CONSULTATION DOCUMENT (SHORT VERSION)
CHANGES TO REHABILITATION SERVICES IN NORTH EAST GLASGOW

1. INTRODUCTION

Proposal for consultation

This paper sets out the detailed information on our consultation proposal for changes to rehabilitation services in NE Glasgow. Those changes replace the services currently provided at Lightburn Hospital by providing:-

- acute inpatient care onto sites with full acute facilities;
- community rehabilitation beds in local care homes;
- more rehabilitation in patients' homes;
- more medicalised outpatient and day services on sites with full acute services;

The proposals outlined in this document have been developed and refined during the engagement process to reflect the issues raised by the patients, carers and local interests who responded to the engagement. The report of that engagement and the other documents referred to in this paper are available on our consultation website at http://www.nhsggc.org.uk/get-in-touch-get-involved/inform-engage-and-consult/changes-to-rehabilitation-services-in-north-east-glasgow-lightburn-hospital/

2. THE CASE FOR CHANGE

Local and National Clinical Services Strategy set out future models of care for Older People's Services to ensure older people stay in hospital only for the period of acute care. The key strategic objectives are to deliver:-

- Early intervention from specialists in the care of older people focussed on multi-disciplinary assessment of frailty;
- Rapid commencement of multi-disciplinary rehabilitation within facilities that enable immediate access to the full range of investigations and specialist advice;
- Services in the hospital and community to enable more people to be discharged directly home or after a shorter lengths of stay in an acute hospital.
- New community rehabilitation beds providing a local service and wider range of care;
- Additional community rehabilitation services delivered in people's homes.
- Acute day hospital services which, for most patients, assess and intervene on a one stop basis and then discharge patients or move them into local services;
- Outpatients in a setting where access to other clinical services enables a one stop approach;

This proposal for an improved model of rehabilitation services in North East Glasgow has been developed with the multi disciplinary teams of consultants, nurses and allied health professionals delivering the current service.

3. CURRENT SERVICES

This section describes the current pattern of services delivered at Lightburn Hospital.

- Elderly patients attend the Glasgow Royal Infirmary from across the whole of the North and East of Glasgow and East Dunbartonshire.
- Most elderly patients assessed at GRI are discharged home after a period of acute multidisciplinary care and do not need a longer period of rehabilitation.
- Inpatient elderly rehabilitation is at Lightburn and Stobhill Hospitals covering the whole NE area.
- Rehabilitation for all NE orthopaedics is at Gartnavel.
- Rehabilitation for all NE stroke is at Stobhill.
- Older people's Day Hospital and outpatient services are provided for the East End at Lightburn.

Lightburn services include:-

- 56 inpatient beds: 714 patient episodes (equating to around 450 elderly patient admissions per year)
- Day hospital: 422 new visits and 3285 return visits
- 4 Consultant led clinics each week: 383 new appointments 584 returns per year
- 1 Nurse led clinic each week: 144 return appointments per year
- Monthly Parkinson's group meeting

4. PROPOSED MODEL OF CARE

The proposals would see a redesign of the rehabilitation pathway across the north east sector supporting earlier discharge from acute care and a more community based approach to rehabilitation.

- The majority of North and East Glasgow patients will be discharged from their assessment ward directly home without requiring a longer period of rehabilitation in hospital. This will mean for most people there will be no change from these proposals as their inpatient care will be provided from Glasgow Royal Infirmary.
- Patients requiring acute inpatient rehabilitation would receive their care on an acute hospital site at Stobhill.
- Patients no longer requiring the support services of an acute hospital but still requiring inpatient rehabilitation would be transferred to a modern local community rehabilitation facility where a strong focus would be on reablement within a homely setting with single en suite rooms.

This approach is designed to ensure an individual's stay in hospital is for the acute period of care only and people are supported to return to their community as soon as possible. For patients requiring acute care this will be delivered in facilities providing access to the full range of acute and diagnostic services. Using a model of community based rehabilitation will further strengthen links between clinicians within the acute sector and community services and complement the approach with community based intermediate care and the emerging models for complex community care.

5. NEW MODEL OF CARE: ACUTE INPATIENT CARE

Our aim is that frail older patients presenting to the GRI as an emergency from their own home should be discharged back home after appropriate treatment.

- Following initial assessment in the emergency receiving complex, patients identified as requiring acute inpatient care will generally be transferred to GRI DME acute assessment wards. This provides multi disciplinary assessment, investigation, treatment and rehabilitation from specialists in the care of older people. In addition there are strong links with community health and social care services to ensure planning for discharge from hospital begins as soon as a patient arrives on the ward.

- Patients identified as needing Comprehensive Geriatric Assessment either at the front door or those referred from other speciality wards will be assessed by a multidisciplinary Target Team, including Senior AHP, Consultant and Elderly Care Assessment Nurse.

