Tameside & Glossop Single Commissioning Function
Equality Impact Assessment (EIA) Form

Subject / Title	Intermediate Care

Team	**Department**	**Directorate**
Commissioning	Commissioning	Commissioning

Start Date	**Completion Date**

Project Lead Officer	Alison Lewin
Contract / Commissioning Manager	Alison Lewin
Assistant Director/ Director	Jessica Williams

EIA Group (lead contact first)	**Job title**	**Service**
Jessica Williams	Interim Director of Commissioning	Commissioning
Dr Alan Dow	CCG Chair	CCG
Alison Lewin	Deputy Director of Commissioning	Commissioning
Simon Brunet		
Jody Smith		
Michael Clegg		

PART 1 – INITIAL SCREENING

1a.	**What is the project, proposal or service / contract change?**	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. A period of consultation on the proposed model was undertaken from 23rd August to 15th November 2017. Due to the richness of evidence arising from the public consultation and in particular from the Glossop neighbourhood, an interim report was presented in December 2017 to inform SCB of the consultation progress and process, initial themes and the next steps to ensure a final report with recommendations to the SCB January meeting.

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		This EIA supports the report to SCB which includes full detail of the consultation analysis, and responds to issues arising within the consultation and explores mitigations.
1b.	**What are the main aims of the project, proposal or service / contract change?**	**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: • 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. In August 2017 the Single Commissioning Board agreed to consult on 3 options for the delivery of 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 23rd August to 15th November 2017. In addition to the public consultation, additional community engagement has taken place through contacting specific groups across Tameside & Glossop. **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). **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. **Option 3: Stimulation of the Local Market to**

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		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. The Strategic 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.

1c. Will the project, proposal or service / contract change have either a direct or indirect impact on any groups of people with protected equality characteristics?
Where a direct or indirect impact will occur as a result of the project, proposal or service / contract change please explain why and how that group of people will be affected.

Protected Characteristic	Direct Impact	Indirect Impact	Little / No Impact	Explanation
Age	✓			The majority of users of the current intermediate care services are frail / elderly people requiring additional support to regain/maintain their independence. The demographics of people accessing current services have been analysed fully as part of this project prior to the development of any proposed model. The age demographics are contained in Section 2c below. This highlights that during 2017 over 90% of those admitted at either Shire Hill or the Stamford Unit were over the age of 65 years 18% of the Tameside and Glossop population are over the age of 65 years.
Disability	✓			The people who will require support from these services could be those with existing disabilities. 18.5% (approx. 48,000) of the population of Tameside and Glossop over the age of 65 years have a long term condition or disability.
Ethnicity		✓		There could be an indirect impact as people across all ethnicities could be

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				users of intermediate care services Section S2c below highlights that over 85% of those admitted during 2017 were 'White British' at the Stamford Unit and over 55% (2015) were White British at Shire Hill. For Shire Hill a large proportion of ethnicity data for service users is unknown (otherwise I think there could be an inference that the other 45% of service users are BME which isn't the case)
Sex / Gender		✓		There could be an indirect impact as people of any sex/gender could be users of intermediate care services
Religion or Belief			✓	There is no anticipation that the development or implementation of this strategy will impact directly or indirectly on Religion or Belief in any significant sense
Sexual Orientation			✓	There is no anticipation that the development or implementation of this strategy will impact directly or indirectly on Sexual Orientation in any significant sense
Gender Reassignment			✓	There is no anticipation that the development or implementation of this strategy will impact directly or indirectly on Gender Reassignment in any significant sense
Pregnancy & Maternity			✓	There is no anticipation that the development or implementation of this strategy will impact directly or indirectly on Pregnancy & Maternity in any significant sense
Marriage & Civil Partnership			✓	There is no anticipation that the development or implementation of this strategy will impact directly or indirectly on Marriage & Civil Partnership in any significant sense
NHS Tameside & Glossop Clinical Commissioning Group locally determined protected groups?				
Mental Health	✓			The commissioner's strategy and the locality proposals for an intermediate care model both include statements referring to the need to address the mental health needs of patients requiring intermediate care, including

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				those with a diagnosis of dementia. There are currently 2,865 living with dementia in Tameside and Glossop and the diagnosis rate is 74.8% Both Tameside and Glossop and England's prevalence for dementia is 0.8%. Tameside and Glossop's Mental Health prevalence rate is: 0.83% (2024 people); and the national prevalence is 0.9% Depression: 10.71% (20969 people) for T&G; 8.3% Nationally. The proposed consultation will include engagement with these groups
Carers	✓			The commissioner's strategy and the locality proposals for an intermediate care model both include statements referring to the need to address the mental health needs of patients requiring intermediate care, including those with a diagnosis of dementia. There are currently 2,865 living with dementia in Tameside and Glossop and the diagnosis rate is 74.8% Both Tameside and Glossop and England's prevalence for dementia is 0.8%. Tameside and Glossop's Mental Health prevalence rate is: 0.83% (2024 people); and the national prevalence is 0.9% Depression: 10.71% (20969 people) for T&G; 8.3% Nationally. The proposed consultation will include engagement with these groups
Military Veterans			✓	There is no anticipation that the development or implementation of this strategy will impact directly or indirectly on Military Veterans in any significant sense
Breast Feeding			✓	There is no anticipation that the development or implementation of this strategy will impact directly or indirectly on Breast Feeding in any significant sense
Are there any other groups who you feel may be impacted, directly or indirectly, by this project, proposal or service / contract change? (*e.g. vulnerable residents, isolated residents, low income households)*				
Group (*please state)*	**Direct Impact**	**Indirect Impact**	**Little / No Impact**	**Explanation**

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n/a				

Wherever a direct or indirect impact has been identified you should consider undertaking a full EIA or be able to adequately explain your reasoning for not doing so. Where little / no impact is anticipated, this can be explored in more detail when undertaking a full EIA.

1d.	**Does the project, proposal or service / contract change require a full EIA?**	**Yes**	**No**
		✓	
1e.	**What are your reasons for the decision made at 1d?**	A full EIA is required as the protected characteristics of **age, disability, mental health and carers** may be directly impacted by the proposed delivery model. The protected characteristics of **ethnicity and sex/gender** may be indirectly impacted by the proposed delivery model.	

