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Report of the Strategic Director of Health and Wellbeing to the meeting of the Health and Social Care Overview and Scrutiny Committee to be held on 6th July 2017

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Subject:

A report to update on the progress made on the implementation of the Health and Wellbeing Departments Great Places to Grow Old Programme

Summary statement:

The Committee received an update report on the delivery of the Great Places to Grow Old Programme at the meeting held on 3 March 2016.

This report provides an update on the progress made over the past year on the implementation of the integrated plan that aims to help older people, including people living with dementia to be independent and have a better quality of life by meeting their care and support needs within their own home, keeping them near their friends and family for as long as possible.

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Portfolio:
Health and Wellbeing

Overview & Scrutiny Area:

Health and Social Care

1. Summary

1.1. The Committee received an update report on the delivery of the Great Places to Grow Old Programme at the meeting held on 3 March 2016.

1.2. This report provides an update on the progress made over the past year on the implementation of the integrated plan that aims to help older people, including people living with dementia to be independent and have a better quality of life by meeting their care and support needs within their own home, keeping them near their friends and family for as long as possible.

2. Background

2.1. The Council Executive approved the establishment of the Great Places to Grow Old Programme at the meeting held on 15 January 2013. The Transformation Programme is a joint plan with health and incorporates the work commenced in 2009 to develop a strategy for the Council's in-house residential and day services. It includes the implementation of some of the Better Care Fund plans which are focused on integrated health and social care service delivery as outlined in West Yorkshire and Harrogate Sustainability and Transformation Plan. The Committee has previously received reports on progress made on integrated service delivery. Performance of the Better Care Fund is measured by a set of agreed metrics. Delayed transfers of care is a key measure, which across the Bradford District we have consistently performed well in relation to other areas in Yorkshire and Humber and nationally.

2.2. **Council managed residential and day services**

2.2.1. The strategy for the Councils in house residential and day services in 2009 focussed on streamlining and modernising the residential and day care services at 5 care homes to focus on specialist dementia care services and short term support alongside a programme to decommission 6 of the initial 11 care homes in existence in 2009.

2.2.2. This strategy was reviewed in the spring of 2012 and this included a public consultation on the future of 3 care homes (Neville Grange, Holme View and Harbourne) where decommissioning was proposed. The consultation was completed in May 2012 and the consultation highlighted significant risks to decommissioning these homes within 2012 as there were insufficient specialist residential dementia care beds in the independent sector. The strategy included a plan to build 5 residential homes across the District and capital was agreed to support this development. A revised financial appraisal of the strategy to redevelop the 5 homes was presented to the Council's Executive on 17 July 2012 which outlined key issues in relation to the affordability of the 5 homes being built.

2.2.3. On the basis of the consultation concerning the future of Harbourne, Holme View and Neville Grange and revised financial appraisal, it was recommended to Council Executive in July 2012 that Council officers work with NHS colleagues in implementing joint plans to improve efficiencies across the whole system to implement and align existing strategies and to create an integrated plan that covered the whole spectrum of services including accommodation and support, day services, specialist housing

(including extra care) short term support (including intermediate and respite care) through to long term residential and nursing care.

2.2.4. In 2013 it was agreed as part of Adult Services budget reductions to decommission in house social care day services over a three year period and by 2016 this had been achieved along with the budget reduction. The remaining day service provision is funded as part of the Better Care Fund and is for people living with dementia and is provided in partnership with the NHS. Social care day care is now provided in communities by community and voluntary sector providers. Support in communities will be reviewed in line with departments Home First vision for wellbeing.

2.2.5. The decision of the Council to approve the closure of two residential homes over two financial years as part of the Adult and Community Services budget proposals for 2014/15 and 2015/16 was made in the context of the Great Places to Grow Old (GPGO) delivery programme which was endorsed by the Executive in January 2013. The plan includes the proposal, previously agreed by Executive in 2009 that the in-house service no longer continues as a long term provider (except for specialist dementia care), to enable the delivery of flexible support as part of the joint community beds strategy in development with the NHS.

2.2.6. In line with the decision made by the Council's Executive on 18th February 2014 to decrease provision by closing a further two in-house residential homes, subject to formal consultation. Consultation on Harbourne residential home commenced on 9 September 2014 and a paper was presented to Executive on 16 October 2014. The decision was made to decommission Harbourne and this home was closed in January 2015.

