Report to:	**STRATEGIC COMMISSIONING BOARD**
Date:	12 December 2017
Officer of Single Commissioning Board	Jessica Williams, Interim Director of Commissioning
Subject:	**INTERMEDIATE CARE IN TAMESIDE AND GLOSSOP**
Report Summary:	Tameside and Glossop Single Commission have led the development of a locality strategy for Intermediate Care. The Single Commission were asked to bring back a fully developed proposed model to the Strategic Commissioning Board (SCB) in December 2017. Due to the richness of evidence arising from the public consultation and in particular from the Glossop neighbourhood, this is an interim report to inform the Strategic Commissioning Board of the consultation progress and process, initial themes and the next steps to ensure a final report to the Strategic Commissioning Board January 2018 meeting.
Recommendations:	The Strategic Commissioning Board is advised to consider the attached report, which provides detail on the consultation process and the initial themes arising. The Strategic Commissioning Board is requested to note that the Equality Impact Assessment is a work in progress and will be developed further to ensure it responds to issues raised within the consultation and explores whether additional mitigations will be required. A further report will be received by the Strategic Commissioning Board in January 2018, to determine the way forward.

Financial Implications:

(Authorised by the statutory Section 151 Officer & Chief Finance Officer)

Budget Allocation (if Investment Decision)	Proposed recurrent budget of £8,032k, which represents a saving against current expenditure. £1,983k of non-recurrent transformation funding from GM Health and Social Care Partnership is available to fund transition to the new arrangements.
CCG or TMBC Budget Allocation	CCG
Integrated Commissioning Fund Section – S75, Aligned, In-Collaboration	S75
Decision Body – SCB, Executive Cabinet, CCG Governing Body	SCB
Value For Money Implications – e.g. Savings Deliverable, Expenditure	Option 2 would deliver £0.7m of recurrent savings compared to budget. Savings released in

Avoidance, Benchmark Comparisons	18/19 would be dependent upon timing of notice to Propco and service transfer dates.

Additional Comments

The finance group have reviewed this business case and support implementation of option 2 (as the option presented through the Clinical Commissioning Group consultation process as the preferred option).

£23.2m of transformation funding has been awarded by GM Health and Social Care Partnership to support transformation of health & social care in Tameside and Glossop. £2m of this non recurrent money has been earmarked for developing a new model for intermediate care and funding double running costs. Receipt of this money is dependent upon attainment of stretching quality and financial targets.

With recurrent savings against budget of £0.7m and savings versus the do nothing scenario of £1.7m, only option 2 will allow us to fully deliver these targets and contribute towards the overall economy gap.

It should be noted that while rental payments are factored into the savings above, the strategic commission in Tameside and Glossop has no control over what happens to the property once notice has been served. Shire Hill is owned by NHS Property Services, a limited company owned by the Department of Health who will determine the future of the site and would take the benefit of any future capital receipt.

Legal Implications: **(Authorised by the Borough Solicitor)**	An open and transparent consultation process has been undertaken 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. The level of engagement means that it is appropriate that sufficient time is taken to consider all responses appropriately and any necessary changes/mitigations as a response.
How do proposals align with Health & Wellbeing Strategy?	The proposals align with the living and ageing well elements of the Health and Wellbeing Strategy.
How do proposals align with Locality Plan?	Intermediate care has been identified as a key project for the locality as a component of the Care Together model of integrated care.
How do proposals align with the Commissioning Strategy?	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
Recommendations / views of the Professional Reference Group:	The Professional Reference Group supported the model outlined in the paper presented in August 2017 and the recommendation to consult on the 3 options for intermediate care in Tameside and Glossop, with option 2 as the preferred option for the Single Commission and Integrated Care Foundation Trust.

Public and Patient Implications:	This report includes the outcome of a 12 week period of public consultation and engagement with communities in Tameside & Glossop. The report includes a full Equality Impact Assessment.
Quality Implications:	A Quality Impact Assessment is in development and will be completed for presentation to the January 2018 meeting of the Strategic Commissioning Board.
How do the proposals help to reduce health inequalities?	The proposal will ensure the delivery of intermediate care services which to meet individuals' needs across the locality and addresses health inequalities.
What are the Equality and Diversity implications?	A full Equality Impact Assessment (EIA) will be finalised and will be presented as an appendix to the report to the Strategic Commissioning Board in January 2018. The Strategic Commissioning Board is requested to note that the EIA is a work in progress and will be developed further to ensure it responds to issues raised within the consultation and explores whether additional mitigations will be required.
What are the safeguarding implications?	The commissioned model will include all required elements of safeguarding legislation, as the provider will be Tameside & Glossop Integrated Care NHS Foundation Trust. The GM Safeguarding Standards are included in the Integrated Care Foundation Trust contract.
What are the Information Governance implications? Has a privacy impact assessment been conducted?	As part of the implementation of this model of care, a data flow mapping exercise will be undertaken to understand what information will be transferred and to where; from that it will be possible to identify the requirements for robust data sharing agreements and protocols between the parties sending or receiving the data. Beyond that the commissioner will seek assurance from all parties involved in the delivery of intermediate care that appropriate arrangements are in place. The locality's Information Governance Working Group will be used as a forum to sense check the data flows and Information Governance requirements relating to this project.
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 :	**Appendix 1** – Pre consultation engagement information sheet. **Appendix 2** – Consultation questionnaire. **Appendix 3** – Intermediate Care Fact Sheet, Frequently Asked Questions and supporting consultation information. **Appendix 4** – Community engagement contacts. The background papers relating to this report can be inspected by contacting Alison Lewin, Deputy Director of Commissioning: Telephone: 07979 713019 e-mail: alison.lewin@nhs.net

1 INTRODUCTION

1.1 Tameside & Glossop Single Commission have led the development of a locality strategy for Intermediate Care. The Single Commission were asked to bring back a fully developed proposed model to the Strategic Commissioning Board (SCB) in December 2017.

1.2 In August 2017 the Strategic Commissioning Board agreed to consult on 3 options for the delivery of bed based Intermediate Care. Two of the options, one of which was proposed as the preferred option, involved the relocation of intermediate care beds from the Shire Hill site. The 3 options have been the subject of public consultation over a 12 week period from 23 August to 15 November 2017. In addition to the public consultation, additional community engagement has taken place through contacting specific groups across Tameside & Glossop.

1.3 Due to the richness of evidence arising from the public consultation and in particular from the Glossop neighbourhood, this is an interim report to inform the Strategic Commissioning Board of the consultation progress and process, initial themes and the next steps to ensure a final paper to the Strategic Commissioning Board January 2018 meeting.

2 BACKGROUND AND THE INTERMEDIATE CARE OFFER

2.1 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 has been used in communication, engagement and consultation work referred to in this report.[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.

