ITEM NO:

Report To:	**OVERVIEW (AUDIT) PANEL**
Date:	24 November 2014
Reporting Scrutiny Panel:	Health and Wellbeing Improvement Scrutiny Panel
Subject:	**REVIEW OF CARE AT HOME IN TAMESIDE**
Report Summary:	This Review has considered the range of health and social care services in Tameside providing care at home.
Recommendations:	That the Overview (Audit) Panel note the recommendations detailed in section 9 of the report.
Links to Community Strategy:	This review supports the Community Strategy priorities relating to 'Supportive Tameside' but also recognises links across all Community Strategy areas.
Policy Implications:	The review itself has no specific policy implications. Should the recommendations of this report be accepted by the Tameside Council's Executive, the relevant services will need to assess the policy implications of putting individual recommendations in place.
Financial Implications: (Authorised by the Borough Treasurer)	The associated recommendations within this report will be supported from the existing and future funding envelopes available within the Tameside economy. It should be noted that the level of available resource is expected to reduce on a continual basis over the medium term as a minimum. The Care Together Integration Programme between the Council, Tameside and Glossop CCG and Tameside Hospital Foundation Trust is committed to enhanced levels of integrated care between the health and social care sectors within the borough. The programme has identified a number of health and social care pathways which are focused on service redesign to deliver significant cost reductions in recognition of the expected reduction in budget resource allocations. It is essential that the integration programme is delivered within the project plan timescale and monitored accordingly.
Legal Implications: (Authorised by the Borough Solicitor)	
Risk Management:	Reports of Scrutiny Panels are integral to processes which exist to hold the Executive of the authority to account.
Access to Information:	The background papers relating to this report can be inspected by contacting Charlotte Forrest by: Telephone: 0161 342 2346 e-mail: charlotte.forrest@tameside.gov.uk

1. INTRODUCTION BY THE CHAIR OF THE HEALTH AND WELLBEING IMPROVEMENT SCRUTINY PANEL

1.1 I am very pleased to present this report of a review undertaken by the Health and Wellbeing Improvement Scrutiny Panel of Care At Home in Tameside.

1.2 With a growing ageing population it is important to ensure that Tameside care at home services are fit for purpose and that residents are supported to live independently and safely in their own homes for longer.

1.3 The Panel are conscious of the demographic issues and also the growing financial pressures that the Council currently faces. It is therefore important that current and future provision of care at home services in Tameside are managed effectively to ensure the quality of care is both sustainable and delivered to a high standard.

1.4 With an increased emphasis on the promotion of independence, the work of the early intervention and prevention and carers services is paramount in preventing adults entering the intensive and costly formal social care system.

1.5 For residents that do require formal social care services it is important that the Council work closely with service users and their families/carers to ensure they are fully informed throughout the different stages of the assessment and referral process, ensuring that current and future needs are met.

1.6 It is vital for health and social care organisations to work closely together and have regular communication; to share information and take a more coordinated approach to caring for residents living in the local community.

1.7 The Panel have been made aware of the integrated health and social care agenda in the form of the Care Together project and look forward to hearing updates on its progress.

1.8 On behalf of the Health and Wellbeing Improvement Scrutiny Panel, I would like to thank all those who have participated in this review.

Councillor John Sullivan
Chair of the Health and Wellbeing Improvement Scrutiny Panel

2. SUMMARY

2.1 Over recent years a key National objective has been to actively reduce the number of adults entering the formal social care system and to provide the necessary level of support in their own homes. To achieve this, investment has been made within early intervention and prevention and carers services, to provide support to adults who are potentially on the cusp of care, or have relatives that they are caring for.

2.2 Where residents do meet the eligibility for formal social care services, the objective of the service is to support them to remain living independently in their own home for as long as possible.

2.3 A range of community services are available to support individuals to remain at home, alongside the offer of a Direct Payment, whereby an individual can choose to take a personal budget and purchase their own support, offering full choice and control.

2.4 Assistance is not only available via the Council but through health organisations and the voluntary sector. The inter relationship and communication between different care providers is vital to ensure that residents are receiving the right services at the right time.

3. MEMBERSHIP OF THE PANEL – 2013/14

Councillor J Sullivan (Chair), Councillor H Bowden (Deputy Chair), Councillors M Bailey, J Bowerman, D Buckley, Y Cartey, M Downs, J Jackson, R Miah, J Middleton, E Shorrock and M Whitley.

4. TERMS OF REFERENCE

Aim of the Review

4.1 To understand the range of health and social care services in Tameside providing care at home and examine the level of coordination and cooperation between community service providers in Tameside delivering effective care and support for patients and service users.

Objectives

4.2 1) To identify the different sources of care at home services.

2) To explore the range of health and social care services available.

3) To consider the role of and work undertaken by the voluntary sector.

4) To explore the effectiveness of the Council's interaction with different providers of care.

5) To explore the relationship and coordination between the different providers of health and care services.

6) To examine if the services provided are meeting the resident's needs and/or any service level agreements.

