Appendix 9

Email from Unison regarding Intermediate Care Consultation 25th September 2017

From: Bull, James
Sent: 25 September 2017 08:36
To: listening2patients (NHS TAMESIDE AND GLOSSOP CCG)
Subject: Web enquiry: Listening to patients

Dear Madam/Sir,

UNISON representatives recently attended the public meeting at Bradbury Community House on 21st October, arranged as part of the ongoing intermediate care consultation. It was evident that a considerable number of people attended but were unable to gain access to the venue because it was at capacity.

Given this, I am writing to request that another meeting is held in Glossop in order to engage with the wider public and discuss the proposals with those unable to put across their point of view or listen to the panel's contributions last Thursday. UNISON feels it is crucial that the strength of interest and feeling in this consultation is met with a commitment to arrange an additional meeting in order to ensure the local community in Glossop is listened to fully, and not disenfranchised. I know this view is shared by a number of our members, and members of the public in the wider community.

Thank you in anticipation of your consideration of this request.

Kind regards,
James.

James Bull
UNISON North West

Sir John Oldham

Response to consultation on intermediate care provision in Tameside and Glossop

I write as a former GP of Glossop (28 years) but also as former national clinical lead for long term conditions at the Dept of Health and previous Chair of the Independent Commission on Whole Person care. On that commission we undertook a global literature review of the evidence base of integrated care. I currently advise on the implementation of integrated care in the UK and other countries.

Firstly I strongly support, and admire, the development of integrated care in Tameside. I also want to recognise the tremendous work of Karen James (CEO Tameside Integrated FT) in turning around Tameside hospital to be a safe and good hospital once more. Unfortunately the intermediate care strategy as set out will not deliver the expected results, and in particular will be detrimental for the people of Glossopdale.

Centralising services such as stroke care is right and has strong clinical evidence. Centralising intermediate care beds is not, and is unsupported by the clinical evidence. The evidence points to better outcomes if people are in facilities closer to their homes, principally because of the psychological benefit. This of course applies to both Tameside and Glossop residents. I was surprised that there was no projected needs assessment for intermediate care beds in the consultation, and a denial at the consultation meeting that this was a matter to consider now. This has to be incorrect. The changes made now need to be future proofed. The Office for National Statistics (ONS) population projection for Tameside and Glossop show that 22% more intermediate care beds than current provision will be needed by 2030. This has not been considered in any of the options.

The range of community services that are being created to support the Home First policy in and of themselves are appropriate, if a little diverse and fragmented with potential for duplication, but the over reliance on a medical model of care to help people stay at home is unsupported by the evidence. For Home First you need home care first. The major influence on whether a person can be safely kept at home, or discharged to home, is the availability of home care support. The strategy as outlined will not work.

The single commissioning board and pooled budget arrangements for the Tameside metropolitan borough area may allow some flexibility that can

compensate in Tameside for the inevitable increase in home care required to meet the increased community demands of the Home First policy. This will not be the case in Glossopdale and the service risks failure. I note the strong reassurances given at the first community meeting in Glossop of close seamless working between health and social care in Glossop. This was in answer to a challenge that there was not close integrated working. The credibility of the reassurances was undermined because it was clear that the person responding did not recognise the questioner was a domiciliary care manager for the Glossop area. She lives the reality daily. I know from my own recent experiences with a relative that integrated care in Glossopdale is sophistry. Yet the intermediate care strategy presumes its existence. In truth, proper integrated care stops at the Tameside boundary.

The voice of Glossopdale on the single commissioning board of Tameside and Glossop is minimal. Understandably the policies and protocols that have been developed by the board focus on the needs of the majority population, and a default position that the same policies and procedures can apply to Glossopdale. We have experienced this phenomenon in the past and although I know it is not anyones intent, the population of Glossopdale are disadvantaged. The same bias will apply in the operation of the intermediate care strategy, with predictable results and a limitation of choice for Glossopdale residents.

I note that the changes that are the subject of the consultation are not primarily financially driven, given the relatively small predicted savings. However my analysis is that, for the reasons outlined above, the strategy will not adequately increase throughput in acute beds and there may be system cost increases. Further the strategy exchanges a building wholly owned by the NHS in perpetuity, for a building with a four and a half year lease. The renegotiation of that lease will be from a weak position. My view is the financial savings will not be realised.

There was a justified and strong criticism of the style and mode of the public consultation at the second consultation meeting in Glossop. Glossopdale residents are the only portion of the Tameside and Glossop population who will be disadvantaged by the proposals. There was no sense that appropriate weighting will be given to the views of Glossopdale, indeed the opposite. This would fail the test of public consultation.

