CYNGOR Sir y Fflint
Flintshire
COUNTY COUNCIL

SOCIAL & HEALTH CARE OVERVIEW & SCRUTINY COMMITTEE

Date of Meeting	Thursday 14th November 2019
Report Subject	Hospital avoidance
Cabinet Member	Cabinet Member for Social Services
Report Author	Chief Officer for Social Services
Type of Report	Operational

EXECUTIVE SUMMARY

This report explains the methods used to support people in their own homes with a view to avoiding hospital avoiding hospital admission.

RECOMMENDATIONS	
1	The committee endorses the work we do supporting people and their families at home, avoiding hospital admissions.

REPORT DETAILS

1.00	**EXPLAINING METHODS OF HOSPITAL AVOIDANCE**
1.01	All new requests for support from Social Services come via Single Point of Access. Requests are taken from members of the public and any health professional involved with a person or family.
1.02	At the first point of contact information is gathered and the Single Point of Contact Officer will have a “What Matters” conversation. The information gathered will then inform which area of Social Services is best placed to visit a person to have a more in depth assessment of their current situation.

1.03	The person could be allocated to a Social worker or Occupational therapist or both. An assessment would take place and decision then made as to who can best support the person .This could be practical support or equipment or both.
1.04	There are a number of teams within Social Services whose aim is to support people to remain living in their own homes. These include social work teams , occupational therapy teams , reablment teams, reviewing team, to name a few .
1. 05	These teams are able to identify people who are experiencing a short term period of illness. Short term illness could be categorised as follows; as an example - • Acute Infection • Increased confusion and disorientation due to temperature and infection • A Fall or decreased mobility • Issues relating to low blood pressure • Unstable Diabetes and blood sugar monitoring • Monitoring a person that has had a change in medication
1.06	Where possible and if it is safe to do so and with consent we will put in services to support the person to stay at home. We will work with health colleagues to do this as appropriate.
1.07	For people already known to us and are currently in receipt of support we are able to use a flexible arrangements to increase and tailor support as required responding to the individual need.

2.00	**RESOURCE IMPLICATIONS**
2.01	Residents of Flintshire have access to a number of different resources that promote hospital avoidance.
2.02	**Community Resource Team** This team comprises of Social Worker, Advanced Nurse Practitioner, Physiotherapist, Occupational and a number of generic health care workers. They provide an extended service to Flintshire residents covering 7 days a week, 8am to 8pm Monday to Friday and 8am to 6pm Saturday and Sunday. Referrals for this team often start following a call from a GP. The GP will assess clinical need and if appropriate refer to Community Resource Team to offer comprehensive support in someone's home rather than admit them into hospital.

2.03	Support can take the form of nursing support utilising District Nursing Service, therapy support offering functional assessment to assess moving and positioning needs or practical support with personal care and general daily living tasks, Meals and drinks. The Community Resource Team has access to equipment via the North East Wales community Equipment service, who can provide equipment within hours
2.04	From April 2019 to September 2019, this team have prevented 53 residents from requiring a hospital admission. Many going on to resume independence, better health, resilience and wellbeing.
2.05	The Integrated Care Fund has been utilised to purchase “Step Up” beds in care homes across Flintshire. This has enabled people who need support and care through the night receive it while they are poorly but without the need to take up an acute hospital bed.
2.06	From April 2019 to September 2019, 12 people benefitted from a “Step Up bed which saved a total of 328 nights stay in hospital. “Step Up” beds are free to the person for up to a period of 6 weeks. The cost of a residential care home bed is £562.24 per week.
2.07	Domiciliary care enables people to remain independent in their own homes. Having the ability to increase and tailor this support during episodes of illness help to prevent the need for hospital admission.
2.08	During April 2019 and September 2019 a total of 122 individual care packages were increased during a period of illness.
2.09	Flintshire Reablement Team comprising of Occupational Therapist and Physiotherapists are able to respond to requests for support quickly often on the same day of request. They work alongside joint stores and our in house care team to provide practical support, equipment, and training for families’ along with rehabilitation and advice that enables people to remain well cared for in their own homes. Local authority home care team are skilled in providing support to people who have the potential to recover from short term illness, and are very successful with many people no longer needing serves.
2.10	The Reablement team worked alongside 289 people from April 2019 to September 2019 with the majority of people assisted to stay in their own homes to recover from infection or illness without the need for a hospital admission.
2.11	Social Work and Occupational Therapy teams in the localities respond quickly to requests for assessment which leads to appropriate use of all resources available to them.

3.00	IMPACT ASSESSMENT AND RISK MANAGEMENT
3.01	During winter months we often see an increased demand for services. This is known a Winter Pressures .At this time capacity to meet demand is a challenge.

4.00	CONSULTATIONS REQUIRED/CARRIED OUT
4.01	None.

5.00	APPENDICES
5.01	None.

6.00	LIST OF ACCESSIBLE BACKGROUND DOCUMENTS
6.01	None. Contact Officer: Janet Bellis Telephone: 01352 701415 E-mail: janet.bellis @flintshire .gov.uk

7.00	GLOSSARY OF TERMS
7.01	**Community Resource Team -** A Multidisciplinary team who work in the community to provide home based care for people with a clinical need as an alternative to hospital admission. **Reablement team -** A short term assessment and multidisciplinary team offering rehabilitation support to individuals. This teams aims to maximise independence, choice and quality of life. **Step Up Beds -** This refers to bed that are purchased in residential care home for a short period of time to support recovery for a short term illness. **What Matters -** This is the initial conversation had when Single Point of access in contacted with query. The conversation concentrates on what matters and what is important to the person. **Integrated Care fund -** A regional grant allocated by Welsh Government