National Institute for Health and Care Excellence

Trauma Service Delivery
Scope Consultation Table
13 September – 11 October 2013

Unique comment ID	Type	Stakeholder	Order No	Section No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
11	SH	British Association for Counselling and Psychotherapy	1	General	BACP welcomes the development of guidance on trauma service delivery and is grateful of the opportunity to comment upon the draft scope.	Thank you for your comment. We would like to bring to your attention that we are trying to recruit a psychologist to be a co-opted member of the GDG.
12	SH	British Association for Counselling and Psychotherapy	2	General	BACP believes that it is important to recognise not only the physical consequences of major traumatic injury, but also the impact upon mental health.	Thank you for your comment. We agree, quality of life measures, such as the EQ5D, should capture impact on both physical and mental wellbeing. Outcomes relevant for particular questions will be decided by GDG and if appropriate will include specific well being and mental health outcomes.
13	SH	British Association for Counselling and Psychotherapy	3	General	BACP would therefore recommend that the scope includes explicit reference to specialist mental health interventions.	Thank you for your comment. As you note the major trauma clinical guideline and the service delivery guidance focus mainly on the immediate acute care of the person with life threatening injuries and the interventions are focused here. We agree the impact of traumatic injuries on a person's mental health is important to

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						recognise and the GDG will take this into account when considering, 'rehabilitation assessment' (4.3.1f of the revised scope) and 'MDT management of on-going care and shared care' (4.3.1e of the revised guideline).
14	SH	British Association for Counselling and Psychotherapy	4	4.4.e	To support the appropriate provision of such specialist mental health interventions, BACP would recommend that functional scales should quantify not only levels of physical disability, but also mental distress.	Thank you for your comment. We agree, and quality of life measures, such as the EQ5D, should capture impact on both physical and mental wellbeing/ distress. Outcomes relevant for particular questions will be decided by GDG and if appropriate will include specific well being and mental health outcomes.
41	SH	British Orthopaedic Association – Patient Liaison Group	1	4.3	Could benefit from a additional sub sub paragraph such as 'liaison arrangements with local council care agencies, bed blocking being a major concern for both the patient, who need to be assured that care has been considered, and that the hospital which needs to be able to release beds and staff.	Thank you for your comment. This is outside the remit of the scope.
67	SH	College of Emergency Medicine	1	3.2	The problem isn't just Consultants in the Emergency Department, it is the whole hospital problem. The text in paragraph d needs to reflect this	Thank you for your comment. This has been reworded to, 'There is no systematic approach to care throughout these 3 overlapping phases and there is a lack of involvement of senior healthcare professionals, particularly in teams receiving patients with major

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						trauma. Major trauma is most likely to occur at night and at weekends, when senior staff are not normally in the emergency department'.
68	SH	College of Emergency Medicine	2	4.3.1 d	Instead of trauma team responses based on injury severity, suggest consider this based on needs of the patient. A man with an isolated chest stab needs very different care to a man with an isolated major head injury, but they can both be very severely injured	Thank you for your comment. We agree and have removed according to injury severity'.
69	SH	College of Emergency Medicine	3	4.3.1 b	Please consider the harms of over triage. Is there scope to identify which patients should not be transferred, but palliated closer to home?	Thank you for your comment. When developing the questions and protocol the GDG will identify specific issues to review and will take into account your comments on over triage.
70	SH	College of Emergency Medicine	4	4.3.1 d	Any bypass protocols need to be supported by equally robust return protocols, so that patients who do not need the services of an MTC can be returned to their local trauma unit.	Thank you for your comment. This was discussed at the stakeholder workshop and while acknowledging the current situation of patients being in a major trauma centre while not needing the services, this was seen as an area that will improve with the implementation of this guideline particularly recommendations that will be developed from 4.3.1b.
71	SH	College of Emergency Medicine	5	General	The shape, composition, functionality and effectiveness of a Trauma Network probably needs defining. This will be useful advice for Commissioners	Thank you for your comment. After taking into account stakeholder views, 'defining an inclusive trauma system' will not be included in the scope. The recent