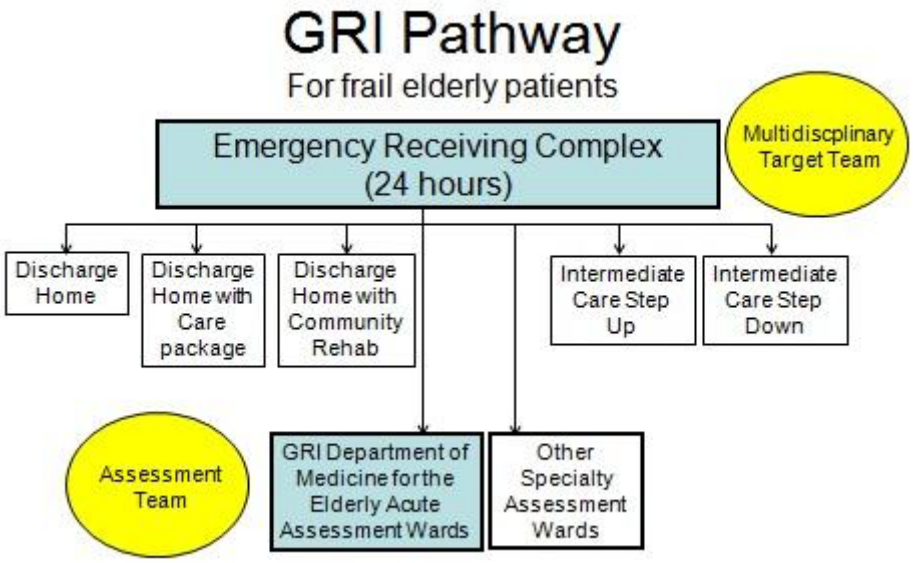
- Patients identified as likely to be able to be discharged rapidly from GRI, if provided with enhanced AHP input, will be supported by the Target Team who will link with established community teams to facilitate discharge back into the community as early as possible.

- Most patients will return directly home but some medically stable patients who do not require acute hospital care but are not ready to be discharged home will access new community rehabilitation beds in local Care Homes.

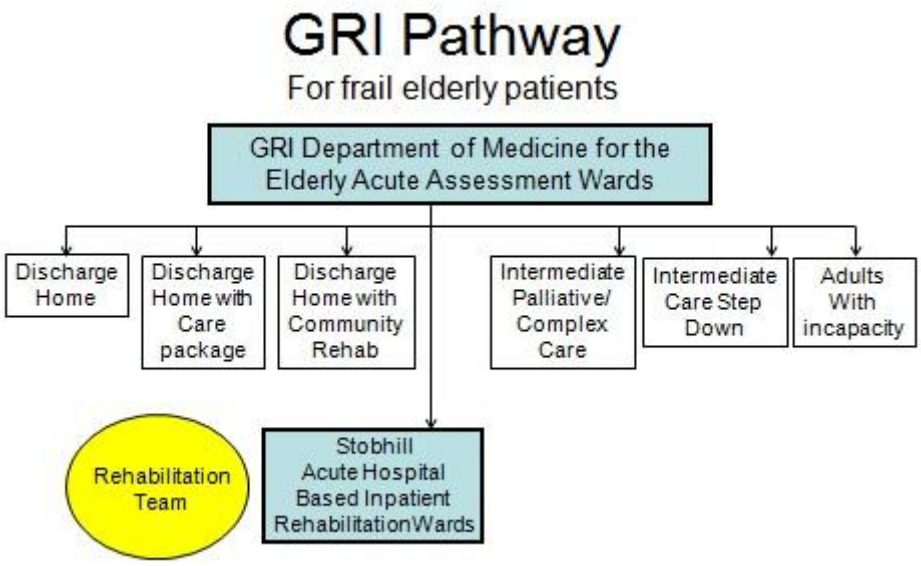
- Patients requiring rehabilitation and ongoing acute inpatient care will move to inpatient rehabilitation wards at Stobhill with immediate access to modern diagnostics, improved junior medical support and opportunities for enhanced AHP input and may then be discharged home.

- There will also be a small number of community beds for patients who do not require acute services but need inpatient end of life care or patients who cannot be discharged from NHS care for legal reasons.

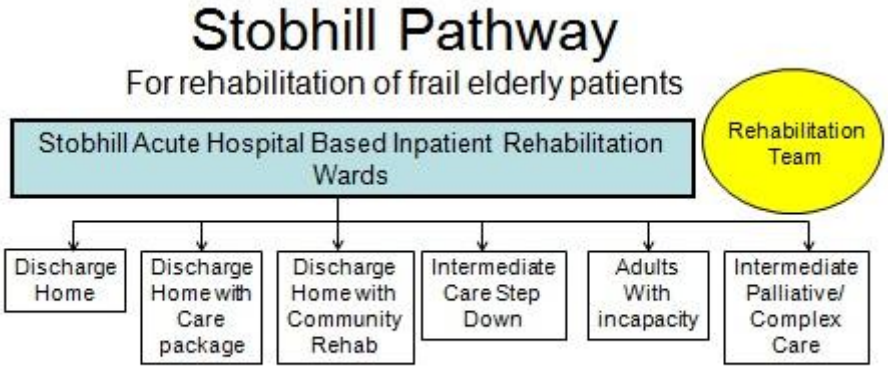
This first diagram shows the pathways for patients from acute assessment at the GRI



This second diagram summarises the options available after a patient has completed their treatment in the Elderly Acute Assessment wards at Glasgow Royal Infirmary.