I also wish to comment on Option 3, the provision of intermediate care beds in nursing homes. This had been tried elsewhere and the experience is that the rehabilitative input for patients is less, the outcomes less good, and the incentives are for people to remain in residential care rather than go home. This option would also not deliver the desired results for Home First.

I believe there is an alternative to the options put forward - **Option4**. This proposal, outlined below, will

- strengthen the input of Glossopdale into commissioning for Glossopdale
- be evidence based
- retain choice for the Glossopdale population
- make financial savings
- meet the expressed views of the population of both Tameside and Glossop

Firstly, a formal subcommittee of the Single Commissioning Board, the Glossopdale commissioning subcommittee, should be set up and meet in Glossop. It should comprise selected elected members of High Peak and Derbyshire County Councils, officer(s) from Derbyshire CC social services, GP, and manager of the Neighbourhood team. Its remit would be to ensure commissioning decisions fully respect the specific circumstances of the Glossopdale population and make a reality of integrated care between health and social care in Glossopdale. This may permit a strengthening of the home care provision in Glossopdale. This is an important component of this option, to address the current governance and accountability gap for Glossopdale.

Secondly, Shire Hill is redeveloped by a third party. My suggestion is that the redevelopment creates flats for the elderly with on site 24/7 care and potential respite accommodation . The development should include an updated 10 bedded intermediate care unit run by Tameside and Glossop IFT. The capital costs would come from the developer and be part of the initial negotiation. It is my view this intermediate care unit should operate on the same lines as the original Homeward bound unit we set up in 1994, then only the second intermediate care unit in the country. This had step up beds from the community and the unit was successfully managed by a multidisciplinary team, and included social services domiciliary care manager and Occupational therapist as well as nursing staff. Crucially staff worked *both* on the unit and in the community ensuring a truly seamless transition for individuals and greater flexibility for the deployment of staff to meet variable need. I would recommend that an expanded Neighbourhood Team is the ideal vehicle for such an arrangement. There would be considerable synergy between the elderly care accommodation and the intermediate care facility. There is also the possibility to seek additional external funding for the provision of palliative care beds in addition to the 10 intermediate care beds. There are precedents in the country where similar developments have been undertaken by joint ventures with Housing Associations. I am confident that such a scheme would be looked on favourably by NHS Properties.

As part of this option, the empty floor of the Stamford unit at Tameside would be opened with an initial 26 intermediate care beds, providing a more appropriate site for Tameside residents and building in flexibility for future expanded needs.

The staffing for this should come from the existing compliment including Shire Hill, and staffing costs for Option 4 would be neutral, as they are suggested to be for Option 2. Financial savings from Option 4 would come from reduced rental costs at the Shire Hill site, in the same way as Option 2, but a lesser amount.

I believe this option is a better solution for all the residents of Tameside and Glossop and seeks to address some of the flaws in the current intended intermediate care strategy. I hope it will receive further serious consideration.

Yours sincerely

Council – Notice of Motion – 30 November 2017

The Council notes that:

- the outcome of the CCG consultation and decisions about the future of intermediate care in Tameside and Glossop will not be made until December 2017

- on 14 September 2017, the full Council overwhelmingly agreed to endorse its current arrangements for responding to such consultations as appropriate, evidence-based, reasoned, comprehensive and robust

- on 12 October 2017, the Executive agreed that its support for the concerns and recommendations from the Community Select Committee and its support for Option 1 in the consultation be sent as the Council's response to the consultation at that stage

- a powerful and persuasive case for an 'Option 4' proposal and actions for specific intermediate care arrangements in Glossop has recently been put forward by former Glossop GP, Sir John Oldham, a copy of whose Glossop Chronicle article of 9 November 2017 is attached as an annex to this amendment.

The Council resolves immediately to inform the CCG of its intentions:

- to engage constructively with them in relation to their proposals for Glossop residents after their December meeting, in particular

- to mandate Group Leaders to liaise and make every effort to establish a consensus to best represent our residents affected by the consultation including arranging any necessary meeting(s), whether these be with the public, CCG, Council or by request to Community Select.

- to give immediate and urgent consideration to and identify any necessary actions, including consideration of judicial review, relating to the legal and practical issues arising from the decisions as they affect the intermediate care available to Glossop residents in future

- to involve relevant stakeholders, in particular Derbyshire County Council, so as to secure the best possible overall intermediate care outcomes for Glossop residents.

