CONSULTATION DOCUMENT
CHANGES TO REHABILITATION SERVICES IN NORTH EAST GLASGOW

1. INTRODUCTION

1.1 Proposals for Consultation

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

- acute inpatient care on to sites with full acute facilities;
- community rehabilitation beds in local care homes providing intermediate care;
- more rehabilitation in patients' homes;
- 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/

The rest of this section shows how we have carefully considered and responded to issues from the engagement in developing our approach to consultation.

- **Impact on inequalities.** There were clear views from responses that Lightburn fulfils a particular need, generated by the socio-economic profile of the area, for health care services to be available locally and a number of responses have highlighted concerns about the impact on a deprived area of losing a local hospital service. An EQIA of the proposed changes, which effect small numbers of patients, did not raise major issues. In the light of this concern the Board's Director of Public Health is commissioning a review of these issues, the brief for which is available on our consultation website. The outcome of that review will be considered by the Board in making a decision.

- **Access and transport issues.** There were a range of issues raised about access and transport with particular concerns about access to Stobhill for patients and visitors. We have a detailed analysis on this issue on our consultation website, including surveys of patients and visitors.

  At headline level:

  - day hospital patients mainly attend by ambulance and car;
  - the aim is that small numbers of patients, less patients than those admitted to Lightburn from the East End, will require acute hospital rehabilitation outside the East End, with local accessible services through the care home model and more care in patients homes;
  - The proposal will reduce follow up attendances, by delivering day services and outpatients on a full acute site.

- **Parkinson's service.** Concerns have been raised that a shift from Lightburn would mean the loss of the multi disciplinary Parkinson's' clinic. We understand the importance of multidisciplinary care and continuity to patients with chronic conditions and our proposal is that the whole clinical team relocate to continue to provide integrated multi disciplinary care.

- **No change to position since previous decision.** The challenge has been made that there is no difference to the position since the previous Cabinet Secretary decision in 2011 not to approve the closure of the hospital. In our view there are a number of different factors. In 2011 the National Clinical Strategy had not been published; Integration Joint Boards, with statutory responsibility for health and social care in the community, had not been established; the proposed model of care did not include key aspects in this proposal, including community based rehabilitation beds providing a range of new services immediately accessible to the local population and reframed outpatient and day services focused on reducing repeat attendances. Since the engagement process the National Health and Social Care Delivery Plan has confirmed the strategic direction, committing to substantial reductions in the use of acute beds.

- **New models of community rehabilitation.** There were a number of challenges to the proposed new model of care. We have explained the model in more detail in this consultation paper and we have developed new material to enable people to understand what we are proposing.

- **Day hospital care.** Submissions acknowledged the higher quality facilities which would be available at Stobhill in a combined NE day hospital but raise the concern that patients would not be able to access this site. The option appraisal included criteria on access and we have analysed transport issues.

- **Current function of Lightburn.** There were misunderstandings in a number of submissions about the current function of Lightburn, including that the hospital provides care for patients discharged from acute services and that it is a local hospital. We have explained more clearly in this paper that:-

    - The patients at Lightburn are not discharged from acute care.
    - The hospital cares for patients from across the NE and East End, patients are currently transferred from Glasgow Royal Infirmary to services in Stobhill and Gartnavel as well as to Lightburn.

- **Parkhead hub is critical to the proposed service changes**. A number of submissions suggested that capital developments are critical to deliver our proposed changes. In our original submission we proposed that some services could be provided in East End HSCP facilities. Further work with the clinical team, the Stakeholder Reference Group and patient feedback have led us to conclude that the most effective model for acute services is provision on full acute sites, so that we can deliver integrated, multidisciplinary care on a one-stop basis, as far as possible. That is now the proposal for consultation. We recognise that the local community want to understand the timing and process for local investment by the HSCP and want the potential for an extended facility to be considered and want to see the option of the Lightburn site explored. Alongside this consultation we will be working with Glasgow City HSCP to plan the development of the new hub for health and social care in the East End and see whether any of our services could be delivered in the hub. The paper launching that programe is at:

    https://www.glasgow.gov.uk/CHttpHandler.ashx?id=36666&p=0

- **Option appraisal:** our engagement process included material on options, and criteria to consider those options, as part of our public events. Preparing for this consulatation we undertook a formal option appraisal, reflecting what we heard in the engagement process. The proposal we are consulting on was the highest scoring option in that option appraisal which we undertook with our Stakeholder Reference Group. The full report of that appraisal is available on our consultation website.

2. THE CASE FOR CHANGE

2.1 Local and national Clinical Services Strategies set out future models of care for older people's services to ensure older people stay in hospital only for acute care. The key strategic objectives are to deliver:

- early intervention from specialists in the care of older people focussed on multidisciplinary assessment of frailty;
- rapid commencement of multidisciplinary 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 a 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 there is access to other clinical services enabling a one-stop approach.

2.2 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

3.1 This section describes the current pattern of services delivered and how Lightburn Hospital fits into that pattern of services:

- 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.

3.2 Lightburn services include:

- 56 inpatient beds: with around 450 admissions each year;
- day hospital: with around 400 new visits and 3000 return visits;
- consultant led clinics each week: around 400 new appointments and 600 returns per year;
- one Nurse led clinic each week: 144 return appointments per year;
- A monthly Parkinson's group meeting.

4. CURRENT FACILITIES

4.1 Stobhill Hospital

The new Stobhill Hospital opened in 2009 and provides state-of-the-art health facilities for the people of Glasgow in a modern care system. The project was a key component of the overall modernisation of Glasgow's acute hospitals.




The building and services are physically very accessible and have been described by patients and carers as bright, modern and spacious.


The inpatient wards, day hospital and outpatient services have onsite access to a full range of acute hospital support services and specialties:

- laboratory medicine (e.g. blood samples analysed);
- imaging and diagnostic services (e.g. CT scans, MRI, Ultrasound);

- orthotics (eg, inserts for shoes or supports for knee);
- pharmacy;
- cardiology (eg, tests and treatment for heart disorders);
- liaison from a range of other specialties

There are two older adult inpatient wards, one for stroke rehabilitation with elements of general rehabilitation when required and the other for elderly rehabilitation. They each have 24 beds composed of 12 single bed ensuite rooms and three 4 bedded bays.


