high quality national trauma data to inform injury prevention
  - better systems of quality improvement, leading to higher quality of trauma care across the spectrum (from pre-hospital to rehabilitation), improved outcomes for injured patients and prevention of secondary injury through medical error.
Australian Government Emergency Management plans

Each of these plans highlights the important role of medical response and civilian trauma systems in the management of disasters. These plans include:

- Australian Emergency Management Arrangements\(^{34}\)
- Australian Government Disaster Response Plan (COMDISPLAN)\(^{35}\)
- Australian Government Plan for the Reception of Australian Citizens and Approved Foreign Nationals Evacuated from Overseas (COMRECEPLAN)\(^{36}\)
- Australian Government Aviation Disaster Response Plan (CAVDISPLAN)\(^{37}\)
- Australian Government Contingency Plan for Space Re-Entry Debris (AUSCONPLAN-SPRED)\(^{39}\)
- National Response Plan for Mass Casualty Incidents Involving Australians Overseas (OSMASSCASPLAN)\(^{40}\)
- Australian Government Overseas Disaster Assistance Plan (AUSASSISTPLAN)\(^{41}\)
- Australian Mass Casualty Burn Disaster Plan (AUSBURNPLAN)\(^{42}\)
- Domestic Response Plan for Mass Casualty Incidents of National Consequence (AUSTRAUMAPLAN)\(^{43}\)

National Safety and Quality Health Service (NSQHS) Standards

The NSQHS Standards are a quality assurance mechanism that tests whether relevant systems are in place to protect the public from harm and improve the quality of health service provision.\(^{44}\)

AusTQIP’s objectives and the capacity of the ATR to provide system measures for quality improvement are well aligned with these standards. The inclusion of ‘people sustaining serious injury’ as an initial priority area, through AusTQIP, would therefore add value and support organisations with MTCs in meeting these standards in the high risk areas of injury management and prevention.

Australian Safety and Quality Framework for Health Care

The Australian Safety and Quality Framework for Health Care specifies three core principles for safe and high quality care:

1. Organised for safety
2. Driven by information
3. Consumer centred

AusTQIP’s governance structure and network of all 26 designated MTCs are organised for safety; the ATR means that trauma quality improvement in Australia can be driven by reliable, high quality information; and AusTQIP’s emphasis on consumer involvement ensures community input into trauma systems development and quality improvement.

With these systems in place, ‘people sustaining serious injury’ as an initial priority would be well placed to enact the principles of the Framework.
**National Health Care Agreement 2011**

The Council of Australian Government’s National Health Care Agreement 2011 (the Agreement)\(^45\) aims to improve health outcomes for all Australians and the sustainability of the Australian health system. Traumatic injury locates well within the parameters of this agreement in that:

- The Agreement includes nationally agreed minimum datasets to be collected and reported on. AusTQIP has realised similar achievements through establishing a nationally agreed trauma minimum dataset with in-principle agreement from all states, territories and relevant MTCs to submit data to the ATR.
- The Agreement stipulates that the Commonwealth, State and Territory Governments will:
  - co-operate in quality assurance and regulatory activities (section 24 f) and
  - continue to improve health service safety and quality (section 24 g).

AusTQIP’s network is structured to facilitate collaborative action in trauma quality improvement and contribute to health service quality and safety.

- The Agreement also outlines policy directions and reforms that include:
  - Implement improvements in hospital quality and safety, building on the priorities of the ACSQHC.
  - Increase the proportion of emergency department patients treated within clinically recommended waiting times.
  - Improve access to rehabilitation, post-acute and transition care services.
  - Improve quality of data on patient services.

AusTQIP reflects these policy directions and reforms through trauma quality improvement efforts that are nationally aligned, supported by high quality data and designed to address the outlined issues.

**Obesity and traumatic injury**

Australia’s obesity epidemic has been well documented and is also a National Health Priority Area. A recent report by the Australian Institute for Health and Welfare (AIHW) indicated that obesity increases the risk of traumatic injury including\(^46\):

- a higher probability of traumatic injury from falls
- sleep apnoea increases road injury risk and is strongly associated with obesity,
- increased risk of traumatic injury in obese children, pregnant women and in the obese workforce.

The report also found obese injured patients have

- significantly longer average length of stay in hospital
- greater requirements for respiratory support
- a high likelihood of complications during hospitalisation following traumatic injury
- an increased risk of death after serious traumatic injury.

