Is high-quality trauma care “business as usual” in New Zealand?

Ian Civil, Siobhan Isles

ABSTRACT

New Zealand is on the cusp of establishing a world-class trauma system. Many of the building blocks are in place with national and regional guidelines in both the pre-hospital and hospital phases of care established. A dedicated clinical workforce is available in all DHBs and national data available through the Major Trauma Registry. The greatest threat to achieving high-quality trauma care in New Zealand at this point is governance stability rather than clinical variability. Now is the time to lock the trauma system into a framework not subject to political or bureaucratic whims.

Physical injuries represent a significant burden to society, the healthcare system and the patient. In New Zealand, injury accounts for as much as 8% of total health loss from all causes. Much of this health loss could be prevented or mitigated. The difference in outcomes between optimal and suboptimal care can impact on survival, total cost of care and quality of life in the months and years that follow.

In the early 90’s, New Zealand had no effective trauma system, but as a result of a sentinel case and with the input of the Ministry of Health and the Royal Australasian College of Surgeons, a set of national guidelines was developed that had the potential to revolutionise the care of the injured and to ensure best practice was evident throughout the country. Further, the Accident Compensation Corporation (ACC) determined to establish a trauma care pilot in the Central Region to test the basic principles embodied in the national guidelines and see what effect they might have on injury outcomes. Optimism about progress was expressed in a leading article published in the NZMJ at that time.

Despite these promising initiatives, progress was not made. The recommendations of the national guidelines were never enacted in health policy and the ACC Trauma Pilot folded before any outcome could be determined. Our failure to progress the 1990’s initiatives was highlighted in another publication in this journal, and ongoing lack of progress brought the issue to a head in 2010.

In 2011, the then National Health Board initiated the development of the Major Trauma National Clinical Network, sponsored by both the ACC and MOH, with the intent to establish a contemporary trauma system in New Zealand. The three initial work streams were to establish a formal trauma structure and system across New Zealand, to establish the New Zealand Major Trauma Registry and to develop consistent guidelines and plans for managing trauma in New Zealand.

The Network has just published its first annual report, which includes data from the three North Island regions, and provides important insights into the overall care of patients and their hospital outcomes. In particular, it shows that the incidence of life-threatening (major) trauma is similar or slightly greater than most of the states in Australia (>40/100,000/year) and that the in-hospital mortality is acceptable (9%) but not as good as contemporary results in both Victoria and NSW. Other initial findings include the fact that over 20% of patients have to be transferred from one hospital to another in the first 72 hours after injury to receive definitive care, and not all hospitals consistently measure blood alcohol
on injured patients, missing an important opportunity to provide injury prevention information.

The activities of the Major Trauma National Clinical Network are providing a window into the quality of trauma care in New Zealand, and in large part the information is reassuring while at the same time showing where trauma care could be improved.

The Major Trauma National Clinical Network has been working to reduce variability within trauma care. The greatest threat to quality in any organisation is variability. The work of the Health Quality and Safety Commission has highlighted this in their promotion of the surgical safety checklist in the operating room and with their other work on hand hygiene and surgical site infection. In trauma care, guidelines are being developed and a national pre-hospital destination policy has been implemented. These will support the delivery of high-quality trauma care by reducing random variation and we hope to see outcome metrics improve.

While clinicians strive to provide high-quality care using best practice guidelines that not only ensure the right patients get to the right hospitals at the right time but also progress through agreed treatment pathways, they are inevitably influenced by the healthcare structure in which they work. The greatest threat to achieving high-quality trauma care in New Zealand at this point is governance rather than clinical variability. As will be evident from the history of trauma system development in New Zealand outlined above, there have been many false starts simply because individuals or structures have changed. Over the last 20 years, various individuals from ministers down to hospital managers have expressed great enthusiasm for trauma care initiatives and have often taken them a way down the track. Sadly, when these individuals change their positions the momentum is lost and new starts have to be engineered. Within large bureaucracies, internal reorganisations are common and the visions developed under previous structures often lost. In Victoria, the trauma care system is defined by legislature and as such is much less prone to changes of direction at political or bureaucratic whims.

New Zealand is on the cusp of achieving a world-class trauma system. We have made significant progress in the last five years to reassure healthcare providers that the quality of trauma care in most situations is good or excellent, but progress has been made before and the momentum lost. It is now time to lock the trauma care system into a structure that is not subject to changes of position or departmental reorganisation.

High-quality trauma care is “business as usual” in most hospitals in New Zealand, but a long-term vision of the system of trauma care and its sponsorship need to be instituted without delay so that the advances made over the last five years are not lost.
Competing interests:
Nil.

Author information:
Ian Civil, Clinical Lead, Major Trauma National Clinical Network; Siobhan Isles, Programme Coordinator, Major Trauma National Clinical Network.

Corresponding author:
Dr Ian Civil, Trauma Services, Auckland City Hospital, Park Road, Grafton, Auckland 1024.
ianc@adhb.govt.nz

URL:

REFERENCES:


