Report to:	**HEALTH AND WELLBEING BOARD**
Date:	21 September 2017
Executive Member / Reporting Officer:	Alison Lewin, Deputy Director of Commissioning
Subject:	**INTERMEDIATE CARE IN TAMESIDE AND GLOSSOP**
Report Summary:	The vision for intermediate care in Tameside & Glossop is for the support to be delivered at home wherever possible. The model should include an element of bed-based care, have clear links with the Integrated Neighbourhoods (including the Extensivists), a robust model for hospital discharge planning, and be able to offer a response to urgent care requests. The outcomes expected from a model of intermediate care are: • Maximising independence; • Preventing unnecessary hospital admissions; • Preventing unnecessary admissions to long term residential care; • Following hospital admissions, optimising discharges to usual place of residence. This report sets out the work undertaken to date, a proposed model for Intermediate Care for Tameside and Glossop, and details of the consultation process approved by the Single Commissioning Board on 22nd August. Also attached to this report are copies of the consultation documents.
Recommendations:	Health and Wellbeing Board are asked to note the decision taken by the Single Commissioning Board on 22nd August 2017 to approve the model outlined in the attached report, and agree to consult with option 2 as the preferred option for the Single Commission and Integrated Care Foundation Trust. The consultation process commenced on 23rd August and will run for 12 weeks until 15th November 2017.
Links to Health and Wellbeing Strategy:	The proposals align with the living and ageing well elements of the Health and Wellbeing Strategy.
Policy Implications:	This report outlines a clear intention to include a programme of engagement and formal consultation to ensure the patient and public implications are understood and taken into account. The report includes a full Equality Impact Assessment. The Care Together programme is focused on the transformation of the health and social care economy to improve healthy life expectancy, reduce health inequalities and deliver financial sustainability. This work is a critical part of the programme

Financial Implications:

(Authorised by the Borough Treasurer)

Finance officer support was confirmed for the proposals presented to Single Commissioning Board on 22 August 2017.

Budget Allocation (if Investment Decision)	£ 1.983 million (via GM Transformation Funding)
CCG or TMBC Budget Allocation	CCG
Integrated Commissioning Fund Section – S75, Aligned, In-Collaboration	Section 75
Decision Body – SCB, Executive Cabinet, CCG Governing Body	SCB
Value For Money Implications – e.g. Savings Deliverable, Expenditure Avoidance, Benchmark Comparisons	Expected savings to be realised of £ 0.453 million in 2017/18 (part year effect) and £ 0.686 million on a recurrent basis from 2018/19.
Additional Comments The flexible bed base proposal has been subject to a stringent business case and has been supported by the Project Management Office gateway review process (Stage 2 complete). It is essential that appropriate legal advice is sought in respect of the public consultation prior to inclusion of the report at the next Single Commissioning Board meeting.	

Legal Implications:
(Authorised by the Borough Solicitor)

An open and transparent consultation process is required to attract maximum public engagement in order to ensure the public sector equality duty has been complied with. This should be reflected in the Equality Impact Assessment, which decision makers must have due regard to before making any decision. What needs to be considered is that Option 1 is unlikely to be a viable option as it is not affordable. Therefore is unlikely to be legal. By including in the consultation it will be responded to as a viable option so there needs to be clear communication as to why it is not.

Risk Management :

This programme will be managed via the Care Together Programme Management Office and therefore the risks will be reported and monitored via this process

Access to Information :

The background papers relating to this report can be inspected by contacting Alison Lewin, by:

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1. BACKGROUND AND INTRODUCTION

1.1 The development of a system wide strategy for Intermediate Care for Tameside and Glossop is required to enhance the delivery of intermediate care in the locality.

1.2 The vision is for the support to be delivered at home wherever possible. The model should include an element of bed-based care, have clear links with the Integrated Neighbourhoods (including the Extensivists), a robust model for hospital discharge planning, and be able to offer a response to urgent care requests.

1.3 The outcomes expected from a model of intermediate care are:

- Maximising independence
- Preventing unnecessary hospital admissions
- Preventing unnecessary admissions to long term residential care
- Following hospital admissions, optimising discharges to usual place of residence

1.4 This report sets out the work undertaken to date, a proposed model for Intermediate Care for Tameside and Glossop, and details of the recommended consultation process.

