Report to: **SINGLE COMMISSIONING BOARD**

Date: 22 August 2017

Officer of Single Commissioning Board Clare Watson, Director of Commissioning

Subject: **INTERMEDIATE CARE IN TAMESIDE AND GLOSSOP**

Report Summary:

The Locality Executive Group, at their meeting in March 2017, agreed to the development of a system wide strategy for Intermediate Care for Tameside and Glossop to enhance the delivery of intermediate care in the locality. The Single Commission have been asked to co-ordinate this work and to develop a clear timeline, bringing back a fully developed model to the Single Commissioning Board in December 2017.

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

The outcomes expected from a model of intermediate care are:

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

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

Recommendations:

The Single Commissioning Board are asked to approve the model outlined in the attached report, and agree to consult with option 2 as the preferred option for the Single Commission and Integrated Care Foundation Trust.

Financial Implications:

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

Budget Allocation (if Investment Decision)	£1.983 million (via GM Transformation Funding)
CCG or TMBC Budget Allocation	CCG
Integrated Commissioning Fund Section – S75, Aligned, In-Collaboration	Section 75
Decision Body – SCB, Executive Cabinet, CCG Governing Body	SCB

Value For Money Implications – e.g. Savings Deliverable, Expenditure Avoidance, Benchmark Comparisons	Expected savings to be realised of £0.453 million in 2017/18 (part year effect) and £ 0.686 million on a recurrent basis from 2018/19.
Additional Comments The flexible bed base proposal has been subject to a stringent business case and has been supported by the Project Management Office gateway review process (Stage 2 complete). It is essential that appropriate legal advice is sought in respect of the public consultation prior to inclusion of the report at the next Single Commissioning Board meeting.	

Legal Implications: **(Authorised by the Borough Solicitor)**	An open and transparent consultation process is required to attract maximum public engagement in order to ensure the public sector equality duty has been complied with. This should be reflected in the Equality Impact Assessment, which decision makers must have due regard to before making any decision. What needs to be considered is that Option 1 is unlikely to be a viable option as it is not affordable. Therefore is unlikely to be legal.
How do proposals align with Health & Wellbeing Strategy?	The proposals align with the living and ageing well elements of the Health and Wellbeing Strategy.
How do proposals align with Locality Plan?	Intermediate care has been identified as a key project for the locality in terms of the model of integrated care and savings assurance programme.
How do proposals align with the Commissioning Strategy?	The Care Together programme is focused on the transformation of the health and social care economy to improve healthy life expectancy, reduce health inequalities and deliver financial sustainability. This work is a critical part of the programme
Recommendations / views of the Professional Reference Group:	The Professional Reference Group supported the model outlined in the paper and the recommendation to consult on the 3 options for intermediate care in Tameside and Glossop, with option 2 as the preferred option for the Single Commission and Integrated Care Foundation Trust.
Public and Patient Implications:	This report outlines a clear intention to include a programme of engagement and formal consultation to ensure the patient and public implications are understood and taken into account. The report includes a full Equality Impact Assessment.
Quality Implications:	A Quality Impact Assessment has been completed and is attached to this report.
How do the proposals help to reduce health inequalities?	The proposal will ensure the delivery of intermediate care services which to meet individuals' needs across the locality and addresses health inequalities.
What are the Equality and Diversity implications?	A full Equality Impact Assessment has been undertaken and is attached to this report.

What are the safeguarding implications?	In the design and implementation of the model for intermediate care the commissioner and Integrated Care Foundation Trust will ensure that the model meets all appropriate safeguarding requirements.
What are the Information Governance implications? Has a privacy impact assessment been conducted?	As part of the implementation of this model of care, a data flow mapping exercise will be undertaken to understand what information will be transferred and to where; from that it will be possible to identify the requirements for robust data sharing agreements and protocols between the parties sending or receiving the data. Beyond that the commissioner will seek assurance from all parties involved in the delivery of intermediate care that appropriate arrangements are in place. The locality's IG Working Group will be used as a forum to sense check the data flows and IG requirements relating to this project.
Risk Management:	This programme will be managed via the Care Together Programme Management Office and therefore the risks will be reported and monitored via this process
Access to Information :	The background papers relating to this report can be inspected by contacting Alison Lewin, Deputy Director of Transformation:  Telephone: 07979 713019  e-mail: alison.lewin@nhs.net

1. BACKGROUND AND INTRODUCTION

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

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

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

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

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

2. PROPOSED TIMESCALE AND MILESTONES

2.1 Attached to this report at **Appendix 1** is the proposed timeline for the further development and consultation process, resulting in the presentation of a final model to the Professional Reference Group and Single Commissioning Board in December 2017.

2.2 The Single Commission will engage and consult on the proposed Intermediate Care model described in section 6 of this report, designed to deliver the requirements set in the strategy at **Appendix 2**. The outcome of the consultation will inform the model presented to the Single Commissioning Board in December.

3 DEFINITION OF INTERMEDIATE CARE

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

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

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

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

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

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.

4. CASE FOR CHANGE

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

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

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

The *Halfway Home* guidance clearly set intermediate care as an integrated part of a continuum or pathway of services, linking:

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

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

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

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

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

The analysis of this report led to the early identification of Intermediate Care as a priority for the developing Care Together programme. A number of developments have taken place, informed in part by this review, which are included in the current model of intermediate care. The National Audit for Intermediate Care is taking place in 2017. The Single Commission and Integrated Care Foundation Trust are participating in the audit to support the ongoing review of the locality's intermediate care system.