7) To produce workable recommendations for the Council and partners to deliver sustainable improvements to the future delivery of care home services in Tameside

Value for Money/Use of Resources

4.3 It is important that service users in Tameside feel supported, informed and listened to. It is essential that assessment, referral and commissioning of care at home services in Tameside continually aim to meet the needs of and protect the most vulnerable.

Equalities Issues

4.4 The effectiveness of care at home can impact on all sections of Tameside's communities. The review will consider strategies that lead to inclusive environments, ensuring that the correct level of support and intervention is commissioned and delivered ensuring more people are cared for and treated at home.

People and Place Scorecard

4.5 The following targets from the People and Place Scorecard relate to the Care At Home review.

Vulnerable Adults	• Early Help. Number of people helped outside the Social Care System. • Re-ablement. % of people completing re-ablement who leave with either no care package or reduced care package. • Helped to live at home. Number of people helped to live at home and remain independent with support from Adult Services. • Care. Number of people living in residential / nursing / short-term care.

5. METHODOLOGY

5.1 The working group met with Martin Garnett, Assistant Executive Director Adult Services, Tameside MBC and Paul Dulson, Head of Assessment and Care Management, Tameside MBC to receive an overview of care at home in Tameside.

5.2 The working group met again with Martin Garnett, Assistant Executive Director Adult Services, Tameside MBC and Paul Dulson, Head of Assessment and Care Management, Tameside MBC to receive further information with regards to the social care referral and assessment process, current service provision and keys issues and challenges.

5.3 The working group met with Bernadette Ashcroft, Chief Executive of Age UK Tameside to understand the role of the voluntary sector in providing care at home services.

5.4 The working group met with Jill Pinington, Head of Adults – Tameside and Glossop, Stockport NHS Foundation Trust on two occasions to receive information on the broad range of services provided to Tameside residents.

5.5 The working group met with Alison Lewin, Deputy Director of Transformation, NHS Tameside and Glossop Clinical Commissioning Group (CCG) to understand the role the CCG plays in commissioning care at home.

5.6 The working group met with Dr Richard Bircher, local General Practitioner (GP) and NHS Tameside and Glossop Clinical Commissioning Group Governing Body Member to gain a GP's perspective on care at home in Tameside.

6. BACKGROUND TO THE REVIEW

6.1 The UK has an increasingly ageing population. There are currently 10 million people in the UK who are 65 and over and this figure is predicted to increase by 50% in 20 years' times and almost double by 2050.

6.2 In light of these demographic pressures the demand being placed on health and social care services is rising at a time when budgets are being reduced and public expectations are increasing.

6.3 There has been a national and local drive to reduce the numbers of people entering into the formal social care system. Intervention has been developed at an early stage of the

process to prevent people entering the formal social care system and help them to remain in their own homes for a longer period of time.

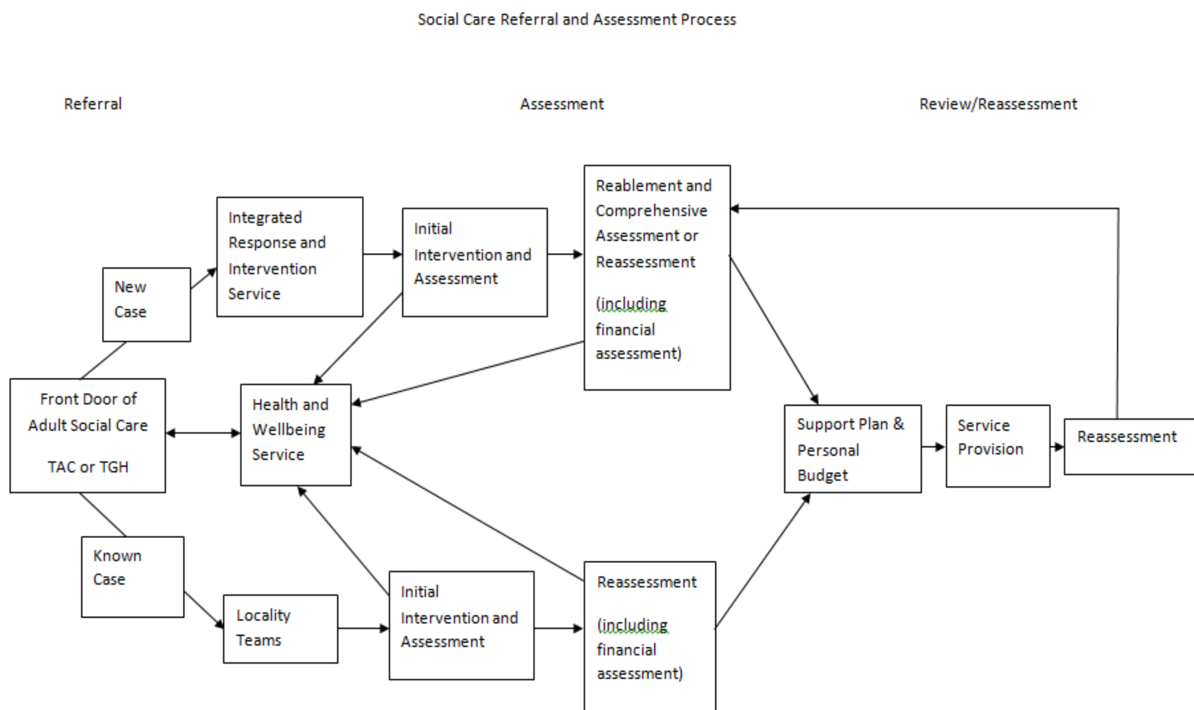
6.4 It is essential that the residents of Tameside are provided with information, advice and support to maintain their independence and are kept informed of their options when accessing care.