Appendix 9

Intermediate Care Consultation Response from Ruth George MP

From: GEORGE, Ruth
Sent: 15 November 2017 17:55
To: Communications (NHS TAMESIDE AND GLOSSOP CCG)
Subject: Consultation Response - Intermediate Care provision in Tameside and Glossop

Dear Sirs

I write in response to the consultation on Intermediate Care, as Member of Parliament for High Peak.

The people of Glossopdale feel very strongly about their local health services and about Shire Hill Hospital in particular. They have evidenced this in full:

- Hundreds of attendees and mass participation in the public meetings in Glossop
- Hundreds of responses to the consultation from the people of Glossopdale
- 3,397 signatures on the online petition to Save Shire Hill Hospital: https://www.change.org.uk/p/tameside-and-glossop-ccg-sos-save-our-shirehil
- 4,670 signatures on my petition to Parliament

The vast majority of responses from the people of Glossopdale, both at the meeting and on the online petition are in favour of keeping Shire Hill Hospital open, of keeping rehabilitation beds in Glossop for local patients, their families and for staff.

There was a justified and strong criticism of the style and mode of the public consultation at both consultation meetings in Glossop. Glossopdale residents are the only portion of the Tameside and Glossop population who will be disadvantaged by the proposals.

I expect the CCG to give appropriate weighting to the views of Glossopdale, especially as the voice of Glossopdale on the single commissioning board of Tameside and Glossop is minimal. Understandably the policies and protocols that have been developed by the board focus on the needs of the majority population, and a default position that the same policies and procedures can apply to Glossopdale. Bearing in mind the overwhelming response to the consultation from Glossopdale, I expect the CCG to take full account of the views of both residents and staff in Glossopdale, and the impact that proposals will have on them.

Many local people are also concerned at the general lack of provision of health services in Glossopdale, especially as traffic into Tameside and public transport have deteriorated over the last few years. There has been a lot of anger at the claim in the consultation document that journey times to Tameside Hospital are 18 minutes, when at usual travel times it is more like 45 minutes. Bus times vary from between 1 hour and 2 hours as there is either a considerable walk required from Ashton Town Centre, or a change of bus.

I call on Tameside Council and Derbyshire County Council to look to re-instate the direct bus service between Glossop and Tameside Hospital, including a Sunday service, as so many families can only visit their loved ones in hospital at weekends.

Now that the Mottram bypass is scheduled, traffic problems will become even more extreme during the period that roadworks take place. This will make it even more important that patients and staff who live in Glossop can access or work in health care in Glossop.

I concur with the very reasoned response set out by Sir John Oldham that unfortunately the intermediate care strategy as proposed in the CCG's preferred option will not deliver the expected results, and in particular will be detrimental for the people of Glossopdale.

Centralising intermediate care beds is unsupported by the clinical evidence which points to better outcomes if people are in facilities closer to their homes, principally because of the psychological benefit. It also enables families to visit more frequently, to have more contact with care staff and to more easily support the transition from hospital to home.

It is very important that we retain the skills, experience and excellent team working evidenced by the staff at Shire Hill Hospital. We are seeing at the Cavendish Hospital in Buxton how a proposed closure of wards – even when no date is fixed – leads to uncertainty amongst staff and to them seeking alternative employment – often not even in health care. It would be a tragedy if highly skilled staff, who are so valuable to the health service and difficult to recruit, are lost to the CCG due to uncertainty about their future.

Almost all staff who work at Shire Hill live in Glossopdale. Most are not prepared to travel to Tameside to work, and if they did so, they would find it difficult to work long shifts due to the journey times, and uneconomic to work short shifts due to the transport costs. The consultation response must take the views of the staff fully into account. The manner of the consultation has already risked alienating staff at Shire Hill and their vital contribution to the service provided must be taken fully into account.

I am concerned that there was no projected needs assessment for intermediate care beds in the consultation, and a denial at the consultation meeting that this was a matter to consider now. With an ever growing elderly population, increased retirement age, and families moving further apart there will be more people to care for, more elderly people living on their own, and fewer families nearby to give the support that the strategy is predicated on.

The changes made now need to be future proofed. The Office for National Statistics (ONS) population projection for Tameside and Glossop show that 22% more intermediate care beds than current provision will be needed by 2030. This has not been considered in any of the options.

There is an over reliance on a medical model of care to help people stay at home that is unsupported by the evidence. The major influence on whether a person can be safely kept at home, or discharged to home, is the availability of home care support. With a decline in home care support, the strategy as outlined will not work and it is very important that the CCG keeps beds available to meet future need.

