Quality standards advisory committee 1 meeting

Date: 4 January 2018

Location: NICE office, Level 1a City Tower, Piccadilly Plaza, Manchester, M1 4TD

Morning session: Trauma – review of stakeholder feedback

Minutes: Draft

Attendees

Quality standards advisory committee 1 standing members:

Bee Wee (chair), Simon Baudouin, Phillip Dick, Tim Fielding (vice-chair), Zoe Goodacre, Sunil Gupta, Ruth Halliday, John Jolly, Rhian Last, Tessa Lewis, Teresa Middleton, Ian Reekie, Hazel Trender, Hugo Van Woerden, Alyson Whitmarsh

Specialist committee members (SCMs):

Lynda Brown
James Piercy
Fiona Lecky
Chris Fitzsimmons
Iain McFadyen
Richard Lee
Heather Jarman

NICE staff
Mark Minchin
Stacy Wilkinson
Shaun Rowark
Jamie Jason (notes)

Apologies Gita Bhutani, Anita Sharma, David Skinner (SCM), Karim Brohi (SCM)

1. Welcome, introductions objectives of the meeting
The Chair welcomed the attendees and the quality standards advisory committee (QSAC) members introduced themselves. The Chair informed the committee of the apologies and outlined the objectives of the meeting, which was to review stakeholder comments on the trauma quality standard. The Chair welcomed the public observer and reminded them of the code of conduct that they were required to follow.
2. Confirmation of matter under discussion and declarations of interest
The Chair confirmed that, for the purpose of managing conflicts of interest, the matter under discussion in the morning session was trauma, including specifically: • Airway management • Image reporting • Open fractures • Assessment for cervical spine injury • Major trauma service The Chair asked standing QSAC members to declare verbally any interests that have arisen since the last meeting and all interests specifically related to the matters under discussion. Interests declared are detailed in appendix 1.
3. Minutes from the last meeting

The committee reviewed the minutes of the last QSAC1 meeting held on 2 November 2017 and confirmed them as an accurate record.

4. QSAC updates

There were no updates from the NICE team.

5. Recap of prioritisation meeting and discussion of stakeholder feedback

SW provided a recap of the areas for quality improvement prioritised at the first QSAC meeting for potential inclusion in the trauma draft quality standard.

SW summarised the significant themes from the stakeholder comments received on the trauma draft quality standard and referred the committee to the full set of stakeholder comments provided in the papers.

Discussion and agreement of amendments required to quality standard

Draft statement 1: People with major trauma who cannot maintain their airway and/or ventilation have drug-assisted rapid sequence induction (RSI) of anaesthesia and intubation within 45 minutes of the initial call to the emergency services	The committee agreed that as there was support for the statement from stakeholders it should be progressed for inclusion in the final quality standard. The committee discussed the following: • Whether details need to be included on what to do if a patient cannot be given RSI. The committee agreed that paramedics would have been trained in what to do if RSI cannot be performed, so alternative options do not need to be added to the statement. Details of when it might not be possible to perform RSI, for example when a patient has facial injuries, can be covered in the definition of the population. • Whether a 45 minute timeframe is realistic, for example in rural areas. The committee were aware that the 45 minute timeframe is taken directly from the guideline to improve the quality of care. The committee heard that RSI is not needed as frequently in rural areas, and that there are rural areas performing it well, so it is achievable. • Whether the timeframe could result in untrained staff undertaking the procedure and patients being inappropriately taken to a trauma unit. The committee heard that untrained staff are not performing RSI, and that the statement should drive the development of the appropriate skills to deliver it. The committee stated that a trauma unit might be the best place to take a patient if they need an urgent intervention, but it should be emphasised that where possible RSI should be performed at the scene. • Whether the statement is achievable locally within available resources. Resource implications were investigated in the guideline and the committee agreed that there are no resource implications that make the statement unachievable above and beyond those identified during the guideline development process. • The committee agreed that there should be 2 process measures, one that measures the proportion of people receiving RSI and another that measures the proportion receiving it within the timeframe. **Action: NICE team to define the population and add detail to the rationale to emphasise that RSI should be performed at the scene.** **NICE team to consider including 2 process measures, one on getting RSI, the other on timing.**

Draft statement 2: People who have had urgent imaging for major trauma have their images interpreted within 60 minutes of the scan	The committee agreed that as there was support for the statement from stakeholders it should be progressed for inclusion in the final quality standard. The committee discussed the following: • Whether the statement wording should be changed to 'imaging' instead of 'scan'. The committee agreed that the key quality improvement area is reporting of 3-dimensional scans (CT and MRI) and there is less of an issue with reporting on other imaging, such as X-rays. • What 'interpreted' means and whether this should be defined. The committee agreed that this should be clarified and defined as a provisional written radiology report. • Defining who interprets the scan. The committee agreed that the list of healthcare professionals in the audience descriptor in the draft quality standard is suitable. • Whether the process measure should measure the person or the number of images. The committee agreed that a patient might have more than one scan, so the number of images should be included in the denominator. **Action: The NICE team to progress the statement but focus on 3 dimensional imaging (CT and MRI) in line with the recommendations in the NICE trauma guidelines. Define 'interpreted' as a provisional written radiology report.**
Draft statement 3: People with open fractures of the long bone, hindfoot or midfoot have fixation and definitive soft tissue cover within 72 hours of injury if this cannot be performed at the same time as debridement	The committee agreed that as there was support for the statement from stakeholders it should be progressed for inclusion in the final quality standard. The committee discussed the following: • Whether to specify if the upper and lower long bone limbs are included in the statement. The committee discussed how this is up to clinical judgment, and agreed that it does not need to be specified in the statement. • Changing the focus of the statement to the combined orthoplastic approach or simultaneous internal fixation and coverage. The committee agreed that the statement focuses on the appropriate quality improvement area and does not need to change. • Whether there is a safety concern that the timeframe could lead to surgery being performed on patients before they are physically fit enough for it. The committee agreed that this is not something that happens as healthcare professionals use their clinical judgement to avoid putting patients at risk. • Whether to add outcome measures on bone infection and delayed union. The committee agreed that the outcome measures in the draft quality standard are appropriate and these outcomes should not be added. • That fixation and cover should be performed at the same time as