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						Implementation of the regional trauma networks was considered to have addressed this area.
47	SH	East and North Hertfordshire NHS Trust	1	General:	Useful presentation? It is important to keep both the generic management of a major trauma patient and some specific life threatening injuries. Some of them already planned but it would be useful to generalise the management of following conditions as a national guideline as significant variation exists nationally: 1. Traumatic Cardiac Arrest – Indications and what should be done? 2. Chest injuries which should include both adults and children, and elderly patients. Rib fractures and/ or lung injuries. 3. I guess the spinal injury and complex fractures/ open fractures have already been planned, which would be very useful.	Thank you for your comment. The GDG will consider your suggestions on the useful presentation of the guideline.
48	SH	East and North Hertfordshire NHS Trust	2	4.3.1 b)	Variation exists between the trauma triage tool and trauma team call out criteria resulting in creating confusion between the pre-hospital trauma alert system and ED call out system. It is advisable to combine and make one system which would wipe out all such confusions from the network to expedite and ultimately deliver a high quality care consistently.	Thank you for your comment. 4.3.1b in the revised scope has been expanded to include the pre-alert system.
49	SH	East and North Hertfordshire NHS Trust	3	4.3.1 d)	Training: Grade and experience should be included in the guidelines. ATLS is the basic minimum requirement to manage trauma victims, but experience or grade should be drawn in to to reach decisions in major trauma cases. Regular cost	Thank you for your comment. In the revised scope 4.3.1d the competence and skills of pre-hospital and trauma teams will be addressed, if it is appropriate the

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					effective in house trauma practice moulages may be made mandatory to teach trainees how to run a trauma team. Training through simulation may also be incorporated.	GDG will consider the grade and experience. Training is focusing on paediatric trauma. This was considered by stakeholders at the workshop as an area that has been neglected in contrast to adult trauma in which training practices are well established. When developing the questions and protocol the GDG will identify specific issues to review and will take into account your comments on training methods.
50	SH	East and North Hertfordshire NHS Trust	4	4.3.1 e)	Succinct CT/ imaging criteria need to be developed to deliver a consistent care. There are huge variations in the practices and therefore, diagnosis of injuries is delayed affecting the outcome of the patient.	Thank you for your comment. In the revised scope this section has been moved to 4.3.1 a 'Access to the services needed to provide care for people with major trauma'. No specific services are now stated, the services to be included here will be dependent on the evidence and recommendations from the major trauma clinical guideline.
37	SH	Faculty of Intensive Care Medicine	1	3.2 c d	There are principles covered in the PHTLS and ATLS courses (ACS and NAEMT licensed by RCSEng in UK) which could be mapped to these areas. There is limited reference to the influence of education to the co-ordination of care which could be usefully addressed in this section	Thank you for your comment. These are now 4.3.1b and d in the revised scope. The developers are aware of these courses. In the revised scope the training for paediatric trauma has been

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						identified as a specific area to review. When developing the questions and protocol the GDG will identify specific issues to review and will take into account your comment on the influence of education to the co-ordination of care.
38	SH	Faculty of Intensive Care Medicine	2	4.3.1 a b	This has to cover the educational needs of the phases of care and use of triage	Thank you for your comment. After taking into account stakeholder views, 'defining an inclusive trauma system' will not be included in the scope (4.3.1a). The recent implementation of the regional trauma networks was considered to have addressed this area. The revised scope addresses the competence of the pre-hospital provider and in particular the skills required to initially manage major trauma. If appropriate the GDG will take into account the educational needs of the phases of care and use of triage when considering the reviews for this area of the scope.
39	SH	Faculty of Intensive Care Medicine	3	4.3.1 d	Again the courses exist already as above plus DSTC and ASSET courses. There is a need to map the skill requirements to both the patient's needs but also to existing courses so that delivery gaps can be identified.	Thank you for your comment. As above the developers are aware of these courses. When developing the questions and protocol the