The wards have excellent access to toileting and showering facilities with ensuite rooms and the wards having 2 in each 4 bedded bay.


The wards have spacious patient common areas improved opportunities to socialise with other patients or meet with family/carers outwith their rooms.


4.2 Lightburn Hospital

Lightburn Hospital was built in the 1960s for geriatric patients. There have been additions to the hospital over the years.

There is onsite access to plain film x-ray 4 half days per week, however, other imaging and diagnostic services are accessed at Glasgow Royal Infirmary and Stobhill Hospital. If an inpatient requires these they are transported off-site accompanied by a member of ward staff.

There are two 28 bedded wards, each composed of 4 single rooms and four 6 bedded bays. In one half of each ward there is two 6 bedded bays and two single rooms with these having access to two toilets and a bathroom; none of the single rooms are ensuite. The building and services are physically accessible, the bed areas, toileting and showering facilities are not of modern standards. There are patient common areas/TV room and dining areas in each ward.


5. PROPOSED MODEL OF CARE

5.1 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.

5.2 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.

6. NEW MODEL OF CARE: ACUTE INPATIENT CARE

6.1 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:

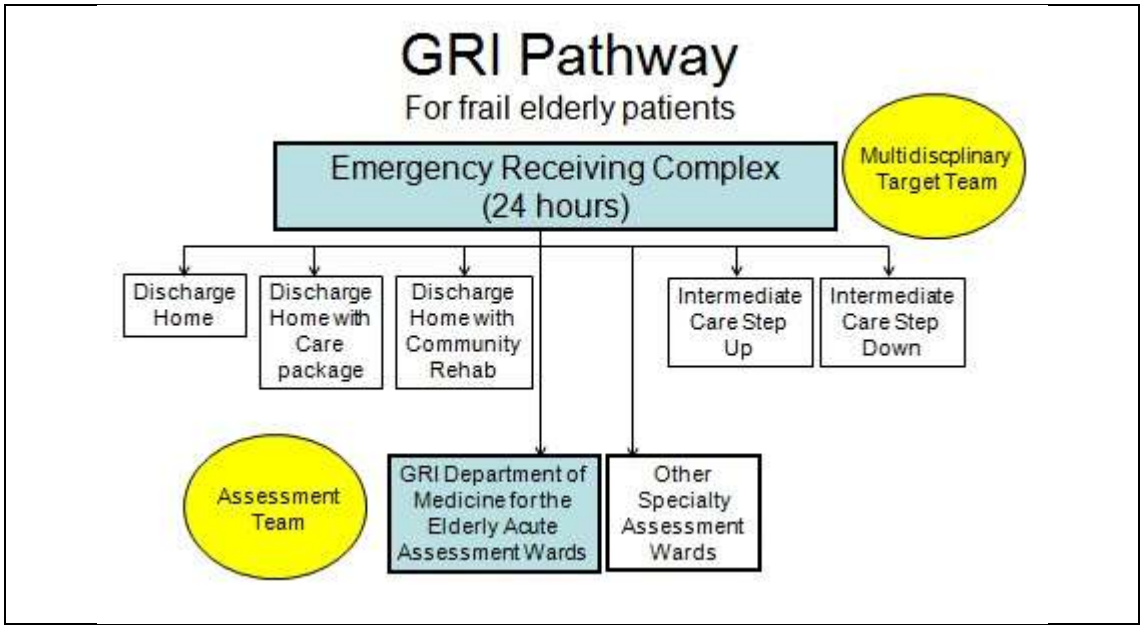
- Following initial assessment in the emergency receiving complex, patients identified as requiring acute inpatient care will generally be transferred to GRI DME acute assessment wards. This provides multi disciplinary assessment, investigation, treatment and rehabilitation from specialists in the care 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;

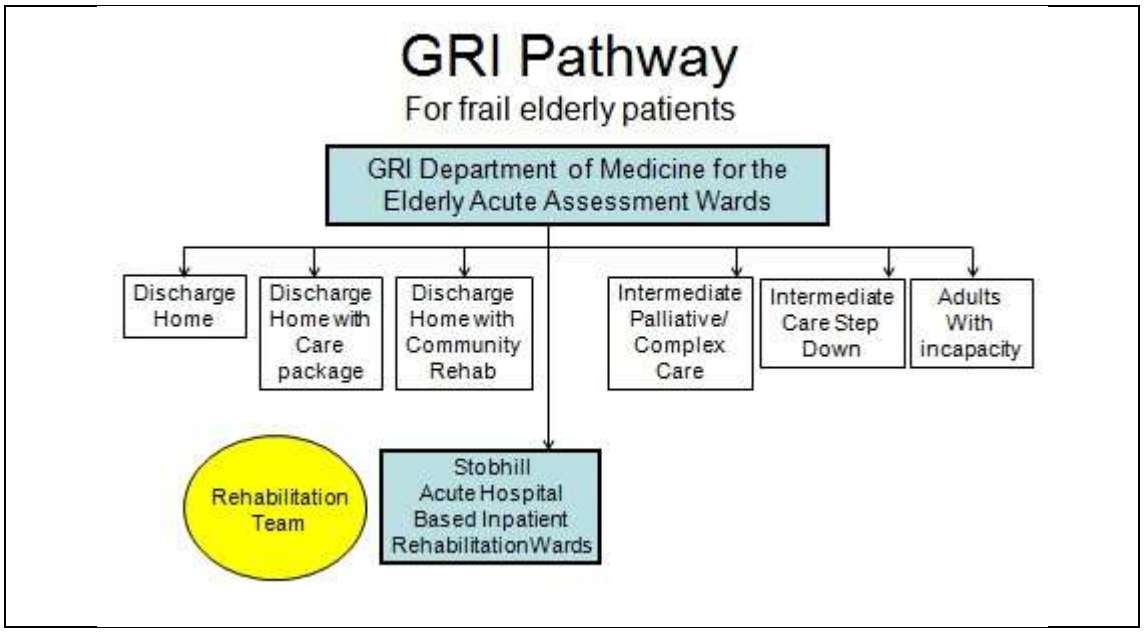
- most patients will return directly home but some medically stable patients who do not require acute hospital care but are not ready to be discharged home will access new community rehabilitation beds in local Care Homes;
- patients requiring rehabilitation and ongoing acute inpatient care will move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

6.2 The diagrams below show how the care pathway for patients will work in our proposed model. Sections 7, 8 and 9 then go on to describe each of the community and intermediate care elements of these services in more detail.

