Tameside Metropolitan Borough

NHS
Tameside and Glossop
Clinical Commissioning Group

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

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|---|---|
| **Subject / Title** | Intermediate Care |

| **Team** | **Department** | **Directorate** |
|---|---|---|
| Commissioning | Commissioning | Commissioning |

| **Start Date** | **Completion Date** |
|---|---|
| 16th May 2017 | 7th August 2017 |

| | |
|---|---|
| **Project Lead Officer** | Alison Lewin |
| **Contract / Commissioning Manager** | Alison Lewin |
| **Assistant Director/ Director** | Clare Watson |

| **EIA Group** (lead contact first) | **Job title** | **Service** |
|---|---|---|
| Clare Watson | Director of Commissioning | Commissioning |
| Alison Lewin | Deputy Director of Transformation | Commissioning |
| | | |
| | | |

## PART 1 – INITIAL SCREENING

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| | **What is the project, proposal or service / contract change?** | To deliver a model of intermediate care in Tameside & Glossop which is in line with the locality strategy and the national definition of Intermediate Care.<br>The Locality Executive Group, at their meeting in March 2017, agreed to the development of a system wide strategy for Intermediate Care for Tameside & 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 |

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| 1b. | What are the main aims of the project, proposal or service / contract change? | 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.<br><br>The outcomes expected from a model of intermediate care are:<br>• Maximising independence<br>• Preventing unnecessary hospital admissions<br>• Preventing unnecessary admissions to long term residential care<br>• Following hospital admissions, optimising discharges to usual place of residence |

**1c. Will the project, proposal or service / contract change have either a direct or indirect impact on any groups of people with protected equality characteristics?**

**Where a direct or indirect impact will occur as a result of the project, proposal or service / contract change please explain why and how that group of people will be affected.**

| Protected Characteristic | Direct Impact | Indirect Impact | Little / No Impact | Explanation |
|---|---|---|---|---|
| Age | ✓ | | | The majority of users of the current intermediate care services are frail / elderly people requiring additional support to regain/maintain their independence. The demographics of people accessing current services have been analysed fully as part of this project prior to the development of any proposed model. The age demographics are contained in Section 2c below, however, this highlights that during 2017 over 90% of those admitted at either Shire Hill or the Stamford Unit were over the age of 65 years<br><br>Almost 18% of the Tameside and Glossop population are over the age of 65 years. |
| Disability | ✓ | | | The people who will require support |

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| | | | | from these services could be those with existing disabilities. 18.5% (approx. 48,000) of the population of Tameside and Glossop over the age of 65 years have a long term condition or disability. |
| Ethnicity | | ✓ | | There could be an indirect impact as people across all ethnicities could be users of intermediate care services<br>Section S2c below highlights that over 85% of those admitted during 2017 were 'White British' at the Stamford Unit and over 55% (2015) were White British at Shire Hill.<br><br>For Shire Hill a large proportion of ethnicity data for service users is unknown (otherwise I think there could be an inference that the other 45% of service users are BME which isn't the case) |
| Sex / Gender | | ✓ | | There could be an indirect impact as people of any sex/gender could be users of intermediate care services. |
| Religion or Belief | | | ✓ | There is no anticipation that the development or implementation of this proposal will impact directly or indirectly on Religion or Belief in any significant sense |
| Sexual Orientation | | | ✓ | There is no anticipation that the development or implementation of this proposal will impact directly or indirectly on Sexual Orientation in any significant sense |
| Gender Reassignment | | | ✓ | There is no anticipation that the development or implementation of this proposal will impact directly or indirectly on Gender Reassignment in any significant sense |
| Pregnancy & Maternity | | | ✓ | There is no anticipation that the development or implementation of this proposal will impact directly or indirectly on Pregnancy & Maternity in any significant sense |