7. REVIEW FINDINGS

Social Care Referral and Assessment Process

7.1 Residents that come into contact with Tameside Adult Services are entitled to an assessment of their needs under the National Health Service and Community Care Act (1990). All efforts are made to ensure that residents remain as independent as possible, with the right level of help and support being offered from a wide range of services. This includes universal services commissioned by the local authority and community services.

7.2 **Chart 1: Social Care Referral and Assessment Process**



7.3 The chart above shows the referral, assessment and review/reassessment process used by TMBC Adult Services. There are two possible routes for residents depending on whether they are known to the service.

7.4 If a case is known to the team it is transferred to one of the four locality teams for initial intervention and assessment. New cases use the Integrated Response and Intervention Service (IRIS) where a coordinated response involving a variety of professionals is adopted followed by an initial intervention and assessment.

7.5 Once an assessment has been completed a care plan is developed in consultation with the person and their family/carer. The plan takes into account the level of support they may require and how this can be appropriately provided.

7.6 Once it is determined how much a person's care package will cost, this becomes known as their 'Personal Budget'. The person and their family can decide how the personal budget is used. Services can be accessed through Adult Services or through Direct Payments.

7.7 A range of community services are available to support individuals to remain at home, alongside the offer of a Direct Payment. An individual can chose to take a personal budget in the form of a direct payment and purchase their own support, offering full choice and control.

7.8 Home care is also provided allowing residents to remain in their own homes and communities. This is delivered by services that can provide support during the daytime; and if necessary throughout the night. Approximately 10,000 hours of home care are provided to over 1,000 residents per week in Tameside.

7.9 There are 525 Tameside residents who use a variety of day care services in addition to external providers such as Mind and Mencap who offer day care alternatives.

7.10 There are 144 residents who utilise respite care and over 5,000 Tameside residents have access to the Community Response Service, which is a 24 hour alarm service to help residents live safely and independently.

7.11 A key objective is to reduce the number of residents admitted to residential / nursing care with a preference to keep them at home living independently for as long as possible.

7.12 Once a person has a care package in place, a review is carried out by a Social Worker six weeks after the service commenced, a further review is carried out six months' later and then on an annual basis.

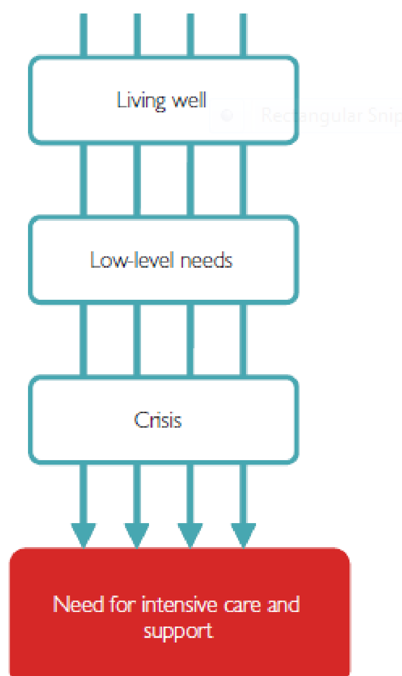
Objectives and White Paper Direction of Travel

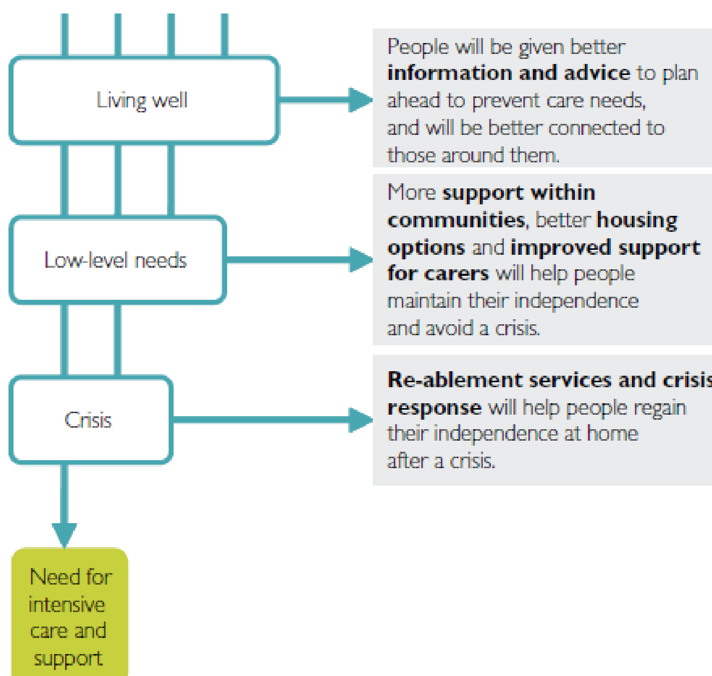
7.13 The core objectives for Adult Social Care are to increase the number of residents supported outside of the Social Care System with a range of prevention based services. Adult Social Care also look to increase the number of residents supported to live at home and remain independent in the most cost effective way whilst reducing the number of residents supported in long term care environments.

