strategies to reduce the time taken to reach definitive care, ensuring that avoidable delays are minimised.

Quality of care and overall volume
In the full report, Trauma: Who Cares?, we point to the lack of appreciation of the severity of illness, of the urgency of the clinical scenario and incorrect clinical decision making that were apparent. Many of these clinical issues were related to the lack of seniority and experience of the staff involved in the immediate management of these patients. It was clear that the provision of suitably experienced staff during evenings and nights was much lower than at other times. In the management of trauma, which very often presents at night, this is a major concern.

Severe trauma is not common in Britain and many hospitals see less than one severely injured patient per week. This has a direct bearing on experience and ability to manage these challenging patients. Not only does this relate to clinical skills but also to the feasibility of providing the entire infrastructure required to manage trauma patients definitively in all centres. In this head injured group of patients, we have shown that higher volume hospitals have a trend towards better care.

Conclusions
This study has shown that the care for trauma patients with a head injury is frequently less than good. Simple remediable steps in the initial care of these patients could be implemented by individual hospitals and trusts using published guidelines, and their use could be self-audited. The National Center for Injury Prevention and Control in the US suggests that 80% compliance with the Brain Trauma Foundation guidelines would not only save 5,000 lives per year but also $250 million per year in reduced medical and rehabilitation costs. Longer term actions that will improve the care (and outcome) of these patients include a robust reconfiguration of trauma services and better provision of neurocritical care facilities.

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References
1. Office for National Statistics. Mortality Statistics: Cause. Series DH2 no.32. London: ONS; 2006.
2. Hutchinson PJ, Kirkpatrick PJ. Acute head injury for the neurologist. J Neurol Neurosurg Psychiatry 2002; 73 Suppl 1: i3–i7.
3. National Institute for Health and Clinical Excellence. Head Injury. London: NICE; 2007.
4. Patel HC, Bouamra O, Woodford M et al. Trends in head injury outcome from 1989 to 2003 and the effect of neurosurgical care: an observational study. Lancet 2005; 366: 1,538–1,544.
5. National Confidential Enquiry into Patient Outcome and Death. Trauma: Who Cares? London: NCEPOD; 2007.
6. Härtl R, Gerber LM, Iacorno L et al. Direct transport within an organized state trauma system reduces mortality in patients with severe traumatic brain injury. J Trauma 2006; 60: 1,250–1,256.
7. Major Trauma Services. NHS Choices. http://www.nhs.uk/NHSEngland/AboutNHSServices/Emergencyandurgentcareservices/Pages/Majortraumaservices.aspx (cited November 2012).
8. Purtill MA, Benedict K, Hernandez-Boussard T et al. Validation of a prehospital trauma triage tool: a 10-year perspective. J Trauma 2008; 65: 1,253–1,257.
9. Neurocritical Care Stakeholder Group. Neurocritical Care Capacity and Demand. London: NCSG; 2006.
10. Brain Trauma Foundation. Guidelines for the Management of Severe Traumatic Brain Injury. 3rd edn. New York: BTF; 2007.
11. Maas AI, Dearden M, Teasdale GM et al. EBIC-guidelines for management of severe head injury in adults. Acta Neurochir 1997; 139: 286–294.
12. Leach P, Childs C, Evans J et al. Transfer times for patients with extradural and subdural haematomas to neurosurgery in Greater Manchester. Br J Neurosurg 2007; 21: 11–15.
13. Faul M, Wald MM, Rutland-Brown W et al. Using a cost–benefit analysis to estimate outcomes of a clinical treatment guideline: testing the Brain Trauma Foundation guidelines for the treatment of severe traumatic brain injury. J Trauma 2007; 63: 1,271–1,278.

Erratum
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A case of reflective evidence-based surgery
D Nikkhah
The fourth sentence in the second paragraph should read: ‘I discovered that suturing conferred no benefit in terms of cosmesis in the paediatric population but that there was a small but statistically significant decreased risk of dehiscence.’ We apologise for any confusion.