PART 2 – FULL EQUALITY IMPACT ASSESSMENT

2a. Summary

The purpose of this EIA is to aid compliance with the public sector equality duty (section 149 of the Equality Act 2010), which requires that public bodies, in the exercise of their functions, pay 'due regard' to the need to eliminate discrimination, victimisation, and harassment; advance equality of opportunity; and foster good relations.

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.

A number of factors and service reviews have led to the identification of Intermediate Care as a priority for the Tameside & Glossop locality, as set out in the paper presented to the Single Commissioning Board on 22nd August (available on the CCG website http://www.tamesideandglossopccg.org/corporate/strategic-commissioning-board). In order to improve the intermediate care offer, and within that a bed-based intermediate care provision, a

revised model for bed-based intermediate care is being proposed.

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:

- 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.

Home First: One of the key principles within the Tameside & 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 & Glossop ICFT 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 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.

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.

Current Provision: Tameside & Glossop ICFT is the provider of all intermediate care beds for Tameside and Glossop as of 1st July 2017, and currently provides community beds from two locations: 64 beds in the Stamford Unit at Darnton House[1], 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.

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.

In August 2017 the Single Commissioning Board agreed to consult on 3 options for the delivery of 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 are:

Option 1: Maintain Current Arrangements - Delivery of bed based intermediate care from the

[1] 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.

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Stamford Unit at Darnton House (32 beds) and Shire Hill in Glossop (36 beds).

Option 2 (presented as the CCG's preferred option): Use of available 96 bedded unit - Transfer of all bed-based intermediate care to a single location in the Stamford Unit at Darnton House.

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.

The 3 options have been the subject of public consultation over a 12 week period from 23rd August to 15th November 2017. Details of the consultation process are included in the January Strategic Commissioning Board report, to which this EIA is an appendix.

2b. Issues to Consider

The consultation on the 3 options for bed based intermediate care, which have been the subject of a 12 week consultation process, were presented with a range of supporting information, including a commissioner and Integrated Care NHS Foundation Trust view on each, as described below.

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 SC and ICFT 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 ICFT 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

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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 1st July 2016 with the CQC the location of The Stamford Unit at Darnton House.
- The Stamford Unit at Darnton House was originally furnished as a 'dementia friendly' building with furniture from the 1950s and décor to aid dementia patients.
- 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: 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.

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.

Consultation Process

The consultation ran from 23rd August 2017 to 15th November 2017. 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.

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 copy responses were inputted to the online consultation system

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

A 'Fact Sheet' was developed by the Single Commission and the Integrated Care Foundation Trust which was posted on the CCG 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.

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.

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). All 4 meetings were filmed and the full recording of the meetings posted on the CCG 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

Details of the issues raised at the public meetings can be seen in the Strategic Commissioning Board report presented on 12th December 2017.

Copies of all consultation materials are appended to the December and January SCB reports.

Planning, assuring and delivering service change for patients
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.[2]

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

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

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- Clear, clinical evidence base
- Support for proposals from commissioners

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

The NHS guidance has been taken into consideration when establishing and running the consultation process described in this paper and the CCG are confident that these standards have been met.

Promotion and Communications
The Intermediate Care consultation has been promoted extensively since 23rd August 2017. In addition to the page on the CCG website (http://www.tamesideandglossopccg.org/get-involved/intermediate-care-consultation) the consultation has been shared and promoted in a number of ways. Details of the promotion of the consultation and media coverage were included in the report presented to the December meeting of the Strategic Commissioning Board.

Community and Patient Engagement
In addition to the consultation hosted on the CCG website, and the public meetings, 105 community and patient groups were contacted by the CCG directly by letter or email to inform them of the consultation and invite them to be involved.

The consultation was presented to a number of stakeholders between 23rd August and 15th November 2017. Full details of the community and wider engagement activities undertaken are included in the paper presented to the December meeting of the Strategic Commissioning Board, This includes details of all meetings attended. Targeted work has been undertaken during the consultation with specific groups including those identified as protected characteristic groups who may be impacted directly by the proposals through the consultation. The groups invited to engage in the consultation process are listed in **Appendix 1** to this EIA.

In total, **1,358** responses were received to the Intermediate Care consultation survey. Over 1,750 paper questionnaires were issued and **153** paper copies returned to NHS Tameside & Glossop Clinical Commissioning Group (CCG) using the pre-paid envelopes provided. These **153** returned paper responses are included in the total number of responses. Details of the responses received are included in section 2c below.

A summary of the response to the consultation questionnaire is as follows:

- Of the 1,358 total responses **797** respondents provided a substantive comment (i.e. to questions 4 to 7) upon which detailed analysis could be undertaken

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- Around two-thirds of respondents provided information around their demographic profile (includes prefer not to say option where relevant)
- Responses to the open questions (question 4 to 7) could be assigned to one or more of **34** consolidated themes
- The most commonly mentioned themes were around reference to expectations or concerns relating to the Home First model (i.e. a home based Intermediate Care service) made by over half of respondents (50.2%); positive comments relating to the Home First model (44.2%); and Support for Option 1 (40.2%).
- The least commonly mentioned themes related to travel costs (5.3%); car drive times (4.8%); and parking good – positive at Shire Hill (2.0%).
- Where analysis could be undertaken by demographic group, the top three mentioned themes remained as reference to expectations or concerns relating to the Home First model, positive comments relating to the Home First model and Support for Option 1.

A full report on the results of the consultation is attached to the January SCB report at Appendix 4.

As detailed in sections 1c and 2c of this EIA, the protected characteristics of **age, disability, mental health and carers** may be directly impacted by the proposed delivery model due to the demographics of the users of intermediate care services. The protected characteristics of **ethnicity and sex/gender** may be indirectly impacted by the proposed delivery model. Service user data was analysed in advance of and during the consultation, around the key protected characteristic groups, to help understand how they may be impacted by any of the 3 options included within the consultation. This data along with potential impact is detailed in Section 2c (below).