7.14 The Council's Re-ablement Service ensures support is available as soon as a person becomes unwell or is unable to cope. In such circumstances a complete wrap around service is mobilised, aimed at avoiding hospital admissions or emergency residential care placements.

7.15 Re-ablement is a short term intensive support (for up to 6 weeks) provided by Adult Services to help adults regain and maintain as much independence as possible. Re-ablement leads to positive outcomes for residents, regaining control of their lives and being supported to maintain their independence by receiving more intense support initially, and opportunities to regain skills leading to less dependence on intensive formal services.

7.16 **Chart 2: The White Paper: Current System and Proposed New System**





7.17 The chart above shows the pathway to care in the current system and the process in the proposed new system[1].

7.18 The use of re-ablement in Tameside has seen a 75% success rate and has vastly reduced levels of home care with an average of three hours of home care per week following re-ablement; in some cases this has led to a zero level package.

7.19 Care Home vacancy levels in the borough have risen from 6.1% in December 2008 to 10.8 % in July 2014 (across residential and nursing beds). This is, in part, attributable to initiatives that are aimed at enabling residents to continue living independently at home by promoting independence, self-sufficiency and providing support and intervention at an earlier stage.

7.20 The use of Care Coordinators ensures communication with other health care professionals such as District Nurses, Occupational Therapists, Physiotherapists and GP's. However, some duplication of work has highlighted the need for a lead professional worker across the spectrum of health and social care.

[1] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/136422/White-Paper-Caring-for-our-future-reforming-care-and-support-PDF-1580K.pdf

Conclusions

1. There has been a shift towards focussing on people's health and wellbeing at an earlier stage, providing support to allow people to remain living independently in their own homes for a longer period of time with a greater emphasis placed on intervention and prevention services to avert crisis situations.

2. The use of re-ablement has seen a 75% success rate and has reduced the number of hours of home care required by service users.

3. It has been observed that there is a certain degree of duplication with many health and social care professionals asking the same set of questions and a growing need for Adult Services to have better integration with other health and social care providers.

Recommendations

1. That consideration be given to allocating a lead professional worker across the spectrum of health and social care to act as a first point of contact and coordinate a care plan.

Age UK

7.21 Age UK Tameside is an independent local charity with an affiliation to Age UK, which offers a range of services to Tameside residents to support older people to live independently in their own homes.