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						GDG will identify specific issues to review and will take into account your comments on mapping the skill requirements to both the patient's needs but also to existing courses so that delivery gaps can be identified.
40	SH	Faculty of Intensive Care Medicine	4	4.3.1 e	Services need to include the different available levels of critical care	In the revised scope this section has been moved to 4.3.1 a 'Access to the services needed to provide care for people with major trauma'. No specific services are now stated, the services to be included here will be dependent on the evidence and recommendations from the major trauma clinical guideline.
42	SH	Paediatric Intensive Care Society	1	4.3.1	We support the inclusion of the pre-hospital phase of care but feel that this is not adequately described at present. Specifically we would like the issue of who delivers pre-hospital care and the skills of the personnel included to be covered. This would aim to get at the research questions 'does at scene attendance by a physician trained in pre-hospital care result in a different pattern of transfer to hospital ie allow a greater number of patients to be transferred directly to a major trauma centre' and ' does attendance at the scene by a trained pre-hospital physician improve outcomes'	Thank you for your comment. This is addressed in the revised scope in 4.3.1b and d. When developing the questions and protocol the GDG will identify specific issues to review and will take into account your comments on the attendance of a physician.
43	SH	Paediatric Intensive Care Society	2	4.3.1 c	The issue of mode of transfer to a MTC does not appear to be covered. Specifically whether the availability of an air transport option (helicopter) reduces transfer times, alters	Thank you for your comment. In the revised scope 4.3.1b covers direct and indirect transfer to

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					hospital destination (MTC versus trauma unit as initial destination), and alters outcomes.	appropriate destination, including travel times and quality of transfer. When developing the questions and protocol the GDG will identify specific issues to review and will take into account your comments on the attendance of a physician. It is possible that mode of transfer will be examined in context of resourcing and costs of providing the optimal service configuration to improve health outcomes. However NICE guidance is written for all settings in which NHS care is funded or commissioned, air transport is not funded or commissioned by the NHS.
16	SH	Patients and Relatives Committee of the Intensive Care Society	1	4.3.1 (f)	The proposal to prepare this Guidance is welcomed but the focus appears to be mainly upon pre-hospital and hospital care. A significant number of major trauma patients will require a period in a critical care setting – often in an Intensive Care Unit or a High Dependency Unit following major surgery. Although the rehabilitation of trauma patients is mentioned as a part of the scope of this Guideline, there appears to be little recognition of the significant rehabilitation needs of patients recovering from trauma who may be suffering from a range of physiological and psychological needs that may continue for many months if not years after the traumatic event. This is particularly relevant to patients who have	Thank you for your comment. As you note the major trauma clinical guideline and the service delivery guidance focus mainly on the immediate acute care of the person with life threatening injuries and the interventions are focused here. We agree the impact of traumatic injuries on a person's mental health is important to recognise and the developers will take this into account when considering, 'rehabilitation assessment' (4.3.1f of the revised scope) and 'MDT

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					been intensive care. There is evidence that post critical care rehabilitation is often poorly co-ordinated and delivered inequitably. This is particularly the case when the care is delivered away from the treating hospital. It is our recommendation that the scope of the Guideline should include wider consideration of the needs of the patient post the trauma care. This will often take place away from Trauma centre at the patient's local hospital or within a community setting where the availability of such services is uneven.	management of on-going care and shared care' (4.3.1e of the revised guideline). These sections (4.3.1f of the revised scope and 'MDT management of on-going care and shared care' 4.3.1e of the revised guideline) will consider the wider needs of the patient post initial trauma care and include both physiological and psychological needs. The specific areas to be addressed in these sections will be decided by the GDG when developing the questions for this area of the scope.
1	SH	Peninsula Trauma Network	1	4.3.1a	This should include enhanced prehospital care including hospital emergency medical services	Thank you for your comment. Defining an inclusive trauma system will not be included in this scope. The scope will build upon the current organisation of Trauma services Prehospital care is included in other areas of the revised scope (4.3.1b and d)
2	SH	Peninsula Trauma Network	2	4.3.1 b and c	Important that geographical considerations are not lost in these discussions. It may not be possible for a single national recommendation	Thank you for your comment. We agree that geographical considerations are important from a

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						resourcing, timing and equality perspective in the formation of recommendations. This will be taken into account by the GDG when considering the evidence for the application of triage tools and direct and indirect transfer and where appropriate different recommendations may be made.
3	SH	Peninsula Trauma Network	3	4.3.1 d	Tiered trauma teams. How to identify the level of injury. This particularly difficult in the elderly (who make up 59% of our major trauma)	Thank you for your comment. We agree that identifying level of injury is difficult in particular populations. When developing the question and protocol the developers will identify appropriate populations (such as the elderly) who may need particular consideration and potentially different recommendations.
4	SH	Peninsula Trauma Network	4	3.2	Important we do not lose sight of the work already done by the networks	Thank you for your comment. We agree it is important not to lose sight of the work already done in developing trauma services by the trauma networks and throughout development we will consider current practice and service configuration so that optimal strategies for practice can be identified.
5	SH	Peninsula Trauma	5	4.1.1	The elderly pose distinct problems and form a significant proportion of the workload.	Thank you for your comment. We agree there are circumstances