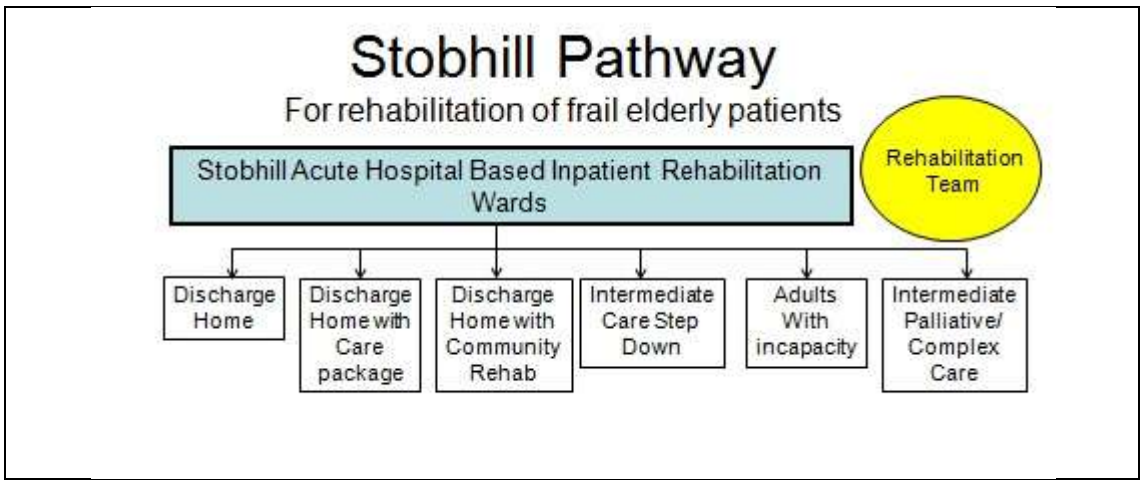
- **This first diagram shows the pathways for patients from acute assessment at the GRI:**



- **This second diagram summarises the pathways available after a patient has completed their treatment in the Elderly Acute Assessment wards at Glasgow Royal Infirmary:**



- **The final diagram below summarises the pathways available in the third phase of the patient pathway from the Acute Rehabilitation wards at Stobhill:**



6.3 The table below summarises the current patient flows through the Glasgow Royal Infirmary for patients aged over 75 referred to the acute care of the elderly service and the estimated flows which form the basis of the new model.

Patient Category	**2015/16 Spells**	**Current Model**	**Future Model**
Patients who have a period of assessment at GRI	4202	100%	100%
Patients discharged home	2279	54%	54% minimum increasing over time
Patients transferred to Lightburn for rehabilitation	456	10.9%	None
Patients transferred to Stobhill for rehabilitation	309	7.4%	10%
Patients who die in GRI	269	6%	6%

Patients discharged to a community facility	482	11.5%	Approx 30%

6.4 In 2015/16, of the around 450 patients undergoing a rehabilitation stay at Lightburn approximately 300 are for East End patients with the remainder being mainly from East Dunbartonshire or North and West Glasgow. Of the East End Lightburn admissions, half of current Lightburn inpatients will be discharged home with a community based rehabilitation package or be admitted to a community rehabilitation bed in the local care home facility. We would therefore expect around 150 East End patients each year to undergo a shorter and more focused acute rehabilitation stay at Stobhill.

7. NEW MODEL OF CARE: COMMUNITY BASED REHABILITATION BEDS

7.1 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.

7.2 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.

7.3 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.

7.4 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.

7.5 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

8.1 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:

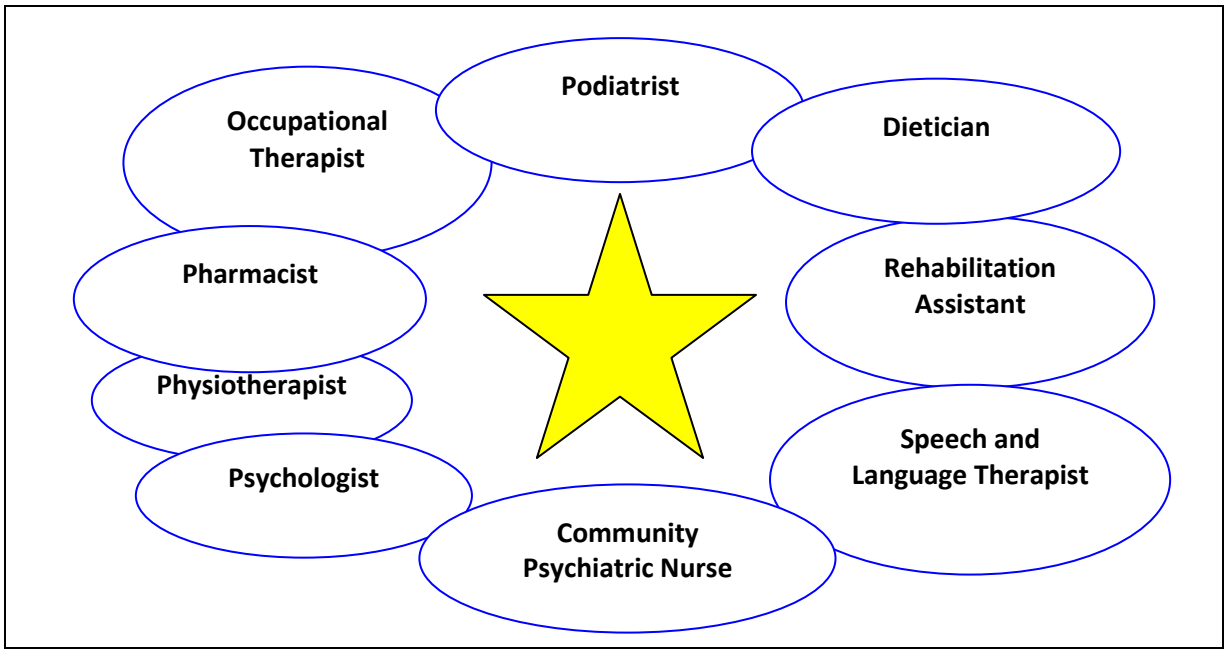
- patients who are at the end of their life, no longer need to be in an acute hospital setting, but due to the nature of their needs, cannot return to their own home or be supported in a mainstream nursing home. This service provides an enhanced level of medical input with nursing care and in-reach from 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

9.1 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.