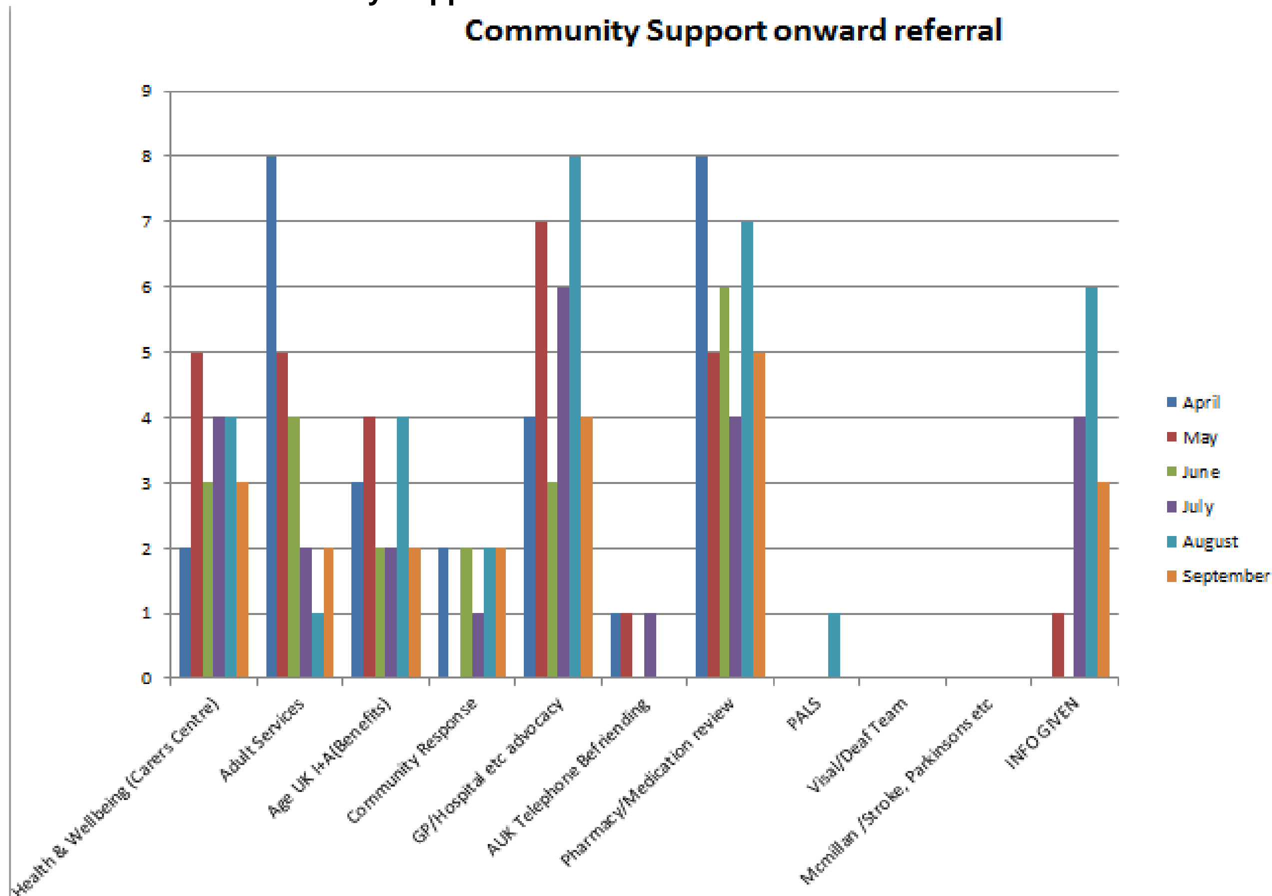
7.22 Age UK Tameside is not registered with the Care Quality Commission therefore does not offer personal or domiciliary care but can provide help in the home via the community support service, handy person minor adaptation and gardening service and offer general information and advice.

7.23 The Community Support Service has recently been re-designed in partnership with commissioners at Tameside Council and is currently funded under schedule three of the partnership agreement with Tameside MBC and is reviewed annually. The service is delivered by one full time Team Leader, three part time Support Workers and a small team of volunteers and operates from 09:00 to 17:00 Monday to Friday.

7.24 The service is aimed at Tameside residents over the age of 50 who lack confidence, are feeling lonely or isolated, have fallen or are at risk of falling, have lost their independence or suffered a bereavement or loss. It is also available for those who have recently been discharged from hospital or need support and practical help in order to be discharged from hospital, those with decreased mobility and need signposting to prevent admission to hospital.

7.25 Once a package of support has been identified it is delivered for up to six weeks with the minimum short term intervention being 48 hours. After this point individuals are directed to other areas of support. Chart 3 shows where individuals were signposted to over a six month period, April to September 2013.

7.26 **Chart 3: Community Support Onward Referral**



7.27 The Handy Person, Minor Adaptation and Gardening Service is provided to Tameside residents via collaborative work between Age UK and New Charter Housing Trust Group and helps to improve safety and security.

7.28 The service is currently funded as part of a three year contract with Tameside MBC and consists of three distinct sections; the provision of aids and adaptations; a handy person service; and a comprehensive gardening service, which is currently under development. The team consists of a manager with part time administrative support. Two full time handymen are currently employed with occasional additional support to manage demand.

7.29 The statutory provision of aids and adaptations is administered through Age UK Tameside working in partnership with New Charter Building Company. The service is free of charge and can include fitting handrails, grab rails, stair rails and key safes.

7.30 The Handy Person Service is a universal service at a cost of £10 per half hour or £28 for a maximum of two hours. A range of small plumbing, electrical and/or joinery jobs can be undertaken in addition to general jobs and repairs, home safety and security measures.

7.31 The gardening service will be developed during the summer of 2014 and will be charged at an estimated cost of a job based on a rate of £15 per hour.

7.32 During 2013/14 Age UK Tameside logged 2,658 aids and adaptation jobs and 949 handy person jobs.

7.33 The Information and Advice Service is based at Katherine Street, Ashton-Under-Lyne and offers a wide range of information concerning the health and wellbeing of older people,

practical assistance and advice around welfare benefits, debt issues, homelessness and housing problems.

7.34 The service can be provided to individuals in their homes. During 2013/14, 30% of support sessions were carried out in resident's homes, 32% over the phone and 38% face to face at Age UK Tameside.

7.35 A contribution towards the operation of this service comes from Tameside MBC as part of the partnership agreement and is reviewed annually. The team comprises of one full time Team Leader, 1.5 full time equivalent Information and Advice Officers and four volunteers.

7.36 There were 3,019 enquiries for information and advice during 2013/14 and benefit entitlement was increased by £1.085 million through supporting individuals with help and advice.

Conclusions

4. Age UK Tameside continues to work with commissioners to ensure that services are responsive to individual needs and developments are in line with the Care Together Programme.