Inclusion of ‘people sustaining serious injury’ as an initial priority area holds the clear potential to simultaneously address other national health priorities. Additionally, the AIHW report highlights the
potential for other data sources to fill information gaps in the relationship between obesity and traumatic injury. The ATR is being designed for data linkage to other national datasets (with the appropriate ethics approvals and governance systems) to provide high quality data for cross-priority areas.

**Ageing population**

One-fifth of the population is over 60 years of age and this proportion is steadily growing. Older people are at greater risk of falls resulting in traumatic brain injuries. At ages 90 years and over, traumatic injury accounts for one in 10 hospitalisations. Older people who present with serious injuries often have age-associated co-morbidities and medications that present significant challenges for trauma care.

**Aboriginal and Torres Strait Islander Health**

Traumatic injury remains an important cause of premature death and disability among Aboriginal and Torres Strait Islander people. Their rates of hospitalisation and death from injury are more than double that of other Australians. Mainstream programs in injury prevention and trauma care are also often not in keeping with Aboriginal and Torres Strait Islander people’s holistic conception of health and well being.

**Relevance across groups, sectors and settings of care**

Trauma care is a multidisciplinary specialty, encompassing multiple professional disciplines and all sectors of health care including:

- Pre-hospital
- Emergency and trauma centres
- Operating theatre
- Intensive care
- Acute hospital wards
- Rehabilitation
- Community-based rehabilitation and ongoing care.

Provision of different levels of trauma services is an important element in most metropolitan, rural and remote health care organisations. Trauma quality improvement has traditionally focused on in-hospital mortality as an outcome. Improvement efforts that impact on longer term outcomes are needed, including pre-hospital, in-hospital and rehabilitation strategies.

Funding for trauma care is multi-sectoral. For example, the total annual cost of TBI in Australia was estimated to be $8.6 billion, comprising:

- costs attributable to moderate TBI ($3.7 billion) and severe TBI ($4.8 billion)
- financial costs ($3.7 billion) and burden of disease costs ($4.9 billion), and
- the greatest portions borne by individuals (64.9%), the State Government (19.1%) and Federal Government (11.2%).
The total cost of SCI in Australia was estimated to be $2.0 billion, comprising:

- costs attributable to paraplegia ($689.7 million) and quadriplegia ($1.3 billion)
- financial costs ($1.2 billion) and burden of disease costs ($803.2 million), and
- the greatest portions borne by the State Government (44.0%), individuals (40.5%) and the Federal Government (10.6%).

Measures and potential measures to monitor progress

The increasing availability of measures to monitor progress in trauma is an indication of the importance of the issue to clinicians, quality and safety professionals, health service leaders, researchers and consumer groups alike. For example:

- A Bi-National Trauma Minimum Dataset (Australia and New Zealand) has been established and made available through AusTQIP in the form of a nationally agreed data dictionary.
- The ATR is currently under development and will empower the MTCs to utilise standardised data for reporting, quality improvement and benchmarking with other centres across the country.
- Accountable and transparent governance processes to report and monitor data from the ATR are also being designed.
- Five trauma clinical indicators were agreed at a national workshop hosted by the Royal Australasian College of Surgeons, the NTRI and AusTQIP in November 2011. These indicators will be aligned with international work and refined prior to being built into the ATR.
- AusTQIP has the epidemiological expertise and statistical capability to support risk-adjusted benchmarking between MTCs.
Summary

Inclusion of ‘people sustaining serious injury’ as a topic area in the section “Appropriateness of care” will:

1. help to improve the care and outcomes in a health priority area that has a huge impact on Australian society
2. enable the ACQSHC to focus specifically on important issues of integration of the many health service providers, from pre-hospital through hospital, rehabilitation and disability care, as well as improving care of each sector
3. capitalise on a national effort and a unique collaboration of all major stakeholders that is already underway, and help to secure its future, and
4. provide for the ACQSHC a work plan that is well-placed to achieve its goals within a 5 year period.

Again, we thank the ACSQHC for the opportunity to respond to the ‘Australian Safety and Quality Goals for Health Care – Consultation Paper ’and invite them to contact us to clarify any aspect of this response or discuss the issues identified here in more detail.
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4. Towler S. Trauma system and services. Trauma Working Group, Department of Health WA; 2007.

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