



**REPORT TO: MORAY INTEGRATION JOINT BOARD ON 25 JANUARY 2024**

**SUBJECT: STRATEGIC REVIEW OF NEURO-REHABILITATION PATHWAY**

**BY: LEAD FOR ALLIED HEALTH PROFESSIONALS AND  
SPECIALIST REHABILITATION SERVICES AND  
TRANSFORMATION PROGRAMME MANAGER**

## **1. REASON FOR REPORT**

1.1 To inform the Board of the findings and recommendations of a strategic review undertaken to identify the most effective delivery of Neurorehabilitation across Aberdeen City, Aberdeenshire, and Moray.

## **2. RECOMMENDATION**

**2.1 It is recommended that the Moray Integration Joint Board (MIJB):**

- i) notes the findings of the strategic review of the neurorehabilitation pathway;**
- ii) agrees that Aberdeen City Integration Joint Board (IJB) as host IJB for this service implements the proposed changes to the neurorehabilitation pathway in collaboration with Health and Social Care Moray (HSCM) and in a phased manner as set out in section 5;**
- iii) agrees that an evaluation of Phase 1 will be shared with MIJB in September 2024 before Phase 2 commences; and**
- iv) notes the engagement to date with the Aberdeenshire and Moray Health and Social Care Partnerships (HSCPs) and support the continuation of the engagement to help ensure the redesign continues to meet the needs of all three Partnerships.**

## **3. BACKGROUND**

3.1 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.

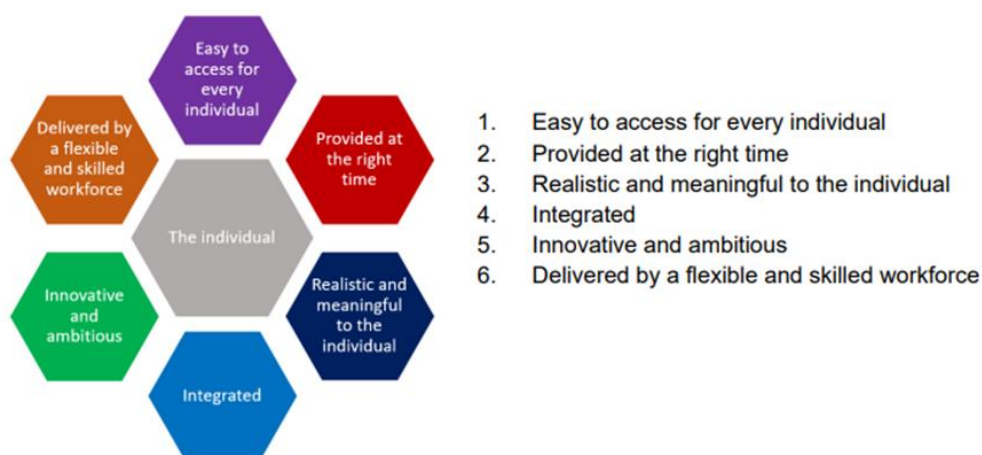
- 3.2 The Public Bodies (Joint Working) (Scotland) Act 2014 sets out the responsibilities of the IJBs. A specific requirement is that IJBs have delegated responsibility for strategic planning. The ACHSCP host the delivery of the Rehabilitation Services, which includes Neurological Rehabilitation.
- 3.3 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
- 3.4 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.
- 3.5 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.
- 3.6 The 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.
- 3.7 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.
- 3.8 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.
- 3.9 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 (<https://www.gov.scot/publications/neurological-care-support-scotland-framework-action-2020-2025/pages/4/>) 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”.

3.10 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 (<https://www.gov.scot/binaries/content/documents/govscot/publications/strategy-plan/2022/06/rehabilitation-recovery-once-scotland-person-centred-approach-rehabilitation-post-covid-era/documents/rehabilitation-recovery-once-scotland-person-centred-approach-rehabilitation-post-covid-era/rehabilitation-recovery-once-scotland-person-centred-approach-rehabilitation-post-covid-era/govscot%3Adocument/rehabilitation-recovery-once-scotland-person-centred-approach-rehabilitation-post-covid-era.pdf>) which sets out the 6 key principles of good rehabilitation.