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.

2.2 **Proposed Model of Intermediate Care in Tameside & Glossop:** The proposals for Intermediate Care 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:

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

2.3 **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.

2.4 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.

2.5 **Community Bed Setting - Overview:** The health and social care economy has commissioned community based beds from a range of sources from across the locality. 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 who 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.

2.6 **Current Provision:** Tameside and Glossop 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[2], 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.

2.7 **Options for the delivery of bed based intermediate care:** The Single Commission and Integrated Care Foundation Trust identified 3 options for the delivery of Intermediate Care beds. All options were considered alongside the ongoing development and delivery of the Care Together model of care, in particular the Home First model, Integrated Neighbourhoods, the Intermediate / Specialist Community Based Services, and acute hospital based elements of intermediate care.

2.8 On 22 August 2017 the Tameside and Glossop Single Commissioning Board agreed to consult on 3 options for the delivery of Intermediate Care beds, for a period of 12 weeks, commencing 23 August and ending on 15 November 2017. The full set of papers presented to the Single Commissioning Board on 22 August is available on the Clinical Commissioning Group website http://www.tamesideandglossopccg.org/corporate/strategic-commissioning-board. A summary of the options is outlined below.

2.9 **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).

2.10 **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.

2.11 **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. 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.

2.12 **Preferred option:** The Single Commissioning Board approved the proposal that the Single Commission with the Integrated Care Foundation Trust enter into formal consultation based on the 3 options outlined above, stating the case for the preferred option as option 2. The

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[2] 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.

information presented to the Single Commissioning Board on 22 August to support the decision is outlined in the table below.

Option 1	The view of the Single Commission and Integrated Care Foundation Trust is that this is not a sustainable model going forwards. 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	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 accessible for patients and relatives. Additionally, 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 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. 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. 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.
Option 3	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.

3 CASE FOR CHANGE

3.1 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 paper and the consultation approved by the Single Commissioning Board on 22 August. This section outlines the case for change presented to the Single Commissioning Board to inform their decision.

3.2 **Intermediate Care – Halfway Home:** The Department of Health's 2009 intermediate care guidance, *Halfway Home*[3] 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 *Halfway Home* guidance clearly set intermediate care as an integrated part of a continuum or pathway of services, linking:

- health promotion;
- housing;
- low level support services in the community;
- early intervention and preventative services;
- social care;
- primary care;
- community health services;
- support for carers;
- acute hospital care.

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

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

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3 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

- 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, informed in part by this review, which are included in the current model of intermediate care. The National Audit of Intermediate Care is taking place in 2017. The Single Commission and Integrated Care Foundation Trust have participated in the audit to support the ongoing review of the locality's intermediate care system. The Greater Manchester Health and Social Care Partnership has supported the National Audit of Intermediate Care 2017, and have stated a requirement that all 10 localities in Greater Manchester participate.

3.4 **Tameside & Glossop NHS Foundation Trust Contingency Planning Team (CPT) Final Report September 2015[4]:** Price Waterhouse Cooper were appointed by Monitor (the body established to authorise, monitor and regulate NHS Foundation Trusts) to carry out a review of the Tameside and Glossop locality. A report was produced 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 Integrated Urgent Care Team 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.

3.5 **Tameside & Glossop Care Together Programme Model of Care:** The Tameside & Glossop Care Together model of care has been developed in response to the Contingency Planning Team report outlined in the section above. The analysis carried out by the Contingency Planning Team, and other reports detailed in this paper, suggest that the current community bed base offer within the intermediate care service is not fit for purpose. The current service does not provide an adequate step up facility and does not offer any capacity for people with dementia or delirium following an acute episode. People remain in an acute bed for significantly longer than necessary, with poorer outcomes. It is expected that the remodelled service will offer improved quality for individuals, resulting in better outcomes and increased chances of returning home. The model described in this report would form a key element of the 'Home First' offer. A priority of the Care Together programme is to support people at home, whenever possible and safe to do so, or in a community bed where home is not appropriate, to avoid unnecessary hospital attendances, admissions and to ensure safe and prompt discharges. Where an admission has been appropriate, a prompt and safe discharge may require a short placement in a community bed for rehabilitation, reablement, recuperation or to facilitate discharge to assess.

3.6 **'Step-Up' facilities:** The level of demand for step beds to avoid admissions is not fully understood, as the decision to admit is usually related to a clinical need, but an alternative option may significantly reduce such admissions. Reviews undertaken in the past by the Emergency Care Intensive Support Team (ECIST) and the Greater Manchester Utilisation

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

Management unit[5] have highlighted an issue with people being in an acute bed when a step up to a nursing bed may have been more suitable and enabled a more accurate assessment of on-going need.

3.7 For people with dementia or delirium, time for recuperation and assessment out of hospital will lead to not only better outcomes but a reduction in length of stay in hospital and reduced risk of premature admission to long term care. Undertaking assessment of people with dementia within an acute hospital setting often leads to inaccurate assumptions being made about their safety to return home, resulting in extended length of stay and increased risk of a permanent residential admission. Intermediate care beds which are staffed to support people with dementia, operating as part of the community bed offer described in this report will enable the assessment and subsequent rehabilitation to be undertaken in a more appropriate location.

3.8 A point prevalence exercise conducted by the Utilisation Management unit in November 2012 at Tameside Hospital (then Tameside Hospital NHS Foundation Trust) showed that 43 out of 272 could have been supported in a community bed-based facility and of these five only had a social need with a further eight having a social and therapy need. Thirteen people needed a level of mental health support with or without other therapeutic and nursing needs. The remaining seventeen required a level of health support.

3.9 The utilisation benchmarking analysis of acute and community beds undertaken in December 2015 identified from a cohort of 133 at Tameside that 68 individuals' needs could be better managed in an alternative care setting. Of these 6 could have been in the current community bed-base facility and a further 30 could have been supported in a more flexible bed-base, 19 with mental health support, 4 with nursing support, 4 with social support and two with stroke rehabilitation support.

3.10 The development of intermediate care services with the appropriate level of home and bed based care supports one of the key priorities identified as part of the Care Together programme – frailty – by reducing length of stay for some of the most vulnerable people and by offering an integrated, wrap around support package. We know that 20% of admissions of older people into hospital are inappropriate (National Audit of Intermediate Care 2015) and that 10 days spent in hospital leads to the equivalent of an additional 10 years ageing in the muscles of people aged over 80 (Giles et al 2004) so it is important that people are supported in a service that offers a therapeutic and reabling environment.