The final diagram below summarises the options available in the third phase of the patient pathway from the Acute Rehabilitation wards at Stobhill



7. NEW MODEL OF CARE: COMMUNITY BASED REHABILITATION BEDS

Delivering community based rehabilitation or intermediate care beds is the responsibility of Health and Social Care Partnerships for North East Glasgow either Glasgow city or East Dunbartonshire HSCPs.

Community inpatient rehabilitation is for two types of patients, those:-

- Patients who no longer need to be in an Acute Hospital setting but are not yet able to return to their own home. This is also called the step down intermediate care model because it is a step down from an acute hospital, providing care which lies between acute care and a discharge home.
- Patients who are unable to remain at home but don't need an acute hospital This is the step up model because it is a step up from care at home.

Patients will be referred by GPs or hospital staff for a period of assessment and support including to determine longer term support and care needs. Community rehabilitation or intermediate care units are designed to feel more like being at home. The assessment and

support period will usually last no longer than four weeks with no charge for the service during the assessment period.

The Intermediate Care Team includes a wide range of staff who may be working with patients depending on their specific needs. These team members include:

- **Social Workers** who will assess social care needs and discuss any practical support.
- The **Rehabilitation Team** who will help patients to be as independent as possible.
- **Carers and Support Workers** who will support patients in carrying out and achieving goals, for example exercises, walking, dressing, kitchen skills.
- **Nurses** who will advise on care needs. This may include wound care; nutrition; pain control and medication.
- A **GP practice** which has additional time to provide cover to these beds and will look after medical needs.

During the assessment period the Team will discuss options with patients and family and carers to assess the most appropriate option for patient's longer terms care needs. These could include:-

- Returning to their own home with care provided at home to support specific needs;
- Moving into alternative housing for example sheltered or extra-care supported housing;
- Moving into a residential care home, with or without nursing care, for long term care.

8. NEW MODEL OF CARE: COMMUNITY BASED COMPLEX/PALLIATIVE CARE

The new model of Intermediate Complex/Palliative Care is being developed alongside an interim service provision for adults with incapacity. This service will have a small number of beds for:-

- patients who are at the end of their life, no longer need to be in an acute hospital setting, but due to the nature of their needs, cannot return to their own home or be supported in a mainstream nursing home. This service provides an enhanced level of medical input with nursing care and in reach from other specialists for example the palliative care liaison nurses. A GP practice assigned to the unit has responsibility for the patient's medical care. The patient's needs are reassessed at regular intervals by the multidisciplinary team. This will include regular liaison with patient and relatives. A consultant geriatrician will visit the beds each week to provide additional review and assessment of patient needs.

- interim placements for patients who lack capacity, do not require acute hospital care but cannot be discharged from NHS care until legal processes are completed;

9. NEW MODEL OF CARE: COMMUNITY REHABILITATION TEAM

Community rehabilitation is provided by multi disciplinary teams based in the Health and Social Care Partnerships. The service provides specialist rehabilitation supports to adults with complex health needs. The service provides coordinated interdisciplinary assessment and treatment in response to community referrals and to support hospital discharge.

Hospital staff will refer patients to the service when they are ready to leave hospital but require further rehabilitation support at home to maintain or improve their health, independence and mobility.

10. NEW MODEL OF CARE: DAY HOSPITAL

The proposal is to transfer Lightburn Day Hospital services into a combined single Day Hospital on the Stobhill site. The modern model of Day Hospital provision is a more clinical model requiring access to the full range of clinical investigations as part of assessment and treatment. This enables earlier progress to definitive treatment and will substantially reduce the pattern of repeat attendances with the aim that for the majority of patients a single visit is required with onward referral to community services or discharge. This change would bring the service into line with all other Day Hospitals across Glasgow by providing modern facilities with access to a range of services that support Day Hospital activity.
Lightburn Hospital has a very limited range of clinical support services and cannot deliver this modern, clinical model of day hospital care.

11. NEW MODEL OF CARE: OUTPATIENT SERVICES

The current outpatient services which are provided from the Lightburn site include clinics for the following services:

- General Geriatric Medicine Clinics one each week;
- Multi disciplinary movement Disorder twice a week;
- Falls: multidisciplinary; once a week;
- Stroke: alternate weeks;

The proposal for consultation is that the current outpatient services will be delivered from Stobhill where our clinicians have access to the necessary support services to provide modern care but with a substantial reduction in repeat attendances. We are aware that there are concerns about access if our proposals go ahead. A key factor is that over 80% of patients travel by car or ambulance and that we can reduce repeat attendances for general clinics.
In the engagement process we suggested that the multi disciplinary movement disorder service might move to Stobhill or the GRI, the Stobhill option scored better in our option appraisal but we will engage further with Parkinson's patients on this issue during the consultation.

Parkinson's Support Group

The Lightburn site also provides a meeting venue for the Parkinson's Support Group meetings. A number of local locations have been scoped for the venue for Parkinson's Support Group meetings and have been offered to the group.