Engaging on proposals to improve care for frail older people in the Vale of Glamorgan

Engagement Period
2nd September 2019 – 1st November 2019

Clinical Frailty 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.

* 1. Canadian Study on Health & Aging Revised 2008.
2. K. Rockwood et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005;173:489-495.

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Comprehensive Geriatric Assessment (CGA)

- The evidence based process for managing Exacerbations of Frailty
- Can be provided in both community & hospital environments
- Best evidence base is in the **acute** hospital setting
- “Hot” as close to front door or inpatient acute hospital setting if clinically needing inpatient care
- “Warm” ideally to avoid admissions in community setting
- “Cold” tailored to managing chronic disease including “Recurrent fallers” in the community

Meet Wyn…..

How and where might he present?

- Frail but not sick
- Frail Faller
- Frail and sick but could be managed at home.
- Frail and sick and clinically needs to be in acute hospital (for investigation/treatment)
- Terminal stages of frailty & probably should avoid hospital
- Final days of Life

We will be using Wyn to illustrate how the Health Board proposes to make improvements to the care of frail older people in the Vale of Glamorgan when they need more support.

What is the current model for looking after Wyn when he needs more support?

- Over last four years, significant investment in primary and community services - keep people living well at home
- In this engagement, we are focusing on the **hospital-based** elements of Wyn's care

Care for frail older people is delivered primarily across two hospital sites for patients in the Vale of Glamorgan:

University Hospital of Llandough (UHL)

- Elderly Care Assessment Service (ECAS)
- Four 'Care of the Elderly' wards
- Day Hospital

Barry Hospital

- Sam Davies

What is the model of care that we want to develop for Wyn?

- Support Wyn via ‘Home First’
- Earlier treatment and rehabilitation
- Reduce delays - no unnecessary time in an acute hospital (harmful for long term health and wellbeing)
- Three main strands to the model of care we want to implement in hospital:
  - **Preventing Hospital Admission**
  - **Acute Frailty Assessment**
  - **Discharge to Assess (D2A)**
- The development and redesign of these services and the different use of acute hospital beds at UHL means that overall we will not need as many hospital beds to meet the needs of patients like Wyn
- We therefore propose to reduce the number of beds at Barry Hospital which would mean the closure of Sam Davies Ward

Why change? What challenges do we face in the care of frail older people?

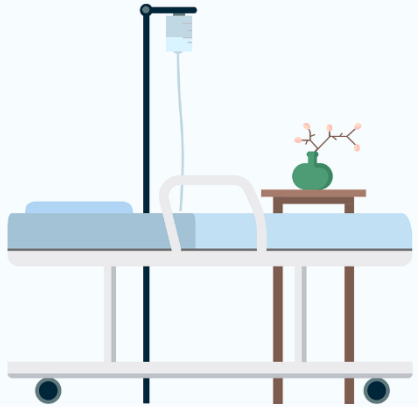
- Projected increase in the population of Cardiff and the Vale
- Over **65s to increase by 15%** over the next 10 years and **over 85s to increase by over 40%** in the same period (2014 Health Needs Assessment)
- The demand for frailty services will **increase by 31%** in the Vale over the next 10 Years
- Our models of care need to adapt
- People tell us they want to be able to live well at home for as long as possible, and that when they need more support, it is available in the community
- People want to have the best possible care, in the most appropriate setting, provided by the most appropriate person and by a multi-disciplinary team

Why change? Why do we feel that the Sam Davies ward is no longer an appropriate place to care for Wyn?

- A single ward operating in isolation at Barry Hospital – not the right environment for Wyn
- Missed opportunities of discharge home for patients in acute setting
- Transfer of patients to Sam Davies **increased** overall length of stay
- Unnecessary long term residential or nursing care eventual needs
- More Acute **early and active CGA & Rehabilitation** earlier in the patient pathway
- Wyn will be able to leave hospital earlier and regain independence

Why does this model of care need to change for Wyn?