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		Network				when it is important to identify specific populations. The multidisciplinary knowledge of the developers and GDG includes representatives who provide specific input around the elderly and trauma care. When developing the protocols for the review questions the GDG will identify subgroups that require specific attention, this may include age ranges of people with certain comorbidities.
15	SH	Royal College of Nursing	1	General	No Comment	Thank you for your comment
51	SH	Royal College of Paediatrics and Child Health	1	General	No comment	Thank you for your comment
25	SH	Royal College of Radiologists	1	4.3.1	National standardised handover from pre-hospital to hospital team should be considered.	Thank you for your comment. We agree and this will be considered for inclusion by the GDG in 4.3.1g, 'patient documentation and transfer of information' (in the revised scope).
26	SH	Royal College of Radiologists	2	general	Adults and children can be treated differently in a trauma setting. There are some centres that are centres for both adults and children but there are MTCs that only treat adults or children. This should be born in mind.	Thank you for your comment. We are aware there are centres for both adults and children and centres that only treat adults or children and the consequences of this. The multidisciplinary

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						knowledge of the developers and GDG includes representatives who provide specific input around both adult and paediatric trauma care and work in all of these settings. We are confident differences in treatment according to setting will be highlighted when developing the recommendations.
28	SH	Royal College of Radiologists	3	General	As above but more specifically the imaging of children can be different e.g. MR should be available 24/7 not as necessary in adults and not necessarily the case in all hospitals receiving trauma. Guidance dedicated to paediatrics would be very useful.	Thank you for your comment. As above we are aware there are centres for both adults and children and centres that only treat adults or children and the consequences of this. The multidisciplinary knowledge of the developers and GDG includes representatives who provide specific input around both adult and paediatric trauma care and work in all of these settings. We agree there are circumstances when it is important to identify specific populations. When developing the protocols for the review questions the GDG will identify subgroups that require specific attention, this may include age ranges of people with certain comorbidities.
29	SH	Royal College	4	4.3.1	If "interventional services" means interventional radiology it	Thank you for your comment.

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		of Radiologists			should state that.	In the revised scope this section has been moved to 4.3.1a 'Access to the services needed to provide care for people with major trauma'. No specific services are now stated identified, the services to be included here will be dependent on the evidence and recommendations from the major trauma clinical guideline.
30	SH	Royal College of Radiologists	5	General	As above – very few centres that can provide paediatric intervention services (a requirement for a paediatric MTC but I don't think it has been achieved) which are widely spaced apart. How can this be addressed?	Thank you for your comment. In the revised scope this issue will be reflected if appropriate in 4.3.1 a 'Access to the services needed to provide care for people with major trauma'. No specific services are now stated; the services to be included here will be dependent on the evidence and recommendations from the major trauma clinical guideline.
31	SH	Royal College of Radiologists	6	4.3.1	What does rehabilitation include? Is it only physical therapies or is psychological support included?	Thank you for your comment. We agree the impact of traumatic injuries on a person's mental health is important to recognise and the GDG will take this into account when considering, 'rehabilitation assessment' (4.3.1f of the revised scope).The revised scope rehabilitation is defined as rehabilitation assessment (4.3.1f),

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						the specific assessments will be identified from the evidence.
32	SH	Royal College of Radiologists	7	General	Think the grade or experience of the health care professional should be addressed.	Thank you for your comment. In the revised scope 4.3.1d, the competence and skills of pre-hospital and trauma teams will be addressed, if it is appropriate the GDG will consider the grade or experience of the health care professionals.
33	SH	Royal College of Radiologists	8	4.4	How will waiting lists be used to assess outcome? Is this for reconstructive treatments?	Thank you for your comment. Taking into account comments in the consultation and from the stakeholder workshop this outcome has been removed from the revised scope.
44	SH	Society for Research in Rehabilitation medicine	1	4.3.1. e	• Services needed to provide care for people with major trauma (including pre-hospital and hospital care). We would suggest access to rehabilitation needs to be included here, specifically access to psychological support whilst in hospital and on discharge. Access to service in the community differs significantly and should be included. Attached is an NHS London draft document on mental health and emotional needs of trauma patients highlighting the lack of access to psychological support. • There needs to be systems in place to ensure patients receive timely follow up appointment after discharge form an MTC or after discharge from a TU (and repatriated). One of the biggest complaints form patients is lack of follow up and lack of services once they are	Thank you for your comment. In the revised scope this is 4.3.1a. The focus of this section is on the immediate acute care of the injured person with life threatening injuries and the access is focused on these services. We agree the impact of traumatic injuries on a person's mental health and access to psychological support is important to recognise. The developers will take this into account when considering, 'rehabilitation assessment' (4.3.1f of the revised scope) and 'MDT management of