9.2 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.

9.3 The Rehabilitation Service consists of:



10. NEW MODEL OF CARE: DAY HOSPITAL

10.1 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.

10.2 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

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

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

11.2 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 factor is that over 80% of patients travel by car or ambulance and that we can reduce repeat attendances for general clinics.

11.3 In the engagement process we suggested that the multidisciplinary 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.

11.4 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.

12. OTHER COMMUNITY SUPPORT SERVICES

12.1 In addition to the community rehabilitation services detailed above patients there are a wide range of community services to support patients without the need for an acute hospital admission or to enable their discharge from an acute hospital.

- **Continence Services - SPHERE Bladder and Bowel Services**

  The SPHERE Bladder and Bowel Service provides a professional, caring, confidential and supportive approach to people with bladder or/and bowel symptoms. The aim of the team is to promote continence by empowering the individual to self-manage their symptoms by teaching behavioural and lifestyle changes that can promote bladder and bowel health.

- **Community Diabetes Service**

  The specialist diabetes teams consist of Diabetes Specialist Nurses, Dieticians and Podiatrists providing specialist care and interventions to people living with diabetes.

- **Physiotherapy**

  The Outpatient Physiotherapy Service is based in health centres and outpatient departments across Greater Glasgow and Clyde. Physiotherapists will assess and treat patients who have any injury, disease or problem that relates to muscles, bones, joints and peripheral nerves and provide advice to help patients manage their condition or refer on to other services.

- **District Nursing**

  The District Nursing Service provides a nursing service to all age groups in the community by working in partnerships with service users, care providers and other agencies.

  Amongst their duties, the District Nursing Service staff:

  - assess, identify and prioritise health needs within the home environment and wider community setting;
  - administer medication and treatments and prescribe where appropriate;
  - manage nurse led clinics and provide specialist advice, diagnosis and treatment of many conditions;
  - promote a coordinated approach to hospital discharge that ensures a seamless service leading to improved health outcomes;
  - provide health education, information and support for patients and carers;
  - some of the care they provide includes:
    - tissue viability/wound management;
    - bowel and bladder management;
    - terminal and Palliative Care management;
  - nursing management and support of patients with chronic degenerative conditions;
  - participation in the rehabilitation of patients following surgery, disability, accident or illness event;
  - teaching self care procedures to enable patients to manage their own health needs;
  - enabling patients and carers to improve their health and wellbeing within the limitations of their illness;
  - Prescribing where appropriate and administering medications and treatments.

- **Older People's Mental Health**

  The Older People's Mental Health Team provides care for people who have dementia or memory loss; clinical depression, extreme stress or anxiety; obsessions or phobias; or other mental health problems which seriously affect daily living. The service is for people over 65, but the team see people of any age suffering from memory loss or dementia.

  Patients can be referred by a GP, Social Worker or District Nurse. Relatives or carers may also contact the service directly.

- **Carer Services**

Carer Services in the NE provide a universal offer of information and support for all unpaid carers supporting family, friends or neighbours who live with long terms conditions, disabilities and frailty. There are a range of services available:

- Information and advice on:
  - how to access services;
  - help with the process of being assessed as a carer;
  - medical conditions affecting the person who is being cared for.

- Staff delivered emotional support:
  - through one to one contact;
  - by helping to access a carers support group;
  - by referring to a specialist support service if required.

- Health checks:
  - personal health check by Carer Community Nurse;
  - support from nurses to improve and maintain health and well being.

- Financial advice:
  - arranging a full check on benefit entitlement including assistance with form filling
  - completion of forms for grants or allowances;
  - signposting to organisations which provide support for tribunals and/or debt advice.

- **Social Work Services**

Social Work Services provide a variety of services which aim to:

- support individuals and families to maintain independence and to exercise choice about the way they live their lives;
- ensure the safety and protection of vulnerable adults, young people and children.

Various services can be provided or accessed after an assessment and these include:

- income maximisation;
- supported living services;
- home care;
- homecare reablement;
- day care and befriending;
- occupational therapy services;
- equipment and adaptations for daily living;
- residential and nursing care;
- respite services;
- carer services.

13. PATIENT ACTIVITY AND GEOGRAPHICAL INFORMATION

13.1 The Glasgow Royal Infirmary catchment for emergency admissions covers a geographical area across the North East of Greater Glasgow including the Health and Social care Partnerships of Glasgow City, East Dunbartonshire and North Lanarkshire. The percentage of patients from each part of the catchment is shown below:

Area of GRI catchment	Percentage of patients
Lightburn locality	37%
North East and North West Glasgow	37%