- Wyn's ongoing care needs are usually being assessed in hospital when Wyn is 'at his worst'
- This may not reflect what Wyn can and can't do and may lead to providing more care than is required
- Wyn could be transferred to an inappropriate care environment, such as the Sam Davies ward
- Assessment in an acute hospital bed often doesn't start until Wyn is medically fit to be discharged -leads to significant delays in his discharge from hospital
- Wyn will start to clinically decondition (eg: muscle wasting, lack of sleep, risk of infection etc) the longer he stays in an acute hospital bed
- Loss of independence and increasing isolation from his family and friends
- His care needs will increase



Preventing Hospital Admission

- Further develop the Day Hospital and Elderly Care Assessment Service (ECAS) at UHL
- Review and enhance the role of Physiotherapists on the Medical Emergency Assessment Unit at UHL to assist patients where able in order to go home without hospital admission, to return to the Day Hospital/ECAS the following day
- Increasing the range of treatments offered at the Day Hospital (reducing the need for hospital admission)

What does this mean for Wyn?

- Wyn has access to community specialist services for frail older people that enables him to stay safe at home and also recover if he becomes unwell, without the need for admission to hospital where possible.

Acute frailty Assessment Services

- Detect patients at the point of emergency/urgent attendance at hospital, and provide a specialist team to quickly assess their reason for admission, and stabilise their condition
- Then either prevent admission to a hospital ward where possible or provide an early supported discharge solution where they have to be admitted.
- AFA beds at UHW/UHL - provide patients and their families with a specialist multi-disciplinary ‘wrap-around’ team, aiming for a maximum length of stay on the unit of up to 48 hours.

What does this mean for Wyn?

- Wyn gets seen as soon as possible by ‘frailty experts’
- He only gets admitted to hospital if absolutely necessary
- Where possible he is supported to manage safely at home as soon as possible
- He stays in hospital for as short a time as possible and necessary – he is less likely to suffer from clinical deconditioning and will be independent for longer

Discharge to Assess (D2A)

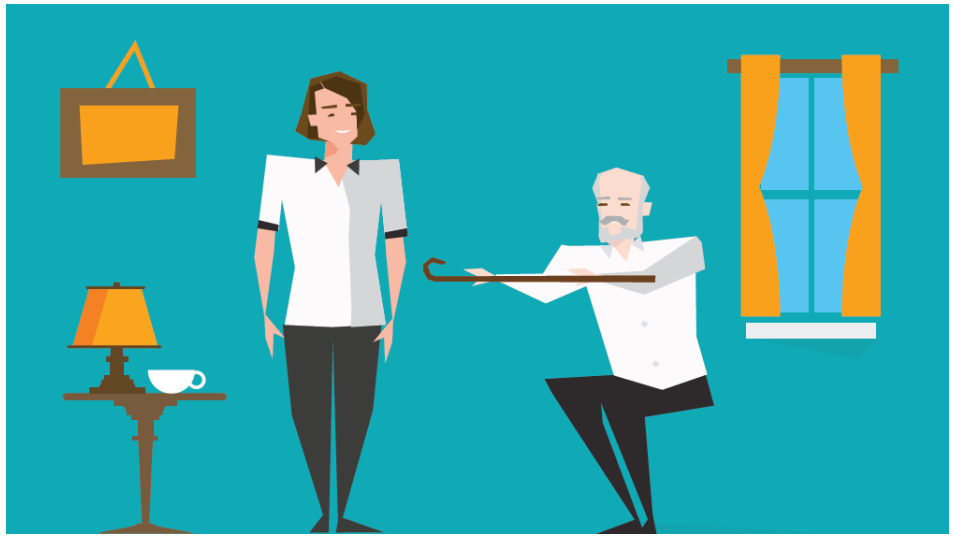
- Discharge-related patient assessments are undertaken outside of an acute hospital setting
- D2A assessments more accurately reflect care needs – the right level of care can then be provided for the right time in the right place
- Going home is always the best/preferred option. If Wyn is currently not able to return home there are a range of D2A beds - at UHL/St David's/Residential care home - that provide him with the care he needs to recover and become more independent – with the plan still for home wherever possible

What does this mean for Wyn?

- No long term decisions have been made about Wyn's care from the acute hospital setting
- Wyn will leave hospital quicker, regain his independence sooner and receive care closer to home
- He stays in hospital for as short a time as possible and necessary – he is less likely to suffer from clinical deconditioning and will be independent for longer
- Wyn will have access to 'get me home' services that are helping people go home earlier following his hospital stay

How else would Wyn be supported in the Vale?