5. The main services provided to the residents of Tameside to help them live independently in their own homes are the community support service; the handy person, minor adaptation and gardening service; and the information and advice service.

6. During 2013/14 2,658 aids and adaptation jobs were recorded, 949 handy person jobs and 3,019 enquiries for information and advice with 30% of these support sessions taking place in resident's homes.

Recommendations

2. The commitment towards joined up working between the Council, voluntary sector and key providers be enhanced through sharing experience and good practices within the borough with closer integration with other health and social care providers.

Stockport NHS Foundation Trust

7.37 Stockport NHS Foundation Trust is the largest provider of community health services in Tameside and has been providing care services to the 219,300 residents of Tameside since April 2011.

7.38 The Trust has 5,800 staff, with almost 2,000 hospital Nurses and District Nurses, and an income of £283 million. Community Services make up one third of the workforce and one fifth of the income.

7.39 There are 17 health centres/clinics across Tameside where residents can access a variety of services. In addition to clinic based services multi-disciplinary teams provide community health services in residents homes.

7.40 **Chart 4: Community Services provided by Stockport NHS Foundation Trust in resident's homes**

7.41 The Community Assessment and Rapid Access team (CARA) operates from 08:00 – 22:00, 7 days a week, 365 days a year. The team consists of Physiotherapists, Occupational Therapists, Nurses, Assistant Practitioners and Support Workers. They work together to provide rehabilitation at home to respond to patients in pre-crisis level, to prevent unnecessary hospital admission and facilitate an early discharge from hospital through improving physical ability and confidence. The average length of assistance is 10 days but can be provided for up to 6 weeks.

7.42 District Nursing provides care in the home for housebound patients, 24 hours a day, 365 days a year. The team work in close partnership with a range of health care professionals including GPs, Go To Doc, advanced practitioners and specialist nursing teams. Packages of care can include end of life/palliative care, which amounts to half of the caseload, long-term conditions, post-operation, wound care, acute care and assessment, continence and bowel care.

7.43 Macmillan provide specialist palliative care, a respite sitting service, assess complex cases and input a care plan. The service works with District Nurses, GPs, Social Workers and the palliative care respite team.

7.44 The Long Term Conditions Team is comprised of advanced practitioners from a nursing background and case managers who care for people with long term conditions, heart failure and COPD. They work closely with GP's and a variety of specialists to support people in managing their conditions in the comfort of their own home and assist in avoiding unnecessary hospital admissions. The service is available in-between the hours of 08:00 –

18:00 Monday to Friday and is extended to include Saturdays and Sundays during the winter months.

7.45 The Case Finding Team which forms part of the Long Term Conditions Team, work closely with the hospital to identify those admitted to hospital at a crisis point who are not currently known to the service. The team work closely with Go to Doc, District Nurses and A & E; an increasing amount of work is being conducted with GPs and Social Workers especially through the introduction of IRIS. They work with the hospital to educate patients to self-administer on discharge which relieves the pressures on the District Nurses.

7.46 The Integrated Rapid Intervention Service (IRIS) is a joint pilot scheme with Tameside MBC available from 08:00 – 22:00 365 days a year. IRIS aims to prevent emergency admissions to hospital and residential care, prevent deterioration and avert a crisis situation, as well as providing enhanced community services in order to safely support people at home. The team consists of Nurses, Physiotherapists, Social Workers, Occupational Therapists and Re-Ablement Support Workers who work together to make a single joint health and social care assessment. The team can respond rapidly to patients, where necessary within the hour.

7.47 Telehealth is an electronic system used to self-support care at home where patients can read their temperature, pulse and lung capacity. Parameters are set for each patient and an alarm is triggered when any of these parameters are exceeded. This prompts a phone call to the patient followed up by a visit by a Nurse if deemed necessary. The system allows professionals to identify trends, improve the health of patients as well as reduce A&E visits, improve quality of life and enable people to remain at home. There are currently 165 units in operation in Tameside and a waiting list of 30.

7.48 Community Physiotherapy provides therapy for patients at home from Monday until Friday from 9:00 – 17:00 to help them recover after a fall or an operation.

7.49 The Community Integrated Diabetes Service delivers Diabetes care in the community and in reaches into Tameside Hospital. The team is made up of Nurses, Podiatrists, Dieticians and Support Workers who provide advice, support and treatment to patients in their home who cannot access community clinics.

Conclusions

7. Stockport NHS Foundation Trust is the largest provider of community health services in Tameside.

8. Multi-disciplinary teams provide a wide range of services in people’s homes to promote and enable independence.

9. The introduction of the Integrated Rapid Intervention Service (IRIS) has seen an increase in collaborative work between health professionals and Social Workers.

Recommendations

3. The Case Finding Team to have closer liaison with the Council to identify those who need help, assisting them in making contact with the right service at the right time.

4. Exploration be given to the range of benefits that could be achieved through expanding the operating hours of the Case Finding Team so as to improve access to services and provide residents with the necessary help, advice and support.