2. PROPOSED TIMESCALE AND MILESTONES

2.1 Attached to this report at **Appendix 1** is the proposed timeline for the project, including the consultation, resulting in the presentation of a final model to the Single Commissioning Board in December 2017.

2.2 The Single Commission will engage and consult on the proposed Intermediate Care model described in section 6 of this report. The outcome of the consultation will inform the model presented to the Single Commissioning Board in December.

3 DEFINITION OF INTERMEDIATE CARE

3.1 The definition of Intermediate Care included in the National Audit of Intermediate Care 2017 (developed with the assistance of the Plain English Campaign) is set out below. This is the definition which will be used in any communication, engagement and consultation work referred to in this report and associated strategy documents. [1]

What is intermediate care?
Intermediate care services are provided to patients, usually older people, after leaving hospital or when they are at risk of being sent to hospital. The services offer a link between hospitals and where people normally live, and between different areas of the health and social care system –community services, hospitals, GPs and social care.

What are the aims of intermediate care?
There are three main aims of intermediate care and they are to:

- Help people avoid going into hospital unnecessarily;
- Help people be as independent as possible after a stay in hospital; and
- Prevent people from having to move into a residential home until they really need to.

Where is intermediate care delivered?
Intermediate care services can be provided to people in different places, for example, in a community hospital, residential home or in people's own homes.

[1] http://www.nhsbenchmarking.nhs.uk/CubeCore/.uploads/NAIC/NAIC%202017/NAIC2017overview.pdf

How is intermediate care delivered?
A variety of different professionals can deliver this type of specialised care, from nurses and therapists to social workers. The person or team providing the care plan will depend on the individual's needs at that time.

4. CASE FOR CHANGE

4.1 A number of factors and service reviews have led to the identification of Intermediate Care as a priority for the Tameside and Glossop locality and the development of the model outlined in this report.

4.2 **Intermediate Care – Halfway Home:** The Department of Health's 2009 intermediate care guidance, *Halfway Home*[2] defined intermediate care as follows: *Intermediate care is a range of integrated services to promote faster recovery from illness, prevent unnecessary acute hospital admission and premature admission to long-term residential care, support timely discharge from hospital and maximise independent living.* The initial guidance set out definitions of intermediate care, service models, responsibilities for provision and charges and planning. The definition included services that met the following criteria:

- They are targeted at people who would otherwise face unnecessarily prolonged hospital stays or inappropriate admission to acute inpatient care, long term residential care or continuing NHS in-patient care.
- They are provided on the basis of a comprehensive assessment, resulting in a structured individual care plan that involves active therapy, treatment or opportunity for recovery.
- They have a planned outcome of maximising independence and typically enabling patients and service users to resume living at home.
- They are time-limited, normally no longer than six weeks and frequently as little as one to two weeks or less.
- They involve cross-professional working, with a single assessment framework, single professional records and shared protocols.

The local intermediate care offer described in this report embraces the philosophy of the Halfway Home guidance, with a focus on delivering care and the required wrap-around support to maximise independence.

4.3 **National Audit for Intermediate Care 2015:** The results of the National Audit for Intermediate Care from 2015 (based on 2013-14 data from providers and commissioners across the locality) identified the following in relation to the Tameside & Glossop intermediate care model (summary / selection of key indicators):

- An above average investment in intermediate care per 100,000 weighted population (4th highest of the 47 localities which participated);
- Above average beds commissioned per 100,000 weighted population (12th highest);
- Above average investment in bed based care compared with national average (£3.9m against a national average of £2.3m);
- A positive response was provided to 6 of the 13 quality standards;
- A negative response to the commissioning of integrated home and bed based intermediate care services.

The analysis of this report led to the early identification of Intermediate Care as a priority for the developing Care Together programme. A number of developments have taken place,

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2 http://webarchive.nationalarchives.gov.uk/20130124050747/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@pg/documents/digitalasset/dh_103154.pdf

informed in part by this review, which are included in the current model of intermediate care. The National Audit for Intermediate Care is taking place in 2017. The Single Commission and Integrated Care Foundation Trust are participating in the audit to support the ongoing review of the locality's intermediate care system.

