Aberdeenshire
Health & Social Care
Partnership

REPORT TO ABERDEENSHIRE INTEGRATION JOINT BOARD
6 DECEMBER 2023

Strategic Review of Neuro-Rehabilitation Pathway

1 Recommendation

It is recommended that the Integration Joint Board (IJB):

1.1 Notes the findings of the strategic review of the neurorehabilitation pathway;
1.2 Agrees that Aberdeen City IJB as host IJB for this service implements the proposed changes to the neurorehabilitation pathway in collaboration with Aberdeenshire HSCP and in a phased manner as set out in section 5;
1.3 Agrees that an evaluation of Phase 1 will be shared with Aberdeenshire IJB in September 2024 before Phase 2 commences; and
1.4 Notes the engagement to date with the Aberdeenshire and Moray HSCPs and support the continuation of the engagement to help ensure the redesign continues to meet the needs of all three Partnerships.

2 Directions

2.1 No direction requires to be issued to Aberdeenshire Council or NHS Grampian as a result of this report.

3 Risk

3.1

2650	Aberdeenshire Clinical/Care Risk Register	Clinical/Care	National Shortage of Physiotherapists
2267	Aberdeenshire IJB Risk Register	Non Clinical	Poor Health & Social Care Policy alignment (2)
1589	Aberdeenshire IJB Risk Register	Clinical/Care	Risk of failure to deliver standards of care expected by the people of Aberdeenshire (8)
1590	Aberdeenshire IJB Risk Register	Non Clinical	Risk of not fully informing, involving and engaging with our patients/clients, the public, staff and partners (5)
2389	Aberdeenshire IJB Risk Register	Non Clinical	Service/ business alignment with current and future needs(6)
1990	Aberdeenshire IJB Risk Register	Non Clinical	Sufficiency and Affordability of Resource (1)

1591	Aberdeenshire IJB Risk Register	Non Clinical	Workforce capacity, recruitment, training development & staff empowerment (3)

4 Background – Strategic Plan Context

4.1 Aberdeen City Health and Social Care Partnership (ACHSCP) holds hosted responsibility for the delivery of Specialist Rehabilitation Services, including Neurorehabilitation services, for Grampian as part of the shared governance arrangements with Aberdeenshire and Moray HSCPs. Recommendations will be progressed through each partnerships IJB Governance process.

4.2 The Public Bodies (Joint Working) (Scotland) Act 2014 sets out the responsibilities of the Integration Joint Boards (IJBs). A specific requirement is that IJBs have delegated responsibility for strategic planning. The Aberdeen City Health and Social Care Partnership host the delivery of the Rehabilitation Services, which includes Neurological Rehabilitation.

4.3 The Aberdeen City IJB committed to a wider strategic review of all rehabilitation services as part of its approval of the ACHSCP Strategic plan 2022-2025. It is an identified project within the 'Keeping People Safe at Home' strategic aim. This aim specifically outlines the following strategic priorities relevant to this review:

- Maximise independence through rehabilitation.
- Reduce the impact of unscheduled care on the hospital.
- Expand the choice of housing options for people requiring care

During the COVID-19 pandemic, Operation Home First created an increased community facing ethos across all services with a focus on delivery and care provision in the community as opposed to traditional provision in a hospital setting. From a rehabilitation perspective this led to patients receiving support in a community setting and within their home environment. This led to greater connections with their community and a more personalised experience.

4.4 In March 2022, Aberdeen City IJB agreed to shorten the notice period on a contract with the operators of Craig Court, a transitional living rehabilitation setting that had been in operation since 2009. This decision was taken to enable the full scope of options to be considered as part of a wider review of the neurorehabilitation pathway. Following the change to the notice period, the provider chose to exit the contract.

4.5 The Aberdeen City IJB agreed at its meeting in March 2022 to undertake a focused review of the neurorehabilitation pathway in advance of the wider review of rehabilitation services. This created a platform for exploring best practice and an opportunity to consider how best to invest the resource that supports the current neurorehabilitation pathway on a sustainable basis and in line with the principles of good rehabilitation and the IJB's strategic priorities. This included giving consideration to the function of a transitional living unit within the pathway and to explore how transitional living support could be

provided in different ways to best meet the needs of patients and carers within Grampian.

4.6 The decision to prioritise the review of the neurorehabilitation pathway ahead of the wider strategic rehabilitation review, has also created an opportunity to take the learning from the process undertaken with neuro rehabilitation and outputs of this as a 'proof of concept' of the approach. Any learning from this will help inform both the wider strategic review work and any further specific pathway reviews to be undertaken.

4.7 A project team was formed to take this work forward. This review has allowed for a wide engagement with a range of stakeholders including patient, family and carer input as well as a wide range of staff, both within the pathway and partners such as HSCP colleagues to gather views regarding priorities for the model of service delivery for current and future patients.

4.8 This review has considered and incorporated relevant National best practice frameworks and relevant reports including:

- Scottish Government, Neurological care and support: Framework for Action 2020 -2025 specifically, Commitment 9:
  "We will support Integration authorities and the NHS to improve services and support with a commitment to evaluate and test generic / neurology based multi-disciplinary team models and test innovative ways of delivering health and social care, including new roles and new arrangements for coordinating care and support for coordinating care and support for people with neurological conditions".

And 5 key objectives were identified and adopted locally by Project Team:

- Ensure people with neurological conditions are partners in their care and support.
- Improve the provision of co-ordinated health and social care and support for people with neurological conditions.
- Ensure high standards of effective, person centred and safe care and support.
- Ensure equitable and timely access to health and social care and support across Scotland.
- Build a sustainable neurological workforce for the future.