	debridement where this is possible. The committee agreed that this should be emphasised in the rationale. **Action: NICE team to emphasise in the rationale that the timeframe applies when fixation and cover cannot be performed at the same time as debridement.**
Draft statement 4: People who have had full in-line spinal immobilisation have their risk of cervical spine injury assessed using the Canadian C-spine rule	The committee agreed that as there was support for the statement from stakeholders it should be progressed for inclusion in the final quality standard. The committee discussed the following: • What the focus of the statement should be and whether the key quality improvement issue is that too many people are immobilised, that immobilisation is left on too long, or that people at risk of cervical spine injury should be assessed. The committee agreed to change the statement to say that people who have full in-line spinal immobilisation have been assessed using the Canadian c-spine rule. • Whether to change the statement to a 'do not do' statement that focuses on not immobilising patients unnecessarily. The committee agreed not to make this change as it could lead to the unintended consequence of patients not being immobilised when they should have been, for example older patients who do not mention any pain. • It is difficult to do the assessment on children, in particular pre-verbal children, and the tool is not validated for use on children. The committee agreed that the Canadian c-spine rule is the best available assessment for children at present, so the statement should still apply to them. • Whether the statement should focus on the pre-hospital setting. The committee agreed that the assessment needs to be repeated when arriving in the emergency department, and patients do not always arrive at hospital via an ambulance, so the statement needs to cover both settings. • Whether a timeframe for performing the assessment should be added to the statement. The committee agreed that this is not needed and that emphasising that imaging should be performed promptly is more important. **Action: NICE team to amend the statement to emphasise that people who have full in-line spinal immobilisation have already been assessed using the Canadian C-spine rule. Emphasise that imaging for spinal imaging should be performed promptly in the supporting sections.**
Draft statement 5: Major trauma centres have a dedicated trauma ward and designated consultant available to contact 24 hours a day, 7 days a week	The committee agreed that as there was support for the statement from stakeholders it should be progressed for inclusion in the final quality standard but there needed to be some amendments to the focus of the statement. The committee discussed the following:

	• Whether the statement should focus on patients with multisystem injuries. The committee discussed that there are issues in fragmented care for patients with both multiple and single injuries, and that care would be improved if major trauma centres provided an integrated multidisciplinary trauma service that includes the aspects recommended in the trauma guidelines, such as specialist input for elderly patients and access to rehabilitation services. • Whether the statement could be written as a person-centred statement. The committee agreed that as not all patients would need all aspects of the major trauma service, it should stay as a structural statement. **Action: NICE team to amend the statement to focus on major trauma centres providing a dedicated multidisciplinary major trauma service and include all the recommended components as specified in the definition of what such a service means.**

6. Additional quality improvement areas suggested by stakeholders at consultation

The following areas were not progressed for inclusion in the final quality standard as the committee agreed that the five quality improvement areas already included were the key areas:

1. Information and patient and carer communication - considered at first meeting and not prioritised
2. Safeguarding adults and children – not a priority area for quality improvement
3. Education - quality statements focus on actions that demonstrate high quality care or support, not the training that enables the actions to take place
4. Workforce - not specific enough to base a quality statement on

7. Resource impact and overarching outcomes

The committee considered the resource impact of the quality standard.

The committee confirmed the overarching outcomes are those presented in the draft quality standard.

SW requested that the committee submit suggestions to the NICE team relating to the overarching outcomes of the quality standard when it is sent to them for review.

The committee did note the following additional overarching outcomes.

- Cost-effective care
- Infection rates
- Morbidity
- Shorter critical care stays

8. Equality and diversity

SW provided an outline of the equality and diversity considerations included so far and requested that the committee submit suggestions when the quality standard is sent to them for review. The committee stated that the time limit in statement 1 will help to reduce inequalities relating to unequal access to services.

9. Any other business

None.

Close of meeting

Appendix 1: Declarations of interest

Name	Membership	Declaration
Lynda Brown	Specialist	None
Chris Fitzsimmons	Specialist	Board member of the TARNIet committee, the paediatric component of the Trauma Audit and Research Network.
Heather Jarman	Specialist	None
Fiona Lecky	Specialist	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.
Richard Lee	Specialist	Richard is an examiner for the Faculty of Pre-Hospital Care at the Royal College of Surgeons of Edinburgh.
Iain McFadyen	Specialist	None
James Piercy	Specialist	Lay member of RESCUE ASDH research steering committee.