SCOTTISH TRAUMA NETWORK NORTH

North of Scotland Trauma Network Recovery Plan - Living with COVID-19

The Position of the North of Scotland Trauma Network

COVID-19 placed significant pressure on the NHS and Health and Social Care Partners. Major trauma was predicted to reduce by a third but instead in the north of Scotland it increased by a third. Trauma is multi-faceted and is defined by the injury, not the mechanism. Therefore a major trauma admission is as likely to be an elderly person falling in the street as a traffic collision. There was an initially a reduction in numbers of trauma in some parts of the Network in March but, even with relatively minimal lifting of restrictions, trauma has increased beyond pre-COVID-19 levels. From November 2019 to February 2020 there were on average 19 people benefiting from major trauma services a month at the Major Trauma Centre (MTC) and Trauma Unit (TU). This has increased to 26 from March 2020 to mid-June 2020.

Major trauma services are recognised as part of critical business and the NoS Trauma Network is justifiably proud of its response and agility to respond to the COVID-19 pandemic. Excellent pre-hospital and acute services, including tracking, support, acute rehabilitation, planning and a continuous point of contact were all maintained. However, COVID-19 required significant redeployment from the Network at all levels to support acute services. Local redeployment, while necessary, impacted the Network's ability to provide a collective and integrated approach to patient care. Changes to the service are shown in appendix 1 with a summary below:

Within the MTC: the tertiary survey, regular in person weekend cover and attendance at trauma calls of the MTC multi-disciplinary team members (case manager and clinical fellow) were suspended; two of the four trauma and rehab co-ordinators were redeployed as well as both Clinical Fellows; the STAG local audit co-ordinators and specialist rehabilitation staff worked across both MTC and non-MTC streams to support the COVID-19 response and support discharge; MDTs continued by using Teams software.

Within the TU: the only rehab co-ordinator was redeployed and consequently all in-hospital patient screening ceased; trauma psychology staff worked from home and tracked patients using remote technology plus provided support and a link back to the hospital system for urgent issues; the trauma Occupational Therapist was community based and provided the link to community supporting discharge.

Rehabilitation: reduced rehabilitation beds due to social distancing requirements; community AHP follow up if urgent only; no outpatient rehabilitation and less access to neuropsychology follow up.

Remobilisation

Within this context of increasing requirements for major trauma services it is clear the Trauma Network provision which was paused or reduced must be resumed as soon as possible, obviously taking into account health and safety guidance. Redeployed staff need to return to their duties and community rehabilitation services urgently restored in order to support planned discharge and maximise the recovery of those affected by major trauma. To not take these steps will significantly impact the flow and outcome of patients. Additionally trauma clinical leads are recommending, given the planning and preparation undertaken for the pandemic and the increase and consistent number of trauma, that any further spike in COVID-19 would only see the requirement to redeploy trauma team staff in the latter phases of an escalating demand.

There have clearly been benefits that have emerged for the Network: flexibility, learning more efficient ways of working, clarity on the value of the Network and working together to maintain the ethos of the Scottish Trauma Network (STN). However, governance, review and collective learning have been suspended. The

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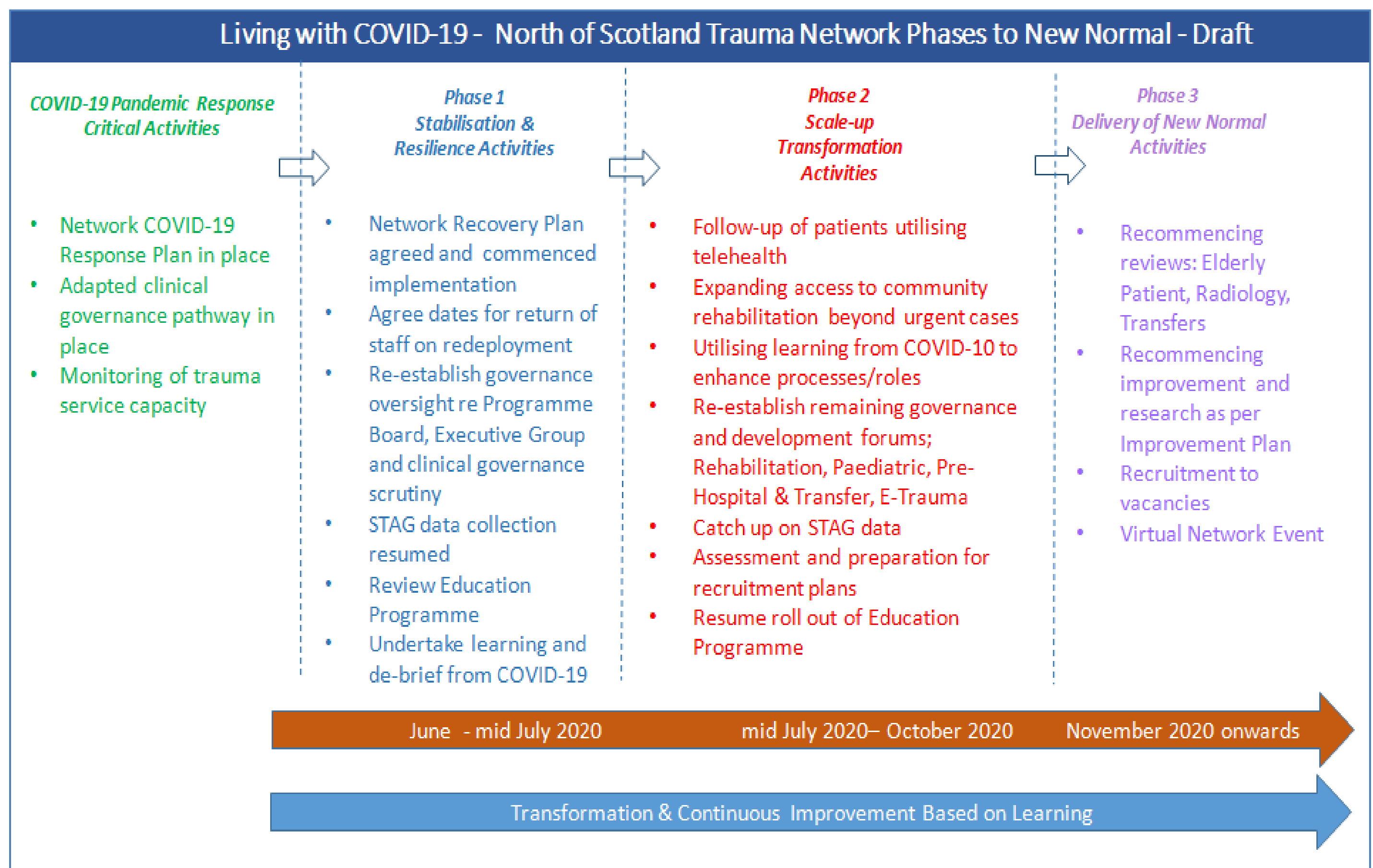
provision of trauma care has been maintained, however, the benefits of an integrated network approach have reduced.

The Network aims to rapidly restore integrated pathways of care, restore governance, formal learning and improvement processes as a matter of urgency through a phased approach. Particular focus will be on re-establishing links and supporting the return of community rehabilitation services. The following diagram indicates the proposed phases of recovery showing priorities and expected timeframes. These phases will obviously need to complement and support the individual Health Board Remobilisation Plans but it is hoped that pressure can be applied to ensure the Network's services achieve the 'new normal' without delay.



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Appendix 1

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