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

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

4.6 'Step-Up' facilities: The level of demand for step beds to avoid admissions is not fully understood as the decision to admit is usually related to a clinical need but an alternative

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

option may significantly reduce such admissions. Reviews undertaken in the past by the Elective Care Intensive Support Team and Utilisation Management have highlighted an issue with people being in an acute bed when a step up to a nursing bed may have been more suitable and enabled a more accurate assessment of on-going need.

4.7 For people with dementia or delirium, time for recuperation and assessment out of hospital will lead to not only better outcomes but a reduction in length of stay in hospital and reduced risk of premature admission to long term care. Undertaking assessment of people with dementia within an acute hospital setting often leads to inaccurate assumptions being made about their safety to return home, resulting in extended length of stay and increased risk of a permanent residential admission.

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

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

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

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

5. STRATEGY DEVELOPMENT AND ENGAGEMENT

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

5.2 The Single Commission have reviewed the outputs from previous consultation and engagement on intermediate care and the wider Care Together model to inform the model of

Intermediate Care. This includes information extracted from the engagement events facilitated by Action Together and the Glossop Volunteer Centre, and information from Care Together engagement events facilitated by the NHS Benchmark Consulting team during 2014/15.

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

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

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

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

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

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

Events were held in May 2014, under the Care Together banner, which were attended by 66 members of staff from across health, social care, independent sector and the 3rd sector. All staff were either providers of intermediate care services, or worked in services forming part

of the pathways using the intermediate care services. The objective of the events was to engage staff in sessions which were intended to:

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

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

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

The pathway which was produced in the first of these sessions illustrated a system with multiple points of entry and 'hand offs'. The output from these sessions was a business case which illustrated a model of integrated admission avoidance and intermediate care which has informed the current delivery of services described in section 6 of this report, and which continues to inform the ongoing development of intermediate care services.

The Commissioning Directorate of the Single Commission have undertaken pre-consultation engagement conversations across the locality with the public and staff. The purpose of these sessions was to understand the views of staff and the public on the current system of intermediate care, and the proposed strategic direction and outcomes we expect to see from the model of intermediate care commissioned. Engagement has taken place with staff, the Patient Neighbourhood Groups, and with a range of stakeholders in the community via Glossop Volunteer Centre and Action Together. Attached at **Appendix 3** is the information which was shared with the groups to inform the discussions.

The session with staff currently working in the intermediate care system identified the following issues in discussions which took place during June 2017:

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

5.4 The engagement has taken place to date with the 5 Patient Neighbourhood Groups. The general response to the proposed model and outcomes was positive and supportive. Comments received from the groups include:

- Services which patients could have in their own homes either in an attempt to keep them out of hospital, or return home quicker, should be publicised more in; order to make patients and their families/carers aware of these, and how to access them.
- the proposed model of intermediate care covers all elements required - we particularly discussed the use of 'step up' beds and those present felt that GPs should be able to use more step up beds rather than admitting to secondary care.
- Welcome the inclusion of dementia patients within the new model.

- Request that the commissioner considers the position of users of intermediate care in relation to support available at home – consider information to show whether users of services live alone and whether this is taken into consideration when determining an appropriate care plan.

At the request of the Single Commission, Action Together have arranged 7 sessions to discuss the intermediate care proposals, 4 of which have taken place at the time of writing this report. So far they have engaged 55 people in the discussions. Initial comments include the need to support people to be independent, but also safe; the model covers the very practical elements of supporting people to live independently but there needs to be a focus on emotional wellbeing, mental health, dementia, as issues that may have an adverse effect on people living independently; the need for a system which doesn't allow people to 'slip through the net'. Action Together will provide a full report of these activities and this will inform the next iteration of the consultation process.