2.2.7. The plan to consult on the decommissioning of another Council managed home as per the GPGO plan was delayed in September 2015 because of concerns regarding the quality of provision in the independent sector as assessed by the Care Quality Commission (CQC). At the time 26% of care homes were assessed as being inadequate and could not be used for new placements, currently 5% of care homes are now assessed as being inadequate which is a significant improvement. This is as a result of joint quality improvement work between Adult Services, NHS colleagues and Care Home Providers with the support of CQC.

2.2.8. The budget saving proposed by decommissioning the in house was mitigated non recurrently in last years budget and will continue to be mitigated non recurrently this financial year.

2.2.9. A report was presented to the Executive Committee on 20th June for members to make a decision on the future of Holme View care home on the Holmewood estate. The decision was made by the Executive to close Holme View. The closure of the home and the move of residents to their new home will be managed in line with the transitions policy. Residents will be supported by staff over a period of time to help them feel safe and secure in their new home. The decision in relation to the local authority to pay top ups was agreed, but this was amended to state that top up fees would be

paid by the local authority for at least 2 years, with further support to be reviewed on an annual basis.

2.2.10. Following the closure of Holme View this will leave 5 in house residential homes which will provide a total of 162 beds across the District. 57 long stay beds; 71 flex beds and 34 intermediate care beds (see Appendix 1). This is a change in the profile of beds used from the profile reported in the last update report because the NHS fund less intermediate care beds and additional savings for 2016/17 included a plan to increase the number of long term placements in the Council managed care homes this meant that up until October 2016 there was an increase in the numbers of people residing in our care homes. The plan has now changed with the focus being on providing short term support as outlined in Home First – Our Vision for Wellbeing. The budget savings will be realised now by reducing the numbers of people going into long term care home placements.

2.3. **Extra Care**

2.3.1. A key element of GPGO is for the Council to support the development of extra care housing schemes as there is a shortage across the District. Extra care housing is designed with the needs of frailer older people in mind and offers and provides 24 hour care and support on site. People who live in these schemes have their own self contained homes with their own front doors, but can also use communal facilities which can include restaurant/dining facilities; hairdressers; health/fitness facilities; computer room.

2.3.2. Neville Grange residential care home in Saltaire closed in November 2013 to allow for the development of a new build of 45 extra care apartments and a 20 bed intermediate care centre. This development was going to be a partnership between Incommunities, Adult Services and the NHS. It was anticipated that the development would be operational in late 2015 but Incommunities made a decision to withdraw from the partnership. This means that the plan to develop the 45 extra care apartments will not now be built. An outline plan for the Council owned land (the Neville Grange site) has been drafted for a 50 bedded residential unit. Discussions are taking place with NHS colleagues about a plan to work in partnership as part of the Sustainability and Transformation Plan.

2.3.3. Elm Tree Court in Thackley a 51 unit extra care facility opened in March 2015 and provides 24 hour care and support services for people, including people with dementia according to their assessed needs. This is proving a popular scheme and is well utilised.

2.4. **Personalised Care and Support**

2.4.1. The Committee received a briefing note on the Integrated Personalised Care and Support Framework on 21 January 2016. The procurement for this framework was concluded in August 2016 resulting in 36 providers being awarded contracts as part of the framework, we also continue to work with

23 non framework providers which we are working with as part of developing the supply of support for people to choose from across the District.

2.4.2. The aim of the Integrated Personalised Care and Support Framework is to ensure people are able to remain in their own home for as long as possible and to achieve and maintain their autonomy, independence, personal identity and to participate in their communities. We want people and their carers to remain at the centre of decisions about their care and support. We want to ensure that people have choice about how their care and support is provided and that the services they receive are person centred.

2.5. Integrated working with NHS and Community and Voluntary Sector Colleagues

2.5.1. The Committee has previously received progress reports on the Better Care Fund and integrated plans which aim to promote independence and wellbeing for older people and reduce reliance on intensive care and support. The in house enablement service (BEST) has been over the past 5 years, redesigned to focus on short term reablement and recuperation, working closely with NHS colleagues in both acute hospitals and community nursing services. The BEST service is almost fully funded via the Better Care Fund now. As reported in the last Committee report enablement can now be provided over 24 hours and works closely with the District Nursing service. A rapid response service (responds within 2 hours) has been implemented co located with the Virtual Ward Team at Bradford Teaching NHS Foundation Trust. The aim of this service is to provide a rapid response to social care needs which if not provided would mean the person was admitted to hospital.

