activities and advocate for local road traffic injury prevention. This approach promotes collaboration to enhance road safety and involvement of grassroots organisations. With the help of the CRSMs, communities are enabled to form Community Road Safety Forums, whose role is to gather local perspectives and inform palika leaders regarding road safety decisions. Quarterly meetings, using participatory learning and action methods, have been planned for the next three years to hone ideas around road safety challenges and possible solutions. The costs of the CRSF meetings are provided and annual evaluations will assess the impact of CRSF activities on local decision making.

Outcomes and Learning We have developed a framework for activities, recruited and trained the CRSMs, obtained authorisation from the mayors of the eight selected palikas, formed community road safety forums and developed meeting guides. Convincing local leadership for historically neglected issues is challenging and time consuming. Formation of a Local Road Safety Committee in each of the selected Palikas is anticipated at the end of the process.

Implications From our learning we will co-produce a toolkit for all palikas in Nepal that describes how this approach to community level advocacy for road safety can be established.

Conclusions Our experience has confirmed our expectation that at local government level in Nepal there is little awareness of the issues that could be addressed to make local roads safer. Our approach has the potential to enable community level advocacy for local government action.

235 PREDICTORS OF 24-HOUR MORTALITY IN PATIENTS WITH MAJOR TRAUMA ATTENDED BY EMERGENCY MEDICAL SERVICES IN NEW ZEALAND

[1]Luisa Montoya*, [2]Gabrielle Davie, [3]Bridget Kool, [4,5]Bridget Dicker, [5]Rebbecca Lilley. *[1]Department of Clinical Epidemiology and Biostatistics, Pontificia Universidad Javeriana, Bogotá, Colombia; [2]Injury Prevention Research Unit, Department of Preventive and Social Medicine, Dunedin School of Medicine, Ōtākou Whakaihu Waka | University of Otago, Dunedin, New Zealand; [3]Section of Epidemiology and Biostatistics, School of Population Health, University of Auckland, New Zealand; [4]Clinical Audit and Research, Clinical Evaluation, Research and Insights, Hato Hone St John, Auckland, New Zealand; [5]Department of Paramedicine, School of Clinical Sciences, Auckland University of Technology, Auckland, New Zealand*

10.1136/injuryprev-2024-SAFETY.122

Background Major trauma is a significant contributor to morbidity and mortality. The provision of optimal prehospital Emergency Medical Services (EMS) care and timely transfer to advanced-level hospital care are vital to increase the likelihood of survival of following major trauma.

Objective To identify factors that predict 24-hour mortality in patients with major trauma who were attended by EMS at the scene of injury in New Zealand (NZ).

Methods Analysis of routinely collected data (major trauma registry and EMS providers) from a retrospectively designed prospective cohort study was undertaken. Patients aged 84 years or less who experienced major trauma between December 2016 and November 2018 that were attended by an EMS provider in NZ were included. Factors predictive of 24-hour mortality were explored using modified Poisson regression.

Results 3,033 patients met the eligibility criteria; 3% (n=99) died within 24 hours following injury. Univariate analysis suggested that being aged between 80 and 84, being triaged by EMS as having threat to life injuries (purple/red), having an ISS greater than 24, experiencing non-blunt trauma or intentional injury, having one or more comorbidities, and having one or more previous hospital admissions increased the risk of mortality. Following adjustment for the characteristics of injury, the relationships between mortality 24 hours after injury with age (80–84 years cf. 0–14 years) (Adjusted Relative Risk [aRR]: 13.17; 95%CI: 2.96–58.55), triage (purple/red cf. orange/green/grey) (aRR: 2.19; 95%CI: 1.38–3.47), having one or two previous hospital admissions compared to no having admissions (aRR: 1.83; 95%CI: 1.13–2.97), experiencing non-blunt trauma in relation to experiencing blunt trauma (aRR: 2.64; 95%CI: 1.16–6.02) and having an ISS greater than 24 compared to having an ISS of 24 or less (aRR: 10.19; 95%CI: 6.03–17.20) remained.

Conclusion Our results suggest that mortality within 24 hours following major injury is predicted by injury severity, a patient's age, and other injury-related factors such as mechanism of injury and injury intent. However, of these, severity of injury was the strongest predictor in this study. The findings reinforce the need for continued primary prevention efforts and the rapid EMS assessment and management of those with severe injuries in the prehospital setting.

237 RELATIONSHIP BETWEEN PREHOSPITAL TIME AND 24-HOUR MORTALITY FOLLOWING INJURY IN PATIENTS WITH MAJOR TRAUMA IN NEW ZEALAND

[1]Luisa Montoya*, [2]Gabrielle Davie, [3]Bridget Kool, [4,5]Bridget Dicker, [5]Rebbecca Lilley. *[1]Department of Clinical Epidemiology and Biostatistics, Pontificia Universidad Javeriana, Bogotá, Colombia; [2]Injury Prevention Research Unit, Department of Preventive and Social Medicine, Dunedin School of Medicine, Ōtākou Whakaihu Waka | University of Otago, Dunedin, New Zealand; [3]Section of Epidemiology and Biostatistics, School of Population Health, University of Auckland, New Zealand; [4]Clinical Audit and Research, Clinical Evaluation, Research and Insights, Hato Hone St John, Auckland, New Zealand; [5]Department of Paramedicine, School of Clinical Sciences, Auckland University of Technology, Auckland, New Zealand*

10.1136/injuryprev-2024-SAFETY.123

Background Time is an important determinant of outcomes for individuals following trauma. Optimising prehospital trauma systems and care, such as (where appropriate) reducing prehospital times, and ensuring patients get to the appropriate receiving facility are necessary in order to reduce serious injury-related mortality and morbidity.

Objective To explore the relationship between time spent in the prehospital phase and 24-hour mortality following injury in patients with major trauma in New Zealand (NZ).

Methods This retrospectively designed prospective cohort study analysing routinely collected data included hospitalised patients aged 84 years or less attended by an Emergency Medical Services (EMS) provider in NZ for major trauma between 1 December 2016 and 30 November 2018. Modified Poisson regression models considered total prehospital time and EMS time intervals, and were adjusted by patient sociodemographic, triage and injury characteristics.

Results 3,033 patients met the eligibility criteria; 3% (n=99) died within 24 hours following injury. Univariate analysis indicated that total prehospital time greater than 60 minutes was a predictor of survival, reducing the risk of death by 49% (Relative Risk [RR]: 0.51; 95%CI: 0.35–0.76). Response times greater than 14 minutes, on-scene times between 30–45 minutes and transport times of 10 minutes or more were independent predictors of lower risk of death. In the