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NHS Grampian

Aberdeen City Intermediate Care Project Newsletter

October 2007 Issue 2

Introduction

The first issue of the Intermediate Care Newsletter was circulated in May 2007 and focused on the forthcoming changes at Woodend Hospital. This issue seeks to provide you with an update on a number of the 'out of hospital' intermediate care initiatives currently being developed and implemented in the city. Future issues will provide you with an update on progress with plans for the changes as they develop over the next year.

Mrs Jackie Bremner
Service Planning Lead

Woodend Day Hospital Review

Assessment and rehabilitation are key components of a geriatric service. One setting for this activity at the interface between primary and secondary care is offered by the Day Hospital. This is a multidisciplinary working environment that allows for assessment and planned interventions to be co-ordinated.

The service offered at The Department of Medicine for the Elderly at Woodend Hospital is undergoing a re-configuration.

A new development to start as soon as is practical is a piloting of a 'Rapid Assessment Clinic' among a number of GP Practices in the city. This is envisaged to support our primary care colleagues by offering an alternative to admission for those patients who are not acutely unwell but are struggling at home. This will provide assessment and support for patients to be managed, where appropriate, in the community rather than in the inpatient setting. The support for this activity will be provided by a new Staff Grade medical post, enhanced and increased resource support from Allied Health Professionals, pharmacy service, enhanced links with social work service and interaction with the Rapid Response Team. The developed service also plans to forge links with Links Unit (upstairs) at City Hospital and other intermediate care facilities if possible (Croft House (RAPS), Smithfield Court).

Other consultant activity will support a falls service which is anticipated to start as soon as resources allow. This service will take in referrals from inpatient and outpatient Geriatric Service, Orthopaedic Service, A&E Department as well as primary care. Further consultant input will support other planned specialised activity such as movement disorders, including Parkinson's disease. The usual Day Hospital Service for targeted activity will continue, however this is being enhanced by appointment slots that optimises transportation by the ambulance service. This has also been well received by those who attend the Day Hospital.

It is anticipated that all the new developments will avoid some admissions and facilitate timely discharges from the hospital service of our elderly patients and continue to support them in the community. Information about how to access these new services will be distributed once the start date is confirmed.

Dr Charles Chithila and Dr Julia Foy
Medical Staff, Day Hospital, Woodend

Community Geriatrician Service

A community geriatrician pilot project has been running in the city for some time, with a plan to roll it out across the city as soon as is feasible; a similar programme is underway within Aberdeenshire. As other exciting developments, including Day Hospital reform and GP/care home alignment, are now well advanced, we feel it is time to optimise the community geriatrician service so that these services can be linked and compliment one another to optimise elderly care. Consultant Geriatricians will align with general practice clusters within the city and work closely with GPs and community health teams. Potential areas for co-operative working include care home reviews (with community pharmacy), multidisciplinary reviews of complex elderly patients within the GP surgery and, perhaps, easier access referral to Day Hospital and the aligned consultant's out patient clinics. Details about how to access this new service and about aligned consultants will be distributed in October/November.

Dr Donald Newnham
Consultant in Elderly Medicine

Alignment of General Practice and Care Homes

In 2001/02 there was a pilot project undertaken in Grampian to explore the proposal that Practices be aligned to specific Care Homes to help co-ordinate medical care, improve the standard of medical care in care homes and to streamline GP attendance at care homes. In 2002 the LMC endorsed the proposal that General Practice and Care Homes should be aligned.

Work to agree an aligned General Practice for each care home (with nursing) in the city is now nearing completion. A list clarifying the agreed alignments is now available. This means that although a Practice may still care for a similar number of people who are resident in a care home, the patients will often be from one or two homes instead of for a number of Practices between 10 and 15 care homes (with nursing) across the city.

Patients can still choose which Practice they register with and are not obliged to register with the aligned Practice to ensure the maintenance of patient choice.

Once the alignment of care homes (with nursing) is settled and well established the working group would like to explore the alignment of all Care Homes and, although it may require a different model, also Very Sheltered Housing. This would allow us to introduce a more 'anticipatory' model of care hopefully improving care and minimising the need for admission to hospital.

Dr Stuart Watson
CHP Clinical Lead

New Care Home Update

Progress is being made with two new care homes in the city with the possibility of more new care homes and improvements in the provision of housing for people with varying needs (Very Sheltered Housing) on the horizon.

Rosewell House at Kings Gate is about to be rebuilt and should be open towards the end of 2008. It will comprise 20 care home (residential) places, 20 respite places and 20 short stay, social care rehabilitation places. The 8 rehabilitation places at Croft House will relocate to Rosewell House. Rehabilitation therapy will be provided in conjunction with NHS Grampian.

Tor-Na-Dee at Milltimber is currently being re-developed and is likely to be open in spring 2008. The Tor-Na-Dee community will provide a range of residential and care facilities. The care facilities include 70 care home places and a young people's unit which will focus on providing services for young people who have a physical disability as a consequence of an accident or acute event. The majority of the accommodation is likely to be utilised for transitional care although a small number of places (6) may be for continuing care. The other accommodation will focus on rehabilitation and preparation for return to independent or supported living. This includes 2 four bed-roomed flats and 2 single room flats. The next issue will provide a more in-depth update.

Mrs Jackie Bremner
Service Planning Lead

Liaison Team Redesign

The Liaison Team was formed in the 1970's to improve communication between the Acute Sector and Community Staff.

Changes in service delivery and a shift in the balance of care made it apparent that the service required to be redesigned.

Louise McLachlan was seconded to the part-time post of Project Manager to take forward and manage the redesign process. A full investigation of practice in different areas was carried out, followed by a period of consultation and agreement with all management structures to introduce a new liaison process.

The new process promoted the practice of Ward Staff taking responsibility for simple discharges leaving the Liaison Team to deal with all complex discharges. Prior to the implementation of the new process, a full programme of teaching was undertaken by the Liaison Team and Louise McLachlan. During the roll out across ARI the Liaison Team provided support and coaching to the Ward Staff to try and ensure an "as easy as possible" transition to the new process.

A project group has been established with representation from the Liaison Team, Community Staff, Acute Staff, HR and Staff Side, the group was implemented to oversee the progress of the redesign.

Following implementation of the new process an evaluation was carried out with both Ward Staff and Community Staff, the results of which were discussed with the Project Group and an action plan drawn up to address the issues identified. It is planned to carry out a further evaluation once these issues have been addressed.

Work on Stage II of the redesign has commenced and involves analysing the workload of the Liaison Nursing Team given the changes to process in Stage I. It is planned to build a proposal outlining what is required to meet current demand and this is being done with the assistance of both HR and Staff Side. It is envisaged that the proposal will be completed by January 2008 and a decision

made on how to implement Stage II and agreement reached with all people concerned.

As work on the redesign continues, we will ensure that information on progress is shared widely.

Mrs Heather Hardisty
Senior Service Manager

Aberdeen City Community Nursing Workforce Plan

In 2004 the City Joint Future Management Team commissioned a review of the untrained/ unqualified workforce within the existing health and social care structure to make sure that in future the city was better able to cope with the changing demands for health and social care in a community setting.

The review highlighted a lack of clarity around the roles and skills among the different unqualified/unregistered carers employed by NHS Grampian and Aberdeen City Council and its commissioned services. This resulted in the creation of a joint plan to address the inequalities in training for staff.

The implementation of this plan, once agreed by NHS Grampian and Aberdeen City Council, will require the development and implementation of a competency framework with a comprehensive training programme and funding to allow staff to be released for training.

Also, a comprehensive review of district nursing revealed that the existing teams are allocated on a historical basis and do not reflect the current workload, with staff often spending a considerable percentage of their working day travelling across town between patients.

The re-design of the District Nursing Team will involve the creation of a number of 'Local Direct Delivery Teams' (DDTs) based in communities throughout the city. 'Practice Attached Teams' (PATs) will continue to exist and will link General Practice with the DDTs, ensuring patients receive nursing care suitable to their needs.

To make sure that this significant re-design project is rolled out in a co-ordinated way a pathfinder project is currently being established in Torry. Once the changes are in place within this community the re-designed service will be rolled out across the city.

Mrs Frances Dunne
Service Manager

Acute Specialty Redesign at ARI in association with Intermediate Care Project

The Grampian-wide intermediate strategy, as described in Healthfit, aims to reconfigure patient flow and re-design services systematically across NHS Grampian so that only patients requiring acute specialist care are cared for in an acute setting such as Aberdeen Royal Infirmary.- extending and increasing, where required, the range of 'out of hospital' and out-patient care/services and creating a focus for CHP led intermediate and rehabilitation care for the City CHP on the Woodend Hospital site.

Operationally, services for elderly patients requiring specialist acute medical assessment will in future (Autumn 2008) be provided at Aberdeen Royal Infirmary (ARI). Whilst patients at ARI who require in-patient intermediate care or post acute rehabilitation will relocate to a community hospital or go home with a home care/rehabilitation package if required following the acute phase of their illness. A key aim of this project will be the physical relocation of the Acute Geriatric Assessment Unit (circa 90 beds) from the Woodend site to ARI.

This relocation of acute elderly services to ARI and the creation of additional intermediate and rehabilitation care beds at Woodend will require some wards/services to move both at ARI and Woodend. This redesign will endeavour to make sure that the new profile of services is well co-ordinated and, where possible, important service co-locations are achieved (e.g. co-location of the Acute Stroke Unit and the Neurosciences Ward).

Discussions with Specialties started in June and are now at various stages of activity modelling (Renal, Diabetes, Endocrine, General Medicine and Medicine for the Elderly), redesign (Orthopaedics), estates enabling and actual moves of services from ARI to Woodend (pilot move of Orthopaedic beds have commenced with a plan to phase the transfer of beds from 6 beds to 14 beds over a period of 3-4 months).

A project plan is currently being drawn up with a critical path of actions for timely execution through the Project Board. A more detailed update will be available in the next issue.

Mr Ken McLay & Dr Steve Wilkinson
Mr Alisdair Chisholm & Dr Manju Patel

Woodend Project Up-date

During the recent months the Care Models and Workforce Working Group and Woodend Blueprint Working Group sub-groups of the Woodend Project Group have been working very hard to try and develop key elements of the detailed plans for

the re-design of Woodend to create 'Aberdeen Community Hospital' and the Acute Elective Orthopaedic Unit on the Woodend site.

From a physical perspective a plan for the reconfigured wards is nearing completion and a bid for capital funding is to be submitted in November. The plan outlines the 4 wards in Westview as the main focus for specialist rehabilitation for patients who have had a stroke or an orthopaedic or vascular admission. General rehabilitation for care of the elderly or medical patients will be provided from the rehabilitation/intermediate care wards which will be located in the main block and south block wards at Woodend. Patients requiring interim and continuing care will also be cared for in this area of the hospital.

Work to develop and agree the care model/s, operational policies and appropriate workforce to be implemented in the new Aberdeen Community Hospital are now being discussed and will be covered in more detail in a future issue.

Mrs Jackie Bremner
Service Planning Lead

Early Supported Discharge Project

The literature shows us that the development of an early supported discharge service for specific groups of patients can materially reduce the length of stay in hospital and allow patients to continue their rehabilitation programme delivered by clinicians with specialist skills in the community either at home or as an out-patient. This concept is being explored currently specifically for patients who have had a stroke in conjunction with the Stroke MCN. If successful, it will be extended to include other groups of patients e.g. orthopaedic, vascular and frail elderly patients.

To obtain a clear picture of the caseload that an early supported discharge team might need to hold, and to assess the impact on the resulting demand for in-patient beds, a 3 month audit will run in the Acute Stroke Unit at ARI and the rehabilitation wards at Woodend between October and December.

Ms Therese Jackson, Consultant Occupational Therapist
and Mrs Jackie Bremner

Communication and Involvement

A key element of the project is the involvement of the public, service users and carers. An involvement and communication framework has been developed and is out for consultation. Links are being established with a number of key groups including:

- The Scottish Health Council
- Older People's Consultation Monitoring Group
- Age Concern
- The Carers Centre
- Friends of Woodend

Specific involvement is also to be undertaken with groups who will be most affected by the changes including the Stroke MCN Public Involvement sub-group and other similar existing groups.

Staff consultation is also a key element of the project. A key stakeholder analysis has been undertaken and outlines who needs to be involved and communicated with. In an effort to ensure good communication with staff; Staff Awareness Sessions will to be delivered at key stages throughout the project, the second round of sessions are scheduled for early October. Issues of this Intermediate Care (IC) Newsletter will also be circulated at key stages of the project. The newsletter will also be circulated to user groups, etc.

Mrs Jackie Bremner
Service Planning Lead

Intermediate Care Website and Notice Boards

The City Intermediate Care Steering Group is to explore the creation of a webpage from which key documents, meeting minutes and information about the project can be obtained. Also for staff at Woodend three Staff Information Intermediate Care Notice Boards are to be erected in prominent locations to help staff to keep up-to-date with the project - watch out for them over coming weeks.

Radiology Services

The Radiology Modelling Working Group has been working for some months now to try and assess the impact of all of the forthcoming changes on the demand for radiology services. This includes the relocation of Geriatric Assessment Services to ARI, the creation of Aberdeen Community Hospital at Woodend, the closure of Woolmanhill Hospital, the relocation of services to new out-patient accommodation at ARI and the Aberdeen Community Health Village. The impact of creating the Emergency Care Centre at ARI will also have to be factored. The project is working to understand the impact and to relocate services where possible to make sure that the radiology department can deliver services efficiently.

Dr Angus Thomson, Consultant Radiologist
and Mrs Jackie Bremner