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					discharged form hospital. Repatriated patients 'gets lost' in the system as they 'lose' their Trauma Patient identification when they are transferred to a local orthopaedic ward etc.	on-going care and shared care' (4.3.1e of the revised guideline).
45	SH	Society for Research in Rehabilitation medicine	2	4.3.1. f	Rehabilitation - Who benefits from rehabilitation? How will this be defined? There is no evidence in the literature to suggest that there is a specific patient group that does not benefit from rehabilitation. Adapting rehabilitation to the patient need is more important. Patients with penetrating injuries may have different rehabilitation needs due to psychosocial needs when compared to patients with blunt injuries.	Thank you for your comment. Taking into account comments in the consultation and from the stakeholder workshop this area has been removed from the revised scope. The revised scope now has rehabilitation assessment as the area to be addressed (4.3.1f of the revised scope).
46	SH	Society for Research in Rehabilitation medicine	3	4.3.1 f	Timing of rehabilitation prescriptions. Whilst the rehab prescription has some merit there is currently no method to check what is included in the prescription or if the recommendations are being carried out. The timing is not essential. The more important part of rehabilitation is to determine if the rehabilitation actually happens. From our experience this often does not take place. Please see attached documents.	Thank you for your comment. Taking into account comments in the consultation and from the stakeholder workshop this area has been removed from the revised scope. The revised scope now has rehabilitation assessment as the area to be addressed (4.3.1f of the revised scope).
6	SH	The Society and College of Radiographers	1	4.3	Major Trauma Main area where imaging/radiographers contribute is linked to section 4.3.1. Part C discusses where imaging assessment of the chest following trauma fits so there is likely to be a need here from consideration of the skill set required to achieve good images and the ability to work with the trauma team. As well recognition major patterns of abnormality and the influence	Thank you for highlighting the areas of the major trauma clinical guideline scope that may influence areas of the service delivery scope with reference to imaging and the potential training needs of radiographers.

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					that image quality has on this as a skill required of radiographers. Part D states the guidelines need to consider circulation and haemorrhage control and the role of radiology through intervention. This may have some thoughts about staff and overall service availability that need to be added. Part F discusses the MDT skills required of the hospital trauma team. Inclusion of radiographers and timely reporting by radiologists or radiographers should be discussed. Further there may be training needs to consider as radiographers historically are left as an also ran when these aspects are being debated. With wireless DR now being available the radiographer may be required to contribute in a wider role in the resuscitation room than was traditionally understood. This links to the trauma services discussion points below.	
7	SH	The Society and College of Radiographers	2	4.3	Trauma Services Section 4.3 Service Delivery seems to be the key area for contributions. Section 4.3.1 part A talks about defining an inclusive trauma system that I believe needs to have joined up thinking about radiographers and the wider role of radiology. Part D considers the skill set required of the MDT for both major trauma and the tiered trauma team methodology of service delivery. Discussion is made about training needs and although radiographers tend to be on the fringe there	Thank you for your comment. After taking into account stakeholder views, 'defining an inclusive trauma system' will not be included in the scope. The recent implementation of the regional trauma networks was considered to have addressed this area. Part D (4.3.1d in the revised scope) will aim to set out the skills required in the pre-hospital and receiving trauma team, it is anticipated that

