FLINTSHIRE COUNTY COUNCIL

REPORT TO: **SOCIAL & HEALTH CARE OVERVIEW & SCRUTINY COMMITTEE**

DATE: **THURSDAY, 9 JANUARY 2014**

REPORT BY: **DIRECTOR OF COMMUNITY SERVICES**

SUBJECT: **ENHANCED CARE AT HOME**

1.00 PURPOSE OF REPORT

1.01 To provide Scrutiny members with an update of the progress of Enhanced Care at Home in Flintshire.

2.00 BACKGROUND

2.01 Following BCUHB's consultation regarding "Healthcare in North Wales is changing" a commitment was made to developed Enhanced Care at Home in each North Wales Locality.

2.02 This service was originally piloted in North Denbighshire in 2010 to provide care for people in their own homes who would otherwise have been admitted to hospital.

3.00 CONSIDERATIONS

3.01 In September 2013, the Enhanced Care at Home service in North West Flintshire was launched. From September to the end of November 2013, 20 people have received support from the team.

Of these:

- 11 were step-up patients from the community (referred by GP or other community services)
- 9 were step down patients (from hospitals to facilitate discharge home)

The average time people receive the service is two weeks.

3.02 All core health staff are in post to support the service.

3.03 Flint General Practitioner's have been part of the service since its inception, BCUHB hope to recruit those from Holywell in the near future.

3.04 Flintshire Social Services are supporting the services in the following ways:-

- Generic Workers in the service have had an opportunity to shadow reablement staff as part of their initial training.
- A locum social worker is in post pending recruitment to the team.
- The team has managed access to Flintshire Social Service electronic database PARIS.
- A number of cases have moved onto our reablement service following successful support at home.
- Good joint working has been evidenced in a number of the cases.

3.05 To date the level of evaluation and patient stories gathered is limited, however examples of patients supported include

- a service user with a high level of dementia who was recently supported to return home. In the absence of the service admission to a care home placement was considered to be the most likely outcome for the individual.
- orthopaedic patients who have required medical monitoring due to co-existing conditions such as hypotension.
- patients who have had slow heart rates and been prone to falls with co-existing conditions such as recurrent Urinary Tract Infections.
- patients who have dementia with coexisting medical conditions such as bradycardia, hypotension and nutritional deficits.
- patients who need stabilisation of their medication regimes due to memory problems and vision loss.

3.06 Enhanced Care at Home services within North East and South Flintshire are planned to be in place in Spring 2014.

3.07 As a simple illustration of process' within Enhanced Care, pathways for individuals who step up from the community into the service and those who step down from hospital are shown in Appendix 1 & 2.

4.00 RECOMMENDATIONS

4.01 That scrutiny note the contents of this update report.

5.00 FINANCIAL IMPLICATIONS

5.01 The financial costs of delivering the service are borne by BCUHB.

5.02 We will continue to consider the impact of the service on the overall costs of delivering social services for adults. We will monitor this on an ongoing basis and report to scrutiny in future meetings.

6.00 ANTI POVERTY IMPACT

6.01 N/A

7.00 ENVIRONMENTAL IMPACT

7.01 N/A

8.00 EQUALITIES IMPACT

8.01 Subject to BCUHB Equalities Impact Assessment.

9.00 PERSONNEL IMPLICATIONS

9.01 N/A

10.00 CONSULTATION REQUIRED

10.01 The development of the Enhanced Care at Home service was subject to consultation as part of the "Healthcare in North Wales is Changing Consultation" in 2011/12.

11.00 CONSULTATION UNDERTAKEN

11.01 As 10 Above

12.00 APPENDICES

12.01 Appendix 1 Home Enhanced Care Service- Step Up Pathway
12.02 Appendix 2 Home Enhanced Care Service- Step Down Pathway

LOCAL GOVERNMENT (ACCESS TO INFORMATION ACT) 1985 BACKGROUND DOCUMENTS

None

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