National Institute for Health and Clinical Excellence

Head Injury (update)
Stakeholder Comments

Please enter the name of your registered stakeholder organisation below. **NICE is unable to accept comments from non-registered organisation or individuals. If you wish your comments to be considered please register via the NICE website or contact the registered stakeholder organisation that most closely represents your interests and pass your comments to them.**				
Stakeholder Organisation:	Headway – the brain injury association			
Name of commentator:	Richard Morris, Information Officer			
Order number *(For internal use only)*	**Document** Indicate if you are referring to the **Full** version or the **Appendices**	**Page Number** **Number only** (do not write the word 'page/pg'). Alternatively write **'general'** if your comment relates to the whole document.	**Line Number** **Number only** (do not write the word 'line'). See example in cell below	**Comments** **Please insert each new comment in a new row.** **Please do not paste other tables into this table, as your comments could get lost – type directly into this table.**
Example	Full	16	45	Our comments are as follows ……
Proformas that are not correctly submitted as detailed in the line above may be returned to you				
1	Appendices	294	27	Consider adding 'sexual difficulties'. Consider also adding reference to neuropsychologist referral.
2	Full	89	1	There is considerable anecdotal evidence that people with brain injury are treated in general units that are completely inadequate for their treatment and management. Has the recommendation taken into account studies such as 'Trend in head injury outcome from 1989 to 2003 and the effect of neurosurgical care: an observational study: Lancet 2005'? It has been shown that outcomes for patients with severe head injury are significantly improved with treatment in a specialist neurosurgical centre. If all current specialist neurosciences unit were equipped to deal with their local population then a recommendation of transfer to the patient's *local* specialist centre could remove the problem of lack of bed space. As an expert in the field, director of neurosciences intensive care at Wessex neurological centre, has stated: "Once a patient has been recognised as having a severe head injury, even before the CT scan, the emergency transfer ambulance should be booked. The local neurosciences unit should be contacted and the neurointensivists should make arrangements to ensure that a bed is available. Only when the CT is available is the neurosurgeon required; to determine whether immediate surgery is necessary." Eynon, C.A. What is the best outcome from severe head injury, *JICS; 9 (3),* p. 215.

3	Full	179	10-12	Should the information and support needs of patients with longer term rehabilitation and support needs be taken more into account in this or other guidelines? People with moderate-severe injury are frequently discharged home with inadequate provision of services and there should be standardised recommendations issued for the proper management of these patients. This requires compulsory follow-up appointments with the appropriate rehabilitation services, such as neuropsychological assessment.
4	Full	187	17	These recommendations are good but should be strengthened to ensure that patients are handed printed copies of publications relevant to their needs, whether produced by the hospital or organisations such as Headway. All support organisations details should be made very clear to the patient's family members and direct referral should be made if possible, at the hospital stage, even if the patient is considered likely to make a good recovery. Staff should be encouraged to contact a local Headway support group on behalf of the patient to set up and appointment, with the patient's permission, which the support group can then follow up in the next few days
5	Full	General		This is linked to the comment above relating to follow up of those with moderate-severe injuries. There is no mention in the guidelines about possible hormonal deficiencies after brain injury. There is good evidence that people can experience undiagnosed hypopituitarism or other pituitary disorders and that testing at 3, 6, etc months after injury can detect these problems. Testing at the acute stage is not satisfactory as hormone levels tend to be wildly fluctuating at this stage, especially after severe TBI. Some English hospitals have already introduced standard follow up testing, such as QE in Birmingham and Wessex in Southampton. Future updates to the guidelines should fully investigate the effectiveness of such standard procedures.
6	Full	General		Some recommendations should be made for specialist staff training in dealing with challenging and disinhibited behaviour from patients and in dealing sensitively with family members. This could be handled by recommending the appointment of specialist brain injury nurses, who can liaise with families and advocate for their needs. Such individuals could also help to facilitate transfers/discharge to the appropriate next stage.
7	Full	18	2-19	The statistics in the new introduction aren't referenced. Please provide full references.

Please add extra rows as needed

Please email this form to: head_injury@nice.org.uk

Closing date: 5pm on 4 October 2013

PLEASE NOTE: The Institute reserves the right to summarise and edit comments received during consultations, or not to publish them at all, where in the reasonable opinion or the Institute, the comments are voluminous, publication would be unlawful or publication would be otherwise inappropriate.