The themes arising from the analysis of the consultation results, which can be seen in the table below, have also been considered and addressed in preparing this EIA:

Consolidated Theme
Public expectations and concerns around the Home First model
Positive comments in support of the Home First model
Support for Option 1 – maintain current arrangements of Intermediate Care beds
Comments around the need for local services – particularly in Glossop
Specific comments / concerns relating to the delivery / implementation of Option 3 – developing a scheme of bed based intermediate care within local private care homes
General comments and concerns relating to travel time and accessibility
Keep Shire Hill / no change to current arrangements
Opposition to Option 3 - developing a scheme of bed based intermediate care within local private care homes
Public transport related concerns (particularly in relation to travelling from Glossop)
Opposition to Option 2 – all bed-based intermediate care in a single location at the Stamford

Unit
Criticism of the consultation process
Future of intermediate care – increasing demand and the need to invest in intermediate care
Concerns and criticisms of private care
Positive comments around care and service at Shire Hill
Support for Option 2 - all bed-based intermediate care in a single location at the Stamford Unit
Comments and concerns about NHS funding
Unfairness to Glossop and need to listen to Glossop residents
Patient care and safety - various comments positive and negative
Need to invest in Shire Hill
Concerns about staffing and capacity
Other comments regarding Shire Hill
Criticism of care at Stamford Unit / Hospital
Other comments
Impact on physiotherapy and other services at Shire Hill
Other suggestions / ideas relating to intermediate care
Traffic congestion (particularly in relation to Glossop)
Support for Stamford Unit and intermediate care delivered there
Concern about staff and jobs at Shire Hill
Support for Option 3 - developing a scheme of bed based intermediate care within local private care homes
Issues around parking at Stamford Unit and Hospital site
Opposition to Option 1 - maintain current arrangements of Intermediate Care beds
Travel costs for those who may have to travel further
Increased car drive times for those who may have to travel further
Parking is good at Shire Hill

More detail on the themes and the proportion of responses to each can be seen in the Consolidated Themes document attached at **Appendix 2.**

2c. Impact

This EIA has identified that protected characteristic groups who could be directly affected by changes to an intermediate care delivery model are **age, disability, mental health and carers**. This EIA has also identified that the protected characteristic groups of **ethnicity** and **sex/gender** could be indirectly affected. Data on local service use and the demographics of service users was collated in preparation for the consultation (and included in the EIA presented to the Strategic Commissioning Board in August 2017) to quantify the potential impact on protected characteristic groups.

The sections below outline the data collated in advance of the consultation, further details prepared

in response to / following the consultation, and evidence that representatives of the protected characteristic groups were involved in the consultation.

Age

Intermediate care is something which, in the main, is provided to support frail and / or elderly people. Activity data for the current facility on the hospital site in Ashton Under Lyne (the Stamford Unit, Darnton House) and Shire Hill Hospital was presented within the EIA accompanying the August 2017 report, and shows the following spilt in terms of the age of the people accessing the bed based intermediate and discharge to assess models:

	2015		2016		2017	
Age on admission	<65	65+	<65	65+	<65	65+
Stamford Unit	43	475	53	362	38	371
%	8.3	91.6	12.77	87.22	9.1	90.7
Shire Hill	19	263	21	352	12	141
%	6.7	93	5.6	94.3	7.8	92.1

The above table breaks down the age range of patients admitted to the Intermediate Care Units and shows that the 65+ age group are higher users of the Intermediate Care facilities.

Targeted work has been undertaken during the consultation with specific groups including those over the age of 65 years who may be impacted directly by the proposals through the consultation. The groups invited to engage in the consultation process are listed in **Appendix 1** to this EIA.

The responses to the consultation show that 624 responses to the consultation included details of the respondents' age. Of the achieved sample from the consultation responses, details of the age of people completing the questionnaire are included in the table below:

Demographic Group	Tameside & Glossop Population (%)	Achieved Sample (%)
Age[3]		
Under 18	21.9	0.2
18 – 29	14.5	4.6
30 – 49	26.3	21.6
50 - 64	19.8	40.1
65+	17.5	33.5

The proportion of the population of Tameside & Glossop who are over 65 is 17.5%, yet the responses to the consultation from this age group exceed 33% which is evidence that we have been able to engage the protected characteristic group in the consultation process, and that their views are represented in the report presented to the SCB.

Disability

As stated in section 1 of this EIA, the people who will require support from these services could be

[3] Based on those respondents who provided an exact age to enable categorisation

those with existing disabilities. 18.5% (approx. 48,000) of the population of Tameside and Glossop over the age of 65 years have a long term condition or disability. The table below outlines long term limiting illness and disability data for Tameside & Glossop CCG area, Tameside MBC and High Peak (the local authority which Glossop is within) (Census 2011).

Disability	NHS Tameside and Glossop	% of Total Population with day to day activities limited	High Peak	% of Total Population with day to day activities limited	Tameside	% of Total Population with day to day activities limited
Day-to-day activities limited a lot	26,080	10.33	7,451	8.20	23,307	10.63
Day-to-day activities limited a little	25,757	10.20	9,013	9.92	22,624	10.32
Day-to-day activities not limited	200,577	79.46	74,428	81.89	173,393	79.06
All categories: Long-term health problem or disability	252,414	100.00	90,892	100.00	219,324	100.00

Census data 2011 provides details of people who live in Tameside who have a long term condition or disability. This shows that over 19,000 people aged 65+ (58% of those aged 65+) are limited in day to day activities, and the total number aged under 65 with day to activities limited are over 25,000 (13% of those aged 65 and under)

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Age	Total Population	Day-to-day activities limited	% of Total Population with Day-to-Day activities limited
All categories: Age	217,736	44,504	20.4
Age 65 to 69	10,486	4,609	43.95
Age 70 to 74	8,420	4,420	52.49
Age 75 to 79	6,294	3,942	62.63
Age 80 to 84	4,262	3,152	73.96
Age 85 and over	3,481	2,989	85.87
Total aged 65+ with day-to-day activities limited	32,943	19,112	58.02
Total under 65 with day-to-day activities limited	184,793	25,392	13.74

Census data 2011 provides details of people who live in High Peak (the local authority which Glossop is within) who have a long term condition or disability. This shows that over 7,600 people aged 65+ (50% of those aged 65+) are limited in day to day activities, and the total number aged under 65 with day to activities limited are over 8,000 (13% of those aged 65 and under).