5. In order for the Council to assist with the demands and tight timescales placed on the District Nursing Team, closer work and improved communication be established around planned road works in the borough enabling District Nurses to plan their visits and routes.

NHS Tameside and Glossop Clinical Commissioning Group

7.50 NHS Tameside and Glossop Clinical Commissioning Group (CCG) are responsible for commissioning community health services for Tameside and Glossop residents and improving the health care of the local population. Collaborative work with the Council and partner organisations helps to improve the health and social care services provided to residents in the borough.

7.51 The CCG is led by 128 local GPs from 41 practices across Tameside and Glossop working to improve the commissioning and decommissioning of a variety of health care services.

7.52 The CCG has a total commissioning budget of £326million. Just under £24million is used to fund services in the community and patients' homes.

7.53 The main contract for community services is with Stockport NHS Foundation Trust. They provide community services as "Tameside & Glossop Community Healthcare Business Group". The services are all designed to support patients in their own homes, supporting them when they have had a stay in hospital, or providing ongoing care to prevent hospital admission.

7.54 NHS England are currently responsible for the commissioning of Health Visiting services however, this will be transferring to Local Authorities in 2015.

7.55 The CCG is currently working closely with the Council in relation to the Care Together integration programme. A number of services will be redesigned in order to develop a greater focus on avoiding hospital admission, increased support in patients' own homes and support to return people to their own homes after a stay in hospital.

7.56 In order for the Council to minimise the number of residents going into care directly from hospital, residents can access a number of intermediate care beds. Tameside and Glossop Clinical Commissioning Group (CCG) have responsibility for the commissioning of intermediate care beds aimed at helping people regain confidence and skills following a stay in hospital.

7.57 There are two locations where intermediate care beds are available; Grange View in Hyde and Shire Hill in Glossop. There are currently 60 beds available across the two facilities and it is common for all beds to be occupied, with the average length of stay being around three weeks.

7.58 The CCG is working closely with the Council to redesign Intermediate Care services to support patients at home or in dedicated units to provide rehabilitation and therapy either after a stay in hospital to prepare them to return home or straight from home to prevent hospital attendance and admission.

7.59 A joint collaborative project for 2014/15 is the Integrated Locality Teams for Adults, in particular the development of teams working in the five localities across Tameside and Glossop. There will be joint health and social care teams supporting patients in their homes and community settings to manage long term conditions and deliver nursing and social care support.

7.60 Specialist Respiratory Services, a community based team to provide specialist support for patients with respiratory diseases such as COPD, is under development.

7.61 End of Life Care services will see the development of integrated health and social care services to ensure patients can be cared for and supported to die in the place of their choice. It is beneficial for patient's wishes to be written down in an end of life care plan that is kept in their own home.

7.62 Dementia services will develop a model of care which provides health and social care support to patients with dementia to enable them to be cared for outside hospital settings.

Care Together

7.63 In the coming months and years, GPs, Health Workers, Social Care staff and voluntary partners will be working more closely together, sharing information and taking a more coordinated approach to caring for people living in the local community. People with long-term health conditions and older people will be the first to see the benefits of these changes.

7.64 At present, if someone has regular support from their GP and receives care visits from a District Nurse but also needs help to wash, dress or prepare a meal, they may have a number of different professionals supporting them and asking similar questions before help can be arranged.

7.65 With health and social care organisations working more closely together, the process will become much smoother. District nurses, Occupational Therapists, Social Workers and other professionals will be in a position to communicate with each other on a more regular basis, sharing information to support people better.

7.66 The aim is for Tameside residents to have one service consisting of one team, one contact number, one assessment, one care plan and one care coordinator who is their main contact.

Conclusions

10. The CCG has seen an increase in demand for health services with less funding whilst meeting the requirements of residents through commissioner led services.

11. The development of the Care Together initiative will simplify the process of accessing care services and improve patient experience.

12. A recurring theme during the development of the five business cases as part of the Care Together project is limited access to records.

13. It would be more convenient for resident's to have a singled named care coordinator who will be the first point of contact in an emergency situation.

Recommendations

6. In order to avoid duplication and improve care services for resident's, different health and social care organisations explore sharing information and patient records where possible.

7. Consideration be given to reviewing the benefits of expanding the intermediate care offer at an earlier stage in order to prevent hospital admission.

8. Care plans to be produced on bright coloured paper so they can be easily and quickly located in an emergency situation.

GP Services

7.67 GP Services are commissioned via the Greater Manchester Local Area Team of NHS England. There are 41 GP Surgeries across Tameside and Glossop open from 08:00 until 18:30 providing medical advice, prescriptions and examinations. Patients can also access out of hours services via Go To Doc by contacting their practice directly.

7.68 The CCG commissions some additional services which exceed a GP's core contract such as the Preventing Hospital Admissions Directed Enhanced Service. This service aims to minimise unplanned hospital admissions which can be distressing and disruptive for patients, carers and families.

7.69 The service is designed to improve care for vulnerable patients and those with complex physical and mental health needs and to reduce avoidable unplanned hospital attendances and admissions. The service is based on a national model designed by NHS England as an Enhanced Service for General Practice.