4.4 **Tameside & Glossop NHS Foundation Trust Contingency Planning Team (CPT) Final Report September 2015[3]:** Price Waterhouse Cooper were appointed by Monitor to carry out a review of the Tameside and Glossop locality and produced a report which states that improving the way services are currently delivered, through an innovative, more joined-up approach across Tameside and Glossop, will improve the care patients receive and put Tameside NHS Foundation Trust back on to a sound clinical and financial footing. The Contingency Planning Team worked with a range of stakeholders across the locality to develop proposals for a model of care which included a new Urgent Integrated Care Service. Intermediate Care is described as a key element of the Urgent Integrated Care Service (now developed and implemented as IUCT and Home First). One of the features included in the Contingency Planning Team report is that the Urgent Integrated Care Service would be increasingly delivered in people's own homes.

4.5 A report presented to the Single Commissioning Board in August 2017 included a range of other reports and analyses which support the case for change and the development of the model outlined in this paper.

5. STRATEGY DEVELOPMENT AND ENGAGEMENT

5.1 An Intermediate Care strategy was developed, outlining national guidance, local expectations of intermediate care, and the action taken over the past 2 years as part of the Care Together programme to refine the Tameside and Glossop locality model. This document outlined the expectations from the Single Commission for the delivery of intermediate care at home wherever possible, therefore requiring a clear model of community based care and an appropriate level of bed based intermediate care.

5.2 The Single Commission reviewed the outputs from previous consultation and engagement on intermediate care and the wider Care Together model to inform the model of Intermediate Care. This includes information extracted from the engagement events facilitated by Action Together and the Glossop Volunteer Centre, and information from Care Together engagement events facilitated by the NHS Benchmark Consulting team during 2014/15.

5.3 The Commissioning Directorate supported a range of pre-consultation engagement events in early summer 2017 to inform the final proposal for a model of intermediate care for Tameside and Glossop.

5.4 Details of the engagement activities referred to in this report are included in the paper presented to the Single Commissioning Board in August 2017.

6. PROPOSED MODEL FOR INTERMEDIATE CARE IN TAMESIDE & GLOSSOP

6.1 The proposals for Intermediate Care set out in this report have been prepared jointly by Tameside and Glossop Integrated Care NHS Foundation Trust and the Single Commission and have been designed to support delivery of the Commissioning Strategy for Intermediate care services. The strategy document describes the aim to support rehabilitation and recuperation, maximising people's ability to function independently, and enabling them to continue living at home in all but most challenging cases. With a requirement for:

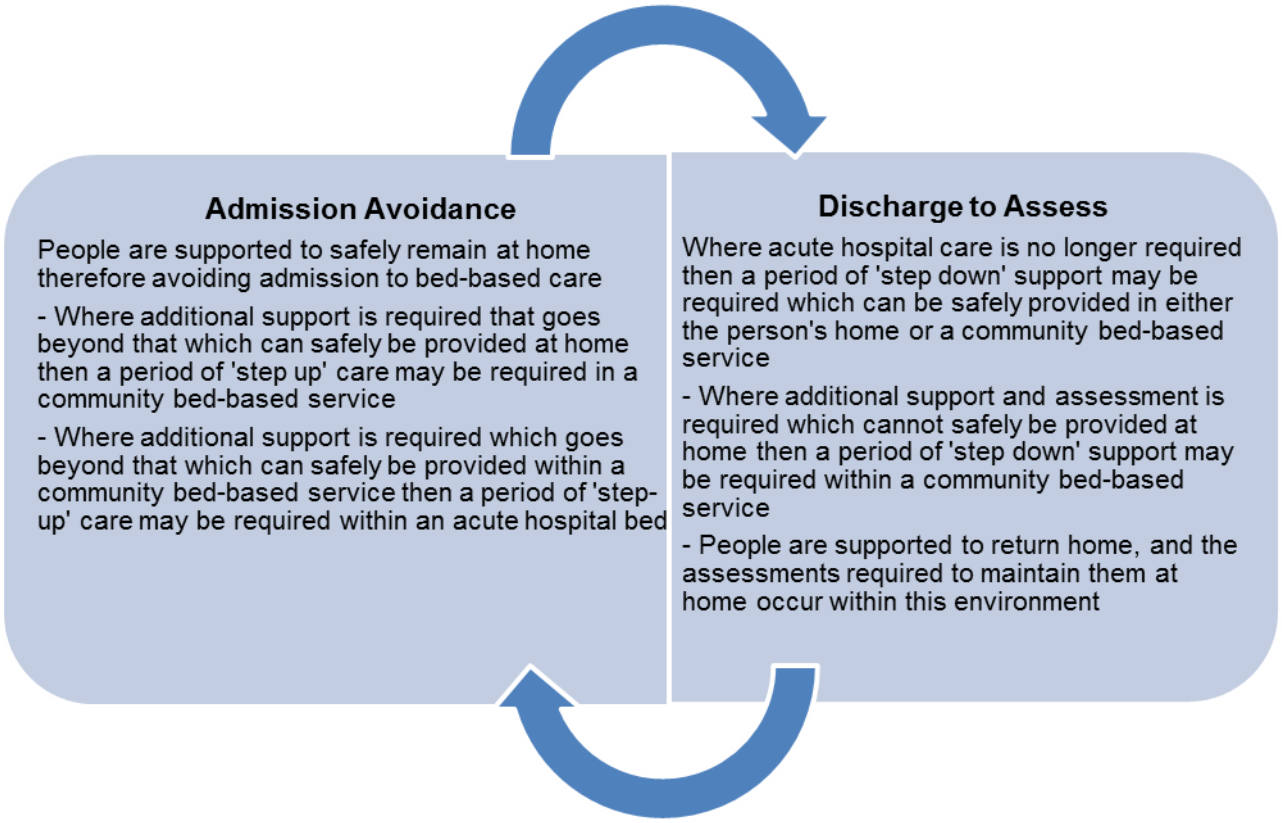
3 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/461261/Final_CPT_report.pdf

- Home-based intermediate tier services, offering intensive packages of care to people in their own homes (including residential and nursing homes) provided by an integrated team providing both health and social care input based on individual need.
- Community intermediate care beds where it is deemed that service users, although medically fit, have a higher level of need and require a period of 24-hour care whilst undergoing intensive short term rehabilitation packages.
- An ability to care for clients with all levels of dementia, in an appropriate setting.

6.2 **Home First:** One of the key principles within the Tameside and Glossop Care Together approach to integrated care is that wherever it is possible for a person to have their care requirements met within their own place of residence, the system will be responsive to meeting this need in a timely manner. This principle is embodied in this proposal for an intermediate care model. In order to be responsive to people's needs and deliver against this principle Tameside and Glossop Integrated Care Foundation Trust has implemented the "Home First" service model. This model will provide a response to meet an urgent/crisis health and/or social care need. Home first is fundamental to the intermediate care offer and is a key interface between the Integrated Neighbourhoods, community services and the acute setting, ensuring people are supported in the environment that is suited to their own care needs and most likely to achieve positive outcomes. This supports the intermediate care aims of:

- Helping people avoid going into hospital unnecessarily;
- Helping people be as independent as possible after a stay in hospital; and
- Preventing people from having to move into a residential home until they really need to.

The Home first model comprises of two key elements:



6.3 The Home First offer will ensure that people are supported through the most appropriate pathway with "home" always being the default position. However, it is recognised that not all individuals' intermediate care needs can be managed safely in their own home. In some cases there is a need for an alternative community based bed, for a short period of time, to

enable the appropriate interventions to be undertaken with the individual to enable them to return home, whether this be following an admission to the Hospital or to avoid the need for an admission in the first place.