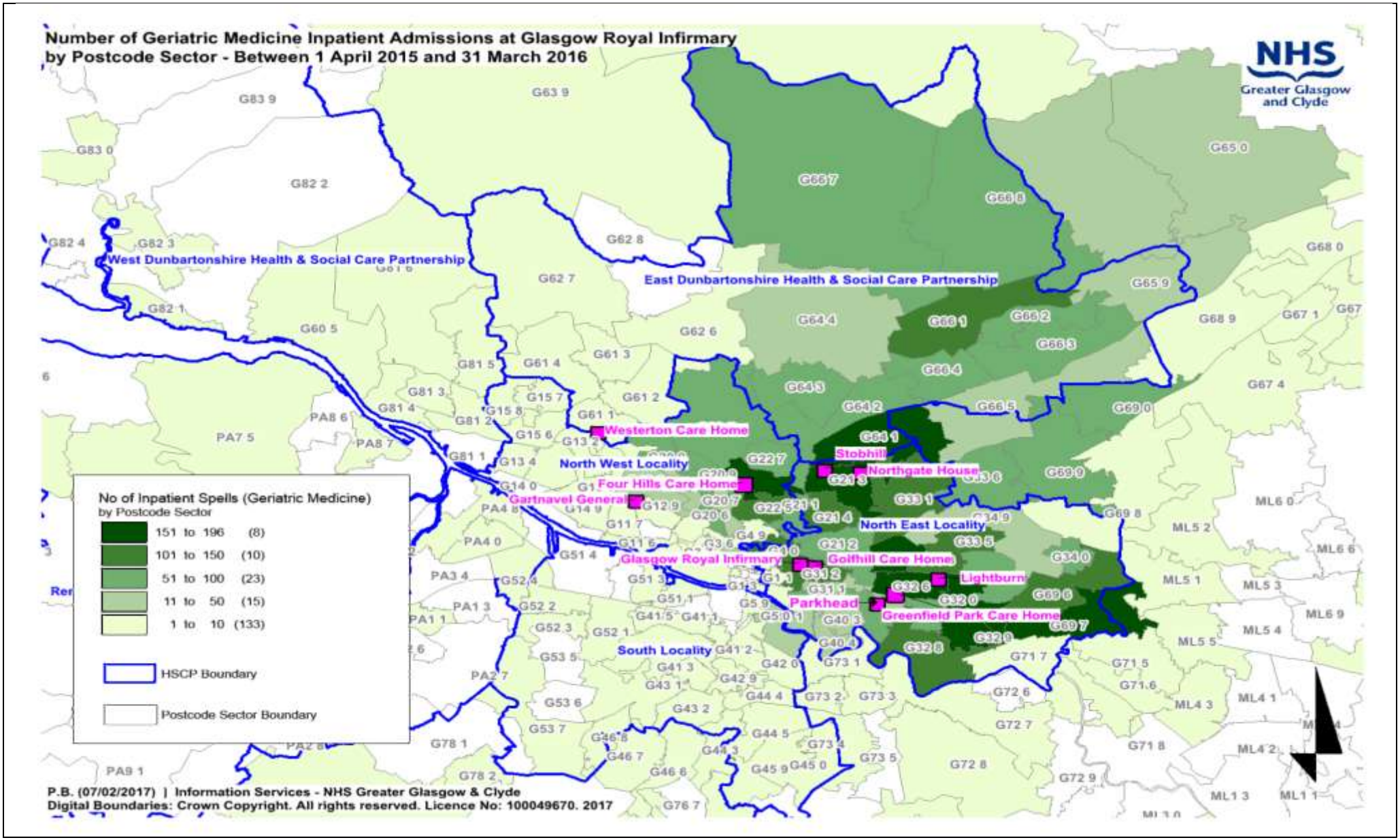
East Dunbartonshire	18%
Non NHSGGC	8%

13.2 Glasgow Royal Infirmary

The table below shows the **Glasgow Royal Infirmary** elderly assessment patient spells split by HSCP in 20115/16

Glasgow Royal Infirmary Total	**5,055**
East Dunbartonshire Health and Social Care Partnership	915
Glasgow City Health and Social Care Partnership - North East Locality	3,046
Glasgow City Health and Social Care Partnership - North West Locality	711
North Lanarkshire Health and Social Care Partnership	198
Other HSCPs	185

The map below shows the distribution of GRI patient admission postcodes.


Number of Geriatric Medicine Inpatient Admissions at Glasgow Royal Infirmary
by Postcode Sector - Between 1 April 2015 and 31 March 2016
NHS
Greater Glasgow and Clyde
West Dunbartonshire Health & Social Care Partnership
East Dunbartonshire Health & Social Care Partnership
North West Locality
North East Locality
South Locality
Westerton Care Home
Four Hills Care Home
Gartnavel General
Glasgow Royal Infirmary
Stobhill
Northgate House
Golfhill Care Home
Lightburn
Parkhead
Greenfield Park Care Home
No of Inpatient Spells (Geriatric Medicine)
by Postcode Sector
151 to 196 (8)
101 to 150 (10)
51 to 100 (23)
11 to 50 (15)
1 to 10 (133)
HSCP Boundary
Postcode Sector Boundary
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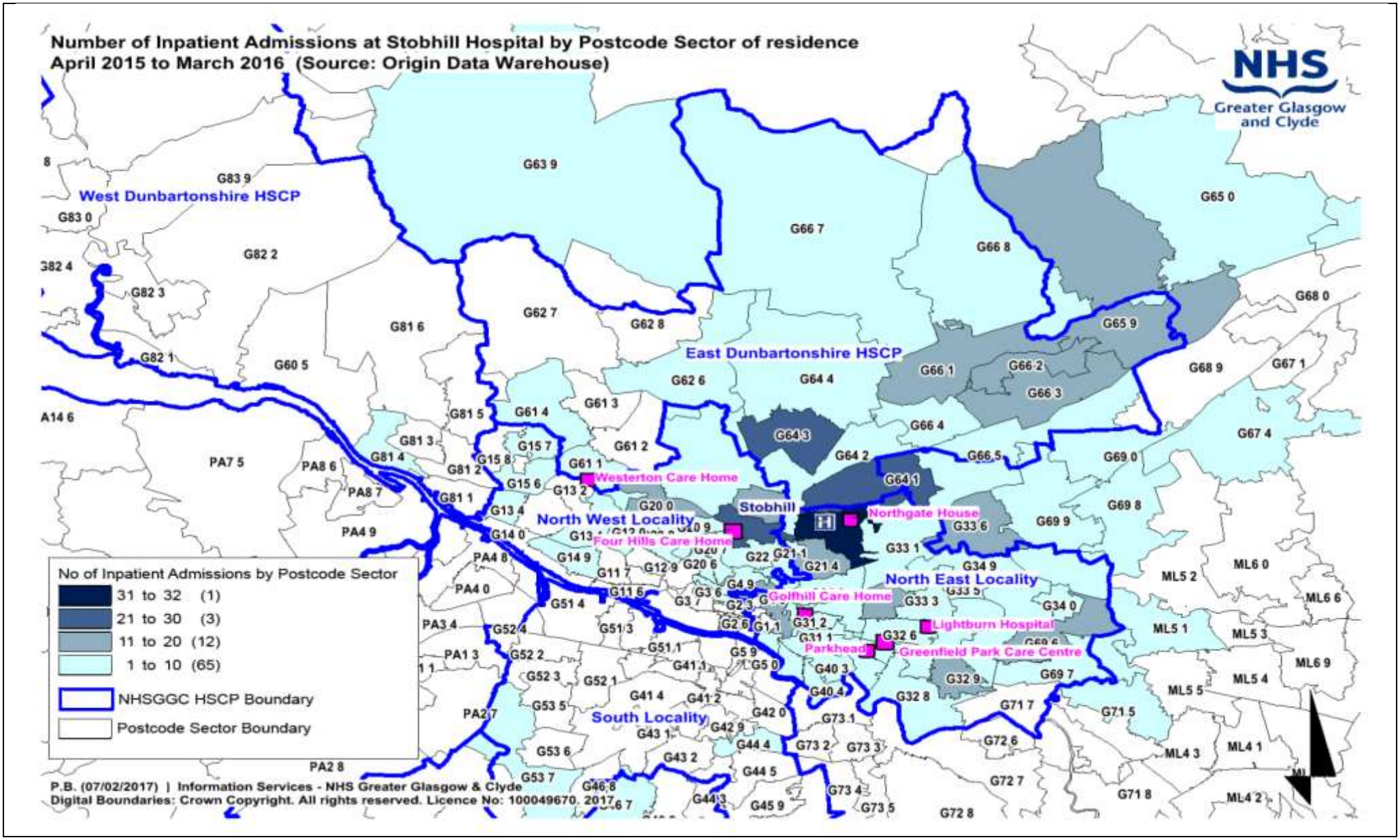
13.3 Stobhill