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| Marriage & Civil Partnership | | | ✓ | There is no anticipation that the development or implementation of this proposal will impact directly or indirectly on Marriage & Civil Partnership in any significant sense |
| **NHS Tameside & Glossop Clinical Commissioning Group locally determined protected groups?** | | | | |
| Mental Health | ✓ | | | The commissioner's strategy and the locality proposals for an intermediate care model both include statements referring to the need to address the mental health needs of patients requiring intermediate care, including those with a diagnosis of dementia. There are currently 2,865 living with dementia in Tameside and Glossop and the diagnosis rate is 74.8%<br><br>Both Tameside and Glossop and England's prevalence for dementia is 0.8%.<br><br>Tameside and Glossop's Mental Health prevalence rate is: 0.83% (2024 people); and the national prevalence is 0.9% Depression: 10.71% (20969 people) for T&G; 8.3% Nationally. The proposed consultation will include engagement with these groups. |
| Carers | ✓ | | | Due to the demographics of users of intermediate care they are more likely to be in receipt of care. Therefore carers could be impacted as a result of any proposed changes to how the service is delivered. The proposed consultation will include engagement with these groups.<br><br>Carers data taken from Census 2011 for Tameside & Glossop CCG area around provision of unpaid care shows that 89.1% of the population do not provide unpaid care. A total of 10.9% of the population provide unpaid care - 6.5% receive no payment for 1-19 hours of care per week; 1.6% of the population receive no payment for 20- |

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| | | | | 49 hours of unpaid care per week; and 2.8% of the population receive no payment for 50+ hours of unpaid care per week. |
| Military Veterans | | | ✓ | There is no anticipation that the development or implementation of this strategy will impact directly or indirectly on Military Veterans in any significant sense |
| Breast Feeding | | | ✓ | There is no anticipation that the development or implementation of this strategy will impact directly or indirectly on Breast Feeding in any significant sense |

**Are there any other groups who you feel may be impacted, directly or indirectly, by this project, proposal or service / contract change? (*e.g. vulnerable residents, isolated residents, low income households)***

| Group (*please state)* | Direct Impact | Indirect Impact | Little / No Impact | Explanation |
|---|---|---|---|---|
| n/a | | | | |

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

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

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# PART 2 – FULL EQUALITY IMPACT ASSESSMENT

## 2a. Summary

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

A number of factors and service reviews have led to the identification of Intermediate Care as a priority for the Tameside & Glossop locality. 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.

The proposals for Intermediate Care have been prepared jointly by Tameside and Glossop Integrated Care NHS Foundation Trust (ICFT) and the Single Commission (SC) in support of the Commissioning Strategy for Intermediate care services. The strategy document (attached Appendix 1) describes the overall aim of the intermediate care services as being 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. 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

One of the key principles within the Tameside & Glossop Care Together approach to integrated care is that wherever it is possible for a person to have their care requirements met within their own place of residence, the system will be responsive to meeting this need in a timely manner. This principle is embodied in this proposal for an intermediate care model. In order to be responsive to patients needs and deliver against this principle Tameside & Glossop ICFT has implemented the **"Home First"** service model, which responds to meet an urgent/crisis health and/or social care need for patients. 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 that people are supported in the environment that is suited to their own care needs and most likely to achieve positive outcomes, and supports the intermediate care aims of:

- 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

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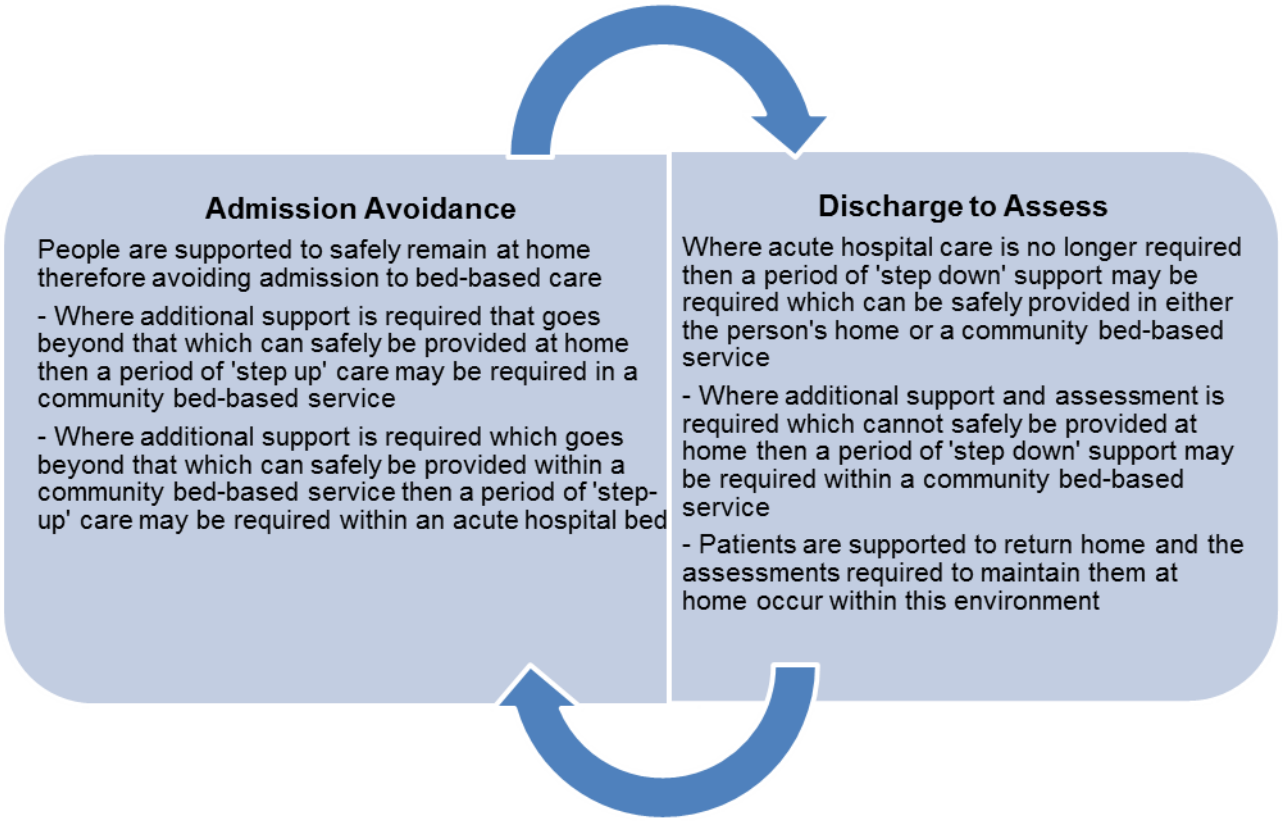
The Home first model comprises of two key elements:




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.

Tameside & Glossop Integrated Care Foundation Trust (ICFT) 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.

**Integrated Neighbourhood Services**: The ICFT and the Commissioners are working collaboratively through the Care Together programme to develop five Integrated Neighbourhood

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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.

**Intermediate / Specialist Community Based Services:** The ICFT 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

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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 (IUCT) 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 (TMBC) 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 & Glossop. Progress is being made with proposals for TMBC 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.

**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. 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

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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 ICFT is the provider of all intermediate care beds for Tameside and Glossop as of 1st July 2017, and currently provides community beds from two locations: 64 beds in the Stamford Unit at Darnton House1, 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.

This EIA seeks to set out how the 3 delivery model options that we are proposing to consult on may impact on protected characteristic groups – specifically those groups who may be impacted directly by changes to how intermediate care is delivered.

This EIA also seeks to ensure that the consultation process is as inclusive as possible to enable all protected characteristic groups to be included and able to input.

Data has been collated to support this project which identifies current service users and their demographic details, including age/ethnicity and patient address/postcode/registered GP.

**2b. Issues to Consider**

The decision to carry out the work to develop a strategy for Intermediate Care for Tameside & Glossop has been taken in the context of national and local analysis of the current delivery model, and local progress already made to address these issues Key findings include:

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

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A number of factors and service reviews have led to the identification of Intermediate Care as a priority for the Tameside & Glossop locality and the development of a delivery model.

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

**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 IUCT and the discharge to assess team, which ensures patients are supported through the most appropriate pathway with "home" always being the goal.

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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

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National Audit for Intermediate Care 2015: The results of the NAIC 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 NAIC is taking place in 2017. The Single Commission and ICFT are participating in the audit to support the ongoing review of the locality's intermediate care system.

Tameside & Glossop NHS Foundation Trust Contingency Planning Team (CPT) Final Report September 20153: Price Waterhouse Cooper were appointed by Monitor to carry out a review of the Tameside & 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 CPT 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 UICS (now developed and implemented as IUCT and Home First). One of the features included in the CPT report is that the UICS would be increasingly delivered in people's own homes.

