Stakeholder Reference Group

Changes to Rehabilitation Services in North East Glasgow: Lightburn Hospital

Jonathan Best
Acute Director North
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Welcome

- Housekeeping
- Introductions
Today

• Present and answer initial questions about:
  – Purpose of Stakeholder Reference Group and Terms of Reference
  – Our proposal to improve care rehabilitation for the elderly in North Glasgow
  – How we intend to inform and engage with stakeholders
Stakeholder Reference Group

Purpose and Remit

• Support NHSGGC in their engagement and make sure people are provided with the information and support they need to be involved by:
  – Sharing information on the proposals
  – Considering how best to inform and engage with people on the proposals
  – Advising us on the development of information and events and as assisting with related processes
  – Utilising local knowledge
  – Providing feedback on and an evaluation of stakeholder engagement.
Improving older peoples care and rehabilitation Services in North East Glasgow
The Case for Change

• The way we provide healthcare is changing
  – The Scottish Government has issued a blueprint for NHS services which sets out that wherever possible, people should be supported to live at home or in a homely setting, and that more people should be cared for in the community.
The Case for Change

NHSGGC’s Clinical Services Strategy set out future models of care for Older People’s Services

• Approach was designed to ensure an individual’s stay in hospital is for acute period of care i.e.
  – Early intervention from specialists in the care of older people focussed on frailty assessment
  – Rapid commencement of multi-disciplinary assessment and rehabilitation within facilities that enable fast access to the full range of investigations and specialist advice
  – People are supported to return to their community as soon as possible
The Case for Change

• In the North East of Glasgow our clinical teams want to improve the way they provide rehabilitation for the elderly
  – The changes we are proposing would allow a more intense, shorter period of rehabilitation in an acute hospital setting with comprehensive support and facilities that would allow a quicker return to home or more homely setting in the community with further rehabilitation where required
The Case for Change

• Most elderly (>75) patients who undergo assessment at Glasgow Royal Infirmary are currently discharged to their home after a period of acute multidisciplinary care and do not need a longer period of rehabilitation.

• Elderly patients attend the Glasgow Royal Infirmary from across the whole of the North and East of Glasgow and East Dunbartonshire

• Elderly rehabilitation is currently provided at Lightburn and Stobhill and these services have a wide catchment area

• Rehabilitation for orthopaedic patients is at GGH
Lightburn Geographical Catchment
15/16 Inpatient Postcodes
The Case for Change

• For intensive inpatient rehabilitation and day hospital patients co-location at Stobhill will improve individual outcomes. The more modern facilities provide ease of access to a wider range of on-site support services including:
  
  – Lab medicine and phlebotomy
  – Imaging and Diagnostic services
  – Orthotics
  – Pharmacy
  – Cardiology; and
  – Liaison from a range of other specialties
Our Vision

• All frail older patients ( >75) admitted to GRI from their own home should be discharged back, after appropriate treatment, to their own home

• Those patients who would most benefit from Comprehensive Geriatric Assessment (likely to be those screened as positive for frailty using Think Frailty Tool) are identified as near to the front door as possible to allow early intervention

• Patients identified as needing Comprehensive Geriatric Assessment either at the front door (Emergency Department/Acute Assessment Unit or medical Assessment Unit AU/MAU) or those referred from none Department of Medicine for the Elderly downstream wards for ‘rehabilitation’ will be assessed by a multidisciplinary Target Team ( Senior AHP, Consultant, Elderly Care Assessment Nurse)
Our Vision

• Patients identified as likely to be able to go home from GRI, if provided with enhanced AHP input, will be supported by the Target Team who will link with established community teams and provide outreach to patients in their own homes to facilitate discharge.

• Patients requiring reablement prior to potential discharge will be referred to the new HSCP teams and move to Step Down beds in one or two clearly defined units in the community.