Age	**Total Population**	**Day-to-day activities limited**	**% of Total Population with Day-to-Day activties limited**
All categories: Age	89,867	15,801	17.6
Age 65 to 69	4,915	1,624	33.04
Age 70 to 74	3,662	1,548	42.27
Age 75 to 79	2,851	1,602	56.19
Age 80 to 84	2,056	1,461	71.06
Age 85 and over	1,619	1,377	85.05
Total aged 65+ with day-to-day activities limited	15,103	7,612	50.40
Total under 65 with day-to-day activities limited	74,764	8,189	10.95

Through the consultation we have engaged with representatives of community groups supporting people with disabilities and long term conditions, as reflected in **Appendix xx** of this EIA.

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The consultation responses (see table below) show that where we have demographic information 33.4% of the responses were from people who deemed themselves to have a disability, against a locality population percentage of 20.5%, therefore showing that the responses received included the protected characteristic group of people with a disability.

Demographic Group	Tameside & Glossop Population (%)	Achieved Sample (%)
Disability		
Yes	20.5	33.4
No	79.5	66.6

Mental Health
The commissioner's strategy and the locality proposals for an intermediate care model both include statements referring to the need to address the mental health needs of patients requiring intermediate care, including those with a diagnosis of dementia. There are currently 2,865 living with dementia in Tameside and Glossop.
Both Tameside and Glossop and England's prevalence for dementia is 0.8%.
Tameside and Glossop's Mental Health prevalence rate is: 0.83% (2024 people); and the national prevalence is 0.9% Depression: 10.71% (20969 people) for T&G; 8.3% Nationally.

Carers
Carers data taken from Census 2011 for Tameside & Glossop CCG area indicates that 10.9% of people across Tameside & Glossop provide unpaid care.

The consultation responses included 42.5% of responses from people who saw themselves as having caring responsibilities, against a locality population average of 10.9%. This shows that we have reached the protected characteristic group of 'carers' through this consultation and that their views are reflected in the consultation report presented to the Strategic Commissioning Board.

Demographic Group	Tameside & Glossop Population (%)	Achieved Sample (%)
Carer		
Yes	10.9	42.5
No	89.1	57.5

Ethnicity
The ethnicity of patients accessing the current intermediate care bed based services has been collated from the past 3 years and is as follows:

2015-2017 Shire Hill

Any Other Ethnic Group	Asian/Asian Brit - India	Not Known	Not Stated	Other Ethnic Gro	White - any other	White - British	White - Irish	Grand Total	% White British	% either not stated or

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	n			up - Chinese	White b/g					not known
3	2	123	118	2	5	308	5	556	55.39	43.34

2015-2017 Stamford Unit, Darnton House

Other	Asian British Bangladesh	Asian British Indian	Asian British Pakistan	Asian British Other Asian	CC_MSG	Mixed White Asian	Not Known	Not Stated	White Other	White British	White Irish	NULL	Grand Total	% White British	% either not stated or not known
11	1	19	4	1	1	3	78	58	13	1127	6	20	1342	83.9	10.1

The above tables highlight the 'White British' ethnicity has the majority of admissions in the community bed bases, and also shows the Stamford Unit, Darnton House having the most varied ethnic diversity for admissions. The overall ethnicity breakdown for T&G from Census 2011 is also included here for comparison:

Ethnic Group	Number	%
All Persons	**252,414**	
White British	225,792	89.5%
White Irish	1,855	0.7%
Gypsy or Irish Traveller	40	0.0%
White Other	4,014	1.6%
All White	**231,701**	**91.8%**
Mixed: White & Black Carribean	1,479	0.6%
Mixed: White & Black African	565	0.2%
Mixed: White & Asian	948	0.4%
Mixed: Other	586	0.2%
All Mixed	**3,578**	**1.4%**
Asian: Indian	3,738	1.5%
Asian: Pakistani	4,954	2.0%
Asian: Bangladeshi	4,296	1.7%
Asian: Chinese	1,031	0.4%
Asian: Other	804	0.3%
All Asian	**14,823**	**5.9%**
Black: African	1,222	0.5%
Black: Carribean	421	0.2%
Black: Other	231	0.1%
All Black	**1,874**	**0.7%**
Other: Arab	168	0.1%
Any Other Ethnic Group	270	0.1%
All Other	**438**	**0.2%**

Source: 2011 Census

Over 89% of the Tameside and Glossop population are White British and of these over 94% are over the age of 65 years.
The data in the consultation report shows that the responses are generally reflective of the Tameside & Glossop population and previous service users from an ethnicity perspective, as detailed in the table below.

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Demographic Group	Tameside & Glossop Population (%)	Achieved Sample (%)
Ethnicity		
White	91.8	97.5
BME	8.2	2.5

Sex/Gender

Demographic Group	Tameside & Glossop Population (%)	Achieved Sample (%)
Gender		
Male	49.1	31.1
Female	50.9	66.8
Prefer to self-describe	Not available	0.2
Prefer not to say		2.0

Accessibility of Services

The proposal covers home and bed-based intermediate care, with home being the preferred option wherever possible. However, the consultation is focused on the model for the delivery of bed based intermediate care, and the 3 options set out in section 2b of this EIA. The consultation process highlighted that accessibility of services, due in part to the age profile of service users and their main carers was an issue.

This was expected to be an issue which would arise, therefore the CCG prepared and shared data as part of the consultation process to review travel times across the Tameside & Glossop locality, and the postcode of previous users of bed based intermediate care at the Stamford Unit and Shire Hill Hospital. This information was included in the EIA which accompanied the report presented to the Strategic Commissioning Board in August 2017, where the decision to consult was made.

The data below (and attached in **Appendix 3** to this EIA) is the data which was prepared for the August 2017 SCB report, and which was used in the consultation process between 23rd August and 15th December.

Postcode Data

Attached at **Appendix 3** are tables including postcodes of patients/service users between 2015-17 including detail of the Tameside and Glossop neighbourhoods they were resident in at the time of admission.