6.4 Tameside and Glossop Integrated Care Foundation Trust has identified four core interfaces where services are provided to patients which make up the Intermediate Care model:

- **Integrated Neighbourhood services;**
- **Intermediate / Specialist Community Based Services;**
- **Community Bed Setting;**
- **Acute Hospital Setting.**

6.5 **Integrated Neighbourhood Services:** The Integrated Care Foundation Trust and the Commissioners are working collaboratively through the Care Together programme to develop five Integrated Neighbourhood Teams, which will be Multi-disciplinary teams comprising Primary care (including GP services and pharmacists), community services such as district nursing and therapy services, social care, Mental Health services and the voluntary/community sector. The vision of these Neighbourhood Teams is to provide place based care to support neighbourhoods to deliver high quality and connected services which look after the whole neighbourhood population, to support self-care in order to improve outcomes, prosperity and wellbeing. The services will aim to:

- Optimise self-care and family/carers support;
- Help people live as independently as possible;
- Improve condition management;
- Co-ordinate delivery of services from all providers;
- Provide seamless support during periods of crisis and the transition to / from hospital based care;
- Ensure a multi-disciplinary case management approach;
- Use risk stratification data to identify those who may benefit from care co-ordination and put this into place;
- Reduce the need for crisis interventions.

In respect of intermediate care model the Integrated Neighbourhoods through the GP, social care services and community teams will provide a co-ordinated care and support service to people who live in their neighbourhood area who have intermediate care needs, long-term conditions, other ongoing care and support needs, or who are most at risk of unplanned admissions to hospital. The multi-disciplinary team will also link with the intermediate tier/specialist and urgent care services to provide additional care input where required, to step-up services to avoid a hospital admission or social care placement, or support people returning to their place of residence following an acute admission, with the aim of supporting people to be as independent as possible.

The Integrated Neighbourhood Teams will also include social prescribing navigators to help patients and carers to identify non-medical, voluntary and community services that will benefit their overall health and well-being, these might include social or physical services/clubs to encourage social inclusion and physical independence.

6.6 **Intermediate / Specialist Community Based Services:** The Integrated Care Foundation Trust has identified a range of more specialist community based services that are available which provide a link between acute services and the Integrated Neighbourhood Teams. These form a core element of the out of hospital intermediate care offer. The Intermediate Tier services will provide short term intensive interventions to people who require higher intensity or more specialist care than is available within the Neighbourhood services, and provide care to meet the specific aims of the intermediate care strategy of:

- Helping people avoid going into hospital unnecessarily;
- Helping people be as independent as possible after a stay in hospital.

Intermediate Tier services will be provided following a referral from a Neighbourhood service or from the acute setting, to support early discharge from hospital care, or to enable people to remain in their own home for treatment. Risk stratification data will in some cases identify those who may benefit from additional care input based on individual needs. The Intermediate Tier will take a proactive approach to care for people who have ongoing health and care needs, or are at a high risk of experiencing worsening health or unplanned admissions, and will in some circumstances accept self-referrals. The Intermediate Tier services which will provide services for the intermediate care offer include:

- A new Extensivist service has commenced to work with those individuals living with complex ongoing health and care needs, to improve their health and wellbeing and reduce demand on services by ensuring that their care is managed more effectively. This will offer a fundamentally different way of organising care around an individual's needs, including medical, social, psychological, functional, pharmaceutical and self-care. This will be staffed by specialist Extensivist consultants or GPs, who will work with a cohort of high risk patients identified through risk stratification.
- 7 day Community IV therapy service to provide IV therapy in the home setting.
- Digital Health Service – a new innovative service which provides Care Homes and the Community Response Service with access via SKYPE to an Advanced Nurse Practitioner for clinical consultation and advice.
- Reablement which is a social care service which provides time limited care to intermediate care patients.
- Community Therapy services
- Integrated Urgent Care Team made up of therapists (physio and occupational), nurses, social workers and other care and support staff. The team works between the hospital and the community, supporting people or who are experiencing some difficulties within their own home or who have been discharged from hospital, intermediate care or other health and social care environments. The team will have a key role in responding to people with urgent care needs. Ongoing support will then be provided for up to 72 hours to allow for close working with the Neighbourhood Teams, who will manage their ongoing care and support needs where possible.
- Community Social Care services provided by Tameside Metropolitan Borough Council and Derbyshire County Council that will assess and provide care to patients to ensure they are able to remain independent for as long as possible and to delay placements into long term residential care. Social care is a fundamental part of the Integrated Care model in Tameside and Glossop. Progress is being made with proposals for Tameside MBC social care staff to transfer to the Integrated Care Foundation Trust in due course. Closer alignment of services is also planned with Derbyshire County Council for Glossop residents.