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

6. PROPOSED MODEL FOR INTERMEDIATE CARE IN TAMESIDE & GLOSSOP

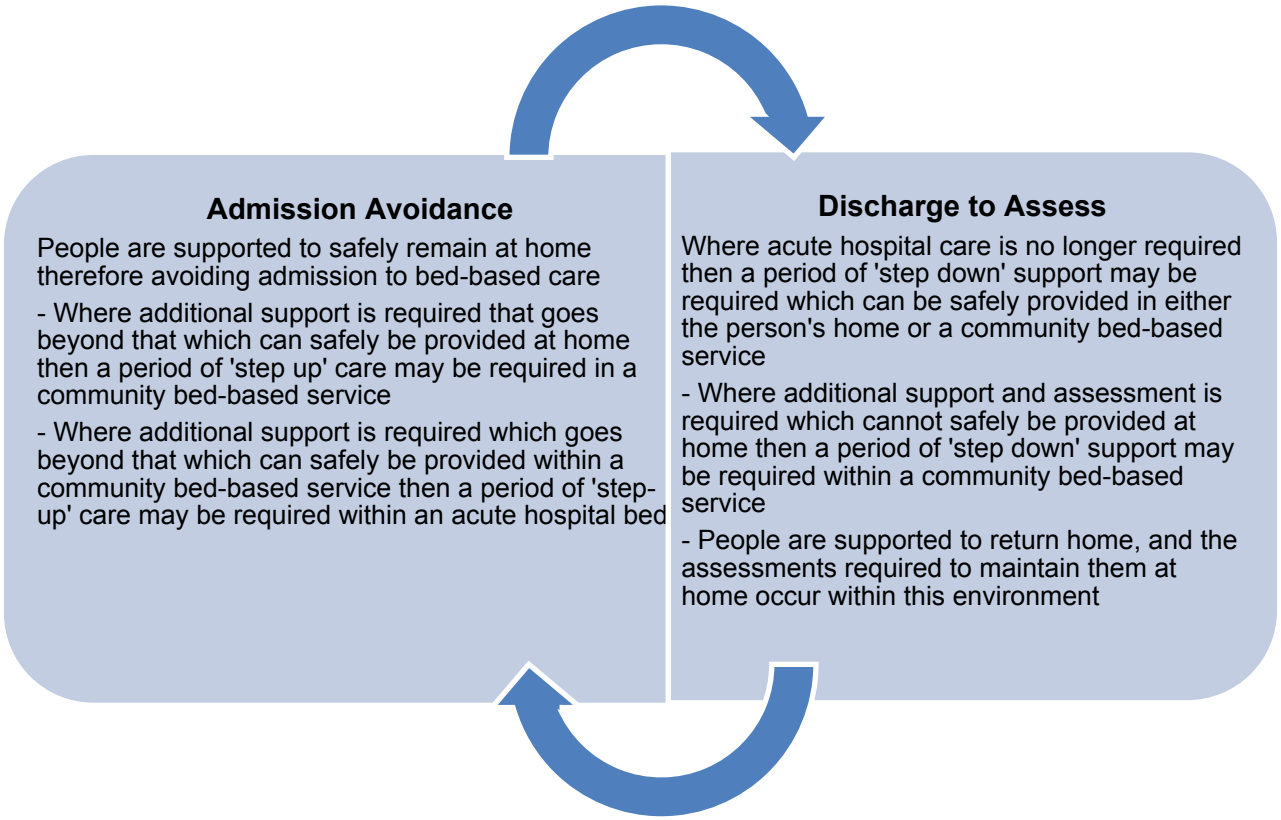
6.1 The proposals for Intermediate Care set out in this report have been prepared jointly by Tameside and Glossop Integrated Care NHS Foundation Trust and the Single Commission and have been designed to support delivery of the Commissioning Strategy for Intermediate care services. The strategy document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

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

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

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

The Home first model comprises of two key elements:



6.3 The Home First offer will ensure that people are supported through the most appropriate pathway with “home” always being the default position. However, it is recognised that not all individuals’ intermediate care needs can be managed safely in their own home. In some cases there is a need for an alternative community based bed, for a short period of time, to enable the appropriate interventions to be undertaken with the individual to enable them to return home, whether this be following an admission to the Hospital or to avoid the need for an admission in the first place.

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

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

Below is a description of how services will be provided at each of these interfaces to make up a holistic intermediate care offer to the local population.

6.5 **Integrated Neighbourhood Services:** The Integrated Care Foundation Trust and the Commissioners are working collaboratively through the Care Together programme to develop five Integrated Neighbourhood Teams, which will be Multi-disciplinary teams comprising Primary care (including GP services and pharmacists), community services such as district nursing and therapy services, social care, Mental Health services and the voluntary/community sector. The vision of these Neighbourhood Teams is to provide place

based care to support neighbourhoods to deliver high quality and connected services which look after the whole neighbourhood population, to support self-care in order to improve outcomes, prosperity and wellbeing. The services will aim to:

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

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

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

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

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

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

- A new Extensivist service has commenced to work with those individuals living with complex ongoing health and care needs, to improve their health and wellbeing and reduce demand on services by ensuring that their care is managed more effectively. This will offer a fundamentally different way of organising care around an individual's needs, including medical, social, psychological, functional, pharmaceutical and self-

care. This will be staffed by specialist Extensivist consultants or GPs, who will work with a cohort of high risk patients identified through risk stratification.

- 7 day Community IV therapy service to provide IV therapy in the home setting.
- Digital Health Service – a new innovative service which provides Care Homes and the Community Response Service with access via SKYPE to an Advanced Nurse Practitioner for clinical consultation and advice.
- Reablement which is a social care service which provides time limited care to intermediate care patients.
- Community Therapy services
- Integrated Urgent Care Team made up of therapists (physio and occupational), nurses, social workers and other care and support staff. The team works between the hospital and the community, supporting people or who are experiencing some difficulties within their own home or who have been discharged from hospital, intermediate care or other health and social care environments. The team will have a key role in responding to people with urgent care needs. Ongoing support will then be provided for up to 72 hours to allow for close working with the Neighbourhood Teams, who will manage their ongoing care and support needs where possible.
- Community Social Care services provided by Tameside Metropolitan Borough Council and Derbyshire County Council that will assess and provide care to patients to ensure they are able to remain independent for as long as possible and to delay placements into long term residential care. Social care is a fundamental part of the Integrated Care model in Tameside and Glossop. Progress is being made with proposals for Tameside MBC social care staff to transfer to the Integrated Care Foundation Trust in due course. Closer alignment of services is also planned with Derbyshire County Council for Glossop residents.

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

6.7 **Community Bed Setting - Overview:** The health and social care economy is currently commissioning community based beds from a range of sources from across the local economy. This includes intermediate care beds, spot beds and an arrangement for discharge to assess beds. In order to improve the community bed offer locally a revised model is being proposed in this report. The key principle of the flexible community bed base model is that support will be delivered through location-based community beds providing general nursing whilst encouraging independence and reablement, alongside in-reach from specialist teams such as therapy services, primary care and mental health. This will ensure individual centred management plans based on care needs that support people's transition back home effectively and ensure a smooth transfer of care, when necessary, to the Integrated Neighbourhood. A flexible community bed-base is key to effective intermediate care as it supports an individual's needs that cannot be met through home based intermediate care. By providing an enabling environment for further assessment, rehabilitation, completion of treatment and/or recuperation, it will prevent unnecessary admissions to hospital (through step up) or into long term care, and facilitate timely discharge to assess for those people not able to be assessed at home but do not require acute hospital based care. When home is not an option for the provision of care for an individual, the flexible community beds base will offer:

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

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

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

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

6.9 **Progress to date:** Through the Care Together programme significant progress has been made in implementing and integrating the services outlined in this proposal which will make up the intermediate care offer;

- Five Integrated Neighbourhood teams now established led by a primary care clinical lead and operational Manager and Neighbourhood delivery boards and governance in place.
- Digital Health service in place and rolled out to 15 nursing and residential homes with a plan to roll out to all Tameside and Glossop homes by December 2017.
- Extensivists recruited and service commences in July 2017.
- IV therapy seven day services commence in July 2017.
- Social Prescribing services commenced in Glossop and out to tender for Tameside.
- Provision of discharge to assess and intermediate care beds in Darnton House building.
- Home First Model rolled out and embedded in the Acute hospital and
- IUCT services in place in the community and Acute Hospital
- Reablement Service fully implemented and embedded in the Intermediate Tier structure

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

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

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

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

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

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

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

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

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

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

and is easily accessible for patients and relatives. Additionally easy access and short journey times for health care professionals and support services into Darnton Building will enable development of in-reach into the unit as proposed in the model.

- Recruitment and Retention – recruitment and retention of nursing and support staff at the Shire Hill hospital site is an ongoing risk due to the remote location at the edge of the conurbation and lack of public transport access.
- Single location – option 2 supports the delivery of bed based intermediate care from a single location to enable the flexible use of community beds to support the Home First model and enable the approaches to Discharge to Assess and Intermediate Care to be flexed depending on the demands in the system at any point in time.
- Tameside and Glossop Integrated Care NHS Foundation Trust registered from 1 July 2016 with the Care Quality Commission the location of The Stamford Unit at Darnton House.
- This option meets the national definition of 'intermediate care' from a combination of home and bed-based services and is in line with the recommendations of the Contingency Planning Team report from 2015 (referred to in section 4.4).

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

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

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

7. FINANCIAL MODEL

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

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

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

7.4 **Current Position vs Proposal –** Flexible Community Beds:

	Proposed £'000	Current Budget £'000	Do Nothing Expenditure £'000
Budget	8,032	8,718	9,746
Variance	NA	*-686*	*-1,027*

7.5 **Financial Summary of Transitional Costs – Flexible Community Beds:** It is assumed that there is **c £1.9m** available for this proposal in transitional funding (non-recurrently) as part of Greater Manchester transformation fund.

- The transitional costs required for this model are outlined in the paragraph below in bold font:
  - Temporary winter beds (32) between November 2016 to June 2017;
  - Double running costs from April 2017 to secure accommodation of Darnton house and facilitate a safe patient transition of service.

- The total cost of the schemes above equate to c £2.2m, leaving a balance of c£0.28m which will be required to pay for any transitional costs associated with relocation of services including:
  - Decanting/Dilapidation/ Removal costs;
  - One off setup costs, required in additional to what has been included within the financial model.

An analysis of the transformational funding costs by financial year is below;

	2016/17 £'000	2017/18 £'000	Total £'000
Planned Spend of Transformational Funds	851	1,132	1.983

8. CONSULTATION

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

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

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

The 3 options will be presented along with the details of how the system came to the conclusion that the preferred option is the co-location of services in the Stamford Unit at Darnton House.

8.3 Details of the consultation questions are included at **Appendix 6** of this document. A consultation booklet and Frequently Asked Questions will be produced to support this consultation.

8.4 The content of this report will be used to produce summary documents to support the public consultation process.

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

8.6 The survey will form part of Tameside MBC's Big Conversation consultation which is prominently publicised via the Council's website. The consultation pack will also be available in paper format from any GP surgery and a range of hospital and community locations from which services are currently delivered.

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

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

8.9 General Practice will be involved in the consultation via the 5 Neighbourhood Commissioning Forums and the Commissioning Business Managers. A Clinical Commissioning Group Governing Body clinical lead for this work has been identified to support the wider consultation process and the engagement with primary care colleagues (Dr Alison Lea).

8.10 Subject to approval from the Single Commissioning Board a programme of consultation will commence on 23 August, and will run for 12 weeks until 15 November 2017.

9. ALIGNMENT WITH REVIEW OF ESTATES

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

10. QUALITY AND EQUALITY IMPACT ASSESSMENTS

10.1 Detailed Quality and Equality Impact Assessments have been undertaken to support the proposals included in this document, which will be used to support the consultation process. These can be seen at **Appendices 4 and 5**

11. ONGOING AUDIT AND EVALUATION

11.1 The Single Commission are participating in the 2017 National Audit of Intermediate Care and will use the outputs of this audit, along with local performance and service quality

information, to ensure a system wide ongoing review of intermediate care services in the locality as part of the locality model of integrated care.

12. RECOMMENDATION

12.1 As set out on the front of the report.

Appendix 1

Timetable for Intermediate Care Model Development & Consultation

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

Appendix 2

Intermediate Care Strategy – Tameside & Glossop

1. Outline of this Strategy

This initial outline strategy sets out the intentions for the commissioning of intermediate care at home wherever possible, the model for bed-based services, and includes links with Integrated Neighbourhoods (including the Extensivists) and a robust model for hospital discharge planning.

This paper sets out an initial draft outline strategy. Commissioners will develop the detail, through wider engagement and consultation, with a view to having a detailed model agreed and ready to implement by late Autumn /early Winter 2017.

2. What is Intermediate Care?

The definition of Intermediate Care included in the National Audit of Intermediate Care 2017 (developed with the assistance of the Plain English Campaign) is as follows.