• Patients requiring rehabilitation and ongoing medical inpatient care will move to intensive inpatient rehabilitation wards with excellent access to modern diagnostics, improved junior medical support and opportunities for enhanced AHP input.
The Benefits

• Increase the proportion of patients being discharged directly from GRI reducing the number of unnecessary hospital moves

• Allow patients access to true Comprehensive Geriatric Assessment at an earlier stage in their admission

• Deliver rehabilitation and reablement in more homely environments – step down beds or patients own home

• Allow closer working between secondary care and community teams

• Concentrate inpatient rehabilitation resources on sites with excellent diagnostics and support services
GRI Pathway
For frail elderly patients

Emergency Receiving Complex
(24 hours)

- Discharge Home
- Discharge Home with Care package
- Discharge Home with Community Rehab
- Intermediate Care Step Up
  - Greenfield Park
- Intermediate Care Step Down
  - Greenfield Park
  - Northgate House
  - Ashton Grange
  - Oakbridge
  - Quayside
  - Westerton

Assessment Team
GRI Department of Medicine for the Elderly Acute Assessment Wards
Other Specialty Assessment Wards

Multidisciplinary Target Team
GRI Pathway
For frail elderly patients

GRI Department of Medicine for the Elderly Acute Assessment Wards

- Discharge Home
- Discharge Home with Care package
- Discharge Home with Community Rehab
- Intermediate Palliative/Complex Care
  - Intermediate Care Step Down
    - Greenfield Park
    - Northgate House
    - Ashton Grange
    - Oakbridge
    - Quayside
    - Westerton
- Adults With incapacity
  - Darnley
  - Quayside

Rehabilitation Team
Stobhill Intensive Inpatient Rehabilitation Wards
Stobhill Pathway
For rehabilitation of frail elderly patients

Stobhill Intensive Inpatient Rehabilitation Wards

- Discharge Home
- Discharge Home with Care package
- Discharge Home with Community Rehab
- Intermediate Care Step Down
- Adults With incapacity
- Intermediate Palliative/Complex Care

Rehabilitation Team

- Greenfield Park
- Northgate House
- Ashton Grange
- Oakbridge
- Quayside
- Westerton
- Darnley
- Quayside
- Greenfield Park
- Fourhills
Proposed Outpatient Model

• Offer local access/one stop service
• Outpatient services will continue to be offered from suitable local Health Board or Health and Social Care facilities
  – General Geriatric Medicine Clinics
  – Movement Disorder (medical & nurse led)
  – Falls
  – Stroke
Proposed Day Hospital Model

- Lightburn Day Hospital services combined in to a single Day Hospital on the Stobhill site.
- This 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.
- 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.
- For this reason it is important that services are delivered within facilities with those services on site.
- Lightburn Hospital has a very limited range of clinical support services and cannot deliver this modern, clinical model of day hospital care.
Feedback

• Tell us what your initial thoughts and views of our proposal are?
Next Steps

How we plan on informing and engaging with local stakeholders.

John Barber
Patient Experience and Public Involvement Manager
Inform and Engage

• Deliver an engagement programme with people across the area which will run from the beginning of September until the beginning of December

• Programme shaped by a Stakeholder Reference Group representative of patient, carer and public affected by proposal to assist with the development of a range of communications resources and advise on the best means of engaging with those affected
Inform and Engage

• Public engagement will be delivered jointly with the Health and Social Care Partnership and shaped through discussions with the stakeholder reference group to include things like:

  – Engagement with local stakeholders
  – Workshops
  – Drop in sessions
  – Outreach at key public locations in the East End
Inform and Engage

September

– Begin process of informing stakeholders of our engagement on proposal
  • Website and social media and press
  • Letter to community groups, community councils
  • Speak to staff

– Form Stakeholder Reference Group
  • Hear initial thoughts about proposal
  • Establish engagement outline
  • Check process is accessible to all
Inform and Engage

October

– Inform and communicate with people about our proposal
  • Draft background document
  • Draft basic leaflet
  • Hold fully accessible public event
  • Hold drop-in sessions in Lightburn Hospital
  • Review Options
Inform and Engage

November

– Publicise and share proposal widely and hear feedback and comments on it
  • Provide background document
  • Provide basic leaflet
    – encourage questions
    – viewpoints and comments
    – encourage discussion
    – test our thinking and information materials

– Record feedback received
Inform and Engage

December

– Evidence the public involvement and present full picture to the Board

– Then decision on whether proceed to full public consultation