The total number of admissions to the existing Intermediate Care Units are as follows:

Stamford Unit, Darnton House Summary

Year	Ward Stays	Notes
2015	518	Transitional Care Unit open March 15 to Nov 15
2016	415	Stamford Unit open June 16 to December 16
2017	409	Jan 17 to May 18th 2017

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Shire Hill Summary

Year	Ward Stays	Notes
2015	293	Apr 15 to Dec 15
2016	398	Jan-16 to Dec 16
2017	161	Jan 17 to May 18th 2017

Further analysis can be seen in **Appendix 3** which contains the following documentation:

- Breakdown of patients/service users 2015-2017 to Shire Hill and the Stamford Unit, Darnton House including postcodes /registered GP practices
- Number of referrals to Shire Hill by postcode sector
- Number of referrals to Stamford Unit (Intermediate Care Unit) by postcode sector
- Table showing number of referrals per postcode sector to Shire Hill and Stamford Unit
- Number of referrals to Shire Hill from GP practices
- Number of referrals to Stamford Unit (Intermediate Care Unit) from GP practices

From the patients/service users admitted during 2015-17, the largest percentage of patients from the Hyde Neighbourhood were admitted to Shire Hill. The largest percentage of patients from the Denton Neighbourhood were admitted to the Stamford Unit, Darnton House.

Further analysis of the postcode data of patients/service users using intermediate care services at Shire Hill and Stamford Unit, Darnton House shows that of all Shire Hill patients between 2015 - May 2017, 7.4% lived within 1 mile of Shire Hill whereas 10.7% lived within 1 mile of Stamford Unit, Darnton House. For more information / analysis please see **Appendix 3**

Maps showing patients/service users living with within a 1, and 5 mile radius of Shire Hill and Stamford Unit, Darnton House are also included.

Travel Times

In order to support the development of the Intermediate Care model and inform the consultation process with the public and patients, transport analysis was undertaken. The transport information was included as part of the consultation materials for transparency and to give the public and patients an opportunity to comment on it and articulate their own experiences of travel and access to services.

Basemap's TRACC software was used to calculate travel times to both Shire Hill and Stamford Unit, Darnton House using public transport at both peak and off peak time periods. This covers all major public transport options across Tameside and Glossop including bus, train and tram.

TRACC was also used to calculate drive times at both peak and off peak time periods, and walk times.

Detailed analysis of this drive time, public transport and walk time analysis is attached. Some of the key headlines can be found below.

<u>Drive Times</u>

Further drive time analysis can be found on page 20 of **Appendix 3**.

- During weekdays 0700-0900, 86.3% of Tameside and Glossop residents are within 0-15

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minutes' drive of the Stamford Unit compared to 19.3% within 0-15 minutes' drive of Shire Hill.

- During weekdays 1000-1600, 89.3% of residents are within 0-15 minutes' drive of the Stamford Unit comparted to 20.8% within 0-15 minutes' drive of Shire Hill.
- During weekdays 1600-1900, 86.2% of residents are within 0-15 minutes' drive of the Stamford Unit compared to 20.2% within 0-15 minutes' drive of Shire Hill.
- At weekends 0700-1900, 92% of residents are within 0-15 minutes' drive of the Stamford Unit compared to 22.2% within 0-15 minutes' drive of Shire Hill.
- For all four of the above drive time periods 99.8% of residents are within 0-30 minutes' drive of both the Stamford Unit and Shire Hill.

Public Transport

Further drive time analysis can be found on page 20 of **Appendix 3**.

During weekdays 0700-0900 (Tuesday as an example):

- 9% of residents can reach the Stamford Unit by public transport within 0-15 minutes compared to 3.1% to Shire Hill.
- 39.1% of residents can reach the Stamford Unit by public transport within 0-30 minutes and 11.3% to Shire Hill.
- 71.6% of residents can reach the Stamford Unit by public transport within 0-45 minutes and 16.7% to Shire Hill.
- 96.4% can reach the Stamford Unit by public transport within 0-60 minutes and 35.9% to Shire Hill.

During weekdays 1000-1600 (Tuesday as an example), using public transport:

- Within 0-15 minutes, 9.2% of residents can reach the Stamford Unit and 1.9% to Shire Hill.
- Within 0-30 minutes, 40.3% can reach the Stamford Unit and 10.7% to Shire Hill.
- Within 0-45 minutes, 79.6% can reach the Stamford Unit and 24% to Shire Hill.
- Within 0-60 minutes, 99.2% can reach the Stamford Unit and 54.8% to Shire Hill

During weekdays 1600-1900 (Tuesday as an example), using public transport:

- Within 0-15 minutes, 8.5% of residents can reach the Stamford Unit and 1.9% to Shire Hill.
- Within 0-30 minutes, 37.8% can reach the Stamford Unit and 11.2% to Shire Hill.
- Within 0-45 minutes, 77.7% can reach the Stamford Unit and 25.3% to Shire Hill.
- Within 0-60 minutes, 99% can reach the Stamford Unit and 57.1% to Shire Hill.

During weekends 1000-1600 (Saturday as an example), using public transport:

- Within 0-15 minutes, 9.2% of residents can reach the Stamford Unit and 1.9% to Shire Hill
- Within 0-30 minutes, 40.1% can reach the Stamford Unit and 10.6% to Shire Hill
- Within 0-45 minutes, 78.7% can reach the Stamford Unit and 23.9% to Shire Hill
- Within 0-60 minutes, 99% can reach the Stamford Unit and 54.9% to Shire Hill

Walk Time

Further walk time analysis can be found on page 20 of Appendix 3.

In terms of walk time alone:

- 3.6% of residents can walk to the Stamford unit within 0-15 minutes and 0.6% can walk to Shire Hill.
- 15.7% can walk to the Stamford Unit within 0-30 minutes and 4.5% can walk to Shire Hill.
- 31.8% can walk to the Stamford Unit within 0-45 minutes and 9.1% can walk to Shire Hill.
- 43.5% can walk to the Stamford Unit within 0-60 minutes and 13% can walk to Shire Hill.