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.

3. Background

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

- An above average investment in intermediate care per 100,000 weighted population (4th highest of the 47 localities which participated)
.
- Above average beds commissioned per 100,000 weighted population (12th highest)

- Above average investment in bed based care compared with national average (£3.9m against a national average of £2.3m).

- A positive response was provided to 6 of the 13 quality standards

- A negative response to the commissioning of integrated home and bed based intermediate care services

The analysis of this report led to the early identification of Intermediate Care as a priority for the developing Care Together programme. A number of developments have taken place, informed in part by this review, which are outlined in section 5 of this strategy.

3.2. **Utilisation Management Review 2014/2015:** The Tameside and Glossop locality commissioned 2 reviews from the North West Utilisation Management Team (Academic Health Science Network) to increase understanding of Intermediate Care service demand and flow. The recommendations included in the 2 reports will be used as background information to support the 2017 review of Intermediate Care and the development of a system wide strategy. The 2015 was undertaken to support the Clinical Commissioning Group in establishing optimal Intermediate Care bed based service capacity.

3.3. **Staff and Public Engagement:** A summary of engagement work undertaken previously as part of the wider Care Together programme will be analysed and the information used in the further development of this model and strategy. This engagement involved patients, public and staff. Patient and service user satisfaction information held as part of the commissioner's ongoing contract monitoring will also be used.

4. National Audit for Intermediate Care (NAIC) 2017

The National Audit for Intermediate Care focuses on services which support, usually frail, elderly people, at times of transition when stepping down from hospital or preventing them being admitted to secondary or long term care. These services are a crucial part of the solution to managing increasing demand in the health and social care system.

This audit was last carried out in 2015, the results of which are summarised in section 3 above, and is being repeated in 2017 (data collection being undertaken during May and June). The audit shines a light on intermediate care and provides a stocktake of current service provision. The unique combination of organisational data and outcomes data collected in the audit enables us to address the following questions:

- Does intermediate care work?
- Is it cost effective?
- Do we have enough capacity to make a difference?
- What are the features of a "good" service?
- How do we make the case for investment?

The audit allows commissioners / funders and providers to consider both the national answers to these questions but also, importantly, how their local health and social care economy is performing on these key issues. Audit participants can access their local results via an online toolkit.[5]

The NAIC covers 4 categories for intermediate care: crisis response, bed based intermediate care, home based intermediate care and reablement.

The Clinical Commissioning Group/Single Commissioning Function are co-ordinating Tameside and Glossop registration and involvement in this audit for 2017 to ensure the data informs the review being undertaken by the economy. The results will be available in late autumn 2017.

[5] http://www.nhsbenchmarking.nhs.uk/CubeCore/.uploads/NAIC/NAIC%202017/NAIC2017auditproposal.pdf

Commissioners and the Integrated Care Foundation Trust have signed up to participate in the National Audit for Intermediate Care.

5. Progress to Date

This section outlines progress to date on the development of a system of intermediate care for the Tameside and Glossop Locality and the current position / provision.

5.1. **Home First:** The Single Commission and Integrated Care Foundation Trust undertook a piece of work in 2016-17 on the Home First model as part of the Care Together programme. The Tameside and Glossop Integrated Care Strategy will take into account the findings and outcomes from this piece of work in the initial draft / proposed model. In summary, the Home First model is the service offer that responds to meet an urgent/crisis health and/or social care need that cannot be managed within the Integrated Neighbourhood. It is a key interface between the Integrated Neighbourhood and the acute setting ensuring that people are supported in the environment that is suited to their own needs and most likely to achieve positive outcomes. It comprises of two key elements: Admission Avoidance and Discharge to Assess. A 'flexible community bed base scheme' is a key element of the home first model, and therefore needs to form part of this Intermediate Care Strategy. The main elements of Home First are:

- **Stamford Unit:** This will offer 32 beds for people who have been in hospital and who cannot immediately return home because they require further recuperation, or possibly further assessments that cannot be carried out at home.

- **Shire Hill and Grange View Intermediate Care beds:** These two facilities offer an ongoing period of rehabilitation to people who are unable to cope in their own home and require intensive rehabilitation to maximise the opportunity for them to return home either before an emergency admission is required or after a hospital admission. The maximum length of stay is 6 weeks and will vary dependant on the needs of an individual patient. Typically patients who need rehabilitation stay less than 26 days. Since April 2017 the number of Intermediate Care beds has reduced to reflect the level of need for bed based rehabilitation. This has resulted in the closure of the Grange View unit from 1 July.

- **Integrated Urgent Care Team (IUCT):** This is an integrated team made up of therapists (physio and occupational), nurses, social workers and other care and support staff. The team currently works between the hospital and the community and works with people or who are experiencing some difficulties within their own home or who have been discharged from hospital, intermediate care or other health and social care environments. The team is an urgent response team and plans to get to people within an hour of the request for help and support. Ongoing support will then be provided for up to 72 hours by when decisions will have been made about onward care and support needs

- **Intermediate Tier Development:** Work is underway within the Integrated Care Foundation Trust to develop an intermediate tier service that is more integrated in nature and as a starting point is beginning to co-locate many of the services that are identified as offering rehabilitation, reablement, urgent and early intervention. The service identified as having an input into an intermediate tier of service include the Integrated Urgent Care Team, Reablement Service, Home First and Digital Health, IV Therapy Team, Long Term Conditions Team, Extensivists, Community Neuro Rehabilitation Team, Community Physiotherapy and Pulmonary Rehabilitation Team, Speech and Language Therapy and Dietetics as well as the community beds currently provided at Shire Hill, Grange View and the Stamford Unit.