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					are situations where further training through the approaches discussed could be contributed to by radiographer inclusion. Should a new approach be discussed about multi-skilling radiographic staff to perform the range of imaging required especially for an out of hours situation? Part E follows on by discussing service access and considers what might be required of the trauma provision. Key aspect here for radiography/radiology is reporting turn around times as a possible link back to the multi-skilling approach linked earlier to part D. There may also need to be discussion about the type of equipment for imaging that can provide the most flexible and reliable service.	this recommendation will be supported by evidence from the major trauma clinical guideline. If interventions are identified that require the skills of a radiographer/radiologist this will addressed here. In the revised scope training is focusing on paediatric trauma. This was considered by stakeholders at the workshop as an area that has been neglected in contrast to adult trauma in which training practices are well established. If it is appropriate the training of radiographers/radiologists will be considered here. Part E (now included in 4.3.1a in the revised scope) refers to access to services, the major trauma clinical guideline includes a review looking at the evidence for' hot reporting' this will inform the recommendation in the service delivery guidance. As you rightly note, no one part of any service works in isolation it is anticipated this area will be

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						supported by evidence from the major trauma clinical guideline.
8	SH	The Society and College of Radiographers	3	4.3	Complex Fractures AS with other areas the key aspects seem to be part D imaging assessment; part F Initial management and the role of intervention (I take this to also include radiology) and finally part H the skills of the multidisciplinary team. Radiographers will need to know what imaging best suits the initial evaluation of complex fractures and where is the best place/modality to perform this. Linked to this is the trauma team needs for patients who might not be stable or could be injured further by moving the patient and therefore how radiographers might deal with this. Radiation protection will also be a concern depending on patient demands as well as site that imaging might be performed. MDT skills will need to be extended so that safe practices may operate outside the resuscitation room, operating theatre or perhaps interventional radiology suite (e.g. associated embolisation for haemorrhage post complex fracture). Contributions to reporting (be it provisional or final) for the event, should also be discussed as part of the advanced practices that radiographers may contribute to in patients with complex fractures.	Thank you for highlighting the areas of the complex fractures clinical guideline scope that may influence areas of the service delivery scope with reference to imaging/radiographers.
9	SH	The Society and College of Radiographers	4	4.3	Fractures Section 4.3.1 lists several points that impact of radiographers/radiology. Part B discusses the acute stage of imaging assessment and makes particular reference to the speed of image reporting. Discussing methods of delivery that might answer this question should be included	Thank you for highlighting the areas of the fractures clinical guideline scope that may influence areas of the service delivery scope with reference to imaging/radiographers.

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					in any reference made to NICE. Part F raises the role of follow up clinics that may be involved with fractures. Again a major contribution could be made through immediate reports by radiographers for orthopaedic clinics as this is an aspect that is frequently left to 'other appropriately educated professionals' under IRMER to provide the evaluation on the image. There is also the potential for the link to be made in an MDT sense for appropriate referral on by radiographers to AHP clinics based on the image appearances. Although the guideline will not be considering other pathological processes that may have led to the fracture in greater depth linkages to 'osteoporosis' or possibly 'falls prevention' clinics for example could be a typical pathway that may be helpful for the patient if an algorithm (or series of such) is developed and probably linked to advanced role personnel. This naturally connects with part F the MDT skills base that is needed so that cross professional needs /role understanding can be achieved. In other words, a joined up service from an attendance for a fracture is created to enhance care and prevent further events.	
10	SH	The Society and College of Radiographers	5	4.3	Spinal Injuries Part D in section 4.3.1 discusses the acute stage of imaging and the skills that should be available in the MDT. Many of the points made earlier apply to this section. Section 4.4 raises the role of accuracy, particularly within imaging and therefore is probably seeking to establish whether the current imaging practices are helpful or not	Thank you for highlighting the areas of the spinal injuries clinical guideline scope that may influence areas of the service delivery scope with reference to imaging/radiographers.