7.70 One part of the service means that a Practice will be required to provide an ex-directory or bypass telephone number to care homes and nursing homes, ambulance services and A&E departments. This will encourage them to contact the patient's GP practice to discuss options before calling an ambulance or to give the ambulance crew access to the patient's GP for more advice and information where they feel this would help their decisions.

7.71 GP surgeries are being encouraged to sign up to this new service and it is anticipated that the service will be implemented and fully operational by September 2014.

7.72 Improving General Practice - A Call to Action was launched by NHS England in July 2013 to explore how to develop GP practices with an aim for GPs to play a stronger role in a more integrated out-of-hospital care system.

7.73 Service improvements so far have resulted in closer working relations between GPs, out of hours GPs and hospitals with increased data sharing. This new way of working needs to also include social care.

7.74 The re-design of diabetic services has had a huge impact since its commencement in February 2014. Patients can now access a single service consisting of Consultants, Diabetic Specialist Nurses, Podiatrists, and other diabetic specialist practitioners. This has resulted in a financial reduction of approximately one-third, a decrease in hospital admissions, a more convenient service and an improved experience for the patient. It is hoped that this method can be adopted to other services.

Conclusions

14. There are 41 GP Practices across Tameside and Glossop open from 08:00 until 18:30. Patients can also access out of hours services via Go To Doc by contacting their practice directly.

Recommendations

9. That service improvements to GP Practices include greater use of electronic records which can be easily and quickly shared with other health and social care organisations.

10. To reduce duplication and improve communication one electronic care plan be produced per patient which can be shared between different health and care providers with closer collaborative working between GPs and social care professionals.

8. CONCLUSIONS

8.1 There has been a shift towards focussing on people's health and wellbeing at an earlier stage, providing support to allow people to remain living independently in their own homes for a longer period of time with a greater emphasis placed on intervention and prevention services to avert crisis situations.

8.2 The use of re-ablement has seen a 75% success rate and has reduced the number of hours of home care required by service users.

8.3 It has been observed that there is a certain degree of duplication with many health and social care professionals asking the same set of questions and a growing need for Adult Services to have better integration with other health and social care providers.

8.4 Age UK Tameside continues to work with commissioners to ensure that services are responsive to individual needs and developments are in line with the Care Together Programme.

8.5 The main services provided to the residents of Tameside to help them live independently in their own homes are the community support service; the handy person, minor adaptation and gardening service; and the information and advice service.

8.6 During 2013/14 2,658 aids and adaptation jobs were recorded, 949 handy person jobs and 3,019 enquiries for information and advice with 30% of these support sessions taking place in resident's homes.

8.7 Stockport NHS Foundation Trust is the largest provider of community health services in Tameside.

8.8 Multi-disciplinary teams provide a wide range of services in people's homes to promote and enable independence.

8.9 The introduction of the Integrated Rapid Intervention Service (IRIS) has seen an increase in collaborative work between health professionals and Social Workers.

8.10 The CCG has seen an increase in demand for health services with less funding whilst meeting the requirements of residents through commissioner led services.

8.11 The development of the Care Together initiative will simplify the process of accessing care services and improve patient experience.

8.12 A recurring theme during the development of the five business cases as part of the Care Together project is limited access to records.

8.13 It would be more convenient for resident's to have a singled named care coordinator who will be the first point of contact in an emergency situation.

8.14 There are 43 GP Practices across Tameside and Glossop open from 08:00 until 18:30. Patients can also access out of hours services via Go To Doc by contacting their practice directly.

9. RECOMMENDATIONS

9.1 That consideration be given to allocating a lead professional worker across the spectrum of health and social care to act as a first point of contact and coordinate a care plan.

9.2 The commitment towards joined up working between the Council, voluntary sector and key providers be enhanced through sharing experience and good practices within the borough with closer integration with other health and social care providers.

9.3 The Case Finding Team to have closer liaison with the Council to identify those who need help, assisting them in making contact with the right service at the right time.

9.4 Exploration be given to the range of benefits that could be achieved through expanding the operating hours of the Case Finding Team so as to improve access to services and provide residents with the necessary help, advice and support.

9.5 In order for the Council to assist with the demands and tight timescales placed on the District Nursing Team, closer work and improved communication be established around planned road works in the borough enabling District Nurses to plan their visits and routes.

9.6 In order to avoid duplication and improve care services for resident's different health and social care organisations explore sharing information and patient records where possible.

9.7 Consideration be given to reviewing the benefits of expanding the intermediate care offer at an earlier stage in order to prevent hospital admission.

9.8 Care plans to be produced on bright coloured paper so they can be easily and quickly located in an emergency situation.

9.9 That service improvements to GP Practices include greater use of electronic records which can be easily and quickly shared with other health and social care organisations.

9.10 To reduce duplication and improve communication one electronic care plan be produced per patient which can be shared between different health and care providers with closer collaborative working between GPs and social care professionals.