The intermediate tier services will focus on ensuring that people have access to specialised care in the community, to avoid unnecessary admissions, and will have a key role in helping coordinate care around an individual's needs, to allow them to return to their normal place of residence as quickly and easily as possible.

6.7 **Community Bed Setting - Overview:** The health and social care economy is currently commissioning community based beds from a range of sources from across the local economy. This includes intermediate care beds, spot beds and an arrangement for discharge to assess beds. In order to improve the community bed offer locally a revised model is being proposed in this report. The key principle of the flexible community bed base model is that support will be delivered through location-based community beds providing general nursing whilst encouraging independence and reablement, alongside in-reach from specialist teams such as therapy services, primary care and mental health. This will ensure individual centred management plans based on care needs that support people's transition

back home effectively and ensure a smooth transfer of care, when necessary, to the Integrated Neighbourhood. A flexible community bed-base is key to effective intermediate care as it supports an individual's needs that cannot be met through home based intermediate care. By providing an enabling environment for further assessment, rehabilitation, completion of treatment and/or recuperation, it will prevent unnecessary admissions to hospital (through step up) or into long term care, and facilitate timely discharge to assess for those people not able to be assessed at home but do not require acute hospital based care. When home is not an option for the provision of care for an individual, the flexible community beds base will offer:

- Step down capacity for discharge to assess (including complex assessments);
- Step up capacity to avoid acute admission;
- Intermediate Care Capacity;
- Recuperation beds that offer an opportunity to re-stabilise prior to undertaking rehabilitation;
- Specialist assessment and rehabilitation for people with dementia.

The model will provide community beds for individuals with dementia who are at risk of being admitted to hospital or remaining in a hospital bed because they are awaiting assessments. At present there is no local provision to meet this requirement outside of the acute settings meaning that these individuals remain in hospital for longer than is necessary.

The Integrated Care Foundation Trust is the provider of all intermediate care beds for Tameside and Glossop as of 1 July 2017, and currently provides community beds from two locations: 64 beds in the Stamford Unit at Darnton House[4], which is a 3-floor 96 bedded purpose-built nursing home adjacent to the Tameside Hospital site (the Trust currently uses two floors, one for intermediate care and one for discharge to assess) and 36 intermediate care beds in Shire Hill Hospital located in Glossop.

6.8 **Acute Hospital Setting**: The Acute element of the Intermediate Care model forms part of the "Home First" service that responds the urgent/crisis health and/or social care need for patients. The Home First model is described in detail above, through the Integrated Urgent Care Team and the discharge to assess team, which ensures patients are supported through the most appropriate pathway with "home" always being the goal.

6.9 **Community Bed Model – the proposal:** All intermediate care models recognise the need for a bed-based offer. The National Audit of Intermediate Care 2014 showed that whilst locally we spend more than the national average on intermediate care, (beds and community based service) the balance is weighted toward beds with 79% more intermediate care beds than the national average. The Integrated Care Foundation Trust believes that the intermediate care model proposed in this paper redresses the balance to align more closely to the national average and restates the focus of intermediate care away from a purely bed based offer with the embedding of the 'home first' principles.

If Tameside and Glossop intermediate care beds were in line with the national average for our population we assessed that we would need 65 beds.

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[4] Tameside and Glossop Integrated Care NHS Foundation Trust registered from 1st July 2016 with the CQC the location of The Stamford Unit at Darnton House. This was to provide a community in-patient facility as part its intermediate care services. Services in the Stamford Unit at Darnton House are accessed via agreed Trust patient pathways and it operates as community wards for medically stable patients who are having their discharge planned and enabled. They form part of services provided by the Trust as a provider of commissioned Acute and Community services for the population of Tameside and Glossop within the Integrated Care Foundation Trust.

The Integrated Care Foundation Trust is the provider of all intermediate care beds for Tameside and Glossop as of 1 July 2017, and currently provides community beds from two locations: 64 beds in the Stamford Unit at Darnton House and 36 intermediate care beds in Shire Hill Hospital located in Glossop. Therefore a total of 100 community beds in the system, 68 of which are currently 'intermediate care' beds.