The table below shows the **Stobhill** elderly rehabilitation patient spells split by HSCP in 2015/16

Stobhill Total	**516**
East Dunbartonshire Health and Social Care Partnership	138
Glasgow City Health and Social Care Partnership - North East Locality	242
Glasgow City Health and Social Care Partnership - North West Locality	111
North Lanarkshire Health and Social Care Partnership	21
Other HSCPs	4

The map below shows the distribution of these Stobhill patient postcodes.


Number of Inpatient Admissions at Stobhill Hospital by Postcode Sector of residence
April 2015 to March 2016 (Source: Origin Data Warehouse)
NHS
Greater Glasgow and Clyde
West Dunbartonshire HSCP
East Dunbartonshire HSCP
North West Locality
North East Locality
South Locality
Stobhill
Westerton Care Home
Four Hills Care Home
Northgate House
Golfhill Care Home
Lightburn Hospital
Parkhead
Greenfield Park Care Centre
No of Inpatient Admissions by Postcode Sector
31 to 32 (1)
21 to 30 (3)
11 to 20 (12)
1 to 10 (65)
NHSGGC HSCP Boundary
Postcode Sector Boundary
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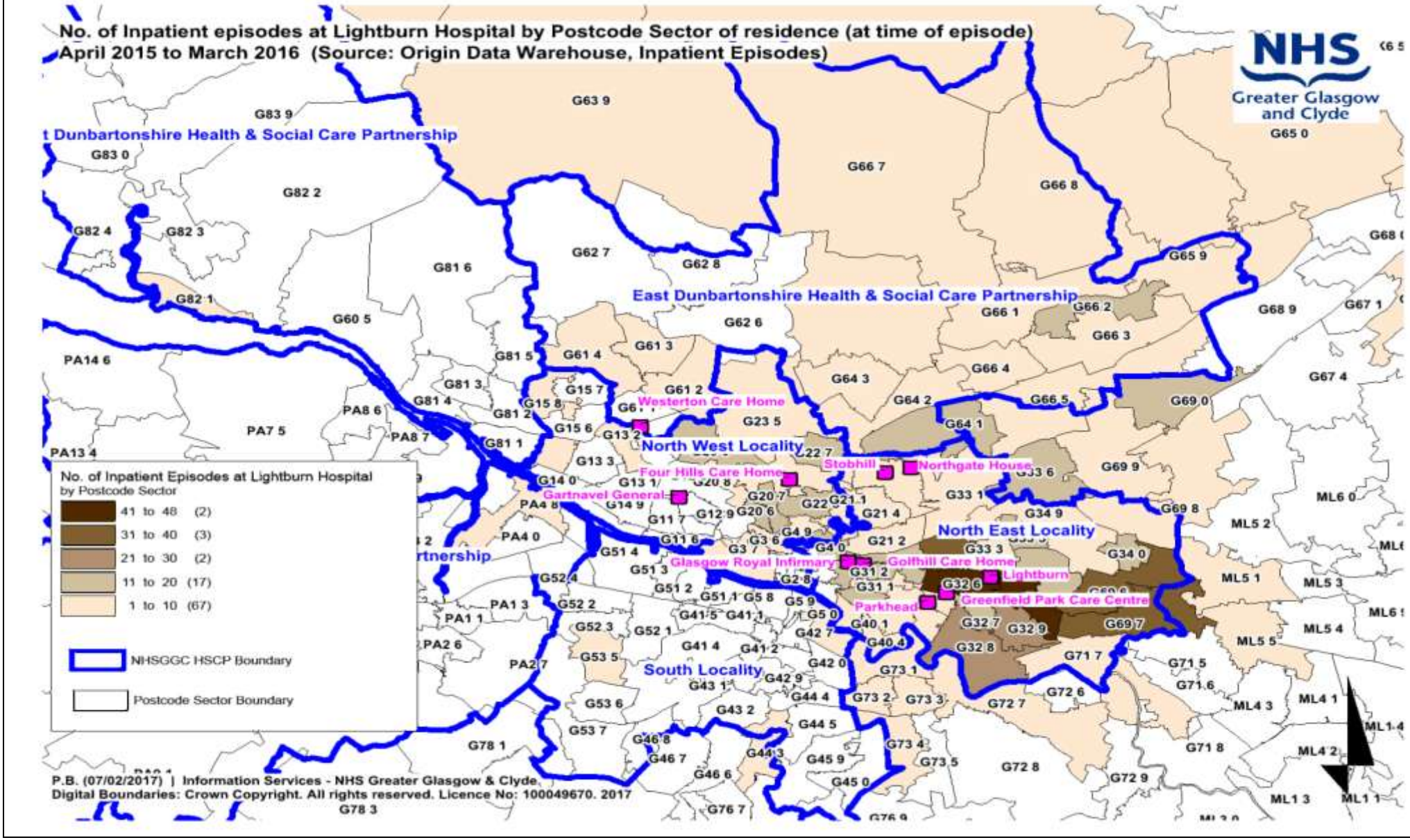
13.4 Lightburn Hospital