**Tameside & Glossop Care Together Programme Model of Care:** The Tameside & Glossop Care Together model of care has been developed in response to the Contingency Planning Team report outlined in the section above. The analysis carried out by the CPT, and other reports, 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,

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

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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.

'Step-Up' facilities: The level of demand for step beds to avoid admissions is not fully understood as the decision to admit is usually related to a clinical need but an alternative option may significantly reduce such admissions. Reviews undertaken in the past by ECIST and UM 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.

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.

A point prevalence conducted by Utilisation Management in Nov 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.

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.

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 (NAIC 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.

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.

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**Staff and Public Engagement**: A significant level of staff, public and wider stakeholder engagement has been undertaken to support the work of the Care Together programme, including pieces specific to the area of intermediate care. The outputs from this engagement have informed the recent developments in the locality and are outlined a pre-consultation engagement document was provided to support this work (Appendix 2)

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 CVS used a range of asset based techniques and engaged with a range of other VCFS 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 proposed delivery model are:

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

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

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

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- Facilities that are homely to help build confidence that they can cope at home

Staff engagement 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 paper, and which continues to inform the ongoing development of intermediate care services.

The Commissioning Directorate of the Single Commission have since May 2017 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 during June and July 2017, and with a range of stakeholders in the community via The Bureau, Glossop and Action Together (Tameside). The Bureau, Glossop received feedback from 100% of patients they engaged with Action Together (Tameside) have to date held 4 sessions with 3 more planned. They have consulted with 55 Tameside residents.

Following engagement the proposal is that the Single Commission with the ICFT enter into a formal consultation programme, based on the 3 options outlined below:

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 ICFT 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 First 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).

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

**Option 2: Use of available 96 bedded unit**
Transfer of all bed-based intermediate care to a single location in the Stamford Unit at Darnton House. This is the preferred option from the assessment carried out by the Single Commission and ICFT for the following reasons:
Whilst the aim of the home first model is to use the community beds flexibly to meet the demand at any point in time, the notional intermediate care bed figure proposed is 64 beds.
Patient Environment; - The Stamford Unit is 100% en-suite single room accommodation with significant communal space on each of the three wards which has been demonstrated to encourage social interaction and independence. Additionally one floor of the Stamford Unit in the Darnton Building has been designed as dementia friendly with access to outside space and wandering routes, which will enable the Trust to provide community beds for patients with Dementia.

- Accessibility – the Stamford Unit is located in a central location and is co-located close to the Tameside Hospital site and therefore has strong public transport links, ample parking and is easily accessible for patients and relatives. Additionally easy access and short journey times for health care professionals and support services into Darnton Building will enable development of in-reach into the unit as proposed in the model.
- Recruitment and Retention – recruitment and retention of nursing and support staff at the Shire Hill hospital site is an ongoing risk due to the remote location at the edge of the conurbation and lack of public transport access.
- Single location – option 2 supports the delivery of bed based intermediate care from a single location to enable the flexible use of community beds to support the Home First model and enable the approaches to Discharge to Assess and Intermediate Care to be flexed depending on the demands in the system at any point in time
- Tameside and Glossop Integrated Care NHS Foundation Trust registered from 1st July 2016 with the CQC the location of The Stamford Unit at Darnton House.
- The Stamford Unit at Darnton House was originally furnished as a ‘dementia friendly’ building with furniture from the 1950s and décor to aid dementia patients.
- This option meets the national definition of ‘intermediate care’ from a combination of home and bed-based services and is in line with the recommendations of the Contingency Planning Team report from 2015

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

are required, and that services could be developed at a neighbourhood level to meet need.

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

Consultation on the three options will primarily be undertaken via the CCG website to ensure that all patients/service users across Tameside and Glossop can have input. Targeted work will be undertaken with specific groups reflecting the demographic profile of service users as those more likely to be impacted directly by any proposals. Those in existing poor health will also be engaged as potential users of a future intermediate care service. Paper copies will also be provided at different locations e.g Shire Hill, Darnton House, GP practices.

Service user data has been analysed around the key protected characteristic groups to help understand how they may be impacted by any of the 3 options included within the proposed consultation. Potential impact is detailed in Section 2c (below)

## 2c. Impact

This EIA has identified that protected characteristic groups who could be directly affected by changes to an intermediate care delivery model are age, disability, mental health and carers. Data on local service use has been collated to review the demographics of the people using these services to quantify the potential demand on protected characteristic groups.