I am receiving complaints from constituents in my surgery of the lack of joined up care between social services and health services in Glossopdale. The people of Glossopdale will need both assurances and evidence from Derbyshire County Council that they are prepared to input both the resources, personnel and integrated working from one hub for all staff that would be needed for a Home First policy to operate effectively.

I am concerned at Sir John Oldham's assessment that the strategy will not adequately increase throughput in acute beds and there may be system cost increases. Further, the strategy exchanges a

building wholly owned by the NHS in perpetuity, for a building with a four and a half year lease. The renegotiation of that lease will be from a weak position so financial savings are unlikely to be realised.

Bearing in mind the very tight finances in the CCG in future years, this could lead to cuts in the services which need to be especially well resourced in the community and would mean that patient care would suffer.

I fully support the proposal from Sir John Oldham for an alternative to the options put forward - Option4. This proposal, outlined below, will

- strengthen the input of Glossopdale into commissioning for Glossopdale
- be evidence based
- retain choice for the Glossopdale population
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Firstly, a formal subcommittee of the Single Commissioning Board, the Glossopdale commissioning subcommittee, should be set up and meet in Glossop. It should comprise selected elected members of High Peak and Derbyshire County Councils, officer(s) from Derbyshire CC social services, GP, and manager of the Neighbourhood team. Its remit would be to ensure commissioning decisions fully respect the specific circumstances of the Glossopdale population and make a reality of integrated care between health and social care in Glossopdale. This may permit a strengthening of the home care provision in Glossopdale. This is an important component of this option, to address the current governance and accountability gap for Glossopdale.

Secondly, Shire Hill is redeveloped by a third party. My suggestion is that the redevelopment creates flats for the elderly with on site 24/7 care and potential respite accommodation . The development should include an updated 10 bedded intermediate care unit run by Tameside and Glossop IFT. The capital costs would come from the developer and be part of the initial negotiation. It is my view this intermediate care unit should operate on the same lines as the original Homeward bound unit we set up in 1994, then only the second intermediate care unit in the country. This had step up beds from the community and the unit was successfully managed by a multidisciplinary team, and included social services domiciliary care manager and Occupational therapist as well as nursing staff. Crucially staff worked both on the unit and in the community ensuring a truly seamless transition for individuals and greater flexibility for the deployment of staff to meet variable need. I would recommend that an expanded Neighbourhood Team is the ideal vehicle for such an arrangement. There would be considerable synergy between the elderly care accommodation and the intermediate care facility. There is also the possibility to seek additional external funding for the provision of palliative care beds in addition to the 10 intermediate care beds. There are precedents in the country where similar developments have been undertaken by joint ventures with Housing Associations. I am confident that such a scheme would be looked on favourably by NHS Properties.

As part of this option, the empty floor of the Stamford unit at Tameside would be opened with an initial 26 intermediate care beds, providing a more appropriate site for Tameside residents and building in flexibility for future expanded needs. The staffing for this should come from the existing compliment including Shire Hill, and staffing costs for Option 4 would be neutral, as they are suggested to be for Option 2. Financial savings from Option 4 would come from reduced rental costs at the Shire Hill site, in the same way as Option 2, but a lesser amount.

I believe this option is a better solution for all the residents of Tameside and Glossop and seeks to address some of the flaws in the current intended intermediate care strategy.

I call on the CCG to give serious consideration to this option which is fully supported by local people in Glossopdale and by staff at Shire Hill Hospital, whose skills, experience, and close teamworking are so integral to the high level of care delivered at Shire Hill.

Yours sincerely

Ruth

Ruth George MP
Member of Parliament for High Peak

Appendix 9

Intermediate Care Consultation Response from Andrew Gwynne

From: "GWYNNE, Andrew"
Date: 3 November 2017 at 09:29:23 GMT
Subject: Shire Hill Hospital

Dear Steven

Having been made aware of the front page article in the Glossop Chronicle dated Thursday 2nd November 2017 relating to Shire Hill, Glossop, we are concerned that the way in which the article is written gives entirely the wrong impression of our position relative to the consultation currently taking place regarding the future of 'Intermediate Care' in Tameside and Glossop.

We wish to confirm that our position is unchanged and that we have stated, both privately and publicly, that Option 2, in our view, is the only sensible way forward, offering the best possible service for residents in a modern purpose built facility adjacent to the hospital site with professional medical assistance being readily and quickly available should it be necessary.

Option 2 also addresses the need for savings to be made across Health and Social Care and would realise upward of £500,000.

Yours sincerely

Andrew Gwynne MP - Denton and Reddish Constituency
Angela Rayner MP - Ashton Constituency
Jonathan Reynolds MP – Stalybridge and Hyde Constituency