Major Trauma considerations in escalations

Major Trauma Services – usual business pattern

Major Trauma services are delivered via a hub and spoke model. The most critically injured patients are cared for within a Major Trauma Centre (MTC) with less severely injured cared for in Trauma Units. Trauma Units therefore have less resources to care for critically unwell patients. Prehospital providers work alongside the MTC and the TU's to deliver best practice pathways for patients. These services are grouped into geographical networks "Major Trauma Networks".

To ensure patients receive the most appropriate care immediately after their traumatic incident tools are in place to support the prehospital staff convey patients to the most appropriate location. In an escalation event these may not be as appropriate, and a more responsive intelligent conveyancing methodology put in place by the clinical staff at scene.

Acute Phase of an escalation

The Major Trauma Network has no role in the acute phase of an incident. This would be coordinated through existing bronze, silver and gold command structures.

In liaison with the ambulance service the following are proposed considerations for silver or gold commander of Trusts:

- Turn off the Major Trauma Triage Tool – during business as usual, this tool ensures that the most critically injured patients are conveyed directly to the Major Trauma Centre (UHS) and bypass their local hospital (usually a Trauma Unit). Turning this tool off will result in patients being conveyed to their closest hospital / Trauma Unit, requiring teams to look after critically ill patients without the specialist resources available at the MTC.
- Turn off the Automatic Secondary Transfer Tool of critically unwell patients – During business as usual, this tool ensures that patients who are too unstable to be directly conveyed to the MTC are stabilised at their local emergency department before being automatically transferred to the MTC. Turning this tool off will result in patients remaining in the closest hospital / Trauma Unit for an extended period. This will have a knock on effect on both the patients and treatment teams as there are fewer resources to manage such critically injured patients in comparison to the MTC.

I**MPLEMENTATION OF ONE OR BOTH OF THE ABOVE MAY RESULT IN POORER OUTCOME FOR PATIENTS. ACCURATE TRIAGE BY THE CLINICIANS AT THE SCENE AND COMMUNICATION WITH THE ACUTE HOSPITALS IS VITAL TO ENSURE APPROPRIATE CONVEYANCE OF TRAUMA.** (e.g. severely injured abdominal bleeding could go to a TU (possibly bypassing the MTC, even if closer) whereas priority of neuro trauma should go to MTC (bypassing TU).

If either of the above are instigated a methodology should be implemented to ensure a list of patients remaining in local hospitals is captured and MTC care can be arranged as soon as possible either within the Major Trauma Network MTC or via Major Trauma Network / MTC mutual aid (supported by NHSE).

Recovery Phase from an escalation event

The Major Trauma Network management team will work with the MTC team during the recovery phase of an escalation event to repatriate / ensure that patients requiring MTC care receive this.

Virtual MDT's with expertise from local / national experts should be facilitated to support colleagues managing less familiar injuries within Trauma units / MTC.

Illustration of Major Trauma Networks, Major Trauma Centre

and Trauma Units within the South of England