**Current Service Users**

**Age**

The focus of this work on the older population groups is consistent with the project's aims and the needs of the population. Intermediate care nationally is something which, in the main, is provided to support frail and / or elderly people. Activity data for the current facility on the hospital site in Ashton Under Lyne (the Stamford Unit, Darnton House) and Shire Hill Hospital shows the following spilt in terms of the age of the people accessing the bed based intermediate and discharge to assess models:

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

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

The overall Tameside and Glossop population age breakdown is:

| Total Tameside and Glossop Population - latest figures available 2016 | | Total Population |
|---|---|---|
| <65 | 65+ | all ages |
| 207,597 | 46,110 | 253,707 |
| 81.80% | 18.10% | |

Almost 18% of the Tameside and Glossop population are over the age of 65 years.

Targeted work will be undertaken with specific groups including those over the age of 65 years who may be impacted directly by the proposals

## Ethnicity

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

***2015-2017 Shire Hill***

| Any Other Ethnic Group | Asian/ Asian Brit - Indian | Not Known | Not Stated | Other Ethnic Group - Chinese | White - any other White b/g | White - British | White - Irish | Grand Total | % White British | % either not stated or not known |
|---|---|---|---|---|---|---|---|---|---|---|
| 3 | 2 | 123 | 118 | 2 | 5 | 308 | 5 | 556 | 55.39 | 43.34 |

**2015-2017 Stamford Unit, Darnton House**

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

The above tables highlight the 'White British' ethnicity has the majority of admissions in the community bed bases, and also shows the Stamford Unit, Darnton House having the most varied ethnic diversity for admissions.

Targeted work will be undertaken with the above ethnicity groups who may be impacted directly

# Tameside & Glossop Single Commissioning Function
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The overall ethnicity breakdown for T&G from Census 2011 is also be included here for comparison:

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

Source: 2011 Census

Over 89% of the Tameside and Glossop population are White British and of these over 94% are over the age of 65 years.

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

## Disability

The table below outlines long term limiting illness and disability data for Tameside & Glossop CCG area, Tameside MBC and High Peak (the local authority which Glossop is within) (Census 2011).

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

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

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

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

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

Tameside Metropolitan Borough

NHS
Tameside and Glossop
Clinical Commissioning Group

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**Postcode Data**

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

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

**Stamford Unit, Darnton House Summary**

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

**Shire Hill Summary**

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

Further analysis can be accessed via appendix 3 which contains the following documentation:

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

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

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

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

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## Accessibility of Services

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

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

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

Drive Times

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

- During weekdays 0700-0900, 86.3% of Tameside and Glossop residents are within 0-15 minutes' drive of the Stamford Unit compared to 19.3% within 0-15 minutes' drive of Shire Hill.
- During weekdays 1000-1600, 89.3% of residents are within 0-15 minutes' drive of the Stamford Unit comparted to 20.8% within 0-15 minutes' drive of Shire Hill.
- During weekdays 1600-1900, 86.2% of residents are within 0-15 minutes' drive of the Stamford Unit compared to 20.2% within 0-15 minutes' drive of Shire Hill.
- At weekends 0700-1900, 92% of residents are within 0-15 minutes' drive of the Stamford Unit compared to 22.2% within 0-15 minutes' drive of Shire Hill.
- For all four of the above drive time periods 99.8% of residents are within 0-30 minutes drive of both the Stamford Unit and Shire Hill.

Public Transport

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

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

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

- 96.4% can reach the Stamford Unit by public transport within 0-60 minutes and 35.9% to Shire Hill.

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

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

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

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

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

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

Walk Time

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

In terms of walk time alone:

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

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Key Location Travel Time Analysis

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

Drive Times

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

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

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

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

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

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

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

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

- Weekends 0700-1900: 17.47 minutes

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

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

Public Transport

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

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

The longest public transport travel times to Shire Hill were:

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

The shortest public transport travel times to Shire Hill were:

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

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

- Tuesday 0700-0900: Gamesley: 48.65 minutes

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- Tuesday 1000-1600: Broadbottom: 47.93 minutes
- Tuesday 1600-1900: Broadbottom: 44.93 minutes
- Saturday 1000-1600: Broadbottom: 47.93 minutes

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

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

Walk Times

Further key location travel time analysis can be found on page 23 of appendix 3.