- Rehabilitation and Recovery: A once for Scotland person-centred approach to rehabilitation in a post-COVID era which sets out the 6 key principles of good rehabilitation.

- National Health & Wellbeing Outcomes Framework

- The British Society of Rehabilitation Medicine's Standards

- WHO 2030 rehabilitation vision describes rehabilitation as an investment with cost benefits for individuals and wider society that go beyond health system benefits too e.g., increased employability, decreases need for financial or care support requirements, contributes to wider healthy

ageing, all of which are relevant for this patient group, particularly given the younger demographic and the life changing experiences they have had and the need to optimise their function and quality of life across their remaining lifespan.

5 Summary

5.1 Demographics – who is accessing Neurological rehabilitation now?

The scope of the review can be broadly defined as the Specialist Neurorehabilitation services provided for those conditions falling under the remit of neurosurgery and neurology including:

- Acquired brain injury
- Spinal injury
- Neurological disorders of movement or posture (for example cerebral palsy)
- Epilepsy
- Functional neurological disorders
- Prolonged disorders of consciousness
- Rehabilitation elements of ongoing care for patients with tracheostomies
- A range of progressive neurological conditions such as Parkinson's disease, Multiple Sclerosis, Huntington's, and Motor Neurone disease

For the progressive neurological conditions, these conditions are considered within scope only in the context of providing rehabilitation in the above outlined services. It is recognised that many of these conditions are involved in separate pathways for their long-term management and care, though patients may be in contact with the neurorehabilitation pathway at times, for example a patient with Parkinson's disease may be seen at the Horizon's clinic.

Stroke falls under the scope of the review only for the parts of the pathway where patients may be provided care in a setting such as a transitional living unit or outpatients centre such as Horizons Rehabilitation Centre. Horizons provides an assessment and therapeutic service for individuals aged 16-65 across Grampian with complex needs whose disability requires a multi-disciplinary approach. There is ongoing work developing the stroke pathway happening in parallel with this review, and the two processes will be closely monitored by programme management for interdependency and shared learning.

The patient profile of those accessing the Grampian Specialist Neurorehabilitation services is:

- 40% patients are from Aberdeen City;
- 40% Aberdeenshire;
- 10% Moray; and
- 10% originating from other local authority areas e.g. Island Boards.

The neurorehabilitation pathway has an age demographic that is younger than some other pathways with over 62% of the patient population under the age of 65.

The latest full year data shows that in 2022 the number of patients admitted to acute neurological settings in Aberdeen Royal Infirmary (ARI) was reported as 1514 and that 81 patients were admitted to the Neuro Rehabilitation Unit (NRU) at Woodend Hospital. While the majority of admissions to NRU are step-down from ARI, there are some direct admissions into NRU from the community.

Reviewing patient recovery destinations, the majority of patients from the acute setting at ARI return to a home environment. In the case of NRU less than 75% go directly home reflecting the complexity of the ongoing rehabilitation of care provision needs of this patient cohort. Many require ongoing care, and some require varying elements ongoing multidisciplinary team (MDT) support.

5.1.1 Stakeholders

A Project Delivery Group was established with a membership of Operational and Specialist leads with significant lived experience of working within the neurorehabilitation pathway alongside third sector and Scottish Care colleagues. The patient's voice was represented through Friends of Neuro and links with Brain Injury Group (both being charities which have had long-held connections with the neuro rehabilitation pathway) and include representation from across Grampian. Qualitative feedback and input from patient workshops and consultations was also evaluated.

This group provided a structure to exploring and leading throughout the review from sense-checking experience and building on learning. This at times has been challenging in terms of gaining assurance that all plans are connecting in each Partnership area given different pattern of needs and staffing structures. We continue to offer Partnership specific meetings to consider and address these and engagement with the Aberdeenshire and Moray HSCPs will continue throughout the redesign.