Alongside the ongoing development and delivery of the Integrated Neighbourhoods and intermediate tier services, and the implementation of the Home First model (which ensures delivery of robust intermediate care services in the home setting) this paper proposes that all the community beds should be located in a single location in order to utilise the resource flexibly to meet the needs of people in Tameside and Glossop, and fully deliver the service model for intermediate care beds. Offering these services from a single site provides the opportunity for a more holistic, flexible and skilled workforce. Staffing resource would be focussed on one site so able to work across and with a wide range of conditions, providing resilience and responsiveness.

6.10 **Options for delivery of bed based intermediate care:** In order to deliver the proposed model, a number of options have been considered. The Single Commission and Integrated Care Foundation Trust identified 3 options for the delivery of a flexible community bed base. All options should be considered alongside the ongoing development and delivery of the Home Frist model, Integrated Neighbourhoods, the Intermediate / Specialist Community Based Services, and acute hospital based elements of intermediate care.

Option 1: **Maintain current arrangements**
Delivery of bed based intermediate care from the Stamford Unit at Darnton House (32 beds) and Shire Hill in Glossop (36 beds).

The view of the Single Commission and Integrated Care Foundation Trust is that this is not a sustainable model going forwards. As described in the report, the economy is not functioning to its optimum: people are in acute beds that do not need to be, they are in these beds for longer than they need to be, and they are unable to access the services they require at the time they need them. The current arrangements are fragmented – beds are delivered across 2 sites – Shire Hill and the Stamford Unit at Darnton House. At present staff are working from a number of bases, with the expectation that community and neighbourhood staff travel across the locality, diluting the capacity and time that could be inputted with individuals to maximise the potential for returning home promptly. This option does not deliver the vision of a single location for bed based intermediate care.

Option 2: Use of available 96 bedded unit
Transfer of all bed-based intermediate care to a single location in the Stamford Unit at Darnton House. This is the preferred option from the assessment carried out by the Single Commission and Integrated Care Foundation Trust for the following reasons:

- Whilst the aim of the home first model is to use the community beds flexibly to meet the demand at any point in time, the notional intermediate care bed figure proposed is 64 beds.
- Patient Environment - The Stamford Unit is 100% en-suite single room accommodation with significant communal space on each of the three wards which has been demonstrated to encourage social interaction and independence. Additionally one floor of the Stamford Unit in the Darnton Building has been designed as dementia friendly with access to outside space and wandering routes, which will enable the Trust to provide community beds for patients with Dementia.
- Accessibility – the Stamford Unit is located in a central location and is co-located close to the Tameside Hospital site and therefore has strong public transport links, ample parking and is easily accessible for patients and relatives. Additionally easy access and short journey times for health care professionals and support services into Darnton Building will enable development of in-reach into the unit as proposed in the model.

- Recruitment and Retention – recruitment and retention of nursing and support staff at the Shire Hill hospital site is an ongoing risk due to the remote location at the edge of the conurbation and lack of public transport access.
- Single location – option 2 supports the delivery of bed based intermediate care from a single location to enable the flexible use of community beds to support the Home First model and enable the approaches to Discharge to Assess and Intermediate Care to be flexed depending on the demands in the system at any point in time.
- Tameside and Glossop Integrated Care NHS Foundation Trust registered from 1 July 2016 with the Care Quality Commission the location of The Stamford Unit at Darnton House.
- This option meets the national definition of 'intermediate care' from a combination of home and bed-based services and is in line with the recommendations of the Contingency Planning Team report from 2015 (referred to in section 4).

Option 3: Stimulation of the Local Market to Develop Single / Multi Site
Engagement with local providers to develop capacity within existing care homes, or the development of capacity in new homes is an option. Whilst the benefits of a larger scheme would not be realised, it is possible that in the longer term, once the Integrated Neighbourhoods and Home First models have fully embedded, that there could be a benefit to developing capacity at a neighbourhood level. The maturity of the wider economy may mean that fewer community beds are required, and that services could be developed at a neighbourhood level to meet need.