**The Six Principles of Good Rehabilitation are:**



- National Health & Wellbeing Outcomes Framework (<https://www.gov.scot/publications/national-health-wellbeing-outcomes-framework/>)

- The British Society of Rehabilitation Medicine's Standards (<https://scottish.sharepoint.com/sites/GRAMStrategicReviewofRehabilitation/Shared%20Documents/GRAM%20Neuro-Rehabilitation%20Review/06.%20Commission%20&%20Business%20Case/bsprm.org.uk/publications/clinical-standards-documents>)
- 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.

#### **4. KEY MATTERS RELEVANT TO RECOMMENDATION**

##### **Demographics – who is accessing Neurological rehabilitation now?**

- 4.1 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
- 4.2 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.
- 4.3 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.
- 4.4 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.
- 4.5 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.
- 4.6 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.
- 4.7 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.

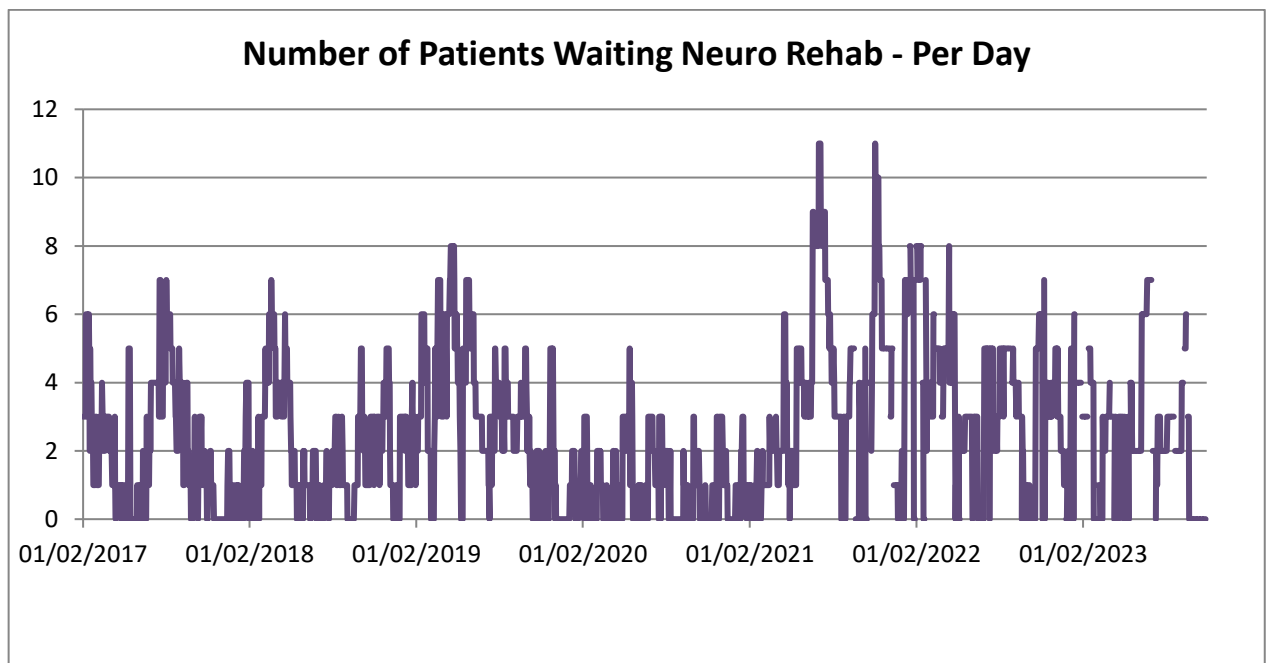
### **Stakeholders**

- 4.8 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.
- 4.9 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.

### **The functional parts of the pathway**

#### **Wards 204/205**

- 4.10 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):



- 4.11 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.

#### **Neuro Rehabilitation Unit (NRU)**

- 4.12 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.
- 4.13 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.

#### **Transitional Living – Craig Court/Home link approach**

- 4.14 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.
- 4.15 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.
- 4.16 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.
- 4.17 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).
- 4.18 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.
- 4.19 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.
- 4.20 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.

- 4.21 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.
- 4.22 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.
- 4.23 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.
- 4.24 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.

#### **Horizons Out-patient Rehabilitation Centre**

- 4.25 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

#### **Approach to this review**

- 4.26 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.



4.27 The co-designed approach enabled a vision statement (**Appendix 1**) 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 2**).