5.2. **Integrated Neighbourhoods:** The Integrated Care Foundation Trust have implemented a model of Neighbourhood working in response to the Single Commission's proposal for

Integrated Neighbourhoods (INs). The Integrated Neighbourhoods vision is to support neighbourhoods to deliver asset rich, high quality and connected services which look after the whole neighbourhood population to support all to have improved outcomes, prosperity and wellbeing. The key objectives are to:

- Proactively identify people at high risk of requiring access to services, through early intervention and prevention;
- Help people live as independently as possible whilst managing one or more long term conditions;
- Co-ordinate delivery of services from all providers, with teams of multi skilled professionals based in each of the Neighbourhoods;
- Optimise self-care and family/carers support to enable people to stay at home for as long as possible, independently and safely;
- Focus on improved condition management to avoid admissions;
- Help prevent people from having to move to a residential or nursing home (24 hour care) until they really need to.

5.3. **Extensive Care:** Extensive Care is a fundamentally different way of organising care around the needs of a specific cohort of people, which includes all aspects of need: medical, social, psychological, functional, pharmaceutical and self-care. The aim of an extensive care service model is to work closely with people with long term conditions, complex needs and those who are intensive users of the health and social care system. Within an agreed timeframe it aims to move to predicting exacerbations of underlying conditions, whilst helping people improve the management of their condition and their overall general health and well-being, therefore reducing the need for hospital admissions. The service implemented by Tameside and Glossop Integrated Care Foundation Trust will be led by a neighbourhood-based doctor (Consultant/GP) known as an Extensivist, supported by a multi-disciplinary team of health and social care professionals. The service includes health and well-being support that pulls together health and social support, including a range of community assets to ensure early intervention and proactive prevention. The service will also reduce the number of appointments that patients attend at different locations within our local health and social care system.

5.4. **Reablement:** The Reablement Service is currently provided by Tameside MBC Adult Services and has been in place for many years. The aim of the service is to enable people to attain or retain key skills for independent living. The service is provided by trained support workers who work with people for a period of up to six weeks following a period of ill health or trauma. The Reablement Service offers an intensive period of assessment and support that enables a person, in partnership with other clinicians and practitioners to realise their optimum potential for regaining, or in some cases learning or re-learning skills to enable them to live fuller lives and to have less dependency on more intrusive longer term services. Successful reablement will result in a person requiring less or no ongoing help and support in their daily living.

6. Future Model

Intermediate care services provide a crucial role in helping people to avoid going into hospital unnecessarily, helping people to be as independent as possible after a stay in hospital, and preventing people from having to move into a residential or care home until they really need to.

The overall aim of the intermediate care services is to support the rehabilitation and recuperation of patients maximising the patients' ability to function, to enable them to continue living at home in all but most challenging cases.

This should include 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. The model should also include 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.

The delivery model for intermediate care, including the assessment processes, must have the ability to care for clients with all levels of dementia, in an appropriate setting.

The further development of a model for Tameside and Glossop will take account of the outputs from previous audits and reviews, and the learning from the developments which have taken place during 2016-17 (as outlined above).

7. Proposed Outcomes

The further development of this Intermediate Care strategy will include the proposal and agreement of a set of system-wide outcome measures to assess the impact on:

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

Service user outcome measure: using the information included in the 2017 NAIC, local service user outcome measures will be developed and refined, initially in the workshops scheduled for June 2017, and then refined through the wider consultation process July-September.

Appendix 3

Pre-Consultation Engagement Material

Intermediate Care in Tameside & Glossop

The Clinical Commissioning Group are leading a review of Intermediate Care services in Tameside & Glossop and are seeking advice from patient and public representatives.

The work done so far has been informed to a significant degree by the engagement activities led by our 3rd sector through Action Together and Glossop Volunteer Centre. Comments made through the engagement work to support Care Together have been used to develop the current Strategy which informs the model we commission from Tameside and Glossop Integrated Care Foundation Trust, and the developments which have taken place over the past 18 months. The reports from the sessions have been analysed and any information which relates to intermediate care has been taken and used in the development of the full strategy presented to the Clinical Commissioning Group/Single Commission committees.

We are seeking further comments on our plans for Intermediate Care.

What is Intermediate Care?

The definition of Intermediate Care included in the National Audit of Intermediate Care 2017 (developed with the assistance of the Plain English Campaign) is as follows.

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.

Intermediate care services are currently delivered to the population of Tameside and Glossop Clinical Commissioning Group by the Integrated Care Foundation Trust as community, hospital and bed-based intermediate care services (the latter at Darnton House and Shire Hill), and by Tameside Metropolitan Borough and Derbyshire County Councils.

Question:	The section below is a summary of the model we intend to commission / deliver in Tameside and Glossop. We would appreciate your comments on whether this is the right model, and any additional suggestions you may have.

Model of Intermediate Care

Intermediate care services provide a crucial role in helping people to avoid going into hospital unnecessarily, helping people to be as independent as possible after a stay in hospital, and preventing people from having to move into a residential or care home until they really need to.

The overall aim of the intermediate care services is to support the rehabilitation and recuperation of patients maximising the patients' ability to function, to enable them to continue living at home in all but most challenging cases.

This should include 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. The model should also include 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.

The delivery model for intermediate care, including the assessment processes, must have the ability to care for clients with all levels of dementia, in an appropriate setting.

The further development of a model for Tameside and Glossop will take account of the outputs from previous audits and reviews, and the learning from the developments which have taken place during 2016-17.

