Trauma Network incidents 2025-26

8 KEY POINTS

40 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 24/25

1 TRANSFER ★

5 cases - Transfer from TU not discussed or inadequate details in referral.

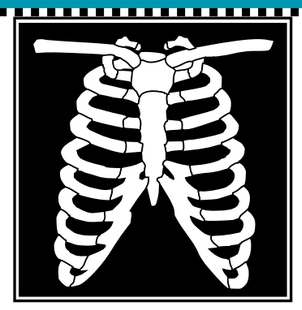
Discuss with MTC TTL and use Referapatient for polytrauma referrals

2 BYPASS TOOL

11 cases - Ambulance service bypass tool not followed. Patients taken to TU when they met bypass criteria and also taken to MTC when they should have gone to TU.

3 INITIAL TU MANAGEMENT

7 cases - Cases include significant missed injuries, inadequate initial resuscitation and delayed transfer.
TUs should lower their threshold for activating a trauma call and ensure senior involvement.



4 IMAGING ★

1 case - Inaccurate report by outsourced reporting

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

5 ADVICE FROM SPECIALTIES AT MTC

4 cases - Difficulty contacting specialty and specialties rejecting referral.

Discuss with MTC TTL in case of referral difficulties with MTC specialties.

6 AMBULANCE TURNED AWAY AT TU ED

3 cases - All ambulance crews should be welcomed to the TU and the patient undergo initial assessment. If onwards transfer is required this should be arranged as per guidelines.

7 SPECIALTY ADVICE INADEQUATE

1 case - Specialties can only advise based on the information that they are given. More detailed referrals with specific questions will lead to more accurate advice.

Referrals should be made by a senior clinician (at least ST3+ with formal trauma training).

8 INADEQUATE SECONDARY TRANSFER

4 cases - Problems included no suitable escort, inadequate resuscitation prior to or during transfer and deterioration during transfer.

Senior involvement with patient and optimisation prior to transfer with appropriate escort.