Key Location Travel Time Analysis

Travel times between 14 key locations (Ashton, Mossley, Stalybridge, Dukinfield, Hyde, Broadbottom, Hattersley, Mottram, Denton, Audenshaw, Droylsden, Hadfield, Gamesley, and Glossop) and both the Stamford Unit and Shire Hill were calculated for various modes of transport

and time periods.

Drive Times

Further key location travel time analysis can be found on page 21 of Appendix 3.

For all four drive time time-periods (weekdays 0700-0900; weekdays 1000-1600; weekdays 1600-1900; weekends 0700-1900) the drive time between 10 of the key locations (Ashton, Mossley, Stalybridge, Dukinfield, Hyde, Hattersley, Mottram, Denton, Audenshaw and Droylsden) was quicker to the Stamford Unit than the drive time between these locations and Shire Hill. For all four drive time time-periods the drive time between Broadbottom, Hadfield, Gamesley and Glossop to Shire Hill was quicker than the drive time between these four locations and the Stamford Unit.

The longest drive time to Shire Hill across all time periods was from Droylsden:

- Weekdays 0700-0900: 25.87 minutes
- Weekdays 1000-1600: 25.2 minutes
- Weekdays 1600-1900: 25.89 minutes
- Weekends 0700-1900: 24.54 minutes

The shortest drive time to Shire Hill across all time periods was from Glossop:

- Weekdays 0700-0900: 3.73 minutes
- Weekdays 1000-1600: 3.99 minutes
- Weekdays 1600-1900: 3.98 minutes
- Weekends 0700-1900: 3.84 minutes

The longest drive time to the Stamford Unit across all time periods was from Glossop:

- Weekdays 0700-0900: 17.55 minutes
- Weekdays 1000-1600: 18.13 minutes
- Weekdays 1600-1900: 18.98 minutes
- Weekends 0700-1900: 17.47 minutes

The shortest drive time to the Stamford Unit across all time periods was from Ashton:

- Weekdays 0700-0900: 4.67 minutes
- Weekdays 1000-1600: 4.5 minutes
- Weekdays 1600-1900: 4.66 minutes
- Weekends 0700-1900: 4.27 minutes

Public Transport

Further key location travel time analysis can be found on page 22 of Appendix 3.

For all four public transport time-periods (Tuesday 0700-0900; Tuesday 1000-1600; Tuesday 1600-1900; Saturday 1000-1600) the public transport travel time between Ashton, Mossley, Stalybridge, Dukinfield, Hyde, Hattersley, Mottram, Denton, Audenshaw and Droylsden to the Stamford Unit was quicker than the public transport travel time between these 10 locations and Shire Hill. For all four public transport time-periods the public transport travel time between Broadbottom, Hadfield, Gamesley and Glossop to Shire Hill was quicker the public transport travel time between these four locations and the Stamford Unit.

The longest public transport travel times to Shire Hill were:

- Tuesday 0700-0900: Droylsden: 76.26 minutes
- Tuesday 1000-1600: Droylsden: 65.69 minutes
- Tuesday 1600-1900: Droylsden: 67.69 minutes
- Saturday 1000-1600: Mossley: 65.18 minutes

The shortest public transport travel times to Shire Hill were:

- Tuesday 0700-0900: Glossop: 9.17 minutes
- Tuesday 1000-1600: Glossop: 9.44 minutes
- Tuesday 1600-1900: Glossop: 9.44 minutes
- Saturday 1000-1600: Glossop: 9.44 minutes

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The longest public transport travel times to the Stamford Unit were:

- Tuesday 0700-0900: Gamesley: 48.65 minutes
- Tuesday 1000-1600: Broadbottom: 47.93 minutes
- Tuesday 1600-1900: Broadbottom: 44.93 minutes
- Saturday 1000-1600: Broadbottom: 47.93 minutes

The shortest public transport travel times to the Stamford Unit were:

- Tuesday 0700-0900: Ashton: 12:13 minutes
- Tuesday 1000-1600: Ashton: 12:13 minutes
- Tuesday 1600-1900: Ashton: 10.96 minutes
- Saturday 1000-1600: Ashton: 12:13 minutes

Walk Times

Further key location travel time analysis can be found on page 23 of **Appendix 3**.
The walk time to Stamford Unit is shorter from Ashton, Mossley, Stalybridge, Dukinfield, Hyde, Hattersley, Mottram, Denton, Audenshaw and Droylsden than the walk time to Shire Hill.
The walk time to Shire Hill from Broadbottom, Hadfield, Gamesley, and Glossop is shorter than the walk time to Stamford Unit.
The longest walk time to Shire Hill is from Droylsden at 208.3 minutes and the shortest is from Glossop at 20.24 minutes.
The longest walk time to the Stamford Unit is from Glossop at 137.32 minutes and the shortest is from Stalybridge at 22.49 minutes.

Updates to Transport Data

The information above was shared through the consultation process to ensure public awareness of the analysis undertaken and the consideration of travel times and access as a potentially key issue. As identified in this EIA and in the report prepared for the Strategic Commissioning Board, the issue of travel times and transport remained a concern, particularly for the residents of the Glossop locality when considering option 2 and the option of removing services from the Shire Hill location.

Concern was also expressed regarding the validity of the data presented and the sources used by the CCG/Single commission.

In light of these concerns, an update of the travel and transport options has been undertaken, using alternative data sources, and providing additional detail on the options available with regard to public transport across the locality. This information is included at **Appendix 4**.

Further transport analysis: Glossop – ICFT journey

The issue of travel times and transport was raised by a number of respondents to the consultation and was a major theme of the feedback, particularly for the residents of the Glossop locality. Concern was also expressed regarding the length of time it takes to travels from the Glossop area to the Stamford Unit at the ICFT site. Alongside this a number of respondents questioned the validity of the data presented and the sources/systems used to arrive at the analysis shown above. In light of these concerns, some further travel analysis has been undertaken for the Glossop – ICFT journey using a number of different tool – 5 in total including the TRACC system. The systems are: TRACC, TfGM Journey Planner, Traveline, Google Maps and Micromarketer. That additional analysis is summarised below and the full travel time analysis, explanations of the systems used and some further information on bus services is attached at Appendix 4 The table below shows the range of travel times across the five tools (where the tool provides data for that mode and time

period).