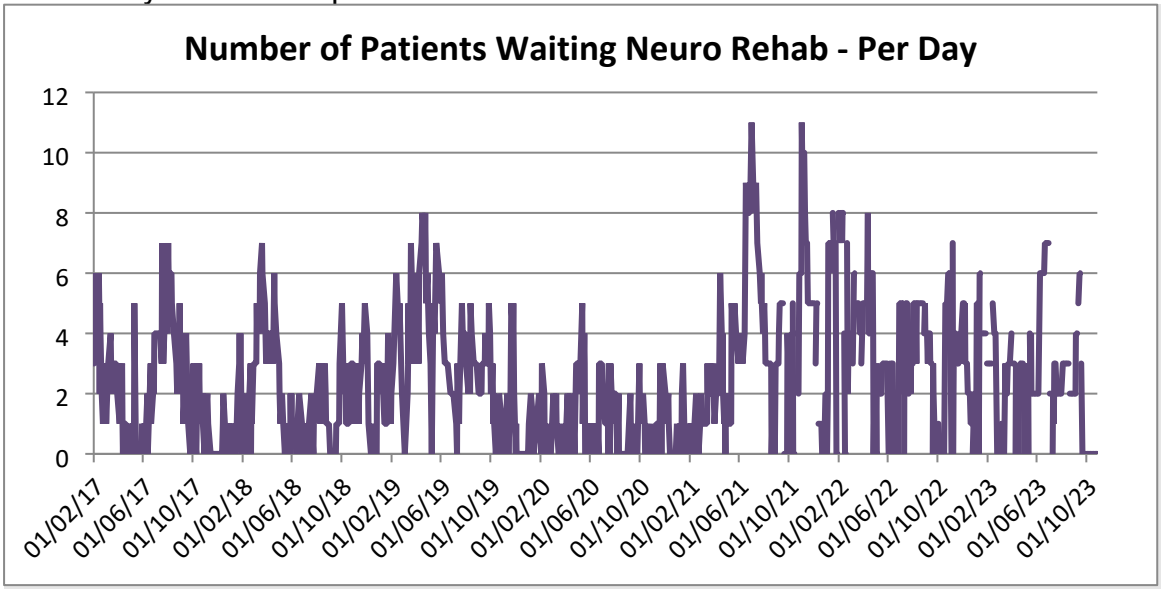
5.2 The functional parts of the pathway

5.2.1 Wards 204/205

The two acute neuro wards in ARI form the initial stage in the pathway and patients requiring in-patient specialist rehabilitation will step down from these areas into NRU. The waits experienced by patients due to 100% occupancy in NRU (see run chart below);

This highlights the potential for appropriate patients to be linked in at an earlier stage with the multi-disciplinary team (MDT) HomeLink approach. The MDT HomeLink approach enables rehabilitation to commence at an earlier stage and potential for progression to a community setting for some patients, rather than NRU, ensuring the

patient is reconnected with their network of support and wider community as soon as possible.



5.2.2 Neuro Rehabilitation Unit (NRU)

The Neuro Rehabilitation Unit is a 12 bedded unit on the Woodend Hospital site. The ward generally runs at 100% occupancy with 0% readmission rate. From the project team reviewing Functional Independence Measures (FIM) data, which is an internationally accepted outcome measure for rehabilitation, it can be seen that high-quality person-centred care is being delivered with a high level of patient satisfaction. Whilst the physical environment is dated, patient feedback focuses upon the goal focussed rehabilitation and their positive experience of this. It is anticipated that the longer-term location of this unit will be considered through NHSG Woodend/future Blueprint planning project that is due to get underway during 2024, where ACHSCP will be a key partner in engaging with this work.

When evaluating the effectiveness of the pathway to create positive outcomes for patients, alongside addressing the wait time for accessing NRU and potentially further reduce length of stay in NRU, a limiting factor identified within the current pathway was therapy capacity in NRU. Therefore, investment in this was explored and quantified to understand how these barriers to optimal achievement whilst minimising in-patient bed days could be addressed. Timely access to rehabilitation and the intensity that can be provided has an impact on patient outcomes and length of stay. An investment in additional therapists would allow more sessions to be available to individuals to focus on personal rehabilitation goals. This in turn would result in a reduction in average bed days and would increase the number of patients who could access NRU each year. In turn, this would reduce bed days waiting for transition through the neuro rehab pathway for patients within ARI stepping down into NRU. This supports flow, creating capacity within ARI having the patient in the “right care, right place”. By having timely access to the intensity of rehabilitation necessary, this will also support earlier discharge from

NRU to the next stage in the patient's journey. This provides value, not only to the patient but to the wider system. The investment in rehabilitation would seek to reduce the impact upon demand across Acute, Primary Care, and Social Care. This capacity is included in phase 1 of the proposed implementation.

5.2.3 Transitional Living – Craig Court/Home link approach

Craig Court opened in 2009 and was commissioned to provide sixteen beds in total. These comprised of six long term beds, with some residents placed as Continuing Care residents due to the complexity of needs; and 10 transitional living rehabilitation beds used as a step down from hospital or step up from the community to support patients across Grampian. Craig Court provided an intensive rehab setting out with a hospital/medically led setting. This setting was designed to bridge the period from in-patient rehab within the NRU to a homely setting for the most complex of rehab presentations. Patients from Craig Court transitioned into general rehabilitation services or home or a residential setting depending on complexity of ongoing care need.

Craig Court operated as a Transitional living unit and was a collaboration between a commissioned provider, providing care and nursing roles alongside an NHS team of staff consisting of Occupational Therapy, Physiotherapy, Neuropsychology, Dietetics and Speech and Language therapy and admin colleagues.

During the pandemic, the NHS team from Craig Court were deployed back into the main hospital settings as part of critical service protection measures. The team were deployed into areas of critical service staffing need and for a period therefore did not operate as part of the neuro rehabilitation pathway.

Following relaxation of pandemic staffing measures the Craig Court staff initially supported the NRU staffing cohort. This staffing model allowed a continuous focus on rehabilitation and allowed therapists to follow patients home to continue work on therapy goals. This change was welcomed by patients and carers. The focus of the team was initially 'badged' as Mobile Craig Court and progressed thereafter into a HomeLink concept. This model allows a multi-disciplinary team to support the patients' transition from ward to home ensuring a goal focused approach is adopted. It allows therapy to be adapted to the person's own living environment (e.g. own cooking facilities and home layout).

A short life working group was formed earlier this year with a representation from the Project Delivery Group to explore options for Transitional Living Arrangements specifically in the new model. Since late 2019, largely due to Covid-19 restrictions, and following its closure in 2022, the Craig Court Transitional living unit has not been in place for neuro patients.

The group explored options based upon recent service delivery experiences and considered a range of options for future models of delivery. They also reviewed what had been in place since the closure of Craig Court and the mitigations for this which have included rehabilitation in community and home-based settings. As a result, a critical shift in thinking occurred.

This shift was from an initial desire to replace the capacity for residential transitional living rehabilitation to an intent to explore further what an extended HomeLink capacity could deliver in supporting rehab at home.