2.5.2. Integrated working takes place at both acute hospitals in the Intermediate Care hubs this work contributes to reducing unnecessary admission to hospital and enabling timely transfers out of hospital to the person's home or to the most appropriate place to support the person to recover.

2.6. Care Home Market

2.6.1. The committee received a briefing note on the Integrated Residential and Nursing Care Framework on 10 December 2015. The procurement for this framework was concluded in October 2016 resulting in 100 homes being awarded contracts as part of the framework, we do however continue to work with 39 non framework residential and nursing homes to ensure people and their families have choice about the provision of their care and support needs.

3. Progress to date

3.1. The Health and Wellbeing Department's Home First – Our Vision for wellbeing

3.1.1. This was presented to the Committee on 2 March 2017 and approved by the Council Executive on 4 April 2017. The "to be" operating model aims to reduce demand for the Health and Wellbeing department by helping people early to delay and prevent minor things developing into major concerns, it aims to build support around people so they can be more independent, it will

focus on what people can do rather than what they cannot do. We want a more positive approach, so that people can live their lives to the full. The Bradford and Airedale and Craven Sustainability and Transformation Plan (STP) have enshrined the same vision and aims of Home First within the Bradford CCG area this is included in the Out of Hospital Programme which is developing integrated plans. In the Airedale and Craven area a new care and support model is being developed. GPGO is a key delivery programme contributing to the implementation of these plans as agreed by the Council Executive in July 2012.

3.2. **Market Shaping and Commissioning Guidance**

3.2.1. As previously reported the Care Act (2014) introduces new duties on local authorities to facilitate a vibrant, diverse and sustainable market for high quality care and support in their area, for the benefit of their whole population regardless of how the services are funded. The statutory guidance to the Care Act states that the market should include a variety of different providers and different types of services and this should include a genuine choice of service type, not simply a selection of providers offering similar services, this must include services for older people. We want to move forward with offering personalised services for older people. The guidance for Bradford Council is currently being refreshed in order to implement the Home First Vision, this will support the implementation of key benefits within the GPGO programme including all social care and support providers workforce development with the shared goal of ensuring a trained, quality workforce who have the relevant skills and appropriate working conditions.

3.3. **Intermediate Care and Out of Hospital Services**

3.3.1. The Better Care Fund implementation plan for 2017/18 will be formulated in the next few months building on the evaluation of integrated working over the past 3-4 years. This is part of the implementation of the local STP. Work is taking place to develop an integrated commissioning approach that aligns resources and supports flexible delivery solutions.

3.4. The following progress has been made since the last update report

3.4.1. BEST capacity across the District has at times been limited because of lack of supply in the independent domiciliary care providers and this has at times adversely affected transfers of care out of hospital in both acute hospitals. Capacity has been managed by transferring people out of Acute hospital beds for short term support to Council managed beds until they can be supported to go home.

3.4.2. Local authority employed Occupational Therapists have taken a more significant role in assessing people referred to BEST from both community and hospital we plan to increase this input over the next year because it has proved very effective. Occupational therapists have also provided increased support to independent support providers.

3.4.3. In the past three months supply in the domiciliary market has improved as a result of the work the departments commissioning and contracting team have undertaken. Action has been taken to stabilise the market through using the precept to increase fees to the sector. Work has also begun with the sector to develop new workforce pathways and an enhanced training offer to care staff.

3.4.4. The BEST service contributes to end of life care because it supports people to come home from hospital and inevitably some of these people will become in need of end of life care and support. We are going to discuss how this role maybe expanded by working with NHS colleagues over the next few months as part of the BCF plan.

3.4.5. The 24 hour BEST element of service will be expanded and optimised by long term care and support for night time care being provided by independent domiciliary providers. The rapid response service will be expanded across the district as part of the new operating model to deliver Home First; this will be included in the BCF plan.

3.4.6. The BEST service is beginning to work more closely with the Voluntary and Community sector providers for example Home from Hospital, this work will be optimised in the enhanced integrated care and support models planned over the next year.

3.4.7. The Council managed Time Out service offers support to people in their own homes to support carers to have a break and this is funded via the Better Care Fund. Over the past year it has been expanded to support people to remain in their own home at a time of crisis, in particular people living with dementia. This has proved successful in preventing some people from being admitted to hospital and enabled people to come home from hospital sooner than expected. In line with plans to enhance short term support in the community to wrap round people at times of crisis we intend to further enhance this offer as part of the BCF plan for this year.