3.11 Current Management of the Urgent Care system: the locality operates a process whereby patient flow and delivery of key access requirements across the urgent care system are routinely monitored. One area which is included within this is the use of the intermediate care system. The current offer is used almost exclusively as step down resource, with little access to the beds for step up support, creating increased pressure on the economy when trying to support people in crisis in the community. This often results in unnecessary hospital admissions that result in significant pressure and cost to the wider economy, and reduces the long term prognosis, particularly for older people. There are also times when although the system is under pressure, there are vacancies in the intermediate care beds, as bed based intermediate care is not what is required for the patients in the system.

4 STRATEGY DEVELOPMENT AND ENGAGEMENT

4.1 The commissioner Intermediate Care strategy outlines 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 outlines the expectations from the Single Commission for the delivery of intermediate care at home

[5] Greater Manchester Utilisation Management Unit: Clinically led analytics service https://www.gmahsn.org/utilisation-management

wherever possible, therefore requiring a clear model of community based care and an appropriate level of bed based intermediate care.

4.2 The Single Commission have 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.

4.3 A number of engagement activities took place during 2014-2016, through which 602 local people were involved in Care Together and the specific work streams. Action Together, Glossop Volunteer Centre and High Peak Community Voluntary Service used a range of asset based techniques and engaged with a range of other voluntary, community and faith organisations. The methodology used included:

- Focus groups to reach a number service users with who have protected characteristics. 32 sessions where undertaken (15 in Tameside, 18 in Glossop). 330 people were involved.
- Large events which focused on developing a shared understanding of the concepts of Care Together and the development of solutions and aspirations for delivery. There were specific group events (such as the faith sector) and then Neighbourhood based events. Over 100 key community connectors where involved in the neighbourhood based events.
- 1:1 interviews with service users who had experience of the Home First and Discharge to Access Services. In addition, 8 members of staff were also interviewed.

Intermediate care crosses several of the work streams. Key messages from these engagement activities which relate to intermediate care and are addressed by the model described in this paper are:

- We experience health and social care that is disjointed and delivered in silos, and we would welcome more joined up services.
- People strongly support the work being done to co-ordinate and join up services and the importance of multi-agency working […] people want to be treated as individuals not in a one size fits all approach or just by their condition and continuity of care also matters.
- Transport and travel to and from services, including voluntary sector support, is one of the biggest issues and influences how people experience and use services. Community based support is seen as a positive solution to address this.

Comments received which were specific to inpatient (bed-based) intermediate care include:

- Surrounding patients by what they have at home so they are confident to return home i.e. home equipment used not industrial.
- Socialising is an important aspect to recovery. The main socialising happens in the dining room, they help each other. They have a purpose to get up and go to it therefore gets people moving and getting stronger walking, therefore become more independent to go home and stay there.
- Social rehab – helps with stand and transfer (people being stronger on their feet) making cups of teas, talking to people.
- People are able to socialise and make new friends – particularly around shared dining.
- There was a strong feeling that having a similar, medically led, set-up in the community would prevent A&E attendance, and provide a bridge between hospital and home.
- Staff understanding and being aware of individual's needs (not treating everyone the same, with the same routine) especially with rehabilitation.

- A co-ordinated approach to the care – caring together.
- Facilities that are homely to help build confidence that they can cope at home.

4.4 Events were held in May 2014, under the Care Together banner, which were attended by 66 members of staff from across health, social care, independent sector and the 3rd sector. All staff were either providers of intermediate care services, or worked in services forming part of the pathways using the intermediate care services. The objective of the events was to engage staff in sessions which were intended to:

- Achieve a shared understanding of the current pathway for patients requiring the support of intermediate care and associated admission avoidance schemes.
- Identify and prioritise the key issues to be addressed within the project scope regarding the review of intermediate care services and admission avoidance schemes.

In the sessions staff identified a range of issues relating to the delivery of care, including:

- Gap in the system with no 'step up' pathway into intermediate care which means patients are admitted to hospital, and community teams can't refer to the inpatient intermediate care units.
- Patients stay in hospital whilst they are assessed.
- Lack of consistency across the intermediate care units.

The pathway which was produced in the first of these sessions illustrated a system with multiple points of entry and 'hand offs'. The output from these sessions was a business case which illustrated a model of integrated admission avoidance and intermediate care which has informed the current delivery of services described in this report, and which continues to inform the ongoing development of intermediate care services.

4.5 The Commissioning Directorate of the Single Commission have undertaken pre-consultation engagement conversations across the locality with the public and staff. The purpose of these sessions was to understand the views of staff and the public on the current system of intermediate care, and the proposed strategic direction and outcomes we expect to see from the model of intermediate care commissioned. Engagement has taken place with staff, the Patient Neighbourhood Groups, and with a range of stakeholders in the community via Glossop Volunteer Centre and Action Together. Attached at **Appendix 1** is the information which was shared with the groups to inform the discussions.

4.6 The session with staff currently working in the intermediate care system in June 2017 identified the following issues:

- Intermediate care services need to operate in a way which is 'goal driven' and with a clear end point.
- Patients with palliative care needs should not be excluded.
- Intermediate care needs to focus on the physical needs of the individual but also taken into consideration and be able to support the wider emotional needs, including people with mental health needs.
- The environment in which intermediate care is delivered needs to be conducive to interaction with the individual and provide this physical space to enable this.
- The 'step up' offer and admission avoidance element of intermediate care needs to be expanded, with the appropriate level of medical support.

4.7 The 5 Patient Neighbourhood Groups were engaged in the pre-consultation engagement. The general response to the proposed model and outcomes was positive and supportive. Comments received from the groups include:

- Services which patients could have in their own homes either in an attempt to keep them out of hospital, or return home quicker, should be publicised more in; order to make patients and their families/carers aware of these, and how to access them.
- The proposed model of intermediate care covers all elements required - we particularly discussed the use of 'step up' beds and those present felt that GPs should be able to use more step up beds rather than admitting to secondary care.
- Welcome the inclusion of dementia patients within the new model.
- Request that the commissioner considers the position of users of intermediate care in relation to support available at home – consider information to show whether users of services live alone and whether this is taken into consideration when determining an appropriate care plan.

4.8 At the request of the Single Commission, Action Together arranged 7 sessions to discuss the intermediate care proposals. Comments included the need to support people to be independent, but also safe; the model covers the very practical elements of supporting people to live independently but there needs to be a focus on emotional wellbeing, mental health, dementia, as issues that may have an adverse effect on people living independently; the need for a system which doesn't allow people to 'slip through the net'.

4.9 Glossop Volunteer Centre held 9 sessions with a range of stakeholders from the Glossop Neighbourhood to present the intermediate care strategy and proposed outcomes. The response to the proposed offer of intermediate care in people's homes was positive, with assurance requested regarding the need for good communication with patients, practical support, and ongoing monitoring to ensure people are safe. The need for 'bed based' care was acknowledged and supported, but with a preference expressed by a significant proportion of those involved for home based care where possible. The proposed aims and outcomes for intermediate care in Tameside and Glossop were supported unanimously, with the proposed addition of an outcome or aim relating to 'person centred care' and the need to acknowledge support for people once the period of intermediate care has been completed.

