

**THE SHAPE OF THINGS TO COME**

**LIKELY FUTURE CONFIGURATIONS**  
**FOR TRAUMA REHABILITATION**  
**SERVICES IN SCOTLAND**

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**“Rehabilitation plan TBC”**

# WHERE ARE WE NOW?

- Patchy provision of specialist rehabilitation services around the country
- Limited capacity, with too few rehabilitation specialists in all relevant professions
- Limited process and outcome data
- Lack of central coordination and drive

# BUT.....

- A growing body of data shows that specialist rehabilitation does work and is cost-effective
- There is now acceptance that the potential benefits of major trauma networks will only be realised if as much attention is paid to rehabilitation as to the front end of care

# WHAT CAN WE LEARN FROM LOOKING SOUTH?

- NCASRI 2016
- Only 5% of patients admitted to MTCs reach specialist rehabilitation services
- The reasons are complex and not yet completely understood, but include capacity issues

# THE POSITION IN ENGLAND

- Wide variation in specialist rehabilitation resources for trauma care:
  - RM consultant input (0-6 per MTC)
  - specialist rehabilitation beds (1-8 per million)
  - staffing in rehabilitation units to manage a complex caseload is inadequate in 50-70%
  - use of rehabilitation prescription to guide care after the MTC (50%)

# WHAT WILL HAPPEN IN SCOTLAND?

- One single Scottish Trauma Network
- Four MTCs (with their TUs and LEHs) that will be expected to work together, to support each other, and to share best practice
- We live in austere and politically uncertain times, but can we really do more with the same or less?

**THE STATED  
REHABILITATION PLANS OF  
EACH QUADRANT OF THE  
FUTURE SCOTTISH TRAUMA  
NETWORK**



# EAST: OUTLINE PLANS

- MTC at Ninewells, based in T&O directorate
- Trauma ward, with RM consultant sessions
- 0.5 wte consultant (RM/AHP) is a priority
- Early appointment of a trauma coordinator, who will work along the whole pathway from early assessment to rehabilitation liaison

# EAST: THE CONTEXT

- Strong interface with current redesigns of the neuro-rehabilitation and amputee services
- A mixed economy of hospital-based and community-based services: hub and spoke
- Well-worked out plans with a lot of clinical, local authority, and public buy-in

# **SOUTH-EAST: THE OVER-ARCHING AIM**

*“Rehabilitation programmes will be initiated very early in the patient pathways, and the service will be delivered in a consistent way, both within the MTC and following repatriation”.*

# **SOUTH-EAST: YEAR 1**

- Develop closed head injury model
- Integrate AHPs into trauma ward
- New interdisciplinary 24/7 rehab model, including coordinator role
- Develop tool to define rehab programme within 24 hours of admission
- Align MTC rehab with local rehab services

# **SOUTH-EAST: YEARS 2+3**

- Continue phased implementation of rehab workforce and 7 day working
- Refine AHP model to prioritise specialisms and develop dietetic and psychology input
- Refine clinical pathways to specialist rehab
- Develop key worker system
- Strengthen links with community rehab

# NORTH: THE CHALLENGES

- Distances, terrain, climate
- Historic under-resourcing of specialist and generic rehabilitation, especially outwith Aberdeen and Inverness

# NORTH: THE RESPONSE

- Emphasis on trauma team coordinator role: team to team, team to patient
- Telemedicine, website, directory of services
- Engagement and buy-in across the NoS
- Good multi-professional leadership

# NORTH: YEAR 1

- Early screening tool for rehabilitation needs
- Develop, test, and refine a Rehabilitation Plan on behalf of the national network
- Gap needs analysis for skills and training
- Agree phased plan to enhance access to rehabilitation across the pathway, addressing capacity, skills, and competencies



# NORTH: YEARS 2+3

- Phased implementation of plan to deliver rehabilitation in MTC and TUs
- Work towards a single team discharge and communication document
- NoS directory of rehabilitation services

# WEST: WHAT IS KNOWN

- It has half of the country's population, and will have by far the largest MTC and the highest patient flows in and out of it
- Delay in decisions about the number of TUs is obstructing detailed planning of trauma services, including rehabilitation

# WEST: SOME UNKNOWNNS

- The preferred rehabilitation model – regional vs local, specialist vs generic
- The necessary size of the trauma ward at QEUH and the patient flows from it
- The resources that will be available to deliver change on the necessary scale

# **WEST: WHERE SPECIALIST REHABILITATION IS NOW**

- Progressive retraction of specialist rehabilitation services over recent years
- Critical shortages of key professionals
- No obvious plan to address this
- Money, clinicians, and belief all now seem to be in short supply

# CONCLUSION

- Some progress, much more to do
- Engagement with rehabilitation issues by planners in most parts of the country, and a realistic approach to change
- An imminent crisis in the West of Scotland
- A need for national leadership