The walk time to Stamford Unit is shorter from Ashton, Mossley, Stalybridge, Dukinfield, Hyde, Hattersley, Mottram, Denton, Audenshaw and Droylsden than the walk time to Shire Hill.

The walk time to Shire Hill from Broadbottom, Hadfield, Gamesley, and Glossop is shorter than the walk time to Stamford Unit.

The longest walk time to Shire Hill is from Droylsden at 208.3 minutes and the shortest is from Glossop at 20.24 minutes.

The longest walk time to the Stamford Unit is from Glossop at 137.32 minutes and the shortest is from Stalybridge at 22.49 minutes.

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**2d. Mitigations** *(Where you have identified an impact, what can be done to reduce or mitigate the impact?)*

Age

The data in section 2C shows that the age group using this type of service is predominantly aged 65+ years and over. Almost 18% (43,515) of the Tameside and Glossop population are over the age of 65 years broken down as follows:

| | No of Patients | % of population |
|---|---|---|
| **65-69 years** | 14,615 | 5.80% |
| **70-74 years** | 10,552 | 4.20% |
| **75-79 years** | 8,024 | 3.20% |
| **80-84 years** | 5,466 | 2.20% |
| **85-89 years** | 3,051 | 1.20% |
| **90 years and over** | 1,807 | 0.70% |

The focus of this work on the older population groups is consistent with the project's aims and the needs of the population. Intermediate care nationally is something which, in the main, is provided to support frail and / or elderly people. To ensure the views of this cohort of the local population are taken into account, the consultation process will ensure local groups and sections of the population who are within this protected characteristic group are supported and encouraged to engage in the consultation, thus ensuring their views are included in the process.

Engagement during the consultation will include service users/patients aged 65+. 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 CVS used a range of asset based techniques and engaged with a range of other VCFS organisations.

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| | |
|---|---|
| Public Transport/Accessibility of sites | The proposal covers home and bed-based intermediate care, with home being the preferred option wherever possible. We will look to manage any impact on service users/patients/carers by minimising the impact of any travel implications to the intermediate care sites<br>No patients will be moved to another base as a result of any of the proposals contained within this document.<br><br>Parking on both the Stamford Unit and Shire Hill sites is available free of charge.<br>Full analysis has been undertaken to around travel times to Stamford Unit, Darnton House and Shire Hill by public transport, drive time and walking.<br>However, in addition to public transport available, The Bureau Glossop does run a volunteer car scheme that provides transport to Tameside Hospital and other hospitals for Glossop residents. Derbyshire Community Transport operates across the county providing a variety of services to meet every need and all vehicles are wheelchair accessible. It enables people who are unable to use public transport to get out and about and make journeys most people take for granted<br>'aCTive' travel operates in Glossop - this is a door-to-door service catering for individual needs and is primarily for getting to health appointments and improving people's quality of life by assisting them to get to places they wouldn't otherwise be able to access. Either a small, wheelchair accessible vehicle, or a volunteer using their own car, will be used depending on a passengers mobility<br><br>Community Transport within Tameside is via 'Transport for Greater Manchester' – 'Local Link'. This is a flexible public transport service for local journeys, connecting people to a range of transport providers.<br><br>Local Link journeys can be made by shared minibuses from and to anywhere specified within each individual service area. Further information on Local Link can be found at:<br><br>http://www.tfgm.com/buses/local_link/Pages/index.html |

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| | |
|---|---|
| Carers | We will ensure the consultation process includes carer groups. (Carers data taken from Census 2011 for Tameside & Glossop CCG area indicates that 10.9% of people across Tameside & Glossop provide unpaid care). |
| Mental Health | The commissioner will ensure that the consultation process is inclusive of people with disabilities to ensure they are involved in the development of the model of care. Data From 2011 Census shows that 10.3% of people across Tameside and Glossop had some form of disability which limited day to day activities 'a lot' and a further 10.2% whose day to day activities were limited 'a little'.<br>From the 2011 Census, 20.4% of the total population of Tameside have day to day activities limited; and similarly 17.6% in High Peak |
| Disability | The commissioner will ensure that the consultation process is inclusive of people with disabilities to ensure they are involved in the development of the model of care. Data From 2011 Census shows that 10.3% of people across Tameside and Glossop had some form of disability which limited day to day activities 'a lot' and a further 10.2% whose day to day activities were limited 'a little'.<br><br>From the 2011 Census, 20.4% of the total population of Tameside have day to day activities limited; and similarly 17.6% in High Peak |