The table below shows the Lightburn patient episodes postcodes split by HSCP in 2015/16.

In total there were 714 patient episodes which equates to around 450 elderly rehabilitation patients in the year.

Lightburn Total		**714**
East Dunbartonshire Health and Social Care Partnership		**74**
G66	Kirkintilloch, Lennoxtown, Lenzie, Milton of Campsie	39
G64	Bishopbriggs, Torrance	29
G61	Bearsden	6
Glasgow City Health and Social Care Partnership - North East Locality		**483**
G32	Carmyle, Tollcross, Mount Vernon, Lightburn, Sandyhills	157
G33	Carntyne, Craigend, Cranhill, Millerston, Provanmill, Riddrie, Robroyston, Ruchazie, Stepps	89
G69	Baillieston, Garrowhill, Gartcosh, Moodiesburn, Muirhead	70
G31	Dennistoun, Haghill, Parkhead	55
G21	Barmulloch, Cowlairs, Royston, Springburn, Sighthill	28
G40	Bridgeton, Calton	28
G34	Easterhouse	25
G4	Calton, Cowcaddens, Drygate, Kelvinbridge, Townhead, Woodlands, Woodside	18
G22	Milton, Possilpark	10
G1	Merchant City	3
Glasgow City Health and Social Care Partnership - North West Locality		**88**
G20	Maryhill, North Kelvinside, Ruchill	48
G22	Milton, Possilpark	23
G23	Lambhill, Summerston	7
G3	Anderston, Finnieston, Garnethill, Park, Woodlands, Yorkhill	5
G13	Anniesland, Knightswood, Yoker	3
G15	Drumchapel	1
G4	Calton, Cowcaddens, Drygate, Kelvinbridge, Townhead, Woodlands, Woodside	1
North Lanarkshire Health and Social Care Partnership		**34**
Other HSCPs		**35**

The map below shows the distribution of Lightburn patient admission postcodes.


No. of Inpatient episodes at Lightburn Hospital by Postcode Sector of residence (at time of episode)
April 2015 to March 2016 (Source: Origin Data Warehouse, Inpatient Episodes)
NHS
Greater Glasgow and Clyde
East Dunbartonshire Health & Social Care Partnership
North West Locality
North East Locality
South Locality
Westerton Care Home
Four Hills Care Home
Gartnavel General
Glasgow Royal Infirmary
Stobhill
Northgate House
Golfhill Care Home
Lightburn
Greenfield Park Care Centre
Parkhead
No. of Inpatient Episodes at Lightburn Hospital by Postcode Sector
41 to 48 (2)
31 to 40 (3)
21 to 30 (2)
11 to 20 (17)
1 to 10 (67)
NHSGGC HSCP Boundary
Postcode Sector Boundary
P.B. (07/02/2017) | Information Services - NHS Greater Glasgow & Clyde
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13.5 Day Hospital Activity

The table below shows the distribution by postcode of Lightburn day hospital attendees in 2015/16.

Lightburn Day Hospital by HSCP	Postcode District	Area	New	Return	Total
East Renfrewshire HSCP	**Total**		**0**	**1**	**1**
Glasgow North East Sector	G1	Merchant City	4	38	42
	G21	Barmulloch, Cowlairs, Royston, Springburn, Sighthill	4	65	69
	G31	Dennistoun, Haghill, Parkhead	53	338	391
	G32	Carmyle, Tollcross, Mount Vernon, Lightburn, Sandyhills	168	1417	1585
	G33	Carntyne, Craigend, Cranhill, Millerston, Provanmill, Riddrie, Robroyston, Ruchazie, Stepps	86	652	738
	G34	Easterhouse	20	134	154
	G4	Calton, Cowcaddens, Drygate, Kelvinbridge, Townhead, Woodlands, Woodside	5	32	37
	G40	Bridgeton, Calton	24	155	179
	G69	Baillieston, Garrowhill, Gartcosh, Moodiesburn, Muirhead	54	401	455
Glasgow North East Sector	**Total**		**418**	**3232**	**3650**
Glasgow North West Sector	G21	Barmulloch, Cowlairs, Royston, Springburn, Sighthill	0	2	2
	G22	Milton, Possilpark	1	10	11
	G3	Anderston, Finnieston, Garnethill, Park, Woodlands, Yorkhill	1	0	1
Glasgow North West Sector	**Total**		**2**	**12**	**14**
Glasgow South Sector	**Total**		**1**	**28**	**29**
Renfrewshire HSCP	**Total**		**1**	**12**	**13**
Total GGC HSCPs			**422**	**3285**	**3707**

13.6 Outpatient Activity

The table below shows the distribution by postcode of each type of Lightburn outpatient clinic in 2015/16.