- To prevent unnecessary admissions to hospital we will deliver more support to people in their own community to enable them to continue living at home safely
- Recently received Welsh Government funding - invest in more services that support the discharge to assess models of care (eg: short term packages of care or a ‘step down’ bed in a residential home)
- Developing plans for three community health and wellbeing centres - will provide a range of local services to support GPs to care for their patients
- Planning has started on developing Barry Hospital into the Health and Wellbeing Centre for the Vale of Glamorgan



What is the future role of Barry Hospital?

- The proposal to close the beds in the Sam Davies ward does not signal any form of downgrading of Barry Hospital
- The Health Board's Shaping Our Future Wellbeing Strategy includes the development of Health and Wellbeing Centres and Wellbeing Hubs to provide community infrastructure to support the shift of care from hospital to community
- Develop Barry Hospital as one of our three Health and Wellbeing Centres
- The space in the Sam Davies ward would be freed up to enable a range of new services to be developed
- This work is being led by our Vale of Glamorgan integrated health and social care team and there will be lots of opportunities for people to shape what this looks like in the coming months through a separate engagement process

What will be the impact on Wyn's family and friends?

- Potential concerns about travel and parking
- A new Park and Ride scheme at UHL that was introduced in July 2019 and is free for the public and staff. This runs Monday to Friday every 20 minutes from early morning to early evening
- Flexible visiting is in place in UHL and St David's Hospital for those visiting frail elderly patients and those with dementia - would help to reduce potential parking issues for Wyn's visitors who would be able to avoid normal visiting hours when there is greater pressure on parking spaces
- There is a regular 95 bus service from Barry to UHL, and a regular 96 bus service from Barry to St. David's Hospital. New Adventure Travel buses 303/304 also run between Llantwit Major, Barry and UHL

What would happen to Staff?

- There are sufficient vacancies within the Medicine Clinical Board to accommodate the staff who currently work on Sam Davies Ward
- We would be supporting our employees to ensure they are able to move to a suitable vacancy in an alternative ward/area
- It is very likely that there will be vacancies at both St David's Hospital and UHL within medicine/care of the elderly, providing similar types of patient care for those staff wishing to continue to care for older patients, and use their skills and experience

Equality and Health Impact Assessment

This assessment shows that particular consideration needs to be paid to the following population groups:

- Those aged 65 and over, and
- Of various ethnic/religious/cultural groups, and
- Suffering with mental health issues/dementia/sensory loss or impairment
- Men and women equally although possible more women than men based upon prevalence of co-morbidity, frailty and life expectancy
- Those who choose to speak using the Welsh language
- Carers – potential travel/access issues

Tell us what you think

We are seeking your views on the following:

1. What are your views on our proposals to improve care for frail older people in the Vale of Glamorgan?

2. Taking into account the information in this Engagement Document and the Frequently Asked Questions, is there anything else we need to consider when taking a decision on the way forward?

3. We would like to know what you think is the most important to frail older people about their experience of care when they become unwell. If applicable, please tick more than one box from the following list on the next slide

4. Any other comments

There is a separate feedback questionnaire to enable you to give us your feedback.

Q4 - What you think is the most important to frail older people about their experience of care when they become unwell

	Only getting admitted to hospital if absolutely necessary
	Being seen as soon as possible by 'frailty experts'
	Staying in hospital for as short a time as possible and necessary
	Starting therapies earlier in the recovery journey
	No delay in leaving after treatment
	Returning home after a hospital stay with community support to help them recover further and stay safe at home
	Where the hospital care takes place within the Vale of Glamorgan
	The accessibility of the place of care

Next steps

- We will collate all the feedback received and share it with the Community Health Council (CHC)

- At the end of this period of engagement (1 November) we will analyse and consider all the feedback and the view of the CHC and make a recommendation on the way forward to the Board at the end of November

How to share your views with us

Please return your completed questionnaire or direct any queries to the following address:

Email: ValeCare.FrailOPengagement@wales.nhs.uk

Postal Address: General Manager, Ward C6 Corridor – Directorate Management Office, Integrated Medicine Directorate (full details in engagement document)

You can also contact the South Glamorgan Community Health Council for more information:

Email: southglam.Chiefofficer@waleschc.org.uk

Postal Address: CHC Offices, Pro Copy Business Centre (Rear), Parc Ty Glas

(full details in engagement document)