3.4.8. Population planning has been undertaken by Public Health for intermediate care across the District, and to support the Home First vision to support people to stay in their own home. It has been identified that 168 step up and step down beds are required for the Bradford area and 66 step up step down beds are required for the Airedale and Craven area which is an increase of 110 beds than currently available. The in-house residential care homes provided 34 recurrent funded intermediate care beds over the winter. To compensate for the current deficit of intermediate care beds the NHS funded an additional 30 non recurrent funded beds taking this up to 64 and to respond to demand this rose at one point to 70 beds.

3.4.9. As part of the Out of Hospital programme a community beds strategy has been formulated and signed off at the Bradford Out of Hospital Programme Board.

3.4.10. As Council managed beds become available these are being converted from long term use to be used more flexibly for short term care to enable greater

independence and to respond to demand for crisis support. This short term support offers an opportunity for people to be supported through a crisis or carer crisis and enabled to return home. Short term beds are also provided to enable people to recuperate after a hospital admission or as part of a rehabilitation plan after an accident. This has contributed to the good performance in the numbers of days people are delayed in hospital.

3.4.11. The services described in this section as intermediate or out of hospital are responding to an increasing demand for younger people from a broader range of people for example older people with a learning disability, physical disability and mental health challenges from both the hospital and the community.

3.4.12. A taster flat has been created at Dove Court (extra care facility) to support rehabilitation, enablement and independence with a view to people moving back in to their own home or in to extra care. All referrals to date have been successful in enabling people to move back in to the community. We are planning to increase this type of service in the next year.

3.4.13. The contract has been signed and sealed for building a 50 bedded care home on the Bronte School site in Oakworth in Keighley, the plan is that these beds will be used as short term beds and end of life beds including for people living with dementia.

3.4.14. An outline plan for the Council owned land (the Neville Grange site) has been drafted for a 50 bedded residential unit. Discussions are taking place with NHS colleagues about a plan to work in partnership as part of the Sustainability and Transformation Plan.

3.5. Extra Care and Future Developments

3.5.1. The Council has been successful in a bid to the Homes and Community Agency for grant funding to support the building of a 69 extra care flats in Keighley at the Bronte school site and a 50 bedded short stay residential unit as described in 3.4.13. Following the tender process using the Yortender framework, the contract for the project has been awarded to Wildgoose Construction. The contract was signed and sealed on 24th March and Wildgoose took possession of the site on 27th March. Site preparation work has been undertaken and full work has started on site for the care facility and extra care scheme alongside the housing scheme. The first formal site meeting took place on 6 June 2017 and work is progressing well.

3.5.2. Abbeyfield are building The Dales at Fernbank Drive, Bingley as a scheme for 47 extra care apartments, 30 bed specialist dementia centre and a community hub and is due to be completed in July 2017. Funding has been secured through the Leeds City Region Enterprise Partnership. The department is working with Abbeyfields to support people to move to the extra care apartments. The nomination criteria has been defined and referrals will be managed via the Shipley Assessment Team.

3.5.3. Discussions are taking place with private property consultants, on the proposals to develop extra care and self contained living accommodation on the Wirefields site at Keighley. Outline planning permission is being progressed with the planning department to move this forward. Expressions of interest have been received from registered social landlords in providing this function at the site.

3.5.4. Bradford Council is in discussions about a potential capital development to build a 64 apartments extra care facility at Wyke.

3.6. Personalised Care and Support

3.6.1. Now that we have established the integrated personalised support framework we want to move forward with increasing the numbers of older people who are able to have personal budgets and personal health budgets because the evidence demonstrates that people report better outcomes if they have personal budgets. To do this we will review our current processes and bureaucracy to make it easier. This will include proportionate support planning and offering Individual Service Funds to support flexible support where a person feels unable to take a direct payment.

3.6.2. The “To Be” operating model to implement Home First will include offering more web based information including guided self directed support planning via Connect to Support and early help within multiagency community hubs across the district. The focus will be on reconnecting people to natural networks of support and working with community organisations to support people within their own communities.

3.6.3. Health and Wellbeing department staff will work in multiagency teams in localities to support older people, the system will be 24 hours a day, seven days a week and will enable people to remain as independent as possible.