5 CONSULTATION PROCESS

Pre-Consultation Engagement

5.1 The report presented to the Single Commissioning Board on 22 August included details of pre-consultation engagement activities, now summarised in section 4 of this report.

Consultation Process

5.2 The Single Commissioning Board approved the proposal that the Intermediate Care service model proposals included options which could lead to a significant change in service delivery and therefore should be subject to a period of formal consultation. This consultation needed to offer local people the opportunity to comment on the proposals and options developed and considered by the Single Commissioning Board and Integrated Care Foundation Trust. The consultation was on the following 3 options:

- **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.

5.3 The consultation ran from 23 August 2017 to 15 November 2017.

5.4 The online consultation closed on Wednesday 15 November. Paper copies of the questionnaire were accepted until 5pm on Friday 17 November 2017.

5.5 The consultation was hosted on the CCG website in the form of a standard questionnaire (http://www.tamesideandglossopccg.org/get-involved/intermediate-care-consultation) with an

introduction to explain the reason for the changes followed by a series of questions. A free format text box was included to allow people the opportunity to provide any comments, views and suggestions they wish to be taken into account. A copy of the questionnaire used is attached at **Appendix 2.**

5.6 In addition to the online consultation, paper copies were made available in all 39 GP surgeries across Tameside & Glossop and made available at all public meetings and meetings with community groups. Paper copies were provided to Tameside and Glossop Integrated Care NHS Foundation Trust for sharing with service users. Copies were also made available in all libraries in Tameside and the High Peak area (Glossop, Hadfield and Gamesley). Pre-paid envelopes were also provided for responses to be returned. Each questionnaire returned was given a 'unique reference number' and inputted to the online consultation system, with the reference number included in the response.

5.7 Posters advertising the consultation were produced and distributed across the locality, including to all GP surgeries. Copies of the posters are included at **Appendix 3.**

5.8 A 'Fact Sheet' was developed by the Single Commission and the Integrated Care Foundation Trust which was posted on the Clinical Commissioning Group website consultation page. This sheet was updated throughout the consultation process to reflect questions raised through the public meetings and other community engagement processes undertaken. This Fact Sheet is included at **Appendix 3**.

5.9 A 'Frequently Asked Questions' section of the consultation page on the CCG website was in place from the start of the consultation process, and was expanded throughout the 12 weeks' consultation to include questions raised through the meetings undertaken during the 12 weeks. A copy of the FAQ is attached at **Appendix 3**.

5.10 Four public meetings were held during the period of the consultation. Two were held in the Glossop neighbourhood, one in Droylsden (Tameside) and one in Ashton (Tameside). A report on each of the public meetings can be seen in section 6 of this report. All 4 meetings were filmed and the full recording of the meetings posted on the Clinical Commissioning Group consultation website The recorded attendance figures for each meeting can be seen below:

Meeting Date and Location	Number of Attendees
21st September 2017, Bradbury House, Glossop	92
11th October, Age UK, Ashton-under-Lyne	12
17th October, Guardsman Tony Downes House Droylsden	4
1st November, Glossopdale Community College, Glossop	205

Planning, assuring and delivering service change for patients

5.11 In October 2015 NHS England published an update to the good practice guide for commissioners on the NHS England assurance process for major service change and reconfiguration. The guidance states that 'NHS England's role in reconfiguration is to support commissioners and their local partners to develop clear, evidence based proposals for service reconfiguration, and to undertake assurance as mandated by the Government.[6]

5.12 The guidance includes four tests of service reconfiguration, with an expectation that the proposal satisfies the four tests. The four tests are:

- Strong public and patient engagement
- Consistency with current and prospective need for patient choice
- Clear, clinical evidence base
- Support for proposals from commissioners

[6] https://www.england.nhs.uk/wp-content/uploads/2015/10/plan-ass-deliv-serv-chge.pdf

5.13 There are also four key themes outlined in the guidance for service reconfiguration. These are:

- **Preparation and planning**: planned and managed approach from the start which establishes clear roles, a shared approach between organisations, and builds alignment on the case for change
- **Evidence**: ensure proposals are underpinned by clear clinical evidence and align with clinical guidance and best practice
- **Leadership and clinical involvement**: Clinicians should determine and drive the case for change
- **Involvement of patients and the public**: Critical that patients and the public are involved throughout the development, planning and decision making

5.14 The NHS guidance has been taken into consideration when establishing and running the consultation process described in this paper.

Promotion and Communications

5.15 The Intermediate Care consultation has been promoted extensively since 23 August 2017. In addition to the page on the Clinical Commissioning Group website (http://www.tamesideandglossopccg.org/get-involved/intermediate-care-consultation) the consultation has been shared and promoted in a number of ways, as summarised in the table below.

A webpage hosting the consultation on NHS Tameside and Glossop Clinical Commissioning Group website which includes a copy of the full report presented at Single Commissioning Board, a booklet outlining key information relating to the proposed options, a key factsheet, frequently asked questions and a link to the consultation itself
An email announcing the launch of the consultation was sent on 23 August 2017 to all MPs, Elected Members for both Tameside and High Peak (Glossop), GPs across Tameside & Glossop, Patient Neighbourhood Groups, Patient Participation Groups, Voluntary, Community & Faith Sector umbrella organisations (e.g. Action Together, The Bureau, High Peak CVS, Healthwatch Tameside and Healthwatch Derbyshire) and to over 90 community groups across Tameside & Glossop
Posters have been provided to all GP surgeries across Tameside & Glossop promoting the consultation
Proactive social media messaging on the social media pages of NHS Tameside & Glossop CCG, Tameside Council and T&G ICFT (Twitter, Facebook or Instagram).
Proactive social media messaging specifically advertising the 4 public meetings
A press release from the CCG – this was also included on the Tameside Council and Care Together websites http://www.tamesideandglossopccg.org/news/intermediate-care-review
A link included on Tameside Council's Big Conversation webpage
A link included on Tameside Council's Big Conversation online community which has 249 members
Item in the Chief Executive's Brief for all TMBC and CCG staff, which also includes pension fund and Elected members, all GPs, Practice Nurses and Practice Managers, CCG Board, ECG Board and Mark Tweedie
Item in NHS T&G CCG monthly update which is distributed to GPs, practice managers, practice nurses and all Single Commissioning Function staff
Paper copies of the survey have also been provided to all GP practices across Tameside & Glossop; Tameside & Glossop Integrated Care NHS Foundation Trust to enable consultation with patients at both Shire Hill and those on the Tameside Hospital site who may want to provide their views via a paper survey; all libraries in Tameside and the High