4.28 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.

4.29 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.

## **5. PROPOSED MODEL - BLENDED MODEL INCORPORATING COMMUNITY AND TRANSITIONAL LIVING ARRANGEMENTS**

5.1 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.

5.2 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.

5.3 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.

5.4 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.

### **A Phased Approach to Proposals**

5.5 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 2**) should it be required.

### **Phase 1**

- 5.6 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**

- 5.7 Based on current understanding it is proposed that phase 2 will be implemented from quarter 3 in 2024 following an evaluation of Phase 1.
- 5.8 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.
- 5.9 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.
- 5.10 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.
- 5.11 Development of the job descriptions and key functions to maximise support to staff, patients and carers are part of the implementation plan (see **Appendix 2**).

## **Evaluation of impact of Redesign – Phase 1**

- 5.12 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.
- 5.13 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 MIJB in September 2024.

## 6. SUMMARY OF IMPLICATIONS

**(a) Corporate Plan and 10 Year Plan (Local Outcomes Improvement Plan (LOIP)) and Moray Integration Joint Board Strategic Plan “Partners in Care 2022 – 2032”**

Recommendations made from the Neuro Rehab Pathway concur with Theme 2 - Home First from Partners in Care 2022-2032, this mirrors the 6 Principles of Good Rehabilitation as highlighted in Section 3.8 above, focusing on providing care in a homely setting, reablement and recovery supported by the most appropriately skilled staff group.

**(b) Policy and Legal**

There are no direct legal implications arising from the recommendations of this report.

**(c) Workforce and Financial**

The workforce have been integrated within the co-production process throughout review. The intention is to continue this engagement throughout the phased implementation period.

Changes to the model will encourage a more community facing rehabilitation model which has received widespread positivity from staff and patients during engagement.

We are aware of recruitment challenges and mindful of the need to balance our needs for developing services alongside sustaining other services that may be impacted by staff moving into new roles.

There is a great opportunity for role development within the additional capacity roles created and developing new roles which enhance career development opportunities supporting ACHSCP workforce strategic plan objectives alongside Scottish Government policy objectives detailed in 3.8 (commitment 9) above, supporting both the recruitment and retention of our workforce.

The financial plan for phase 1 and phase 2 can be described in two parts; 1) the financial envelope and 2) the spend plan.

The financial envelope to enable the proposals for additionality detailed earlier in this paper comes from two sources;

- a) cessation of the Craig Court contract; and
- b) Horizons vacant non-clinical posts (Centre Manager and admin – currently vacant.)

This totals £1,242,000 recurring funding, which covers the implementation of the two phases. It is anticipated that the funding for phase 2 will be maintained within medium term financial framework due to be considered by the Integration Joint Board in March 2024.

The costs proposed for phase 1 total £554,000. These on costs consist of:

- £172,000 (3.22 wte) invested in therapy staffing in NRU (including a neuropsychologist);
- £115,000 (2.3wte) invested in HomeLink therapy staffing; and
- £267,000 (5.35wte) invested in Out-Patient Plus (Horizons) capacity.

Investing this as proposed would leave £688,000 for the remainder for investment in Phase 2.

In phase 2, the potential further areas for investments, informed by the evaluation are;

- further investment clinical posts in NRU;
- further investment in clinical posts in Horizons;
- new investment in non-clinical support posts; and
- commissioning 3 nursing/rehab beds (However, different models of providing this capacity, if needed, will be explored in phase 1) \*any commissioning activity will be based upon evaluation of demand. The geographical location of any beds will be agreed in conjunction with all 3 partnerships based on demand data. The ratio of virtual to physical beds will be reviewed with spending based upon this blended model within budget e.g. may conclude 5:1 modelling is required.

Further change ideas produced by the PDG will be costed, evaluated and incorporated for inclusion into the implementation plan as appropriate.

The PDG has been regularly appraised of the unacceptability of any spend plan beyond the identified finance envelope. This group will monitor recruitment as an area of high risk alongside balancing patient need whilst having oversight of the recurring budget and ongoing staff cost commitments. Indeed, the evaluation of phase 1 and planning of phase 2 will include the requirement to seek to identify any opportunity for recurring cost reductions to contribute towards ACHSCP and hosted services financial recovery plans. Consideration will also be given to the impact of any investment against preventable demand and associated costs elsewhere in the system.