3.6.4. Connect to Support Bradford is currently being developed and this is an online market place for providers and the community. Through Connect to Support members of the public will be able to purchase their own care, access advice and information which will include assessment and screening tools, buy equipment and be able to search for local groups and activities. This is free for providers to sign up to and will provide links to good practice to improve quality and training and development. We currently have 400 providers registered and over 1300 local groups.

3.6.5. The department will continue to work to develop a vibrant supply as described in earlier and this will include developing the supply of personal assistants. Closer working between the commissioning and contracting team and providers will be developed. Provider forums have been re-established and we are working closely with all providers to support them to improve quality, workforce and training.

3.6.6. The use of technology such as Just Checking, and adaptations will be increased so that people are supported to maintain independence and risks are managed.

3.6.7. We are working to reduce the number of people going into care homes through an enhanced preventative focused (early intervention) approach, which will aim to minimise the need for long term support by addressing underlying needs at the earliest stage possible.

3.7. Care Home Market

3.7.1. The Integrated Residential and Nursing Care Framework 2016-2020 was awarded in October 2016 as outlined in 2.4.1. The new framework arrangements support providers to shape their services to meet the needs of individuals and to support the personalisation and integration agendas locally in partnership with the Council and NHS colleagues. The new models of care in all the CCG areas support people living in care homes and build on the learning from the Advanced Care in Care Home Vanguard, which has previously been reported at the Committee.

3.7.2. We will support care home providers to respond to people's changing needs either at a time of illness or deteriorating condition so that people can remain at their place of residence with additional support rather than be transferred to hospital unnecessarily. When someone who lives in a care home is admitted to hospital we will work closely with the care *home* to support the person to return to their home. The BCF includes plans that support this partnership approach with Care Home providers. Multi agency provider forums have been re-established and we are working closely with providers to improve quality, workforce and training.

3.8. Quality

3.8.1. The frameworks support providers in fostering a culture of continuous improvement and quality which is monitored by the contract monitoring team who work closely with providers to ensure that service improvement action plans are in place to raise quality and standards. Homes of concerns are reviewed fortnightly and a log has been set up to evidence the input of support provided by the Local Authority and the CCGs.

3.8.2. The Local Authority and CCGs have worked together with providers to improve the quality of care and support. The number of providers who were assessed by the Care Quality Commission (CQC) as inadequate across the District in April 2016 was 12%, this has now reduced to 5%.

3.8.3. Connect to Support Bradford is currently being developed and this is an online market place for providers and the community. Through connect to support member of the public will be able to purchase their own care, access advice and information which will include assessment and screening tools, buy equipment and be able to search for local groups and activities. This is free for providers to sign up and will provide links to good practice to improve quality and training and development. We currently have 400 providers registered and over 1300 local groups.

4. Contribution to corporate priorities

4.1. Bradford Council Plan 2016-2020 to create as good a quality of life as possible for the people and communities of the Bradford District.

4.2. Health and Wellbeing Strategy 2013 – 2017 to improve health and wellbeing and reduce health inequalities, in particular contributes to the following action plan priorities:

4.2.1. Priority 9 – to improve diagnosis, care and support for people with dementia and improve their, as their carers' quality of life.

4.2.2. Priority 10 – to promote the independence and wellbeing of older people.

4.3. Home First - Our vision for wellbeing January 2017 to help people to be independent and have a better quality of life by meeting their care and support needs within their own home, keeping them near their friends and family for as long as possible.

5. Finance and resources

5.1. The savings required for older people residential care for 2017/18 is £1.2m. This comprises of saving £200,000 by reducing the number of long term placements in the independent sector by utilising in house beds and saving £1m by reducing long term placements of older people into nursing and residential care.

5.2. The latter will be achieved by supporting more people in their own homes or in extra care supported housing. The Council will also aim to achieve reductions in the numbers of older people needing long term residential and nursing care by using technology to help them stay independent and by working closely with health services to plan and deliver services.

5.3. In 2016/17 the Council moved towards reducing the number of long stay beds within the in house homes. This may place increasing pressure on purchasing care in the independent sector and meeting the savings target as well as reducing the income received from long stay service users.

5.4. In 2016/17 the Council reduced the number of service users in residential care by 51, although there was an overall increase in costs of £44k as a result of the price uplifts and the cumulative impact of the fee uplifts in 2015/16. The pressure in 2017/18 will be to make further reductions in placements within the independent sector in the light of the recent increase in fees.

5.5. The Council has undergone a process of closing some house residential homes as part of the Great Places to Grow Old programme. Harbourne care home has closed and the Executive have approved the closure of Holme View. Savings are attached to the closure of these homes.