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					from a cost and time effectiveness basis. Adverse effects from imaging are mentioned in particular poor handling techniques. This links back to many other areas of MDT skills and training previously discussed and should be explored across all areas with a clear focus on this aspect for its particular impact. There is no apparent link to the radiation load that may be placed on these patients which might be an aspect to include as well due to the long term nature of a need for imaging.	
17	SH	UK Clinical Pharmacy Association	1	General	Importance of emphasis on multidisciplinary working with clinicians and other Allied Healthcare professionals at each stage of treatment	Thank you for your comment. We agree that multidisciplinary working with clinicians and other Allied Healthcare professionals at each stage of treatment is imperative to the successful implementation of trauma care and this has been reflected throughout the scope (for example, 4.3.1d and e).
18	SH	UK Clinical Pharmacy Association	2	General	Highlight the co-ordination of trauma care when more than one discipline involved for polytrauma – importance of communication between the teams including handover from A&E to ward	Thank you for your comment. We agree and this has been reflected in 4.3.1 e, 'continuity of care' and 4.3.1g, 'patient documentation and transfer of information' (revised scope).
19	SH	UK Clinical Pharmacy Association	3	General	Allocation of beds and the importance of 'right patient, right ward' depending on the speciality required for most appropriate care	Thank you for your comment. We agree and this has been reflected in 4.3.1 e, 'continuity of care' focusing on trauma co-ordinators.
20	SH	UK Clinical Pharmacy	4	Major trauma	To include guidance on the use of tranexamic acid? Timing of administration and documentation etc	Thank you for your comment. Consultation with stakeholders was

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		Association		4.3.1 d)		limited to the Trauma Service Delivery scope because consultation on the 4 clinical trauma scopes has already concluded. The comment you make refers to the major trauma clinical guideline scope which has been agreed.
21	SH	UK Clinical Pharmacy Association	5	Spinal injury 4.3.1 a)	To mention the triaging of patients pre-hospital by paramedic crew as per 'major trauma protocol' to direct initially to appropriate hospital	Thank you for your comment. Consultation with stakeholders was limited to the Trauma Service Delivery scope because consultation on the 4 clinical trauma scopes has already concluded. The comment you make refers to the spinal injuries clinical guideline scope which has been agreed.
22	SH	UK Clinical Pharmacy Association	6	Spinal injury 4.3.1 b)	To include specific and detailed neurological examination	Thank you for your comment. Consultation with stakeholders was limited to the Trauma Service Delivery scope because consultation on the 4 clinical trauma scopes has already concluded. The comment you make refers to the spinal injuries clinical guideline scope which has been agreed.
23	SH	UK Clinical Pharmacy Association	7	Spinal injury 4.3.1 d)	Timing to investigations? Is there a target time to have undergone and had imaging reported?	Thank you for your comment. Consultation with stakeholders was limited to the Trauma Service

Unique comment ID	Type	Stakeholder	Order No	Section No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						Delivery scope because consultation on the 4 clinical trauma scopes has already concluded. The comment you make refers to the spinal injuries clinical guideline scope which has been agreed.
24	SH	UK Clinical Pharmacy Association	8	Spinal injury 4.3.1 g)	Emphasis on clear documentation and communication between the teams on how to transfer /move patients and resting positions etc – to state clear plans for AHP	Thank you for your comment. Consultation with stakeholders was limited to the Trauma Service Delivery scope because consultation on the 4 clinical trauma scopes has already concluded. The comment you make refers to the spinal injuries clinical guideline scope which has been agreed.

These organisations were approached but did not respond:

Addenbrookes Hospital
Aintree University Hospital NHS Foundation Trust
Alder Hey Children's NHS Foundation Trust
Archimedes Pharma Ltd
Association of Anaesthetists of Great Britain and Ireland
Association of British Insurers
Association of Orthopaedic chartered physiotherapists
Association of Paediatric Anaesthetists of Great Britain and Ireland
Barnsley Hospital NHS Foundation Trust

Brain Injury Rehabilitation Trust
British Association of Critical Care Nurses
British Association of Hand Therapists
British Association of Plastic Reconstructive and Aesthetic Surgeons
British Association of Spinal Surgeons
British Blood Transfusion Society
British Geriatrics Society
British Medical Association
British Medical Journal
British National Formulary
British Nuclear Cardiology Society
British Orthopaedic Association
British Psychological Society
British Red Cross
British Society for Children's Orthopaedic Surgery
British Society of Gastrointestinal and Abdominal Radiology
British Society of Interventional Radiology
British Society of Rehabilitation Medicine
BSN Medical
Cambridge University Hospitals NHS Foundation Trust
Capsulation PPS
Care Quality Commission (CQC)
Central London Healthcare NHS Trust
Chartered Society of Physiotherapy
Childhood Bereavement Network
College of Emergency Medicine
Croydon Clinical Commissioning Group
Croydon Health Services NHS Trust
Croydon University Hospital
Department of Health
Department of Health, Social Services and Public Safety - Northern Ireland
Device Access UK Ltd
Disaster Action
East Kent Hospitals University NHS Foundation Trust
East Lancashire Hospitals NHS Trust