It is suggested that this is a significant highlight from this work. The investment in time with a variety of stakeholders to iterate and develop the conversation regarding what is needed for the future. By holding the space of interim arrangements, the conversation opened perspectives to what is possible/appropriate. This has been incorporated into the proposed two-phase approach outlined below.

The HomeLink approach has enabled patients to continue with their goal setting and rehabilitation as they transitioned home from NRU. HomeLink commenced with the workforce who had been aligned to Craig Court testing out a different approach to how they could work to support patients as they transition from in-patients back to the community. This testing has highlighted the need to consider how this approach can provide support geographically and has highlighted the need to expand the workforce to be able to support the needs of patients going through this redesigned pathway across Grampian. This includes the need to recruit a neuropsychologist to enhance the MDT, and to develop a Clinical leadership role for the pathway to provide oversight and to support more integrated working across professions.
HomeLink has operated on a criteria basis ensuring that patients have goals in place and then provide support for up to 12 weeks before referring onto Horizons Out-patient rehabilitation centre and/or generalist community therapy teams. The team ensure a person-centred approach for each individual patient, with individual support plans that reflect their specific goals. These are many and varied ranging from accessing local community and activities of daily living. The individual goal setting focus on independence and reconnection offers great benefits to the individual and their families and on a broader perspective to wider community by reducing dependencies on services.

5.2.4 Horizons Out-patient Rehabilitation Centre

The Horizons service provides a ‘one-stop shop’ out-patient approach (as opposed to the in-patient approach at ARI and NRU) by a multi-disciplinary team for adults across Grampian with a neurological condition and rehabilitation need, providing assessment, review and rehabilitation. This service was able to demonstrate significant waiting lists especially for physiotherapy and this correlated with one of the

improvement ideas identified from the co-production process; the augmentation of this capacity to address waiting list pressures. This would enable a more prompt out-patient follow-up on discharge. In addition, the need to build a further community response resource was also quantified to enable out-patient staff to out-reach when appropriate to provide continuity for patients in applying rehabilitation processes at home which aligns with the Home First ethos. This additionality would enable a more seamless transition to home from in-patient/residential rehabilitation capacity as well as from out-patient to independent living.

5.3 Approach to this review

The review has taken a co-design approach and has involved engagement with patients, carers and staff using lived experiences to inform pathway design. Engagement has taken many forms from 1:1 discussion, workshops, surveys and attending user groups in a bid to gain a wide sample and offer different means of participation.

The co-designed approach enabled a vision statement (Appendix C) to be created and key themes for improvement to be captured.
From the series of engagements, 23 change ideas were generated which were then themed into 15 change action ideas (Appendix D).

These were then further refined resulting in 4 locally agreed objectives:

- Enabled staff and patient in decision making;
- Equitable access to neuro rehabilitation care and support;
- Enabled and supported transition to independent living; and
- Patient pathway is seamless and timely.

5.3.1 Additionally, a number of cross cutting themes emerged that needed to be considered in each proposal including:

- upskilling of existing staff;
- increase in regional access to specialist care;
- more intensive and timely rehab;
- improved MDT and cross regional working;
- increased coordination and usage of communication tools; and
- enhanced working with third and independent sector.

6.0 Proposed model - blended model incorporating community and transitional living arrangements.

Building on the improvement ideas generated and iterative consultation at the Programme Delivery Group (PDG) a proposal was developed, and based on current demand it was proposed that a total of 6 ‘beds’ were required in the community. The PDG identified that a notional 3 virtual beds (person’s home) and 3 community beds (i.e., physical beds based in a community setting) model could deliver a Transitional Living Arrangement as opposed to a Transitional Living Unit. The ‘virtual’ to physical bed ratio was difficult to

determine as it is based on patient need, and the consensus of the PDG was to commence with this 3:3 ratio, reviewing and shaping within budget.

Options for the 3 physical beds that were considered included the potential for transforming a mothballed ward and existing staff space at Woodend Hospital into an interim option of a step down from rehab. This being co-located or adjacent to the Neurorehabilitation Unit was considered a benefit by the PDG. However, on conducting a feasibility study, initial costings indicate that capital costs of this would be prohibitive (circa £1 million), alongside ongoing discussions with NHSG regarding sustainability of their clinical sites. The location also presented an environment that contradicted our strategic vision around delivering services closer to home and broader home first principles and the intent of transitional living support in a community setting.

In addition, a block commissioned model had some initial market testing and this identified a significant likely contract cost which would be significantly more expensive than the Craig Court model, which would utilise a significant amount of the financial envelope identified. A block commissioned model is where a set number of beds is funded on an ongoing basis and can include community provision also. This has the benefit of ensuring a certain amount of capacity is always available when predicted needs are known.

Therefore, the preferred model proposed by the PDG, given these considerations and the positive experience of the testing of the HomeLink approach, is to augment existing capacity in the MDT workforce to enhance HomeLink delivery across Grampian. This would also see the creation of up to three commissioned rehabilitation beds within available resources with a criteria for delivering rehabilitation and transitional support in a homely setting. The proposed first phase will strengthen the workforce and through evaluation of the demand and patient needs during this period, this will inform the second phase of investment, reviewing the ratio of these virtual to physical beds to determine how the available funding can best be deployed to meet these needs. The location of any commissioned beds and how we will most effectively deploy the additional community based workforce will be determined following further consultation with all Grampian HSCP colleagues. Further to this, we will continue to explore market options with our contract's teams across Grampian.