This option relies on their being the engagement from providers to invest locally in increasing capacity. Should this be available there would be a lead in time to any new building, which would again require a short term solution until additional bed capacity is developed. There are a number of providers who have indicated their interest in working on developments with the Single Commission so this is something that is possible to negotiate. While the current capacity has been estimated, it is difficult to commit at this time to the capacity that may be required in the economy in 2-3 years' time, which is the information a provider would need in order for providers to invest in new capacity.

6.11 **Proposal**: The proposal is that the Single Commission with the Integrated Care Foundation Trust enter into a formal consultation programme, based on the 3 options outlined above, stating the case for the current preferred option as **Option 2**.

7. FINANCIAL MODEL

7.1 The Care Together Project Management Office are supporting the locality's 'Savings Assurance' programme by ensuring a consistent approach is applied to all projects, using a gateway approach to scope and approve projects via the Finance Economy Workstream and Locality Executive Group.

7.2 **Financial Summary of Current Position:** The recurrent funding available for the provision of intermediate care inpatient services within Tameside and Glossop equated to c £8.7m per annum, with a total spend if we "did nothing" of £9.75m due to overspends on agency spend due to recruitment pressures. Spot beds were funded in 2016/17 non-recurrently, this equated to £0.75m.

7.3 **Financial Summary of Proposal – Flexible Community Beds:** The proposal requires funding for £8.26m for the provision of 96 flexible community beds at Darnton house. This delivers a saving on a recurrent basis of **£0.69m** against recurrent budget from 1 April 2018.

8. CONSULTATION

8.1 The proposals included in section 6 include the intention to bring together a community bed provision on a single site that can be flexed and responsive to meet clinical demands, whilst supporting the principles of 'home first'. This is a level of change to service delivery which requires a period of formal consultation.

8.2 The consultation offers local people the opportunity to comment on the proposals and options which have been developed and considered by the Single Commission and the Integrated Care Foundation Trust. The options for consultation, the details of which can be seen in section 6.11, are:

- **Option 1:** Maintain current status.
- **Option 2:** Use of available 96 bed facility and co-location of all intermediate and community beds as 'flexible bed base' model (Stamford Unit, Darnton House).
- **Option 3:** Stimulation of the market to develop a single / multi-location base.

8.3 The consultation is in the form of a standard questionnaire with an introduction to explain the reason for the changes followed by a series of questions. There are free format text boxes to allow people to provide any comments, views and suggestions they wish to be taken into account.

8.4 The consultation is available on the CCG website at:
http://www.tamesideandglossopccg.org/get-involved/intermediate-care-consultation

8.5 In order to encourage as many people as possible to express their views contact has been made with a range of organisations with a request to make their service users, groups and members aware. Due to the identification of an impact on certain Protected Characteristic Groups, this work will include some focused discussions with representatives from stakeholder groups representing over 65s, those with dementia, carers, and people with disabilities. The link to the on-line consultation along with a word document version for printing in paper format will be provided.

8.6 Staff in the Integrated Care Foundation Trust, Tameside MBC and Derbyshire CC will be made fully aware of the consultation and will be encouraged to complete the survey so that their perspective can be included in the evaluation.

8.7 A programme of consultation will commence on 23 August, and will run for 12 weeks until 15 November 2017.

9. ALIGNMENT WITH REVIEW OF ESTATES

9.1 The Single Commission and Integrated Care Foundation Trust are working together, via the Strategic Estates Group, on a review of the 'Neighbourhood Assets' to ensure alignment between any proposals arising from the intermediate care strategy and the plans for the estate in the locality.

10. QUALITY AND EQUALITY IMPACT ASSESSMENTS

10.1 Detailed Quality and Equality Impact Assessments have been undertaken to support the proposals included in this document, which will be used to support the consultation process. These can be seen in the Single Commissioning Board paper via the Clinical Commissioning Group website.

11. RECOMMENDATION

11.1 As set out on the front of the report

Appendix 1

Timetable for Intermediate Care Model Development & Consultation

	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17
Draft initial strategy										
Ongoing development of strategy & model										
Pre-consultation engagement										
Paper to PRG & SCB - draft strategy & plan										
Produce consultation documents/model										
Consultation and engagement										
Produce final proposal										
Final proposal to SCB										