Peak area (Glossop, Hadfield and Gamesley). Paper copies have also been provided to voluntary and community sector organisations upon request; specifically Healthwatch Tameside and The Bureau (Glossop) to date.
Statement from Alan Dow, Chair NHS CCG, sent to the Glossop Chronicle to address concerns from residents who had contacted the paper. 30 August.
Half page feature from Karen James and Steven Pleasant on Intermediate Care and encouraging to take part in the consultation. Tameside Reporter 31 August.
Included on the Information Ambassadors E-Newsletter on 1 September.
Alan Dow, Chair of NHS Tameside & Glossop CCG, provided a radio interview on 7 September to High Peak Radio. This was broadcast at 10:30 and 15:30 on 8 September.
A letter from Alan Dow, Chair NHS CCG, regarding the consultation included in The Reporter (14 September)
Half page advertisements promoting the consultation included in The Tameside Reporter and Glossop Chronicle on 14 September
Further item on Intermediate Care in Chief Executive's Brief on 15 September.
Paper copies of the consultation were available at Tameside & Glossop Integrated Care NHS Foundation Trust's Open Day on Sunday 17 September
Email sent to All GPs encouraging them to place the link to the consultation on their websites and social media pages where they have them.
Social media assets/messages emailed to internal and external comms contacts for use on their channels
Information and the link to the consultation included in Tameside Council's monthly E-News email newsletter for September.
Half page advertisements promoting the public events published in the Tameside Reporter and Glossop Chronicle.
Public meetings have taken place in Glossop on Thursday 21 September, Ashton on Wednesday 11 October, Droylsden on Tuesday 17 October, Glossop on 1st November.
The Glossop Chronicle and Tameside Reporter were invited on a tour of the Intermediate Care facilities on Thursday 21 September.

5.16 In addition to the information included in the section above, and sharing of the information from the Clinical Commissioning Group/Tameside MBC social media accounts by partner organisations and local stakeholders, the consultation received media coverage from:

- ITV Granada Reports
- BBC North West News
- Tameside Reporter and Glossop Chronicle
- Tameside Reporter online – 29 August 2017[7]
- Glossop Chronicle online – 16 September 2017[8]
- Glossop chronicle online – 28 September 2017[9]

Response Rates

5.17 In total, 1,358 responses were received to the online questionnaire hosted on the CCG website.

[7] https://tamesidereporter.com/2017/08/tameside-and-glossop-intermediate-care-consultation-launched/

[8] https://glossopchronicle.com/2017/09/public-meeting-over-shire-hill-hospital-announced/

[9] https://glossopchronicle.com/2017/09/shire-hill-hospital-is-a-godsend/

5.18 Over 1,750 paper questionnaires were issued and **153** returned to the CCG using the pre-paid envelopes provided. These **153** returned paper responses are included in the total number of responses quoted above.

5.19 A full and detailed analysis of the responses to the questionnaire is currently being undertaken and will be produced for the January SCB report.

5.20 Once the full analysis has been undertaken we will be ensuring there is an external validation of the consultation process and analysis.

6 COMMUNITY AND WIDER FEEDBACK

Community and Patient Engagement

6.1 In addition to the consultation hosted on the Clinical Commissioning Group website, and the public meetings, 105 community and patient groups were contacted by the Clinical Commissioning Group directly by letter or email to inform them of the consultation and invite them to be involved. A full list of the groups contacted to inform them of the consultation, and inviting them to participate, is attached at **Appendix 4.**

6.2 On 23 August emails were sent to the community groups identified in **Appendix 4** to confirm the launch of the consultation and invite their involvement. The same email message was sent to a number of stakeholders across Tameside and Glossop, representing statutory and 3rd sector organisations and patient groups.

6.3 Throughout the consultation the Clinical Commissioning Group (through the Care Together Programme Management Office) has maintained a log of all engagement activities undertaken, and all contact with community and patient groups / individuals.

6.4 Action Together and The Bureau (Glossop's Voluntary and Community Network) provided support to the Clinical Commissioning Group in this consultation programme by ensuring that the web link for the consultation documents and online form for residents to have their say was publicised on their websites and social media pages, and that the Clinical Commissioning Group had information on local groups to optimise the community engagement.

6.5 The consultation was presented to a number of Local Authority fora and meetings, as listed in the table below, across the Tameside (Tameside Metropolitan Borough Council) and Glossop (Derbyshire County Council) neighbourhoods.

Executive Board - Tameside Council	14 September 2017	Dukinfield Town Hall
Executive Board - Tameside Council	18th October 2017	Dukinfield Town Hall
Tameside Integrated Care and Wellbeing Scrutiny Panel	14 September 2017	Dukinfield Town Hall
Scrutiny - Derbyshire - Health	18 September 2017	County Hall Matlock
Health and Wellbeing Board – Tameside	21 September 2017	Dukinfield Town Hall
Health and Wellbeing Board – Derbyshire	30 August 2017	Committee Room 1, County Hall, Matlock
Health and Wellbeing Board – Derbyshire	5 October 2017	Committee Room 1, County Hall, Matlock
Community Select Committee (High Peak)	4 October 2017	Café Area, Pavilion Gardens, Buxton.

Dukinfield Town Council	7 September 2017	Lesser Hall 2 - Dukinfield Town Hall
Audenshaw Town Council	12 September 2017	Ryecroft Hall, Audenshaw
Mossley Town Council	20 September 2017	George Lawton Hall, Mossley
Droylsden Town Council	14 September 2017	Guardsman Tony Downes House, Droylsden
Longdendale Town Council	19 September 2017	Hattersley Hub, Hattersley
Stalybridge Town Council	20 September 2017	Stalybridge Civic Hall,
Ashton Town Council	26 September 2017	Tameside Age UK Ashton-under-Lyne,
Denton Town Council	5 October 2017	Denton Town Hall, Denton
High Peak and Derbyshire Councillor Briefing	25 September 2017	Municipal Buildings, Glossop
Joint Trade Union Meeting	13 September 2017	Silver Springs ICFT
Briefing with the Leader of High Peak Borough Council	14 September 2017	Committee Room in the Municipal Buildings, Glossop.