5.6. The fee increases have been largely due to the increase in the National Living Wage which increased from £7.20 to £7.50 in April 2017. Based on the proportion of staffing costs within the fee structure, it was decided that an uplift of 3.2% would be

necessary. In addition, it was determined that to promote the market for older people and people with physical disabilities in the home care market, it was necessary to increase the uplift by a further 1% to 4.2%. These increases are to be funded through the Adult Social Care precept.

5.7. The number of service users at the end on 2016/17 was 892 for older people in residential care. In order to achieve the £1.2m savings reduction for residential care, the Council would need to reduce the number of service users by approximately 10% to 803.

6. Recommendations

6.1. Members are invited to comment on the update on the progress of the implementation.

7. Background documents

7.1. Report to the Strategic Director Adult and Community Services to the meeting of the Executive on 14th July 2009 – Long Term Support for Older People – The Future Of The Council's Residential Care Homes and Day Care Services
7.2. Report to the Strategic Director Adult and Community Services to the meeting of the Executive on 3rd December 2010 – Long Term Support for Older People – The Future Of The Council's Residential Care Homes and Day Care Services
7.3. Report to the Strategic Director Adult and Community Services to the meeting of the Executive on 10th February 2012 – Long Term Support for Older People – The Future Of The Council's Residential Care Homes and Day Care Services
7.4. Report to the Interim Strategic Director Adult and Community Services to the meeting of the Executive on 17th July 2012 – Long Term Support for Older People – The Future Of The Council's Residential Care Homes
7.5. Report to Strategic Director Adult and Community Services to the meeting of the Executive on 15th January 2013– Review of Residential Strategy – Great Places to Grow Old
7.6. Health Inequalities Action Plan 2013 – 2017
7.7. Health Needs Assessment – Dementia in Bradford and Airedale (July 2014)
7.8. The Care Act (2014) Report to the Director of Finance to the meeting of Executive to be held on 18th February 2014 – The Council's Revenue Estimate for 2014-15 and 2015-16
7.9. The Government's Spending Review and Autumn Statement (2015)
7.10. Report of the Interim Strategic Director Adult and Community Services to the meeting of the Health and Social Care Overview and Scrutiny Committee 3 March 2016
7.11. Report of the Strategic Director of Health and Wellbeing to the meeting of the Health and Social Care Overview and Scrutiny Committee 26 January 2017
7.12. Home First January 2017 – Our vision for wellbeing

8. Not for publication documents

8.1. None

9. **Appendices**

9.1. Appendix 1 - Summary of Current In House Care Provision (January 2017)

Appendix 1

In House Care Provision (January 2017)

Area	Care Home	Total (beds)	Current Designation			Registration categories	Comment
			Long Stay	Flex Beds	Intermediate Care (IC)		
Homes with specialist mental health registration							
Keighley BD22 6AB	Holmewood	28	15	9	4	Dementia	Recent Investment £378,000
Bradford BD15 7YT	Woodward Court	28	11	13	4	Dementia / challenging behaviour	Significant investment to make dementia friendly
Bradford BD4 9BT	Holmeview	35	22	13		Dementia	To close Autumn 2017
Subtotal		**91**	**48**	**35**	**8**		
Homes with no specialist mental health registration							
Bradford BD2 4BN	Beckfield	34	14	12	8	Older people 65+	Long stay beds are also used as IC beds
Bradford BD6 1EX	Norman Lodge	35	7	20	8	Older people 65+ (2 younger adults	Unit to become short stay/IC
Bingley BD16 2EP	Thompson Court	37	10	17	10	Older people 65+ (8 younger adults)	
Subtotal		**106**	**31**	**49**	**26**		
TOTAL		**197**	**79**	**84**	**34**		
Homes decommissioned							
Shipley BD18 4JJ	Neville Grange	31	15	8	8		Closed 2013 - Saltaire
Bradford BD6 2LE	Harbourne	28	4	14		Dementia / functional mental health needs	Closed January 2015

If Holmeview is decommissioned the number of beds in homes with specialist mental health registration would be:

Total (beds)	Designation		
	Long Stay	Flex Beds	Intermediate Care (IC)
56	**26**	**22**	**8**

If Holmeview is decommissioned the total number of beds in-house would be:

Total (beds)	Designation		
	Long Stay	Flex Beds	Intermediate Care (IC)
162	**57**	**71**	**34**