Service User and Carer Engagement Event

Acute Frailty Unit Antrim Area Hospital

Wednesday 27 October 2021

Northern Health and Social Care Trust

Engagement Event Overview

An engagement event took place, with a number of service users, carers and representative groups using Zoom technology on 27 October 2021. The engagement event provided the opportunity to share information about the development of the Acute Frailty Unit at Antrim Area Hospital.

The project team provided a detailed presentation about the pathway and the background behind the Unit. The event also provided an opportunity for attendees to ask questions to the project team.

The key questions, comments and feedback from the event are outlined in this report.

We have also included a copy of the presentation shared by the project team at the end of this report.

Acknowledgement

We would like to extend our sincere appreciation to everyone who participated in the engagement event. Your valuable contributions, questions and insights will help to inform communications and planning for the future of the Acute Frailty Unit at Antrim Area Hospital.

Key Questions, Answers and Comments

What is the Acute Frailty Unit?

The Acute Frailty Unit is based in Antrim Area Hospital and includes 10 beds providing specialist management of frail, elderly (75 years and over), and medical patients (Phase one). The Acute Frailty Unit was launched during unpredictable times amid the Covid-19 pandemic and due to increasing pressures within the health service the unit has been moved two or three times and have experienced delays regarding its progress.

What does the Frailty Service offer?

The service offers an alternative admission pathway providing specialist, multidisciplinary care for a specific cohort of frail elderly patients with urgent and emergency care needs. The service focuses on providing early geriatric assessment and a care management plan for each patient.

What is the criteria for admission??

- Patients are aged 75 or older.
- A Rockwood frailty score of over 5. We have also included overleaf a user-friendly guide as to how frailty is assessed using this scale.
- On admission a patient presents with an identified feature associated with frailty (e.g., a care home resident, has had a fall, reduced mobility or declined cognition ability).

Key Questions, Answers and Comments

Rockwood Clinical Scale

1 **Very Fit** – People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.

2 **Well** – People who have **no active disease symptoms** but are less fit than category 1. Often, they exercise or are very **active occasionally**, e.g. seasonally.

3 **Managing Well** – People whose **medical problems are well controlled,** but are **not regularly active** beyond routine walking.

4 **Vulnerable** – While **not dependent** on others for daily help, often **symptoms limit activities.** A common complaint is being "slowed up", and/or being tired during the day.

5 **Mildly Frail** – These people often have **more evident slowing,** and need help in **high order IADLs** (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.

6 **Moderately Frail** – People need help with **all outside activities** and with **keeping house**. Inside, they often have problems with stairs and need **help with bathing** and might need minimal assistance (cuing, standby) with dressing.

7 **Severely Frail** – **Completely dependent for personal care**, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).

8 **Very Severely Frail** – Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.

9. **Terminally Ill** - Approaching the end of life. This category applies to people with **a life expectancy <6 months**, who are **not otherwise evidently frail.**

Scoring frailty in people with dementia

The degree of frailty corresponds to the degree of dementia. Common **symptoms in mild dementia** include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In **moderate dementia**, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In **severe dementia**, they cannot do personal care without help.

Key Questions, Answers and Comments

What are the benefits of the Acute Frailty Unit?

- Provides patients with comprehensive multidisciplinary care from different professionals.
- Reduces for patients their length of stay in hospital.
- Improves patient flow: patients are admitted to the correct bed and not continuously moved around the wards/hospital.
- Prevents the significant physical and mental deconditioning which can be associated with prolonged hospital admission in elderly patients.
- Reduces in care home admissions.

Where does someone who has a mental illness fit into the Acute Frailty plan?

Each patient is assessed using the Rockwood Clinical Scale and consideration is given to each patient's normal daily functioning and how mental illness can affect this. We also have many patients coming in with dementia and as it is a growing issue we do understand these complexities. We do reach out to this group of patients and provide a comprehensive assessment.

How are patients referred and admitted into the Acute Frailty Unit?

Admissions to the Acute Frailty Unit are presently through the current medical admissions pathway such as Accident & Emergency and acute assessment area. The average stay in the Acute Frailty Unit is 5-7 days. We hope that moving forward in the future admissions could potentially come from primary care rather than A&E which is currently not ideal for some of these patients.

Key Questions, Answers and Comments

Are the Acute Frailty beds specifically protected given all the pressures on services (e.g. Covid)?

We do have strict criteria for Acute Frailty Unit beds. Unfortunately, beds are currently not totally protected due to Covid-19 pressures. There are pathways which have been drawn up in conjunction with patient flow. This very much tries to direct which patients should be coming to the those beds with an agreed timeframe to hold these beds.

We have done a lot of work internally as to when patients actually arrive and present at A&E. For example, patients may come from GPs in the morning not feeling well or coming from to A&E, they tend to arrive in the afternoon. Based on this we link with senior management to advise that we need to hold these Acute Frailty Unit beds for later in the day. We do hold these beds until late in the evening and early morning. If there is no-one suitable using these beds we can then use them with more general geriatric patients.

Are there any plans to extend the current Acute Frailty Unit?

Our Ward in A5 has 24 beds. We have started the specialist Acute Frailty Unit with 10 beds to carefully build up our service by staring smaller, ensuring we get it right as elderly and frail patients are a top priority. Northern Health and Social Care Trust has the most frail and elderly patients out of all the Trusts in Northern Ireland. In the future we do plan to extend this. We are currently moving through those phases working towards developing a ward and this is linked to capacity on our Antrim site. Our work is also linked to the work and capacity of colleagues in Antrim and Causeway Direct Assessment Units. They also deal with frailty patients. They have beds set aside on a daily basis for those patients. So when someone comes in and is assessed, they have a bed they can move to relatively quickly. But again, everything is dependent on bed pressures for that given day.

Key Questions, Answers and Comments

What is the Direct Assessment Unit (DAU)?

Both our DAU are designed to take patients away from A&E to reduce the wait for patients with referrals coming in from GPs. They provide patients with comprehensive multidisciplinary assessment with specialised doctors and consultants. It ensures patients are seen in the right place at the right time. For example, GPs can make direct contact with the DAU to avoid unnecessary waits in the Emergency Department. It ensures patients are treated in the appropriate place and in a timely manner. In the DAU, patients are either treated and discharged, stabilised or, for a very small number, then referred to the appropriate ward. From this, we have improved outcomes for patients with access to the services they need quicker and helped ease the pressure on our emergency department.

What is the timeframe for further development of the Acute Frailty Unit? Do you know over what period of time we could have extended service?

We have been planning this service before Covid happened. Progress has been delayed due to the pandemic. For the future phases of the service development, we are going to need further investment (such as more doctors and general clinicians). We all know with how the NHS works that does take time so it's very difficult to put a timeframe on our next Phases 3 and 4. A lot also rests with the Health and Social Care Board and the Department of Health. Our team has been pro-active working hard with senior management. We will be very strongly putting our case forward to get that investment to deliver. We are however in the meantime looking at how we can do things slightly different with the resources we have from our learning over the last 18 months.

Key Questions, Answers and Comments

Many different services have co-production groups. Specialist co-production groups can be really practical and effective in helping develop services. Would you have any plans to have something similar for the Acute Frailty Unit?

From our first phase, we have an established project group in place which has been in-house as it was right at the start of developing our Acute Frailty Unit idea. One piece of work already done working with expert patients was to co-produce an Acute Frailty Unit information leaflet to make sure we are communicating without jargon so everyone easily understands what the service is about.

And today, as we are in our next second phase, is the start of reaching out and involving other people to come in and join us on our journey. We need you, service users, carers and other experts by experience to be at the heart of this as we move forward and let's develop this with your inputs together.

We want to engage with you, your organisations or groups to hear your experience and stories relevant to what we do to see how we can connect together and help patients when they present; have an acute stay and beyond.

Other comments

- As the service progresses, just to flag up that any presentations and communication as you engage more with the general public needs to be kept as simple and accessible as possible. Simple language (e.g. such as avoiding terminology and abbreviations) works best.
- When you move to engaging more widely, we are here to help you through the Patient Client Council so please link with us.

Your closing thoughts and feedback about the Acute Frailty Unit

I want to compliment the team on this. It is such a needed and desired service.

I thought when I saw the advertisement for this session today that 'This is great!'

I think that this looks like fantastic work and all those phases that have gone into planning are admirable and needed. Looking forward to seeing it happening!

It's excellent the service has this ambition. So many services in NI are separate with different systems and don't communicate.

The fact that in this service that patients will be meet with multi-disciplinary professionals means they will be able to speak with the right people at the right time in a timely fashion. Great job, we so support you!!!

Something like this is long overdue. I have come across so many service barriers in elderly care. What you are doing here in Antrim should be rolled out across all Trusts. It's absolutely marvellous.

So many people are living longer. The action taken by the is team is giving this issue such good attention.

The Way Forward and Next Steps for the Acute Frailty Unit

As the Unit continues to develop, the Acute Frailty Team are keen to keep engaging with service users and carers and have invited those who attended today to join and work directly with the Project Team who meet every 6/8 weeks.

The project team would like to continue with the open conversations such as today's event, and any future engagement opportunities will be shared with the service users and carers.

If you would like to be involved further with the Trust and hear about other opportunities and support then please contact Lynda at ppi.coordinator@northerntrust.hscni.net for further information.

Acknowledgement

Thank you once again to everyone who took the time to join in the engagement event.

The next section of this report contains the presentation delivered at the event.

Northern Health and Social Care Trust

Care • Compassion • Community

Acute Frailty Unit
Antrim Area Hospital

Dr Ann McLoughlin

+ Dr Jackie Grier

332255

Working together | Excellence | Openness & Honesty | Compassion

#teamNORTH

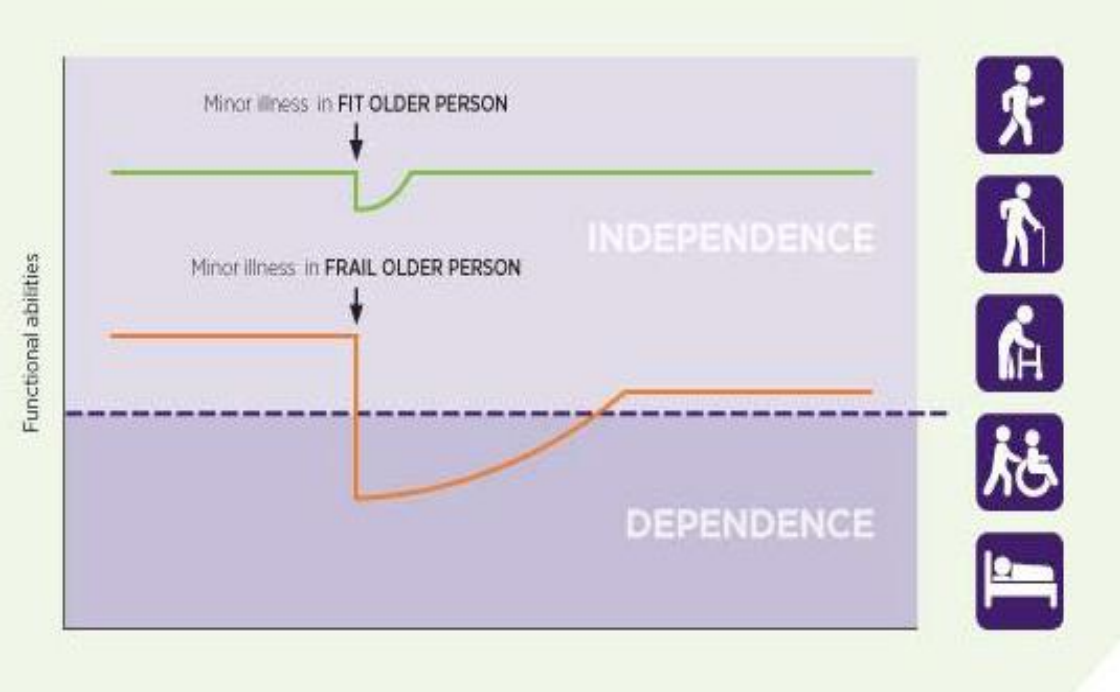
Frailty

What Is It?

- Reduced resilience and increased vulnerability to acute decompensation

Why Is It Important?

- Strong predictor of adverse outcome



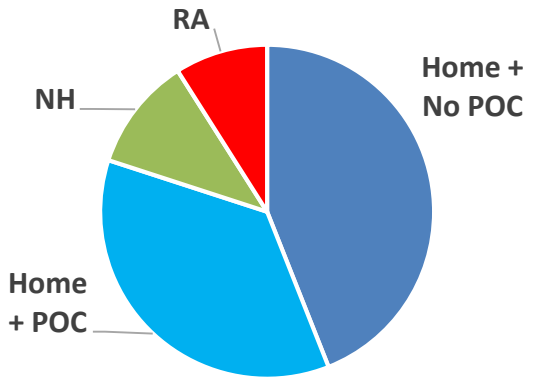
What Can We Do?

- Specialist Multidisciplinary Assessment (CGA)
- Encourage a return to independence

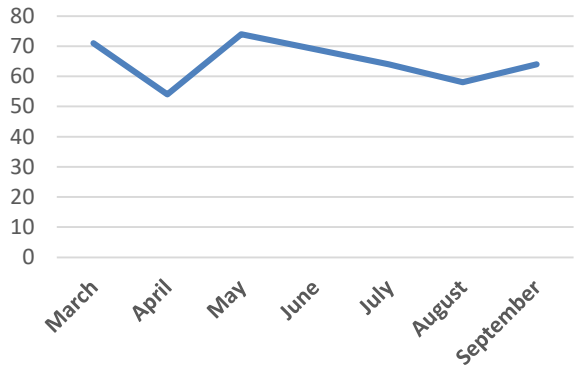
Acute Frailty Unit (AFU)

- 10 beds in Antrim Area Hospital (Ward A5) providing specialist management of frail, elderly (≥75 yrs), medical patients

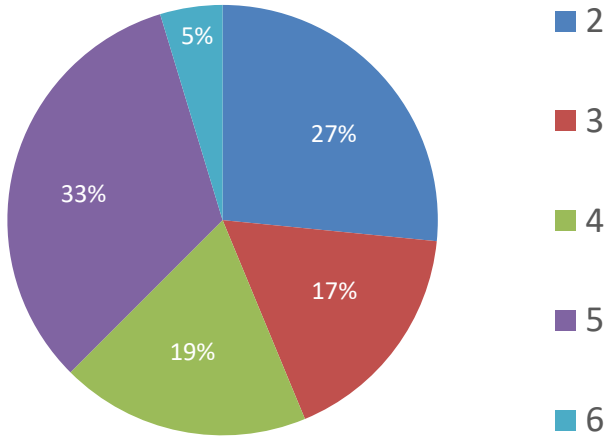
A. Pre Admission Care



B. Number of Admissions



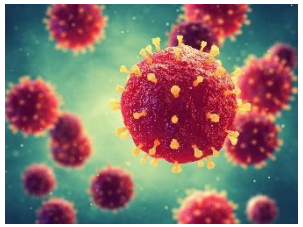
C. Multidisciplinary Team Input



- Average AFU Stay 5-7 days

Next Steps

- Challenges of Covid-19



AFU

- Strengthen Existing Pathways
- Engage with service users and staff
- Improve discharge process and follow up

Beyond AFU

- Screening patients for frailty presenting to ED
- Closer working with primary care
- Providing support for other medical and surgical inpatients
- Providing support to Nursing and Residential Care Homes

PHASE 1
17 Aug 2020

Aim: Develop Acute Frailty Unit (AFU)

10 beds
Specific criteria
Early CGA
MDT Focus
Safe discharge within 72 hrs
Early follow up

PHASE 2
Feb / Mar 2022

Aim: Extend Frailty Service to ED (link to Urgent Care reset)

Front door reviews
Admission avoidance
Signposting to AFU /appropriate frailty services

PHASE 3

Aim: In-reach into medical / surgical wards AAH

Optimise care
Review and advice on the care of frail older patients
Reduce LOS / readmissions

PHASE 4

Aim: In-reach into community including nursing / residential homes

Optimise care
Review and advice on the care of frail older patients
Reduce hospital admissions

Questions?

Comments?