| **2e. Evidence Sources** |
|---|
| - National Audit of Intermediate Care (2015)<br>- Utilisation Management Review (2014/15)<br>- Staff & Public Engagement<br>- Census 2011<br>- QOF 2015/2016<br>- Basemap – TRACC Software<br>- ONS 2014 health geography mid-year population estimates |

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| **2f. Monitoring progress** | | |
|---|---|---|
| **Issue / Action** | **Lead officer** | **Timescale** |
| A project group is being established to support this work, led by the SCF Commissioning officer and reporting as required via the established Locality Care Together programme.<br><br>We will ensure that progress on the monitoring of the consultation will be undertaken. | Alison Lewin | Ongoing |

| **Signature of Contract / Commissioning Manager** | **Date** |
|---|---|
| | |
| **Signature of Assistant Director / Director** | **Date** |
| | |

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**Appendix 1**

## 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 & Glossop intermediate care model (summary / selection of key indicators):

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

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- 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 T&G locality commissioned 2 reviews from the North West Utilisation Management Team (Academic Health Science Network) to increase understanding of IC service demand and flow. The recommendations included in the 2 reports will be used as background information to support the 2017 review of IC and the development of a system wide strategy. The 2015 was undertaken to support the CCG in establishing optimal IC 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 NAIC 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?

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

The CCG/Single Commissioning Function are co-ordinating T&G 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. Commissioners and the ICFT have signed up to participate in the NAIC.

## 5. Progress to Date

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

5.1. **Home First:** The Single Commission and ICFT undertook a piece of work in 2016-17 on the Home First model as part of the Care Together programme. The T&G IC 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 1st 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

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

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 ICFT have implemented a model of Neighbourhood working in response to the Single Commission's proposal for Integrated Neighbourhoods (INs). The IN 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 T&GICFT 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.

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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 & 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.

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**Appendix 2**

**Pre-Consultation Engagement Material**

**Intermediate Care in Tameside & Glossop**

The CCG 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 & 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 CCG/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 & Glossop CCG by the Integrated Care Foundation Trust as

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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 & 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

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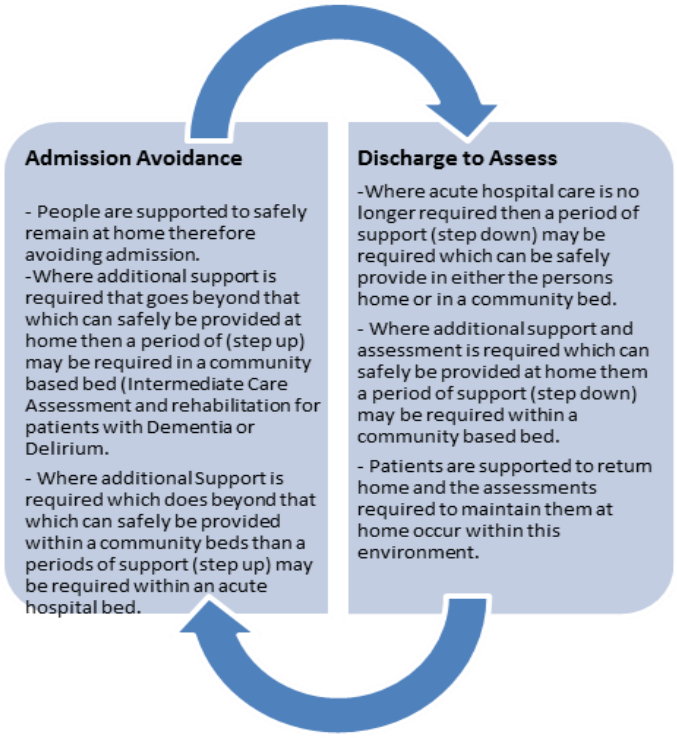
## Intermediate Care in Tameside & Glossop

This summary outlines progress to date on the development of a system of intermediate care for the Tameside & 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.

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- **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.