**(d) Risk Implications and Mitigation**

The delivery of the re-modelled hosted neurorehabilitation pathway has been consulted with Stakeholders and clinical leaders across the three Partnerships. As we move forward to the implementation phase further engagement with key stakeholders will continue.

The plan proposed for re-modelling will be met within the existing financial envelope. The phased nature of planned delivery will enable regular reviews re outcomes and implementation to ensure the redesign remains within the available budget. Due to this, the financial risk is deemed to be low.

We understand rehabilitation impacts on optimising recovery from medical and surgical interventions (so optimises costs in other parts of the pathway and avoids waste), reduces/manages complications associated with health conditions/long term conditions, reducing length of stay, and preventing re-admissions so cost avoidance, and beyond the more acute phase of rehab, in terms of keeping people well and independent for as long as possible and equipping people with self-management approaches.

Risk to Quality of service delivery/patient/staff experience are low given controls in place through which highlight that activity data, demand and patient experience will be monitored as key function of phase one.

Patient evaluation has been built into the HomeLink team to capture feedback for learning and review.

The re-modelling of pathway with additional staffing in existing services at Horizons and HomeLink should create an enhanced experience for patients and carers through more timely access. Considerations of impact upon carers has been addressed within IIA and greater connections with Commissioned Carer support organisations will provide further mitigation. Risk of adverse outcome to staff, patients and carers within this pathway following the re-modelling is low.

Communication and engagement with all three Partnerships, has ensured that recommendations to progress the review have gained understanding and support. This position creates a low risk for reputational damage. In terms of risk to hosted/commissioned services, risks have been minimised due to co-design approach whereby all Partnerships have been invited to participate and have been consulted with. With changes in the City HSCP project team and some of the key personnel in the other HSCPs, meetings are taking place to bring these key stakeholders up to date with progress and we recognise the need to continue to work collaboratively as we progress through the two phases of implementation to ensure best outcomes right across Grampian.

The plan to formally commission beds in Phase 2 to provide transitional living support will be based upon data and will be supported by the shared City and Aberdeenshire Council Contracts team. There are no commissioned contracts in place at present that are reliant upon any funding or support from Neuro–rehabilitation pathway.

**(e) Property**

There are no direct property implications arising from the recommendations of this report.

**(f) Equalities/Socio Economic Impact**

An Impact assessment has been completed (**Appendix 4**). Costs to implement the changes will be met through the existing financial envelope for neurorehabilitation through redesign of the existing pathway model for neurorehabilitation and transitional support. The budget for phase 2 spending will be maintained within the medium term finance framework.

Stakeholders including carers, patients and families have been consulted as part of co-design process and have inputted their needs for consideration.

The phasing of project delivery will ensure that oversight of recruitment activity is managed and balanced in terms of budget available for commissioning activity.

Although not in the scope of this review, one area of need identified through this process through engagement with colleagues working across other parts of the wider pathway has been around practice education capacity within the acute part of the neuro pathway for nursing and an approach will be made to Friends of Neuro to consider funding this.

**(g) Climate Change and Biodiversity Impacts**

There are no direct environmental implications arising from the recommendations of this report. Considerations have been re-use of existing workplaces and use of community facilities to support individual rehabilitation goals.

**(h) Directions**

There are no directions arising from the recommendations of this report.

**(i) Consultations**

Significant discussion across the engagement activity undertaken in planning this redesign was used to explore achieving an appropriate person-centred balance in supporting individuals in rural settings using digital technology such as Near me video calls and working with the local HSCP rehabilitation teams with enhanced knowledge and clinical oversight provided by virtual MDT with specialist team colleagues. This is designed to support both a Home First and sustainability strategic objectives of the IJB.

## **7. CONCLUSION**

- 7.1 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 made by Aberdeen City IJB in October 2023 to approve the implementation of a two phased approach to redesign.**
- 7.2 A staged approach to implementation of the change ideas will 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, a review of 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.**
- 7.3 An update report on the evaluation will be taken back to the Aberdeen City IJB in September 2024, which will be shared across Aberdeenshire and Moray Partnerships thereafter.**
- 7.4 ACHSCP 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.**

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Background Papers: Appendix 1: Vision Statement  
Appendix 2: Improvement Ideas  
Appendix 3: Implementation Plan  
Appendix 4: EQIA

Ref: