NICE National Institute for Health and Care Excellence

Quality Standards Advisory Committee 1

Trauma – Prioritisation meeting

Minutes of the meeting held on 7th September 2017 at the NICE offices in Manchester

Attendees	**Quality standards advisory committee (QSAC) standing members** Bee Wee (Chair), Anita Sharma, Zoe Goodacre, Sunil Gupta, Tessa Lewis, Hugo van Woerden, John Jolly, Phillip Dick, Gita Bhutani, Tim Fielding, Ian Reekie, Simon Baudouin, Lauren Aylott, Alyson Whitmarsh, Ruth Bell **Specialist committee members** Iain McFadyen, Richard Lee, Chris Fitzsimmons, Heather Jarman, Lynda Brown, David Skinner, James Piercy, Fiona Lecky, Karim Brohi **NICE staff** Mark Minchin, Jamie Jason, Rick Keen, Shaun Rowark, Stacy Wilkinson, Edgar Masanga
Apologies	**Quality standards advisory committee (QSAC) standing members** Hazel Trender, Teresa Middleton, Rhian Last, Nicola Hobbs, Ruth Halliday

Agenda item	Discussions and decisions	Actions
1. Welcome, introductions and plan for the day (private session)	The Chair welcomed the attendees and the quality standards advisory committee (QSAC) members introduced themselves. The Chair informed the committee of the apologies and reviewed the agenda for the day.	
2. Welcome and code of conduct for members of the	The Chair welcomed the public observers and reminded them of the code of conduct that they were required to follow. It was stressed that they were not able to contribute to the meeting but were there to observe only. They were also reminded that the committee is independent and advisory therefore the	

Agenda item	Discussions and decisions	Actions
public attending the meeting (public session)	discussions and decisions made today may change following final validation by NICE's guidance executive.	
3. Committee business (public session)	**Declarations of interest** The Chair asked standing QSAC members to declare any interests that were either in addition to their previously submitted declaration or specific to the topic under consideration at the meeting today. The Chair asked the specialist committee members to declare all interests. The following interests were declared: <u>Specialist committee members</u> Lynda Brown: • None. James Piercy: • Lay member of RESCUE ASDH research steering committee. Fiona Lecky: • Collaborative European Neurotrauma Effectiveness Research in Traumatic Brain Injury (CENTER TBI) EU FP7. • Resuscitative Endovascular Balloon Occlusion of the Aorta (REBOA) – National Institute for Health Research – Health Technology Assessment. • Study of the Management of Blunt chest wall trauma (STUMBL) – National Institute for Health Research – Health and Care Research Wales. • Research Director, Trauma Audit and Research Network – partial salary contribution. Chris Fitzsimmons: • Board member of the TARNlet committee, the paediatric component of the Trauma Audit and Research Network. David Skinner: • None. Karim Brohi:	

Agenda item	Discussions and decisions	Actions
	• Karim's research group is part of a consortium funded by the EU FP7 programme of which the haemostasis device companies TEM International and Haemonetics are collaborators. Iain McFadyen: • None. Richard Lee: • Richard is an examiner for the Faculty of Pre-Hospital Care at the Royal College of Surgeons of Edinburgh. Heather Jarman: • None. **Minutes from the last meeting** The committee reviewed the minutes of the last meeting held on 6th July 2017 and confirmed them as an accurate record.	
4. QSAC updates	No updates.	
5 and 5.1 Topic overview and summary of engagement responses	SW presented the topic overview and a summary of responses received during engagement on the topic. Break, Headway, Back up, British Orthopaedic Association, Trauma Society and BASICS were identified as key stakeholders.	
5.2 Prioritisation of quality improvement areas	SW led a discussion in which areas for quality improvement were prioritised. The QSAC considered the draft areas as outlined in the briefing paper prepared by the NICE team. The outcome of discussions is detailed below.	

Suggested quality improvement area	Prioritised (yes/no)	Rationale for prioritisation decision	If prioritised, which specific areas to be included?
Organisation of services a) Pre-hospital triage b) Transfer c) Organisation and access to services	Yes	<u>Pre-hospital triage</u> The committee discussed that only a small percentage of trauma calls to the emergency services are life threatening, and therefore paramedics may not be used to dealing with major trauma. As a result it may be beneficial for paramedics to use triage tools, but the tools used vary. The committee also discussed how major trauma is usually blunt injury with no visible signs, so trauma triage tools do not always identify trauma well, especially in older people. The committee was aware that the source recommendations do not recommend a specific pre-hospital triage tool. The committee agreed that this was not a key area for quality improvement. <u>Transfer</u> The committee discussed whether the transfer time between trauma units and major trauma centres was a priority area. It was suggested that the transfer time between emergency departments and major trauma centres might be the focus of a statement. The committee discussed further the reasons for, and types of, transfer and suggested that not all transfers are time-critical. The committee agreed that transfer time was not a key area for quality improvement. <u>Organisation and access to services</u> The committee discussed the importance of patients	Organisation and access to services - having a dedicated major trauma service.

		being treated by consultants in a dedicated trauma ward. Not all major trauma centres and trauma units have a coordinated approach to treating major trauma, and it is unclear who the main clinician should be when there are multiple injuries which may cover multiple specialties. It was suggested that a statement on providing a dedicated major trauma service for patients, with a dedicated trauma ward and consultant-led care could be developed, as this would ensure coordinated care and improved outcomes. The recommendation on which this statement would be based includes specific references to children and older people, rehabilitation and having a named key worker at each stage of the care pathway, all of which were areas of concern that had been raised. The committee agreed that having a dedicated major trauma service should be prioritised.	
Airway management	Yes	The committee discussed whether airway management was a priority. The committee noted that ambulance services are not always able to provide medication to secure an airway and an appropriately skilled healthcare professional would need to be sent to the scene. However, even where RSI is not possible, other means for securing the airway were critically important. The committee agreed that the time taken to secure the airway is crucial as loss of airway can lead to mortality. It was suggested that securing an airway within 45 minutes is critical and should be developed as a statement.	Securing the airway using RSI within 45 minutes of the call.

		The committee agreed to prioritise airway management.	
Management of haemorrhage a) Fluid replacement b) Haemostatic agents c) Haemorrhage protocols	No	The committee discussed whether management of haemorrhage is a priority area. The committee agreed that having a haemorrhage protocol would not necessarily improve the quality of care, and giving tranexamic acid is already being done well. It was felt there would be limited added value or benefit to patients in developing a quality statement for this area. The committee agreed not to prioritise this area.	Not prioritised.
Radiology a) Access and use b) Image reporting	Yes	The committee discussed whether radiology is a priority area. The committee agreed that smaller numbers of patients need interventional radiology, so access to it is less of a priority area. The committee noted that there have been improvements in access to imaging, but there are current issues with the timing of image reporting, in particular hot reporting. The committee discussed the resource implications for image reporting. It was noted that there wouldn't be an increase in imaging, just the speed of reporting, so there is limited resource impact. The committee agreed to prioritise the timing of image reporting.	Image reporting - timing of reporting.
Pain management	No	The committee felt this area is covered already in NICE's patient experience quality standard (QS15) and is not a priority. The committee agreed not to prioritise this area.	Not prioritised.

Spinal injury and fractures a) Spinal immobilisation b) Pelvic fractures c) Open fractures	Yes	The committee discussed spinal injuries and fractures. It was noted that the British Orthopaedic Association did not submit comments and should be targeted again at consultation. <u>Spinal immobilisation</u> The committee discussed how very few people have spinal injuries, but it is important to make sure that the few who do are protected, whilst also improving patient experience by removing immobilisation for people who do not need it as soon as possible. The committee agreed that rapid assessment using the Canadian C-spine rule to determine whether or not immobilisation is needed is the key area for quality improvement. <u>Pelvic fractures</u> The committee discussed the potential for pelvic binders to be overused and for an increase in automatic transfers to the major trauma centre, which might not be appropriate. The committee agreed not to prioritise this area. <u>Open fractures</u> The committee discussed the management of open fractures and how this is currently poor. Patient numbers are small but poor management can lead to poor outcomes, such as amputation. The committee discussed the importance of orthoplastic services' involvement and how improving fixation and soft tissue cover would reduce infections and complications. The committee agreed to prioritise open fractures and performing fixation and definitive soft tissue	Spinal immobilisation – assessment using Canadian C-spine rule. Open fractures - perform fixation and definitive soft tissue cover within 72 hours.

		cover.	
Information and support for patients, family members and carers	No	The committee discussed support for children and vulnerable adults, support after discharge and having an allocated member of staff as a point of contact. The committee felt that providing information, such as a written summary about management, is specific to trauma as patients can be unconscious and might not remember what treatment they have had. The committee agreed that this area could be covered by the prioritised area on a dedicated major trauma service including a named member of clinical staff to act as a key worker at each stage of the care pathway. The committee agreed not to prioritise this area.	Not prioritised.

Additional areas suggested	Committee rationale	Area progressed (Y/N)
Data submission to the Trauma Audit and Research Network (TARN)	The committee were keen to progress this area as a statement. The committee discussed whether submitting data to an audit would improve the quality of care in and of itself. The NICE team noted that quality standards focus on interventions to improve patient outcomes, with an emphasis on measurement, suggesting that quality standards underpin audits. It was noted that the Trauma Audit and Research Network (TARN) is no different from other audits and data submission is not something NICE could normally progress as a statement. The drive for TARN will come from the fact that it provides the means for measurement for individual quality statements. The committee felt strongly that that this was an important area. Submitting data to TARN would be considered in the drafting of the QS but if a separate statement could not be included, it will be added to the statement measures, wherever possible.	**No**
Distal femoral fractures and hip fractures	This area is not covered within the development sources (NICE guidelines NG37, NG38, NG39, NG40 and NG41) and the committee therefore did not wish to progress this.	**No**
Orthogeriatric review for	This area is not covered within the development sources (NICE guidelines NG37, NG38, NG39, NG40	**No**

elderly patients	and NG41) and the committee therefore did not wish to progress this.	
Evidence on pre-hospital medical care	NICE quality standards do not review nor re-appraise the underlying primary evidence base and the committee therefore did not wish to progress this.	**No**
Injury prevention programmes	This area is not covered within the development sources (NICE guidelines NG37, NG38, NG39, NG40 and NG41) and the committee therefore did not wish to progress this.	**No**
Radiographer-led discharge	This area is not covered within the development sources (NICE guidelines NG37, NG38, NG39, NG40 and NG41) and the committee therefore did not wish to progress this.	**No**
Staff training	Quality statements on staff training are not usually included in quality standards as healthcare professionals involved in assessing, caring for and treating people with trauma should have sufficient and appropriate training and competencies. Training may enable quality improvement to take place but is not considered as a quality improvement area, and the committee therefore did not wish to progress this.	**No**
Helicopter emergency medical systems	This area is not covered within the development sources (NICE guidelines NG37, NG38, NG39, NG40 and NG41) and the committee therefore did not wish to progress this.	**No**
Sepsis	The areas suggested are covered in the quality standard on sepsis and the committee therefore did not wish to progress this.	**No**

6. Resource impact		
6.1 Overarching outcomes	The NICE team explained that the quality standard would describe overarching outcomes that could be improved by implementing a quality standard on Trauma. It was agreed that the committee would contribute suggestions as the quality standard was developed.	
6.2 Equality and diversity	The NICE team explained that equality and diversity considerations should inform the development of the quality standard, and asked the committee to consider any relevant issues. It was agreed that the committee would contribute suggestions as the quality standard was developed. The committee noted the following. • Geographical location of major trauma centres and trauma units • Older people • Homelessness	

7. Next steps and timescales (part 1 – open session)	SW outlined what will happen following the meeting and key dates for the Trauma quality standard.	
8. Any other business (part 1 – open session)	No other business. **Date of next meeting for Trauma: 4th January 2018** **Date of next QSAC 1 meeting: 2nd November 2017**	