6.1 A Phased Approach to Proposals

The proposals are reliant upon the successful recruitment of additional staff. Given recruitment of staff has previously been challenging, we want to ensure stability within the model and build in a review next year to review progress against Phase 1. That review will allow us to consider alternative modelling using commissioning (as detailed in Appendix E) should it be required.

Phase 1 implementing an increase in therapy capacity within:

- NRU in order to increase time-critical rehabilitation capacity to optimise rehab goal outcomes and minimise length of stay (therefore increasing flow through and improved outcomes for patient and staff

in NRU) and thereby minimising costs associated with preventable demand.

- HomeLink capacity, enabling basing of posts to take account of geographical spread of patient group (e.g., exploring basing some capacity in northern aspects of NHS Grampian) in order to; increase rehabilitation capacity to optimise rehab goal outcomes and minimise length of stay (therefore increasing flow through and improved outcomes for patient and staff in the HomeLink capacity) and thereby minimising costs associated with preventable demand.
- Horizons Rehabilitation Centre Out-patient capacity in order to increase rehabilitation capacity to address historical waiting lists, improve access on discharge and enable out-reach of out-patient staff where this creates more seamless rehab experience for this patient cohort. Current data from June 23 highlighted 95 patients awaiting “routine” rehabilitation with longest wait of 66 weeks to access treatment. Data collated on a three-monthly basis has highlighted an upward trend on patient waiting times creating costs associated with preventable demand.
- The benefits across all three areas of increasing therapy capacity will be enhanced access and more intensive rehabilitation given in a timely manner, will improve outcomes for people and support earlier transition back into the community.
- The investment in additional staffing should support an enhanced flow from acute to rehab, this, whilst meeting patient outcomes minimises costs caused by preventable demand by having the patient in the right place, at the right time.
- Risk assessment is a key part of discharge planning, if the patient is unable to transfer directly home due to environmental or personal circumstance the opportunity for step down to community rehab facilities or a spot purchase bed will be undertaken.

Phase 2
Based on current understanding it is proposed that phase 2 will be implemented from quarter 3 in 2024 following a evaluation of Phase 1. Phase 2 would consider the commissioning of residential beds, if this is evidenced as required from phase 1, and/or the further investment in existing rehabilitation therapy teams to optimise service delivery, minimal length of stay and pathway flow.
Further key developments that have been scoped within the projected budget to enhance neuro rehabilitation as part of Phase 2 is the creation of two distinct roles to support learning, development and support via the creation of;

- Workforce Neuro Educator role, and;
- Information Hub coordination.

These roles will be considered in the planning of phase 2. Although the roles have been incorporated within the projected budget, a final decision on recruitment will be weighed against the number of beds that is required to be commissioned to support transitional living. This will require an ongoing review of patient needs within this cohort and exploring whether all step-down rehabilitation from the pathway can be delivered by a HomeLink

team model. It is possible that these posts may need to be de-prioritised if not within financial envelope for phase 2.

Development of the job descriptions and key functions to maximise support to staff, patients and carers are part of the implementation plan (see appendix E).

6.2 Evaluation of impact of Redesign – Phase 1
The following metrics will be used to evaluate the impact of these proposals:

- Length of stay in NRU and Home Link;
- Goal setting and achievement data and/or Functional Independence Measure;
- Bed days awaiting the rehab pathway (both NRU and HomeLink capacity) NB – this is a balancing measure;
- Delayed discharges from Acute wards and NRU, providing a further balancing measure, to evaluate cross system impact of investment;
- Review complaints regarding waiting times for specialist rehab;
- Review the waiting list times for therapy for Home Link;
- Out-patient waiting times for Horizons service; and
- Patient and staff experience survey feedback.

This will be a comprehensive evaluation, working with colleagues from ACHSCP Strategy and Transformation, Health Intelligence and Public Health Scotland, to evaluate change in flow whilst implementing remodelling of service delivery. We note that the evaluation focus is not only focused upon patient outcomes, but will be able to review impact cross system including associated costs. It is proposed that the evaluation be provided to the meeting of the IJB in August 2024.

6.3 The Chief Officer, along with the Chief Finance Officer and the Legal Monitoring Officers within Business Services of the Council have been consulted in the preparation of this report and their comments have been incorporated within the report.

7 Equalities, Staffing and Financial Implications

7.1 The first stage of an Integrated Impact Assessment (IIA) has been carried out as part of the development of the proposals set out above. It is included as Appendix F and no impact has been identified at this point

8 Appendices

8.1. Summary

Introduction

Aberdeen City Health and Social Care Partnership {ACHSCP} host Neuro rehabilitation for Grampian . This means that Aberdeen hold responsibility for the delivery of this service on behalf of NHS Grampian, Aberdeenshire Health and Care Partnership and Moray Health and Social care Partnership.

A decision was taken by the IJB in March 2022 to shorten the notice period on the contract for the transitional living arrangements in Craig Court. This created the conditions to repurpose the budget and provided an opportunity to enable a full review of the neurorehabilitation pathway . This has included exploring how best to provide transitional living support in different ways to support the needs of patients across Grampian.