6.6 The consultation was presented to formal meetings of a range of stakeholders, as outlined in the table below:

NHS Tameside and Glossop Clinical Commissioning Group Part A Governing Body meeting	27 September 2017	Dukinfield Town Hall
ICFT Board of Directors Meeting	28 September 2017	Silver Springs, ICFT
GP TARGET session (CCG General Practice engagement and education)	21 September 2017	Curzon Ashton Football, Ashton Under Lyne
Tameside & Glossop GP Practice Managers	19 September 2017	Stamford Park Pavillion
Tameside & Glossop Practice Nurse Forum	4 September 2017	Ashton Primary Care Centre
Ashton Neighbourhood meeting	6 September 2017	Ashton Primary Care Centre.
Glossop Neighbourhood meeting	31 August 2017	Lambgates Health Centre
Hyde Neighbourhood meeting	1 September 2017	Thornley House Hyde
Stalybridge/Mossley Neighbourhood meeting	12 September 2017	Millbrook Practice
Denton Neighbourhood meeting	5 September 2017	Churchgate Surgery

6.7 The consultation was presented to meetings of a number of community and patient groups who responded to the initial invitation to engage, and the offer for Clinical Commissioning Group representatives to attend their meetings. This information is summarised in the table below.

Joint meeting with The Bureau, Healthwatch Derbyshire and High Peak CVS.	7 September 2017	The Bureau, Glossop,
Patient Neighbourhood Group-Glossop	12 September 2017	Lambgates Medical Practice, Wesley Street, Hadfield, SK13 1DJ
Patient Neighbourhood Group – Hyde	13 September 2017	Brooke Surgery Hyde
Patient Neighbourhood Group - Ashton	15 September 2017	Ashton Primary Care Centre
Patient Neighbourhood Group - Dukinfield/ Stalybridge/Mossley	27 September 2017	Millbrook Medical Centre
Glossop Action for Local Older People (GALOP)	3 October 2017	Bradbury House, Glossop
St Mary's Friendship Group In Hyde	24 October 2017	St Mary's Church Hall, Hyde
Age UK Tameside	9 November 2017	Age UK Tameside, Ashton Under Lyne

6.8 A summary of the issues raised in the meetings referred to above is included here. A number of groups and organisations have submitted comments and shared views on the proposals as follows:

- Transport concern over travel time and lack of public transport for those without a car.
- Cost of Public Transport to see loved ones.
- Carer's travel of carers using Intermediate Care.
- Staff and how this affects them.
- Concerns about standard of care in The Stamford Unit.
- Glossop has different needs to Tameside, and should have a different offer.
- Lack of validity of consultation process and consultation literature.
- Ownership of Shire Hill and what will happen to the land should Shire Hill close.
- Glossop is losing another asset.
- Concern of standards of private care homes and the cost.

Positive comments:

- Expressions of understanding of the reasons for the preferred option.

- Support for idea that the intermediate care offer for people in Tameside and Glossop would be clear and would be set out in the discussions regarding people's discharge from hospital care.
- Positive report for care received in the Stamford Unit and for location and facilities.

Tameside & Glossop Integrated Care NHS Foundation Trust

6.9 Tameside and Glossop Integrated Care Foundation Trust were a partner in the consultation process; attending and presenting at all public meetings, providing response to questions received during the consultation process, and providing information to include in the consultation materials hosted on the Clinical Commissioning Group website.

6.10 The Integrated Care Foundation Trust Medical Director, Mr Brendan Ryan, has confirmed his clinical support for the preferred option – Option 2.

Customercare Enquiries

6.11 All enquiries for the Clinical Commissioning Group and Tameside Metropolitan Borough Council, in the form of Freedom of Information requests (FOIs), complaints, MP enquiries / correspondence and general comments, are received and dealt with by the Executive Support team in the Governance, Resources and Pensions directorate.

6.12 During the period of the consultation, the Clinical Commissioning Group have received Freedom of Information Requests (FOIs), complaints and MP enquiries relating to the consultation and intermediate care. All have been acknowledged, and where required, answers provided. Details of these can be seen below.

Enquiry Type & Date	Summary of request	Summary of response
FOI	Request for confirmation of the cost to the commissioner of developing the proposals presented to the Single Commissioning Board on 22 August 2017	A number of officers of the CCG and Local Authority, working with colleagues across Tameside & Glossop (including our clinical leaders) have developed proposals for the model of intermediate care. The paper presented to the Single Commissioning Board on 22nd August was the culmination of a programme of work spanning a number of years, as summarised in section 5 of the document. This work was to support the development of the Care Together model of care. It is not possible to specify exactly how much time and therefore proportion of a number of individuals' salaries has been used in developing this proposal, as this is not the only area of work for officers and managers
MP	Request for further information on the expansion of community services in the Glossop neighbourhood	Response provided with details of plans for the Glossop Integrated Neighbourhood and contact details for the ICFT's Operational Manager leading this work
Complaint	Request for paper copies of the questionnaire	50 copies sent to the complainant as requested
Query / Concern	Views expressed regarding the intermediate care proposals	Response requested submission of the views expressed via the formal consultation process, to ensure views included

Query / Concern	Query regarding potential technical issues with the online consultation	Link checked, and response to confirm there were no technical issues, but to ask for further contact if the issue continued and further support or paper copies required

6.13 During the consultation, the Clinical Commissioning Group received comments from a number of community and patient representatives / members of the public. This contact was made outside the meetings referred to above, and the public meetings. A record was kept of all contact made and the responses provided. In total 60 items of correspondence were received from 45 people. A summary of the issues raised is included in the table below.

Comments	**Response**
Requests were made for public meetings to take place in the Glossop area for residents to meet with senior staff involved in this consultation to gain a greater understanding of the consultation options.	Four Public Meetings were held in both Tameside and Glossop and were held on: 21st September 2017, Bradbury House, Glossop 11th October, Age UK, Ashton-under-Lyne 17th October, Guardsman Tony Downes House Droylsden 1st November, Glossopdale Community College, Glossop
Concerns regarding travel times from Glossop to the Stamford Unit.	Basemap TRACC software has been used to calculate travel times to both Shire Hill and Stamford Unit on the site of Tameside Hospital (Tameside and Glossop Integrated Care NHS Foundation Trust) at both peak and off peak time periods. The software covers all major public transport options including bus, train and tram. TRACC was also used to calculate drive times at both peak and off peak time periods, and walk times. A full assessment of public transport and drive time accessibility has been undertaken as part of our Equality Impact Assessment.
Requests were made for more paper copies of the consultation document to be sent to some GP surgeries in Tameside and Glossop to replenish the copies that were originally sent to every GP surgery in Tameside and Glossop.	All GP surgeries in Glossop received a phone call to check for adequate copies of the paper consultation document. Those needing additional copies were then sent some via the post.
Additional information was requested regarding Home Care Services.	Information was distributed regarding Home Care Service, Urgent Care Service and Emergency Response Teams.