East of England Trauma Network
Emergency Medicine Research in Sheffield
Ethical Medicines Industry Group
Faculty of Dental Surgery
False Allegations Support Organisation
Five Boroughs Partnership NHS Trust
Harrow Local Involvement Network
Health Quality Improvement Partnership
Healthcare Improvement Scotland
Healthwatch East Sussex
Herts Valleys Clinical Commissioning Group
Hiraeth Services Ltd
Hull and East Yorkshire Hospitals NHS Trust
Humber NHS Foundation Trust
Intavent Orthofix Ltd
Johnson & Johnson Medical Ltd
Limbless Association
London Ambulance Service NHS Trust
Luton and Dunstable Hospital NHS Trust
Maquet UK Ltd
Market Access & Reimbursement Solutions Ltd
MASCIP
Masimo Corporation
Medicines and Healthcare products Regulatory Agency
Medtronic
Midlands Centre for Spinal Injuries
Ministry of Defence
National Institute for Health Research Health Technology Assessment Programme
National Osteoporosis Society
National Patient Safety Agency
National Treatment Agency for Substance Misuse
Neurosupport
NHS Barnsley Clinical Commissioning Group
NHS Connecting for Health
NHS Cumbria Clinical Commissioning Group

NHS Direct
NHS England
NHS Plus
NHS Sheffield
NHS South Cheshire CCG
NHS Wakefield CCG
NHS Warwickshire North CCG
NHS West Hampshire CCG
North of England Commissioning Support
North West Ambulance Service NHS Trust
North West London Critical Care Network
Nottingham City Council
Nottingham Healthcare NHS Trust
Nottinghamshire Healthcare NHS Trust
Ossur UK
Oxford University Hospitals NHS Trust
Oxfordshire Clinical Commissioning Group
Primary Care Pharmacists Association
Primary Care Rheumatology Society
Public Health Wales NHS Trust
Public Health Wales NHS Trust
Queen Elizabeth Hospital King's Lynn NHS Trust
Robert Jones & Agnes Hunt Orthopaedic & District Hospital NHS Trust
Royal College of General Practitioners
Royal College of General Practitioners
Royal College of General Practitioners in Wales
Royal College of Midwives
Royal College of Obstetricians and Gynaecologists
Royal College of Obstetricians and Gynaecologists
Royal College of Pathologists
Royal College of Physicians
Royal College of Physicians and Surgeons of Glasgow
Royal College of Psychiatrists
Royal College of Psychiatrists
Royal College of Speech and Language Therapists

Royal College of Surgeons of Edinburgh
Royal College of Surgeons of England
Royal National Lifeboat Institution
Royal Pharmaceutical Society
Salisbury NHS Foundation Trust
Scottish Intercollegiate Guidelines Network
Sheffield Childrens Hospital
Sheffield Teaching Hospitals NHS Foundation Trust
Social Care Institute for Excellence
South East Coast Ambulance Service
South East Coast Ambulance Service NHS foundation Trust
South London & Maudsley NHS Trust
South Wales Critical Care Network
South West Public Health Observatory
South West Yorkshire Partnership NHS Foundation Trust
South Western Ambulance Service NHS Foundation Trust
Southport and Ormskirk Hospital NHS Trust
Speak Out Against Psychiatry
Spinal Injuries Association
St Georges Healthcare NHS Trust
St John Ambulance
St John Ambulance
Staffordshire and Stoke on Trent Partnership NHS Trust
Stockport Clinical Commissioning Group
The Patients Association
The Royal Centre for Defence Medicine
Trauma Audit & Research Network
UK Acquired Brain Injury Forum
United Kingdom Council for Psychotherapy
University Hospital Birmingham NHS Foundation Trust
University Hospital Southampton NHS Foundation Trust
University Hospitals Birmingham
University Hospitals Coventry and Warwickshire NHS Trust
WAVE Trust
Welsh Government

Wessex Trauma Network
Wessex Trauma Network
Western Sussex Hospitals NHS Trust
Wigan Borough Clinical Commissioning Group
Wirral University Teaching Hospital NHS Foundation Trust
York Hospitals NHS Foundation Trust