	Morning	Afternoon	Evening
Walk	2 hours 17 minutes – 2 hours 19 minutes	2 hours 17 minutes – 2 hours 19 minutes	2 hours 17 minutes – 2 hours 19 minutes
Drive	18 minutes – 35 minutes*	18 minutes – 26 minutes	16 minutes – 35 minutes**
Train	59 minutes – 1 hour 12 minutes	1 hour 16 minutes – 1 hour 57 minutes	1 hour 1 minute – 1 hour 8 minutes
Bus (+Walk)	41 minutes – 1 hour 3 minutes	41 minutes – 1 hour 3 minutes	41 minutes – 51 minutes
Bus (Direct)	47 minutes – 1 hour 9 minutes	1 hour 15 minutes – 1 hour 21 minutes	54 minutes – 59 minutes

* 35 minute figure is Peak/Rush Hour: 7:00am-9:00am

** 35 minute figure is Peak/Rush Hour: 4:00pm-7:00pm

Note: Table indicates the range across the five travel time calculator tools. Not all tools were able to calculate times for all modes of travel.

SUMMARY

The data above identifies how we have engaged representatives from the protected characteristic groups in the consultation process, and how the results of the consultation reflect this (where demographic information is available). However, there are key themes arising from the consultation which require particular attention, and which cut across all protected characteristic groups. These are:

- Accessibility of Services (travel time and access)
- Quality of patient care (across all intermediate care services)
- Delivery of services to the Glossop neighbourhood

These issues are therefore included in section 2d below, where mitigations are identified, in some cases specific to the areas of the Tameside & Glossop locality where they were deemed to be of particular concern. The impact of the accessibility of services, and services in the Glossop neighbourhood, impact predominantly on the Glossop neighbourhood and not the other 4 Tameside neighbourhoods.

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2d. Mitigations (where you have identified an impact, what can done to reduce or mitigate the impact?)	
Age	The data in section 2C shows that the age group using intermediate care services are predominantly aged 65+ years and over, and that the response to the consultation include responses from this age group. To ensure the views of this cohort of the local population are taken into account, the consultation process included local groups and sections of the population within this protected characteristic group, and they were supported and encouraged to engage in the consultation. This is evident in the consultation results, and in the information included in this report. Through the process of implementation and ongoing service review, the CCG (Single Commission) and ICFT will ensure the ongoing engagement with service users, including those from the protected characteristic groups, to ensure services delivered are in line with their needs. The sections below including the mitigations relating to accessibility, service quality and services in the Glossop neighbourhood are in response to views expressed by respondents irrespective of their protected characteristic group, and are therefore included as issues in their own right, with respective mitigations.
Disability	The data in section 2c shows that the consultation process effectively engaged people with disabilities, and that their views are reflected in this report. The CCG (Single Commission) and ICFT will ensure that the implementation and ongoing review of intermediate care services is done with input from people representing the local population and the protected characteristic groups identified in this EIA. The sections below including the mitigations relating to accessibility, service quality and services in the Glossop neighbourhood are in response to views expressed by respondents irrespective of their protected characteristic group, and are therefore included as issues in their own right, with respective mitigations.
Mental Health	The CCG ensured engagement of groups representing people with mental health needs, as shown in the list of groups who were involved in the consultation process, attached at **Appendix 1**. The CCG (Single Commission) and ICFT will ensure that the implementation and ongoing review of intermediate care services is done with input from people representing the local population and the protected characteristic groups identified in this EIA. The implementation of the intermediate care model will include the appropriate standards in relation to support for people with dementia, to ensure that people with intermediate care needs who also have dementia are able to benefit from both home and bed based intermediate care. The CCG leads for the commissioning of dementia

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	services (from the commissioning and quality & safeguarding directorates) are providing guidance on this work. The sections below including the mitigations relating to accessibility, service quality and services in the Glossop neighbourhood are in response to views expressed by respondents irrespective of their protected characteristic group, and are therefore included as issues in their own right, with respective mitigations
Carers	The data include in section 2c shows effective engagement of carers in the consultation process. We will ensure that throughout the implementation and ongoing review of intermediate care services, we engage representatives of this protected characteristic group. The Partnership Engagement Network will be used to ensure ongoing engagement with a range of stakeholders in further work on intermediate care, and will include representation from the protected characteristic groups, including those representing carers. The sections below including the mitigations relating to accessibility, service quality and services in the Glossop neighbourhood are in response to views expressed by respondents irrespective of their protected characteristic group, and are therefore included as issues in their own right, with respective mitigations.
Ethnicity	The CCG / Single Commission will work with the Integrated Care NHS Foundation Trust to ensure that any future engagement and involvement relating to intermediate care reflects the population who access these services, including consideration of the ethnicity of service users. The commissioners will ensure the ICFT record the ethnicity of users of intermediate care, so that this information can inform any ongoing review and monitoring or the services.
Sex / Gender	The CCG / Single Commission will work with the Integrated Care NHS Foundation Trust to ensure that any future engagement and involvement relating to intermediate care reflects the population who access these services, including consideration of the gender of service users.
Accessibility of Services (travel time and access)	The proposal covers home and bed-based intermediate care, with home being the preferred option wherever possible. We will look to mitigate any impact on service users/patients/carers by minimising the impact of any travel implications to the intermediate care sites, including minimising the movement of existing patients to another base as a result of the implementation of the proposals contained within this document. Transport on admission to the intermediate care beds for the patients / service users will be arranged by the Integrated Care Foundation Trust. There will be no need for patients to arrange their own transport The CCG have re-run the analysis of travel times, as set out in section 2c and **Appendix 4** of this document, to ensure the original calculations

	on which the proposals were based are not as unrealistic as suggested in some responses to the consultation. The Strategic Commission and Integrated Care Foundation Trust will ensure details of all community transport options are made available to people using intermediate care and other ICFT services. A piece of work is being undertaken to review the delivery of all patient transport services across the Tameside & Glossop locality. As stated in the main report and in previous presentations, including those given at the public meetings, one of the key principles within the Tameside & Glossop Care Together approach to integrated intermediate 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. '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 offer will ensure that people are supported through the most appropriate pathway with "home" always being the default position. The ongoing development and expansion of home based intermediate care services, and the neighbourhood offer in all 5 Tameside & Glossop neighbourhoods aims to reduce the need for bed based care, including bed based intermediate care. To consider the needs of carers and families who need to visit their relatives the CCG and ICFT will be as flexible as possible in relation to visiting times in bed based intermediate care. Derbyshire County Council have emphasised their intention to work with the ICFT and CCG on the delivery of whichever model is the outcome of this consultation / SCB decision, ensuring the needs of the Glossop population are met, whether at home or in bed based care, and wherever this is located. To offer choice of local Intermediate Care provision in light of increased travel times for some carers/ relatives, the Strategic Commissioning Board are to be asked to approve up to 8 beds at any one time for purchase on an individual basis for residents of Glossop, and to agree