Question:	The section below is a summary of the outcomes we want to achieve from our Intermediate Care model. We would appreciate your comments on whether these are the right outcomes, and any additional suggestions you may have.

Proposed Outcomes

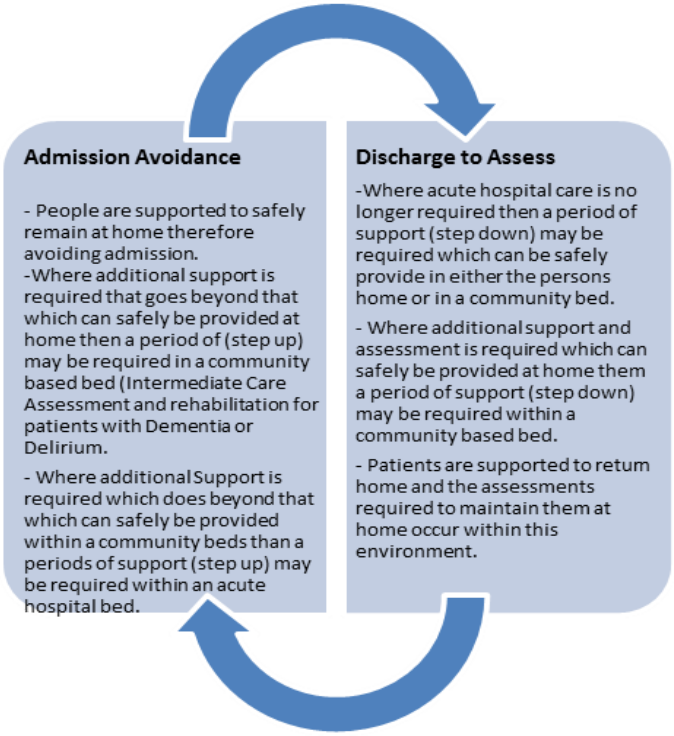
The further development of this Intermediate Care strategy will include the proposal and agreement of a set of system-wide outcome measures to assess the impact on:

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

Intermediate Care in Tameside & Glossop

This summary outlines progress to date on the development of a system of intermediate care for the Tameside and Glossop Locality and the current position / provision.

Home First: In summary, the Home First model is the service offer that responds to meet an urgent/crisis health and/or social care need that cannot be managed within the Integrated Neighbourhood. It is a key interface between the Integrated Neighbourhood and the acute setting ensuring that people are supported in the environment that is suited to their own needs and most likely to achieve positive outcomes. It comprises of two key elements: Admission Avoidance and Discharge to Assess. A 'flexible community bed base scheme' is a key element of the home first model.



The main elements of Home First are:

- **Stamford Unit:** Offers bed based support for people who have been in hospital and who cannot immediately return home because they require further recuperation, or possibly further assessments that cannot be carried out at home.

- **Intermediate Care beds:** These facilities offer an ongoing period of rehabilitation to people who are unable to cope in their own home and require intensive rehabilitation to maximise the opportunity for them to return home either before an emergency admission is required or after a hospital admission. The maximum length of stay is 6 weeks and will vary dependant on the needs of an individual patient. Typically patients who need rehabilitation stay less than 26 days.

- **Integrated Urgent Care Team (IUCT):** This is an integrated team made up of therapists (physio and occupational), nurses, social workers and other care and support staff. The team currently works between the hospital and the community and works with people or who are experiencing some difficulties within their own home or who have been discharged from hospital, intermediate care or other health and social care environments. The team is an urgent response team and plans to get to people within an hour of the request for help and support. Ongoing support will then be provided for up to 72 hours by when decisions will have been made about onward care and support needs

Intermediate Tier Development: Work is underway within the Integrated Care Foundation Trust to develop an intermediate tier service that is more integrated in nature and as a starting point is beginning to co-locate many of the services that are identified as offering rehabilitation, reablement, urgent and early intervention. The service identified as having an input into an intermediate tier of service include the Integrated Urgent Care Team, Reablement Service, Home First and Digital Health, IV Therapy Team, Long Term Conditions Team, Extensivists, Community Neuro Rehabilitation Team, Community Physiotherapy and Pulmonary Rehabilitation Team, Speech and Language Therapy and Dietetics as well as the community beds currently provided.

Reablement: The Reablement Services are currently provided by Tameside MBC Adult Services and Derbyshire County Council. The aim of the service is to enable people to attain or retain key

skills for independent living. The service is provided by trained support workers who work with people for a period of up to six weeks following a period of ill health or trauma. The Reablement Service offers an intensive period of assessment and support that enables a person, in partnership with other clinicians and practitioners to realise their optimum potential for regaining, or in some cases learning or re-learning skills to enable them to live fuller lives and to have less dependency on more intrusive longer term services. Successful reablement will result in a person requiring less or no ongoing help and support in their daily living.

Appendix 4

NHS
Tameside and Glossop
Clinical Commissioning Group

Tameside
Metropolitan Borough

Quality Impact Assessment

Title of scheme: Intermediate Care in Tameside & Glossop
Project Lead for scheme: Alison Lewin
Brief description of scheme: The vision for intermediate care in Tameside & Glossop is for the support to be delivered at home wherever possible. The proposed model includes an element of bed-based care, has clear links with the Integrated Neighbourhoods (including the Extensivists), a robust model for hospital discharge planning, and offers a response to urgent care requests. The outcomes expected from a model of intermediate care are:

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

The paper to be presented to PRG and SCB sets out the work undertaken to date, a proposed model for Intermediate Care for Tameside & Glossop (developed by the Single Commission and ICFT), and details of the recommended consultation process on 3 potential options.