Partnership Engagement Network Conference

6.14 Tameside Council, Tameside and Glossop Clinical Commissioning Group and Tameside and Glossop Integrated Care NHS Foundation Trust have established a Partnership Engagement Network. This will create the framework for the organisations to work in partnership with the public, stakeholders, partners and organisations in the voluntary, community and faith sectors. This structure will involve a wide range of partners and stakeholders and ensure that they are able to play an active role in developing the approaches that we take in the delivery and commissioning of services.

6.15 A key element of Partnership Engagement Network will be a twice yearly conference made up of around 100 representatives from stakeholder organisations and representatives of

groups that represent the public. Best practice and learning will be shared at the conference, and it will be an opportunity for relationships to be built across the multi-agency partnership. The first of these conferences took place on Friday 13 October 2017 at Hyde Town Hall. The conference consisted of introductory talks followed by a series of workshop sessions. The event included a workshop on the Intermediate Care consultation, providing an opportunity to engage with members of the local community.

6.16 This conference was attended by over 60 people from a range of groups across Tameside & Glossop, who all were offered the opportunity to participate in the workshop on the Intermediate Care proposals.

6.17 A summary of the notes from the 2 workshop sessions held at the event on 13th October is included in the table below:

Shire Hill Building
It was highlighted that rationally, option 2 is the best option for quality of care, but emotional ties to the Shire Hill building make rationality difficult. It was mentioned that Shire Hill is not being lost, but that simply the intermediate care beds may be moving.
Glossop residents are sceptical about the future of the Shire Hill building. They are worried it will be turned into housing. *Community services and physiotherapy will all remain in the Glossop Health Neighbourhood. It is not the CCG's decision as to what could happen to the building as it is owned by NHS England.*

Stamford Unit
The Stamford Unit is better for dementia which is a growing issue. It has more specialist staff who struggle getting to Glossop. This means there would be significant financial gains in going with option two, but also a far better quality of care.
Patients from Glossop who receive intermediate care in the Stamford Unit will receive better care. The issue was raised about those who may struggle to see their families, but a Glossop volunteer raised that The Bureau already drive people to and from Shire Hill and the Stamford Unit, and this service would continue.

Home Based Care
It was raised that the full utility of beds depends upon good housing stock. What forward planning is done to help people at home? *Discharge to assess carries out assessments to see what the home environment is like.*
Action Together have been part of the Home First consultation and the ticket home system ensures every patient has a safe and easy journey from hospital to home by ensuring small questions (do you have your house keys? Is there milk in the fridge? Is your gas and electricity on?) are answered by the team to ensure people can get home quicker and their quality of care is improved.
The need to ensure that Home First, Ticket Home, and Intermediate Care work together and ensure the patient is involved in their own journey was raised as important. *One of the advantages of having a Single Commissioning Function is that managers from health, finance, housing and transport can now all have these conversations more easily.*
The plans for home base care are located within the development of integrated neighbourhoods.

Public Meetings

6.18 During the consultation period, four public meetings were held. The details of the meetings and the number of people attending each are included in the table below:

Meeting Date and Location	Number of Attendees
21 September 2017, Bradbury House, Glossop	92
11 October, Age UK, Ashton-under-Lyne	12
17 October, Guardsman Tony Downes House Droylsden	4
1 November, Glossopdale Community College, Glossop	205

6.19 The public meetings were all recorded and the links to the videos uploaded onto the consultation page on the Clinical Commissioning Group website, so that people unable to attend were able to view the events.

6.20 Key points and issues raised at the meetings were captured and are included in the summaries below:

Thursday 21 September 2017, Bradbury Community House, Glossop

- T&G ICFT is difficult to reach via car and public transport from Glossop, Gamesley, Hadfield due to traffic, for visitors and staff who live in Glossop
- In other parts of the country hospitals can be much further away from residents than T&G ICFT is from Glossop
- Some views were that traffic is always bad; other that sometimes traffic is bad, not always
- Glossop is continually having medical (and other) services cut, stop cutting and invest in Glossop
- Is Option 2 predicated on the need to make the already arranged lease of the Stamford Unit financially viable? Why is rent being paid on two buildings
- T&G CCG is biased towards Tameside and against Glossop, they do not recognise that Glossop is different and part of Derbyshire
- The clinical reputation of T&G ICFT is not good
- Population of Glossop is expanding, particularly aging population
- Are the Stamford Unit facilities as good as Shire Hill's when infection prevention is considered, when socialisation of patients is considered, when extra physiotherapy facilities are considered, when the level of urban/rural pollution is considered
- What is the future of the Shire Hill building if the Intermediate Care facilities are closed down?
- Issues with the consultation process/document: the style of the consultation documents are too biased, the consultation process itself is a waste of money that can be used on patients, the consultation is a waste of time as the decision has already been made

Wednesday 11 October, Age UK Tameside, Ashton-under-Lyne

- Currently, are Tameside residents being sent to Shire Hill despite the Stamford Unit being closer
- Will charges be involved in any of the proposed options
- With option 3, would patients have a choice of the location of their care
- Lease signed with healthcare provider by ICFT is the reason for Shire Hill Intermediate Care being closed, the decision has already been made, and the consultation is biased towards this decision
- Shire Hill patients, from Glossop and Tameside, find Shire Hill to be a great location and conducive to recovery, closing Shire Hill and moving Intermediate Care to the Stamford Unit exclusively would be detrimental to the health and wellbeing of Intermediate Care users
- Traveling to Tameside from Glossop is difficult, by car but especially by public transport
- Housebuilding is taking place in Glossop and population is increasing
- Medical services are leaving Shire Hill, dentists, etc. the closure of Intermediate Care at Shire Hill is part of this but also exacerbates the process
- Enough resources to look after people in their own homes as part of care in the

community
- What will happen to staff who currently work at Shire Hill?
- Is the Stamford Unit fit for purpose, is it the best environment for Intermediate Care, i.e. falls, atmosphere etc.

Tuesday 17 October 2017, Guardsman Tony Downes House Droylsden

- Concern over lack of Derbyshire County Council Involvement in the whole process
- Question regarding decrease in number of beds
- Concern from Glossop residents over a difference of care and provision in Tameside and Glossop
- Question regarding user specialist hospitals across Greater Manchester, and will there be a re-design that includes Tameside Hospital
- What will happen to the land that Shire Hill is built on?
- Concerns over consultation process and validity of the literature used for consultation
- Concern about travel time for Glossop based staff should option two be implemented
- Assurance asked from the Panel to make sure that Glossop residents don't receive 'a second rate service'
- Concern about Transport times from Glossop to the Stamford Unit

Wednesday 1 November 2017, Glossopdale School, Glossop

- Transitioning from care into the home and it shouldn't be an hour and a half journey away.
- Concern regarding the validity of the App used for Transport times.
- Suggestion that better communication and partnership working is needed with Derbyshire County Council to put things in place after the outcome of the consultation.
- Issues with the validity of Statistics and data due to being skewed in favour of option two.
- Concern over transport and access if proposed Mottram Bypass is to be implemented.
- Concerns that George Street is being underutilised and has very little public parking.
- Queries regarding the former Darnton Building.
- Queries regarding the number of Intermediate Care beds at the Stamford Unit.
- Concerns regarding re-admission rates from home and transporting patients back to the hospital.
- Concerns about carers and family members having to make long and expensive journeys to see loved ones.
- The ownership of Shire Hill and concerns over future plans of the land if Shire Hill were to close.