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	that the need for individually purchased beds within Glossop will be reviewed by commissioners annually. The Strategic Commission and Integrated Care NHS Foundation Trust will continue to develop services in all five neighbourhoods and maximise the use of the Glossop primary care centre Tameside and Glossop Strategic Commission will work with partners/stakeholders to continue to develop local, appropriate health and social care provision, including supported accommodation, to meet the needs of our population in the future
Quality of patient care (across all intermediate care services)	The CCG have produced a Quality Impact Assessment to accompany the Strategic Commissioning Board report on Intermediate Care. This QIA sets out the measures the CCG will put in place to provide assurance in relation to the delivery of intermediate care. This includes: Patient Safety: The Single Commission will commission a service which ensures high levels of patient safety whether in patients' homes or bed based. The commissioner will ensure routine quality assurance mechanisms are in place to support the development and delivery of this strategy. Irrespective of the eventual option for the delivery of bed based intermediate care, the provider(s) of the model of care outlined in the paper will include Tameside & Glossop Integrated Care NHS Foundation Trust. Therefore we will monitor delivery of these services via our existing quality and contract monitoring processes. This intention has already been expressed in the Quality & Performance meetings held between the CCG and ICFT Patient experience: There will continue to be high levels of patient engagement and involvement in the further development and implementation of this model following the SCB decision in January 2018. The commissioner and provider expectation is that the model commissioned and delivered will deliver improvements in patient experience, addressing any areas identified by the public / patients during the consultation. The commissioners will seek assurance on expected Improvements in patient experience via the existing quality and contract monitoring process. Safeguarding: The commissioned model will include all required elements of safeguarding legislation, as the provider(s) will include Tameside & Glossop Integrated Care NHS Foundation Trust. The GM Safeguarding Standards are included in the ICFT contract and will be included in any contracts relating to the delivery of intermediate care arising from this consultation. Statutory duty/ inspections: As the providers of the services will continue to include the ICFT, TMBC and DCC they are subject to

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	statutory duties and inspections. The proposed location for the single site intermediate care service, expressed as the preferred option in the consultation, has been subject to CQC assessments via T&GICFT. Any other providers delivering intermediate care as a result of this consultation will be subject to appropriate inspections.
Delivery of services to the Glossop neighbourhood	Although the focus of the consultation was Intermediate Care, assurance was given in the public meetings and in responses to communication received during the consultation that the locality's plans for Integrated Neighbourhood services would not reduce the community provision in the Glossop neighbourhood, but would enhance this provision. Tameside & Glossop ICFT have provided a summary of additional services and details of the integration of existing services within Glossop – attached to the main Strategic Commissioning Board report. The ICFT management structure includes 5 Neighbourhood Clinical Director posts. These are GPs working within the neighbourhoods tasked with clinically leading the development and delivery of services for their neighbourhood. The Glossop role is shared by 2 GPs working in the neighbourhood. In addition, there is a dedicated Integrated Neighbourhood Manager (ICFT employed) for Glossop, driving forward the development of the neighbourhood model (a role which also exists for the other 4 neighbourhoods). Derbyshire County Council have emphasised their intention to work with the ICFT and CCG on the delivery of whichever model is the outcome of this consultation / SCB decision, ensuring the needs of the Glossop population are met, whether at home or in bed based care, and wherever this is located. The response from Derbyshire County Council Adult Social Care is included in the main SCB report at Appendix 6. The Strategic Commission and Integrated Care NHS Foundation Trust will continue to develop services in all five neighbourhoods and maximise the use of the Glossop primary care centre

2e. Evidence Sources
- National Audit of Intermediate Care (2015) - Utilisation Management Review (2014/15) - Staff & Public Engagement / Consultation findings - Census 2011 - QOF 2015/2016 - ONS 2014 health geography mid-year population estimates - Basemap – TRACC Software - TfGM Journey Planner - Traveline

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- Google Maps
- Micromarketer

2f. Monitoring progress		
Issue / Action	**Lead Officer**	**Timescale**
Monitor impact of the Home First service to establish if there has been a reduction in Intermediate Care bed use	ICFT to provide relevant information to T&G CCG (Ali Lewin)	Propose quarterly as part of ICFT contract monitoring
Monitor demographics of Intermediate Care service users to further understand the profile of those who use the service and ensure it continues to fit their needs	ICFT to provide relevant information to T&G CCG (Ali Lewin)	Propose quarterly as part of ICFT contract monitoring
Monitor readmission rates of patients who have previously used Intermediate Care services in Tameside & Glossop	ICFT to provide relevant information to T&G CCG (Ali Lewin)	Propose quarterly as part of ICFT contract monitoring
Continue to monitor the application of routine quality assurance mechanisms to ensure high levels of patient safety for those in receipt of Intermediate Care - whether as part of Home First model or bed based	ICFT to provide relevant information to T&G CCG (Ali Lewin)	Propose quarterly as part of ICFT contract monitoring
Continue to monitor patient experience of implemented Intermediate Care model	ICFT to provide relevant information to T&G CCG (Ali Lewin)	Propose quarterly as part of ICFT contract monitoring

Signature of Contract / Commissioning Manager	**Date**
Alison Lewin	
Signature of Assistant Director / Director	**Date**
Jessica Williams	