Trauma Network incidents 2024-25

8 KEY POINTS

32 incidents were reported, these are the common themes.

NHS South West London & Surrey TRAUMA NETWORK

TU - Trauma Unit
MTC - Major Trauma Centre (St George's)
TTL - Trauma Team Leader
★ Repeated theme from 23-24

1 TRANSFER ★

5 cases where patients were either transferred to the MTC without discussion or were transferred when they should have been managed locally.

Discuss with MTC TTL and document decisions around transfer clearly.

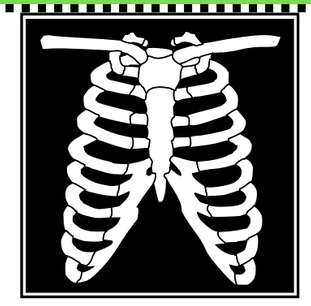
2 PRE- ALERT

2 cases of lack of ambulance pre-alert for patients transferring to MTC.

All trauma transfers should pre-alert 10 minutes out.

3 SENIOR INVOLVEMENT

6 cases of lack of senior involvement at TUs, this includes patient assessment and referral.
Strong team leadership is the key to initial management. Consultant or at least ST3+ involvement is essential.



4 IMAGING ★

7 cases of incomplete or inadequate scans and the use of non-contrast CT.

Refer to the Network imaging guideline.
Include CT report when transferring patients

5 OPEN FRACTURES ★

4 cases of delayed transfer or cases not discussed ortho to ortho.

Follow network open fracture guideline and checklist on Network website.

6 TRAUMA CALLS

2 cases of polytruma patients being managed in TUs without a full trauma team.

TUs should lower threshold for trauma team activation.

7 REFERRAL ★

12 cases of inadequate or inappropriate referrals.

- **No TU to TU transfers**
- **Referrals should be made by a senior clinician (at least ST3+ with formal trauma training).**
- **Specialty transfer? still inform MTC TTL.**

8 GUIDELINES ★

Many of these incidents could have been avoided by following the Network guidelines

https://swlstrauma.net/guidelines.