Post Scrutiny - Executive Response

In Respect of: Scrutiny Review of Care At Home in Tameside

Date: 23 October 2014

Cabinet Deputy: Councillor Brenda Warrington (Adult Social Care and Wellbeing)

Coordinating Officer: Paul Dulson, Head of Adult Assessment and Care Management, Adult Services

Partnership: Health and Wellbeing Board

Recommendations	Accepted/ Rejected	Executive Response	Officer Responsible	Action By (Date)
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.	Accepted	The Care Together Integration Programme between TMBC, Tameside and Glossop CCG and Tameside Hospital Foundation Trust have identified a number of health and social care pathways which are the focus of service redesign over the next two years. The workstream for Local Community Care Teams has recognised the importance of having a named lead professional who will be responsible for co-ordinating a persons care. It is anticipated that a pilot will be run from April 2015 to test out this model of working.	Julie Moore (Service Unit Manager – Locality Teams)	April 2015
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.	Accepted	The Care Together Programme is committed to more joined up integrated care between the health and social care sectors in Tameside and Glossop. Regular reports are brought in to the Health and Wellbeing Board where the Care Together programme is a standing item.	Doreen Hounslea (Care Together Programme Manager)	Ongoing and monthly updates to Health and Wellbeing Board

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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.	Accepted	It is anticipated that the Case Finding Team within Stockport Foundation Trust will be integrated in the new Local community Care Teams once they are established bringing much closer liaison between the Council and Health colleagues	Julie Moore (Service Unit Manager- Locality Teams)	April 2015
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.	Accepted	Once established the Local Community Care Teams of which the Case Finding Team will be a part will operate between 8.00am and 10.00pm 7 days a week.	Julie Moore (Service Unit Manager- Locality Teams)	April 2015
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.	Accepted	The Council already put all road works on the public website and in addition it now has a new Twitter account TMBC_highways which gives out live information when roads are suddenly closed as a result of accidents and other emergencies. Stockport Foundation Trust have been made aware of this.	Paul Dulson (Head of Adult Assessment)	November 2014
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.	Accepted	One of the fundamental principles of integrated working is the sharing of information and patient records. All partners within the Care Together Programme are committed to finding ways to avoid unnecessary duplication of effort in this area. A suitable information technology solution is currently being sought and it is recognised that finding ways of removing the barriers attached to sharing information is a critical outcome for the success of the programme.	Paul Dulson (Head of Adult Assessment)	April 2016

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7. Consideration be given to reviewing the benefits of expanding the intermediate care offer at an earlier stage in order to prevent hospital admission.	Accepted	The importance of intermediate care cannot be emphasised enough as a key tool for the rehabilitation and recuperation of someone who has been ill or is recovering from a specific condition. One of the first Workstreams to be integrated will be the intermediate care services which include both community and bed based intermediate care. The plan is to integrate the two community services that currently exist, namely the Integrated Response and Intervention Service (IRIS) and the Community Assessment and Rapid Access Team (CARA) and to expand the current use of intermediate care beds at Shire Hill and Grange Close to incorporate a step up facility from the community.	Tricia O'Connell (Service Unit Manager – Intermediate and Urgent Care)	April 2015 although step up beds are on line from 3/11/2014.
8. Care plans to be produced on bright coloured paper so they can be easily and quickly located in an emergency situation.	Accepted	Once agreement has been achieved with shared documentation and paperwork we will develop a joint care records book with health service colleagues which will have all the relevant information with regards the patient/service user which will be easily identifiable and be able to travel with them if they need to be admitted to hospital or any other health or social care environment.	Paul Dulson (Head of Adult Assessment)	April 2015
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.	Accepted	Although this recommendation falls outside of the remit of the Executive Member it is acknowledged that the work of the Care Together Programme in terms of shared and joint records will include the GP records as well. GP practices will form part of the Local Community Care Teams.	Paul Dulson (Head of Adult Assessment)	April 2016
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.	Accepted	As previously described this recommendation is in line with the key aspirations of the Care Together integration programme and we will strive to achieve a shared assessment and care plan as quickly as the data sharing agreements are in place.	Paul Dulson (Head of Adult Assessment)	April 2016