Why did we need this review?
We needed this review to:

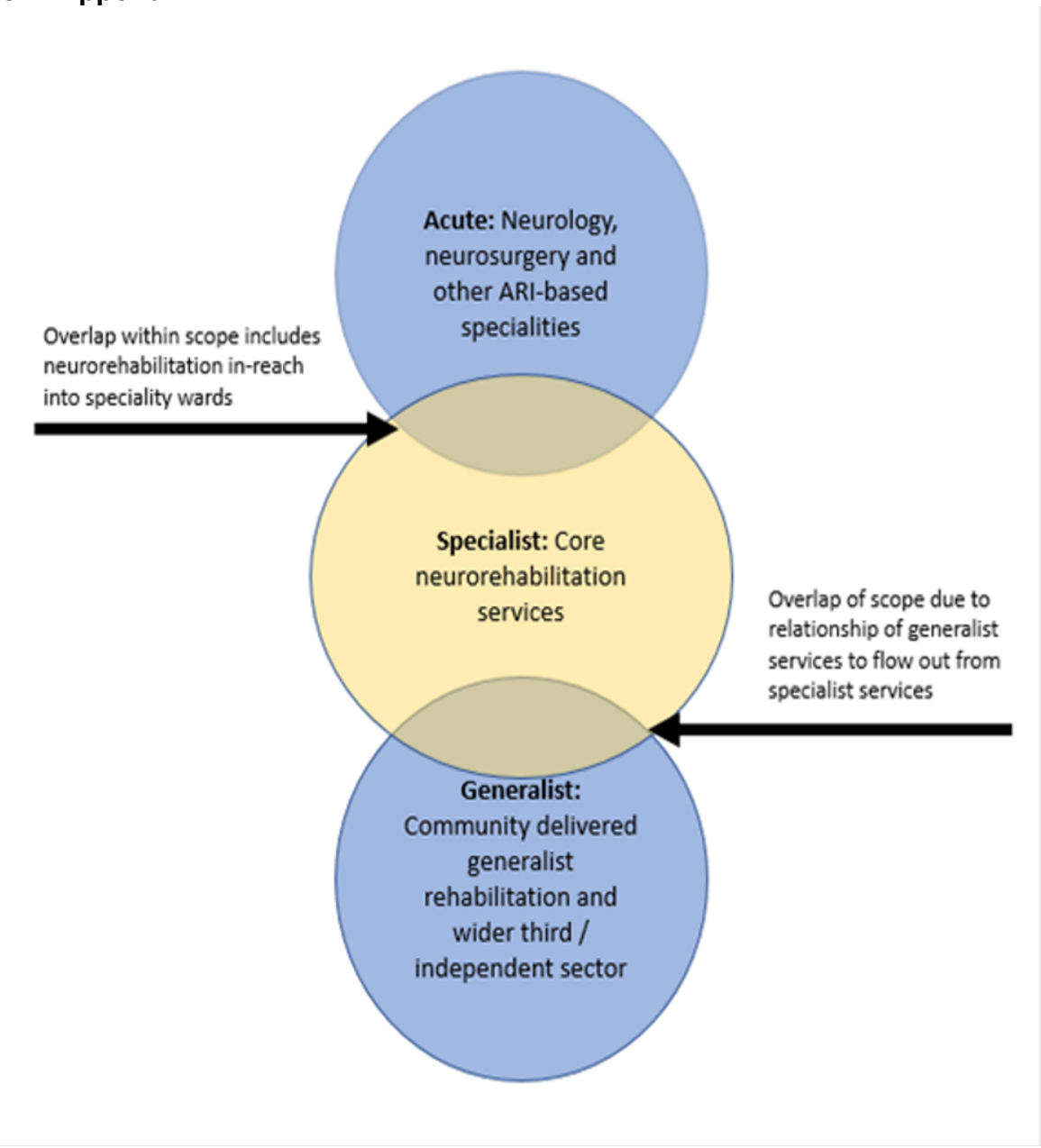
- Ensure that the services we provide to patients and carers who require access to specialist neuro-rehabilitation are clinically and cost effective, ensuring the best outcomes for people to support them to maximise their potential and achieve their personal goals;
- Deliver the best experience for patients and their families and carers;
- Ensure that we are embedding the 6 principles of good rehabilitation as set out in the national framework for rehabilitation Rehabilitation and Recovery: A once for Scotland person-centred approach to rehabilitation in a post-COVID era and that locally we are delivering timely access to the appropriate rehabilitation support to meet individual patient needs;
- Ensure that people can receive time critical rehabilitation and not be unduly delayed in a hospital setting or awaiting specialist rehab whilst in the community in order to optimise their recovery and quality of life; and
- Ensure that the pathway is aligned to the strategic direction of NHSG and the three HSCPs.

What did we do?
Through a model of co-design, we widely engaged and involved individuals and groups with lived experience (patient, carer and staff experience), third sector and other key stakeholders to design a pathway that incorporated their experience to enhance and build a pathway that considered patient outcomes .
We identified gaps in what we do and ideas to improve services and patient experience.
With this information we have developed recommendations for how best to achieve best value within the pathway to develop a more community facing model of delivery to improve access for patients across Grampian and improve flow of patients across the pathway from acute services through to the community.
We evaluated data and looked at demand across Grampian. This has highlighted the impact upon other areas cross system that are impacted if neuro -pathway is not maintaining response to demand. We are confident that the investment proposed will address the current demand expressed through waiting lists and waits between transfer and will offer a community focused rehabilitation.

Next steps?
We will take a phased approach to implementation of the change ideas to ensure optimum use of the available resources. In phase 1, to develop the community model and further understand the balance needed between this and the need for commissioned beds to support the transitional support needs for patients unable to be supported in their own home.
Within phase 2, we will review the impact of investment and look to invest further in community rehabilitation. The decision and balance of commissioning a bed

base in tandem with further community investment including new roles will be made within existing budget with ratio of spending based upon evaluation.
An update report on the evaluation will be taken back to the IJB in August 2024.
Continue to engage with a range of stakeholders i.e. patients, families, staff to implement changes, and continuing to work in partnership with Aberdeenshire and Moray HSCPs.