OPA Clinic	OPA CHP Sub Sector Desc At Attend	OPA Patient Postcode District At Attend		Consultant			Nurse Practitioner		Total
				New	Return	Total	Return	Total	
Falls	East Dunbartonshire Community Health Partnership	G64	Bishopbriggs, Torrance		3	3			3
		G66	Kirkintilloch, Lennoxtown, Lenzie, Milton of Campsie	1	8	9			9
		Total		1	11	12			12
	Glasgow North East Community Health & Care Partnership	G1	Merchant City	1	4	5			5
		G21	Barmulloch, Cowlairs, Royston, Springburn, Sighthill	1	1	2			2
		G31	Dennistoun, Haghill, Parkhead	19	17	36			36
		G32	Carmyle, Tollcross, Mount Vernon, Lightburn, Sandyhills	49	35	84			84
		G33	Carntyne, Craigend, Cranhill, Millerston, Provanmill, Riddrie, Robroyston, Ruchazie, Stepps	39	28	67			67
		G34	Easterhouse	8	10	18			18
		G4	Calton, Cowcaddens, Drygate, Kelvinbridge, Townhead, Woodlands, Woodside	1	4	5			5
		G40	Bridgeton, Calton	10	9	19			19
		G69	Balleston, Garrowhill, Gartcosh, Moodiesburn, Muirhead	17	15	32			32
		Total		145	123	268			268
	Glasgow North West Community Health & Care Partnership	G20	Maryhill, North Kelvinside, Ruchill		1	1			1
		G22	Milton, Possilpark		1	1			1
		G3	Anderston, Finnieston, Garnethill, Park, Woodlands, Yorkhill	1		1			1
		G4	Calton, Cowcaddens, Drygate, Kelvinbridge, Townhead, Woodlands, Woodside	1	1	2			2
		Total		2	3	5			5
	Glasgow South Community Health & Care Partnership	G44	Cathcart, Croftfoot, King's Park, Muirend, Netherlee		1	1			1
		G45	Castlemilk	1		1			1
		Total		1	1	2			2
	Total			149	138	287			287
General Geriatric Medicine	East Dunbartonshire Community Health Partnership	G64	Bishopbriggs, Torrance		2	2			2
		G66	Kirkintilloch, Lennoxtown, Lenzie, Milton of Campsie		1	1			1
		Total			3	3			3
	Glasgow North East Community Health & Care Partnership	G21	Barmulloch, Cowlairs, Royston, Springburn, Sighthill	1	3	4			4
		G31	Dennistoun, Haghill, Parkhead	7	17	24			24
		G32	Carmyle, Tollcross, Mount Vernon, Lightburn, Sandyhills	44	61	105			105
		G33	Carntyne, Craigend, Cranhill, Millerston, Provanmill, Riddrie, Robroyston, Ruchazie, Stepps	26	35	61			61
		G34	Easterhouse	5	12	17			17
		G4	Calton, Cowcaddens, Drygate, Kelvinbridge, Townhead, Woodlands, Woodside	3	4	7			7
		G40	Bridgeton, Calton	12	15	27			27
		G69	Balleston, Garrowhill, Gartcosh, Moodiesburn, Muirhead	10	18	28			28
		G71	Bothwell, Uddingston		4	4			4
		Total		108	169	277			277
	Glasgow North West Community Health & Care Partnership	G11	Broomhill, Partick, Partickhill	1		1			1
		G20	Maryhill, North Kelvinside, Ruchill	2	2	4			4
		G22	Milton, Possilpark	1	2	3			3
		G4	Calton, Cowcaddens, Drygate, Kelvinbridge, Townhead, Woodlands, Woodside	1		1			1
		Total		5	4	9			9
	Glasgow South Community Health & Care Partnership	G42	Battlefield, Govanhill, Mount Florida, Strathbungo East	1	1	2			2
		Total		1	1	2			2
	Total			114	177	291			291
Stroke	East Renfrewshire Community Health & Care Partnership	G78	Barrhead, Neilston, Uplawmoor		1	1			1
		Total			1	1			1
	Glasgow North East Community Health & Care Partnership	G31	Dennistoun, Haghill, Parkhead		1	1			1
		G32	Carmyle, Tollcross, Mount Vernon, Lightburn, Sandyhills		3	3			3
		G33	Carntyne, Craigend, Cranhill, Millerston, Provanmill, Riddrie, Robroyston, Ruchazie, Stepps		3	3			3
		G69	Balleston, Garrowhill, Gartcosh, Moodiesburn, Muirhead		1	1			1
		Total			8	8			8
	Total				9	9			9
Movement Disorders	East Dunbartonshire Community Health Partnership	G64	Bishopbriggs, Torrance		1	1			1
		Total			1	1			1
	East Renfrewshire Community Health & Care Partnership	G46	Giffnock, Kennishead, Thornliebank, Deaconsbank		1	1			1
		Total			1	1			1
	Glasgow North East Community Health & Care Partnership	G1	Merchant City	1		1			1
		G21	Barmulloch, Cowlairs, Royston, Springburn, Sighthill	6	2	8			8
		G31	Dennistoun, Haghill, Parkhead	11	36	47	19	19	66
		G32	Carmyle, Tollcross, Mount Vernon, Lightburn, Sandyhills	46	94	140	55	55	195
		G33	Carntyne, Craigend, Cranhill, Millerston, Provanmill, Riddrie, Robroyston, Ruchazie, Stepps	26	61	87	27	27	114
		G34	Easterhouse	3	20	23	4	4	27
		G4	Calton, Cowcaddens, Drygate, Kelvinbridge, Townhead, Woodlands, Woodside	7	3	10	4	4	14
		G40	Bridgeton, Calton	3	5	8	4	4	12
		G69	Balleston, Garrowhill, Gartcosh, Moodiesburn, Muirhead	15	41	56	26	26	82
		G71	Bothwell, Uddingston	1	1	2			2
		Total		119	263	382	139	139	521
	Glasgow North West Community Health & Care Partnership	G21	Barmulloch, Cowlairs, Royston, Springburn, Sighthill		2	2	2	2	4
		G22	Milton, Possilpark				1	1	1
		G3	Anderston, Finnieston, Garnethill, Park, Woodlands, Yorkhill	1		1			1
		Total		1	2	3	3	3	6
	Glasgow South Community Health & Care Partnership	G42	Battlefield, Govanhill, Mount Florida, Strathbungo East		1	1			1
		G5	Gorbals		2	2	2	2	4
		Total			3	3	2	2	5
	Total			129	270	399	144	144	534
Total				383	594	977	144	144	1,121