6.21 The issues above have been included in the section 5 of this report, which identifies the key themes of the responses to this consultation, and the commissioner response.

Public Petition - Glossop

6.22 In addition to the comments received via the online questionnaire and the methods outlined above, a public petition was created by Glossop Residents and the 'Save our Shire Hill' campaign. This petition was presented by Ruth George MP to the Houses of Parliament.

7 CONSULTATION RESPONSES BY THEME

7.1 Responses to questions 4 – 7 of the questionnaire are being classified by theme, based on commonly mentioned issues and concerns.

7.2 The summary of the community and wider engagement carried out to support the consultation process identifies a number of issues raised and comments made during the discussions with representatives of the Clinical Commissioning Group.

7.3 This section of the report identifies the key themes from issues raised in response to the questionnaire, at public meetings, and through the wider community engagement, and provides a commissioner response to each issue. From the initial analysis of the survey responses, we reflected key themes in the tables below. Further details will be provided in the report presented to the Strategic Commissioning Board in January 2018, following a more detailed analysis and independent review of the consultation process and responses.

7.4 The table below summarises the high level themes identified from the initial analysis of the consultation responses.

CONSULTATION FEEDBACK THEME	DETAIL
TRANSPORT	• Public transport availability • Parking • Journey times (car and public transport)
SHIRE HILL	• Site • Staff
PATIENT CARE	• Safety • Quality of services (Shire Hill, Stamford Unit / T&GICFT, home based, other potential providers) • Staffing issues • Future capacity
GLOSSOP PROVISION	• Intermediate care in the neighbourhood • Community provision • George Street site – Glossop Primary Care Centre
PASTORAL CARE	• Proximity of intermediate care beds to patients' family and carers • Connection with communities
AFFORDABILITY	• Funding of future intermediate care model
CONSULTATION PROCESS	

8 EQUALITY IMPACT ASSESSMENT

8.1 To ensure compliance with the public sector equality duty (section 149 of the Equality Act 2010) public bodies, in the exercise of their functions, must pay 'due regard' to the need to eliminate discrimination, victimisation and harassment; advance equality of opportunity; and foster good relations.

8.2 The Equality Act 2010[10] makes certain types of discrimination unlawful on the grounds of:

- Age;
- Being or becoming a transsexual person;
- Being married or in a civil partnership;
- Being pregnant or on maternity leave;
- Disability;
- Race including colour, nationality, ethnic or national origin;
- Religion, belief or lack of religion/belief;
- Sex;
- Sexual orientation;

These are called 'protected characteristics'.

[10] https://www.gov.uk/guidance/equality-act-2010-guidance#overview

8.3 Tameside and Glossop Clinical Commissioning Group have an additional 4 locally determined protected characteristic group:

- Carers;
- Mental health;
- Military veterans;
- Breastfeeding.

8.4 A copy of the initial EIA presented to the Single Commissioning Board in August 2017 can be seen within the Single Commissioning Board papers from August 22 2017 http://www.tamesideandglossopccg.org/corporate/strategic-commissioning-board

8.5 A full Equality Impact Assessment (EIA) will be finalised to support this report and will be presented as an appendix to the report to the SCB in January 2018. SCB are requested to note that the Equality Impact Assessment is a work in progress and will be developed further to ensure it responds to issues raised within the consultation and explores whether additional mitigations will be required.

9 CONCLUSIONS

9.1 In August 2017 the Single Commissioning Board agreed the outline of a model of Intermediate Care for Tameside and Glossop and approved a proposal to carry out a formal consultation on 3 options for the bed based element of Intermediate Care services.

9.2 Extensive consultation has been undertaken over a period of 12 weeks. The initial themes from this are included in this report.

9.3 The Single Commission are confident that the four key themes set out in the NHS England October 2015 guidance on major service change and reconfiguration (see section 5 of this report) have been met as follows.

9.4 **Preparation and planning:** The development of the model for intermediate care – home and bed based – has been a key workstream for the Care Together programme, therefore ensuring a locality based approach between organisations, and ensuring engagement with / involvement of key stakeholders in the delivery of health & social care in Tameside & Glossop. The Clinical Commissioning Group, Tameside Metropolitan Borough Council (Single Commission) and Tameside and Glossop Integrated Care Foundation Trust have led a planned and managed approach to the development of the model and the subsequent consultation process, ensuring engagement with all key partners, the public, and patients.

9.5 **Evidence:** the 'case for change' information included in this report indicates that proposals for intermediate care have been developed based on clear clinical evidence and that they align with clinical guidelines and best practice.

9.6 **Leadership and clinical involvement**: The case for change for the intermediate care model, including the bed-based service model, has been driven by the Care Together programme, with the Integrated Care NHS Foundation Trust, the Local Authority and the Clinical Commissioning Group as key partners in the programme. This has involved working with a wide range of health and social care providers and community organisations / 3rd sector partners. The consultation and engagement work which has been undertaken between 23 August and 15 November has been under the leadership of the Clinical Commissioning Group Chair supported by the Chief Executive of the Integrated Care NHS Foundation Trust, with a significant level of input from local clinicians as document in sections 5 and 6 of this report.

9.7 **Involvement of patients and the public:** The consultation process outlined in sections 5 and 6 provide details of an extensive public and patient engagement in the consultation. Public meetings have been held, in addition to extensive publication and promotion of the consultation to encourage engagement and involvement. Meetings with a wide range of community / 3rd sector groups have taken place as part of the consultation process. The Strategic Commissioning Board meetings, where decisions are taken in relation to commissioning proposals, are public meetings.

9.8 It is recognised that to complement the Intermediate Care bed based services, the community intermediate care and Neighbourhood offers will continue to be developed and implemented, led by the Care Together Programme Board.

9.9 The impact of the proposed model is being fully evaluated and along with the outcome of the consultation will form a comprehensive Equality Impact Assessment which will be presented with the report to Strategic Commissioning Board in January 2018.

9.10 An independent assessment of the consultation process, including the analysis of the results, will be undertaken ahead of the presentation to a full report with recommendations to the January Strategic Commissioning Board.

10 RECOMMENDATIONS

10.1 The recommendations are as presented on the front sheet of this report.