8.2. Appendix B



8.3. Appendix C

Neurorehabilitation Vision Statement

There is a need to transform our service to ensure we continue to be person-centred in response to our changing patient needs, enhance staff satisfaction, and facilitate both a timely and outcomes-based transition through the pathway, with a "home first" approach to patient care.

Quality & Best Practice	A flexible workforce	A pathway approach	Outcomes/Goal-focussed	Homefirst	Effective governance	Experience-focussed;
We (strive to) deliver an (regionally-)equitable, seamless, safe and timely service where staff and patients are enabled in their decision-making, and patients are adequately supported and enabled in their transition to independent living or living as independently as possible.	We (will) take a 'one team' approach across the pathway, ensuring staff can respond most effectively and efficiently to patient needs, ensuring we can see patients at the right time and in the right place, rather than being confined to one physical place of work. [E.g., out-reach from out-patient capacity to support rehab need in the community.] This requires co-ordination to enable a fit for purpose MDT response in each element of the pathway.	Whilst our [rehabilitation] is delivered across several settings, including in-patient beds, transitional arrangements (non-hospital residential beds); out-patient and community settings and within patients own homes, our facilities will be used flexibly by the team in response to patients' needs.	A core focus of all parts of our pathway will be through goal-setting co-produced with patients, their families and our multi-disciplinary teams; and the focus on flow to progress through the elements of the pathway in a timely manner, in keeping with 'homefirst' principles.	Our approach is deeply embedded in cross-system working, with a focus on effective and efficient collaboration and coordination across the pathway and in particular with community-based rehabilitation services and 3rd sector organisations, to ensure our patients continue to be supported as they move through their rehabilitation journey, and to provide timely step-up care if required in the future. [For example, flexible use of facilities – e.g. community rehab team able to use out-patient facility at Horizons; or out-reach from OP staff to community settings.]	Our service is based on a robust model of service delivery, enabled through pragmatic and transparent governance and leadership that embeds continuous improvement to ensure our service's responsiveness to the changing needs of our patients, staff, and the wider health care system.	Our service is strong because we proactively train and evaluate the existing and required skill mix to provide the best service possible for our patients. A key feature of the redesigned pathway will be systematic measures to understand and continue to improve patient experience and outcomes; as well as staff experience.

8.4. Appendix D

Neurorehabilitation – Coproduced Improvement ideas

IMPROVEMENT IDEAS

Neuro specific educator roles for staff and patient support	Improved pathway access to support for FND Patients and secondary pathologies	Implementation of new Transitional Living support.	Focus on intensive and timely rehabilitation
Develop a continuous training, education and skills development framework	Improved access and provision to PDOC Patients.	Increased physiotherapy provision	Increased community rehabilitation provision.
Information hub & coordination	Improved access to neuropsychological support.	Review of vocational rehabilitation opportunities	Undertake a review of the skill matrix
Upskilling healthcare support workers and reablement and wellbeing practitioners.	Increase regional access to specialist rehabilitation care and support	Enhanced volunteer support	

8.5. Appendix E

Neuro rehabilitation Pathway - Implementation Plan - High Level		
Action Item (List steps required to implement solutions)	**Responsible (List person(s) responsible for action steps)**	**Due Date (Indicate when action items must be completed)**
Commence Recruitment to agreed under Phase 1	***PDG***	***Oct 23***
Create an awareness of carers to all staff into the referal pathway, through sharing Quarriers literature	Programme Team	Sept 23
Link in with NHSG HR colleagues regarding our recruitment plan	Programme Team	Sept 23
Meeting with NHS Communications Team to plan advertising campaign for coordination of shared advertisement	Programme Team	Sept 23
Meeting with ACC/ACHSCP Communications Team to plan advertising campaign for coordination of shared advertisement	Programme Team	Sept 23
Hold face to face meetings for all Clinical Leads ensuring that up to date job descriptions are sent in advance in order to coordinate recruitment campaign	Programme Team	Oct 23
Develop the identity of HomeLink team by working with our Organisational Development colleagues by establishing clear team focus and goals	Programme Team	Oct 23
Creation of a leaflet for HomeLink - for review with PDG and wider stakeholders i.e. staff groups and patients	PDG	Oct 23
Re-establish and present baseline data to Public Health Scotland to form basis of evaluation	Programme Team	Oct 23
Link in NHSG Quality Improvement regarding development patient feedback methodology	Programme Team	Oct 23

Neuro rehabilitation Pathway - Implementation Plan - High Level		
Action Item (List steps required to implement solutions)	**Responsible (List person(s) responsible for action steps)**	**Due Date (Indicate when action items must be completed)**
Commence Evaluation under Phase 2	***PDG***	***Apr 24***
Review recruitment campaign and evaluate any gaps and impact of those in post	Programme Team	Apr 24
Review recruitment with specific focus on the effect on Shire and Moray teams	Programme Team	Apr 24
Review patient feedback working with NHSG Quality Improvement	Programme Team	Apr 24
Review data in conjunction with Public Health Scotland	Programme Team	Apr 24
Following reviews, consider next steps with the PDG regarding focus of spending	PDG	Apr 24
A Stage 2 IIA will be completed, to ensure assessment regarding impact is informed	Programme Team	Apr 24
Engage with ACC, Shire and Moray contracts teams regarding commissioning if deemed appropriate following review	Programme Team	Apr 24