What is the anticipated impact on the following areas of quality? **NB please see appendix 1 for examples of impact on quality.**							**What is the likelihood of risk occurring?**						**What is the overall risk score (impact x likelihood)**			**Comments**
	Neutral / Positive	Negligible	Minor	Moderate	Major	Catastrophic	No risk identified	Rare	Unlikely	Possibly	Likely	Almost certain	**Low**	**Moderate**	**High**	
	0	1	2	3	4	5	0	1	2	3	4	5	0-5	6-12	15-	

Patient Safety	0						0						0			The SCF 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. The provider of the model of care outlined in the paper will be Tameside & Glossop Integrated Care NHS Foundation Trust, therefore we will monitor delivery of these services via our existing quality and contract monitoring processes.
Clinical effectiveness	0						0						0			The proposed model described in the paper will ensure delivery of clinically effective services which will be outlined in contractual documentation. The case for change included in the paper describes the reasons for the proposed changes, and the benefits are included in the description of the proposed model
Patient experience		1						1					1			There will be high levels of patient engagement and involvement in the development of this model, including a period of formal consultation. This QIA will be repeated to accompany the final paper to SCB in December, which will be recommending a model of intermediate care taking into account the outcome of the consultation and patient/public views. The commissioner and provider expectation is that the model commissioned and delivered will deliver improvements in patient experience. However we need to understand the patient / public perspective through the consultation process.
Safeguarding children or adults	0						0						0			The commissioned model will include all required elements of safeguarding legislation

Please consider any anticipated impact on the following additional areas only as appropriate to the case being presented. **NB please see appendix 1 for examples of impact on additional areas.**							**What is the likelihood of risk occurring?**						**What is the overall risk score (impact x likelihood)**			**Comments**
	Neutral / Positive Impact	Negligible	Minor	Moderate	Major	Catastrophic	No risk identified	Rare	Unlikely	Possibly	Likely	Almost certain	**Low**	**Moderate**	**High**	
	0	1	2	3	4	5	0	1	2	3	4	5	0-5	6-12	15-25	

Human resources/ organisational development/ staffing/ competence			2							3				6		If the commissioner and provider's preferred option is the one which is ultimately recommended to SCB and subsequently implemented there will be an impact on staff from the perspective of the location from which they work. However there is also a positive impact on ALL staff working in the intermediate care services, as this will improve the effectiveness of their working model and reduce the current levels of travel time across the locality. Staff groups have been involved to some extent in the pre-consultation engagement and have supported the move towards a single location model for bed based intermediate care and the ongoing delivery of the Home First model of care. Staff will be included in the consultation process, including those staff currently working from the Shire Hill unit.
Statutory duty/ inspections	0						0						0			As the providers of the services will continue to be the ICFT, TMBC and DCC they are subject to statutory duties and inspections. The proposed location for the single site intermediate care service has been subject to CQC assessments via T&GICFT
Adverse publicity/ reputation			2								4			8		There is the potential for an adverse public reaction from a proportion of the population in the locality to one of the options included in the paper, due to the geographical location of the current vs proposed bed based services. This will be addressed via the formal consultation process proposed in the paper, which will run for 10 weeks from 23rd August. All areas of the locality will be covered by this consultation process, and a detailed EIA will be provided to support the PRG/SCB decision making process and the consultation.

Finance	0						0						0			This strategy is being developed to support key T&G locality Savings Assurance and Care Together programmes, and is being developed working closely with the locality finance team (commissioner and provider). Delivery of the proposals included in this paper are key to the delivery of a financially sustainable integrated care model.
Service/business interruption	0						0						0			The implementation of the model developed as a result of this work will be done with minimal service / business interruption. As the delivery of intermediate care is a time limited intervention – usually to a maximum of 6 weeks – there should be no requirement to transfer patients from one location to another. The commissioner and ICFT will ensure that the implementation of whichever model is approved by SCB has minimum service / business interruption and impact on patients / public.
Environmental impact		1					0						1			Travel times for car users and public transport routes are being considered as part of the EIA which will enable the consideration of the impact on car use and travel time as a result of the final proposal to be presented to PRG/SCB in December.
Compliance with NHS Constitution	0						0						0			The delivery of intermediate care services is part of the locality's wider 'urgent care' system, as it supports patient flow through local services, therefore supporting delivery of the NHS constitution relating to standards for urgent care / A&E
Partnerships	0						0						0			This is a key programme of work for Care Together and therefore involves key providers in the system. 3rd sector and patient groups are being included in this process, along with the public via the formal consultation process.

Public Choice	0						0						0			There has been and will continue to be significant public and patient involvement and engagement via the formal consultation process (in addition to the pre-consultation engagement which has taken place)
Public Access	0						0						0			Full mapping to be undertaken and included in the EIA, which will determine the impact on travel times and accessibility by car and public transport of any proposed option. Default position with this model will be home based care as the preferred option, thus minimising issues and negative impact regarding public access.

Has an equality analysis assessment been completed?	YES / ~~NO~~	Please submit to PRG alongside this assessment
Is there evidence of appropriate public engagement / consultation?	YES / ~~NO~~	Please submit to PRG alongside this assessment

Sign off:

Quality Impact assessment completed by	**Alison Lewin**
Position	**Deputy Director of Commissioning**
Signature	**Alison Lewin**
Date	**20 July 2017**

Nursing and Quality Directorate Review	
Name	**Lynn Jackson**
Position	**Quality and Patient Experience Lead**
Signature	**Lynn Jackson**
Date	**21/07/2017**