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

SCOTTISH TRAUMA NETWORK NORTH

What changes to the major trauma service has worked well due to the COVID-19 response?

- Combined role of trauma case manager and rehab co-ordinator
- Senior clinician advice phone line for SAS/prehospital BASICS responders
- In TU surgical specialties consultants taking responsibility of moderately severe paediatric trauma without Emergency Medicine consultant
- In TU paediatric rehab coordinator contactable via mobile phone (not ASCOM)input.
- PPE adherence
- Use of NHSG, NHSH trauma email address & delay letter
- Use of Near Me with patients. TEAMs for meetings.
- Remote working opportunities.
- continuation of patient identification
- The duplication of heaps of our paperwork has stopped
- communication with families via text/whatsapp
- VC / tele follow up
- Good communication locally and timely advice and support from Grampian has been very effective and enabling.
- Trauma patients follow the same pathway

Are there lessons to be learnt through this period?

Part 1

Part 1
- Resilience of service when staff pulled to other roles/services.
- The attributes of being dynamic and flexible should be a core competency in any role.
- Discharge back into the community should not necessarily be expedated for those with TBI to 'free up beds' especially where robust community support is not available.
- The lack of physical space
- the deployment of key staff to other areas has been to the detriment of the service.
- Trauma is still possible in a major outbreak yet we seem to have abandoned all the principles on how to handle it during Covid 19. It has been radio silence.
- The need to evaluate our actions before, restructuring the team
- Not to be lulled into a false sense that we will see fewer paediatric major trauma cases.
- In the next air ambulance contract there needs to be provision made for planes to be suitable for isolated transfers - so that if there is doubt about the diagnosis or worries about asymptomatic disease, patients with non-covid problems can still be transferred. The lack of a clinician on the SSD for this period has exacerbated the problem.

Are there lessons to be learnt through this period?

Part 2

Part 2
- Importance of good communication between MTC and TU. Advice has been clear and accessible in helping us to deal with current challenges
- VC could be used for senior support from trauma centre in future
- Smaller group meetings more efficient/productive
- Avoidance of reliance on individuals/ specialist skills lost to redeployment
- Ongoing collaboration with other sectors and Networks
- Discuss whether STAG staff should be required to work in clinical areas when peak is over.
- we can achieve with less duplication of roles and paperwork!
- We are entering an era of patients possibly having unknown and compromising viral infections. We have now put in place protocols to manage this.
- A MTC consultant would often be useful but has been unusual.
- The polytrauma unit would be useful for certain patients and the re starting of it or somekind of step down area like a COU for this complex patient group
- Our patient flow is very dependent on having step down community facilities or some kind of AHP input in the home and this has been slower/stopped for a while/missing.
- there are issues with taking patients to the small gym areas we have in ARI currently unless patient on a specific ward with a gym area and this is affecting rehab too - especially as issue when Woodend was closed.
- Less "reactive" more "proactive" planning and learning lessons from elsewhere who were ahead in pandemic
- Transport of trauma patients with potential Covid requires reviewing.
- several projects in the pipeline are perhaps outdated, with all of this use of tech in the past few months it has allowed us to revamp our plans to be in line with modern day
- flow of conversation and discussion is not achieved through teams meetings,
- Non Covid trauma morbidity and mortality cannot be abandoned in favour of a Covid only response after the peak is over.
- consistency in the patients care is imperative
- Don't go to Italy ….

Phase 1 - Stabilisation & Resilience Activities

- PPE work up for sustained service, the adaptation to clinician exposure, risk assessments, and changes to practice whilst living with COVID19
- assessment of staff resources
- redeployment of the MTC & TU team is a priority
- Look at specific governance issues that have arisen during the pandemic
- to ask each department to confirm that Trauma Care protocols still stand as pre-COVID.
- review of membership of mailing lists.
- Practicalities around transfer for rural areas and staff capacity with appropriate skills
- Agreement by NHSG and NHSH boards and HSCP that the major trauma service is a critical service for prioritisation in the recovery plan
- Enhanced support and risk assessment for shielded staff
- Base for MTC and TU teams to allow social distancing,
- IT access, opportunities for remote working.
- Review meeting with trauma clinical leads to understand wider impact of covid 19 on trauma patient pathway and impact on staff and services
- Review previous roles eg TCM/RC, AHP input, MDT working
- Identify priorities for each subgroup ed education, clinical governance, prehospital, rehabilitation, eHealth
- catch up on STAG data collection entering minimum data set only until up to date.
- Reassess priorities for the network, projects as these are likely to have changed
- using different approach ie. virtual meetings, delegate tasks for those working from home etc

Phase 2 - Scaling Up Transformation Activities

- safe secure working,
- use technology for education and follow up
- Take time to review rehab facilities and how these areas may also have changed and altered the way they are working
- Probably worth dedicating first 2 Trauma Education meetings to 'revision' of Trauma processes with an adult and a paediatric case
- Consider which platform (VC/Teams/NHS Near me?) is most suitable for future meetings .
- Governance, case reviews & meeting audit requirements
- Ensure capacity for repatriation of rehab patients
- Follow up of MT patients since 23.3.20, telephone, near me reviews
- Update of data collection
- Re-establish relationships with Network partners
- Prepare for recruitment of new posts
- Work within limitations of fluctuating covid arrangements
- Re-establish governance and development forums
- Returning to standard SOP with precautions
- Supporting staff members on return from redeployment.
- Establish criteria and thresholds of trauma resurgence that STAG can use to trigger local responses to a return to full clinical pathways

Phase 3 - Delivery of New Normal Activities

- re introduce education programmes to maintain skills
- Review of post covid arrangements/restrictions re pre-hospital/ transfers/ diagnostics/ elderly/rehabilitation
- Recruitment to posts
- Improvement projects
- Consistency in communication and the contact for the patients and the relatives at all times.
- Robust protection protocols
- TEAMS/Near Me or alternative accounts for all community staff.

What could be paused/stepped down if there are further significant surges in COVID-19?

- Adapting to phone / virtual clinical input rather than f2f.
- try and maintain a more robust service than has been available over the last 10 weeks.
- STAG data collection should be prioritised ahead of network clinical governance meetings and education
- Education
- network event
- entering only minimum data required for KPI compliance and outcomes.
- trimming down documentation again eg rehab plan
- development/research projects which don't have immediate impact
- recruitment to new posts
- PROMS
- More thought given to patients going to the nearest appropriate hospital rather than always triaged to the Major Trauma Centre
- increasing telerehab strategies to replace face to face services.
- Establish that single post staff should be repatriated to MTC after the peak or if possible not deployed.

Are there any education & training issues which should be a priority?

- Online resources
- Potentially having education session via Microsoft teams?
- Sharing knowledge and skills gained over the last few months
- nurse/AHP formalised education plan should be prioritised over the MTC simulation course.
- local ETC provision
- Review of previously scheduled courses which were cancelled
- How will practical training be delivered going forward
- Use of webinairs to deliver training
- Some training or ed for staff on various local anaesthetic blocks or on the deteriorating patient within some ward areas if no PTU for patients to step down too.
- Shared learning / lessons / good practice now to prepare for another surge
- simulated Covid positive scenarios
- management of paediatric head injury to ensure consistent approach
- ensuring staff returning from deployment have appropriate training where there have ben significant changes in ways of working during their period of redeployment
- I feel the SPOC system is not bedded in, and that this should be the focus of educational activities, with case based discussion.
- There needs to be some thought given to delivering trauma courses in a different way with blended, learning, pre-course, virtual, and minimal FtF with appropriate social distancing. For rural sites this should be presented in a locally relevant way.
- Off the peg courses happening far from base are simply not possible now. There has also been skills decay with very little trauma seen for three months.

Can you specify if there should be changes to the timelines in Phases 1-3 as suggested in the Draft Recovery Plan?

- No - I guess it is being aware of another potential peak in COVID - 19 activity and also taking into account staff annual leave
- Early consideration of recruitment of new posts
- Staffing issue and reestablishing team should hopefully be done June / July, not August.
- Follow up patients should start sooner, as should governance meetings.
- the time lines should be adjusted in line with Scottish Government and NHS Scotland guidance
- Rather than establishing months, it should be based on incidence of trauma in each region and linked to local R0 calculations. NoS has a wide variation of Covid incidence.

Any other comments

- Focus on early discharge from immediate service(s) so early prompt access to these high quality services is more significant. Once patients are home what services remain available that can be accessed remotely for patients to continue their recovery at this difficult time Especially with previous support measures that had been available previously(precovid) but not anymore (easy family access / friends inputting/ employer support etc) More trauma patients will be facing more hardships- unemployment/financial hardship/relationship/isolation issues. This (once at home) aspect of the Network needed more now than ever.
- Genuine concern for the Network given its early first few years and now this bludgeoning viral novel illness putting the whole NHS service under considerable strain. Thanks for the opportunity to share concerns
- Recognition of covid 19 stress/ fatigue amongst staff/teams
- Build the motivation/ energy to re-establish the trauma network, MTC and TU collaborative working
- Ensure robust, sustainable systems of working whilst living with Covid19.
- Well done to everyone in all their efforts in this pandemic
- Ongoing communication while re-deployed so that everyone on the team is kept in the loop.
- I think the trauma service is meeting needs as much as possible in very abnormal times
- As always rural issues centre on transfer, access to promptly reported imaging and easy access, for patients to the major trauma centre. All of these have been compromised by the covid pandemic. I am not convinced that the transfer issue has been sorted despite the low prevalence in all the island sites, except Skye.
- Thank you for being so quick to respond to the resurgence of trauma

20 respondents:

8x MTC clinicians
3xTU clinicians
1x LEH clinician
1x ANP/PHC
4x Trauma Clinical Leads
2x Managers
1X Specialist Rehab clinician