8.6. Appendix F

ACHSCP Impact Assessment – Proportionality and Relevance

Name of Policy or Practice being developed	Neurological Rehabilitation Review
Name of Officer completing Proportionality and Relevance Questionnaire	Rae Flett (Project Manager)
Date of Completion	08/09/23
What is the aim to be achieved by the policy or practice and is it legitimate?	To create a streamlined and responsive person-centred neurological rehabilitation service. Those accessing this Pathway would generally be considered as having a Disability as defined by the Equality Act 2010.
What are the means to be used to achieve the aim and are they appropriate and necessary?	The overall aim of this Review is to ensure that we have a service that will meet the person-centred neds of those who require neurological rehabilitation services. In order to determine what this should look like a Project Delivery Group was formed which included key stakeholders with relevant expertise of the needs of patients and individuals with lived experiences {former patients and their carers} to collate ideas of how to achieve this aim. This was carried out through holding workshops and using a co-design approach to ensure all voices are heard. A number of recommendations have been submitted to IJB to approve the remodelling of the Neuro Rehab Pathway, the change ideas were generated through engagement with a range of stakeholders, including patients and their families.
If the policy or practice has a neutral or positive impact, please describe it here.	**A number of positive impacts have been identified which should be realised by the reviewed service. These are outlined as follows;** **<u>Protected Characteristics</u>** **Disability –** This service will improve access for patients, receiving patient centred care for their rehabilitation creating the ability to reach more people across Grampian. Disabled people, their carers and families accessing

	Neurological Acute wards 204 / 205 at ARI, Neuro rehabilitation Unit at Woodend, HomeLink concept users and users of Horizon rehabilitation services will be positively impacted by an increase in MDT staffing to ensure a timely and intensive rehabilitation service can be offered. **Age –** This service is for adults (over 18) who require Neurological rehabilitation. Young people (under 18) are supported via RACH. The service will be available to all adults based on patient needs and will have a positive impact. **Race –** The service has considered how translation services will be accessed from community settings and will utilise the Language Line to ensure that there is no disadvantage to using a community-based model. **Sex –** The creation of the community-based model, which focuses on individual goals, ensures that there will be no gender bias within the delivery of the service. A neutral impact has been identified at this stage in relation to the other protected characteristics. **Marriage and Civil Partnership –** the service recognises the support from potential carers and so a neutral impact has been identified at this stage. **Gender Reassignment –** the service is patient centred and goals are individual. A neutral impact has been identified at this stage **Pregnancy and Maternity –** the services recognises links with other team and their involvement should they be required. A neutral impact has been identified at this stage. **Religion and belief –** the service is patient centred and goals are individual. A neutral impact has been identified at this stage **Sexual orientation -** the service is patient centred and goals are individual. A neutral impact has been identified at this stage **<u>Fairer Scotland Duty</u>**

	This service will be available to patients based on individual need. The proposed 'HomeLink' model will enable patients to receive support in their own home which minimises the financial impact and potential challenges experienced by those who have a low income and / or are experiencing material deprivation, and their Carers, from travelling to appointments for their treatment. There may be occasions due to a patients living environment where it is not appropriate for the Homelink concept to be implemented. Therefore, a commissioned bed may need to considered as an interim option. The recommendations give the flexibility for this to be pursued. The proposed model will collaborate with Aberdeenshire and Moray colleagues to determine the most appropriate means of ensuring the service is available to reach more people across Grampian. Whilst no negative impacts have been identified at this stage this will be monitored during the phased implementation. **Health Inequalities** No additional impacts have been identified in relation to Healthy inequalities. **Carers** Carers as part of discharge planning are consulted as per Carers (Scotland) Act 2016 legislation. This ensures that the individual needs of Carers are considered. Additionally, the pathway will ensure that staff have an awareness of their local commissioned Carer Support organisation and know where to signpost to. **Human Rights** There will be a positive impact in relation to 'Article 8 – The right to respect for private and family life, home and correspondence' – The proposed model will enable patients to return home to their own homes to receive their treatment enabling them to return to family life. It will also support a

	person-centred approach which has a further positive impact.
Is an Integrated Impact Assessment required for this policy or decision (Yes/No)	Yes – this will be reviewed in Phase 2
Rationale for Decision **NB: consider: -** • **How many people is the proposal likely to affect?** • **Have any obvious negative impacts been identified?** • **How significant are these impacts?** • **Do they relate to an area where there are known inequalities?** • **Why are a person's rights being restricted?** • **What is the problem being addressed and will the restriction lead to a reduction in the problem?** • **Does the restriction involve a blanket policy, or does it allow for different cases to be treated differently?** • **Are there existing safeguards that mitigate the restriction?**	Potential patient group, their carers and families within Neuro Acute wards 204 / 205 at ARI, Neuro rehabilitation Unit at Woodend, HomeLink concept users and users of Horizon rehabilitation services will be positively impacted by an increase in MDT staffing to ensure a more timely and intensive rehabilitation could be offered. No negative impacts identified Significant positive impact to those neuro patients requiring to move through the pathway to have rehab have been identified as outlined above. Carers will be positively impacted in that support is available and will be highlighted better through the pathway. No one's rights will be restricted by this. The focus of changes includes the improvement of person-centred care process which includes; working in collaboration with patients and their families to achieve the best outcomes for the patient.
Decision of Reviewer	Agreed
Name of Reviewer	Lynn Morrison
Date	13/09/23

Report prepared by
Lynn Morrison
Lead for Allied Health Professions (AHP) and Specialist Rehabilitation Services, Aberdeen City Health & Social Care Partnership

Tracey McMillan Transformation Programme Manager, Aberdeen City and Social Care Partnership

Date 7th November 2023