Appendix three – Scheme progress made to date

Scheme name	Scheme progress/highlights
1. Care home assessments at the weekend (iBCF)	• Business case produced • Partner meeting to discuss business case • Discussions have taken place with providers via provider forums regarding this scheme and what the current blockages are to enabling existing residents to return back to their care home over the weekend. • Providers stated that the discharge process has been better recently, providers Also been getting better notice from hospital before discharge. • Providers weren't opposed to facilitating discharges at a weekend but stated that often hospital weren't able to provide the necessary paperwork or equipment needed to ensure a safe discharge, i.e. assessments; care plans have not been updated. • Providers not confident that they can trust the information being sent over is correct which is why they insist on caring out their own reassessments before the resident can return to the care home. • Discussed using a Trusted Assessor role, providers not against this model but concerns that the hospitals need to ensure this role is done correctly so they can trust the information being provided
2. Care Package retention of 7 days	LHT • Number of admissions = 170 • Under 7 days = 78 • Under 14 days = 70 (Discharged between of 7-13 days = 32) • 14 days and over = 98 MDGH • Number of admissions = 198 • Under 7 days = 38 • Under 14 days = 101 (Discharged between 7-13 days = 23) • 14 days and over = 92 OTHER (i.e. any other hospital listed or admissions where no hospital is listed) • Number of admissions = 45 • Under 7 days = 7 • Under 14 days = 12 (Discharged between of 7-13 days = 5) • 14 days and over = 32
3. Innovation and Transformation Fund	• 'Soft' procurement for additional bed capacity from January 2018 set in train. • Rapid return home scheme operational • Care Home Support fully operational
4. Funding for	• Locality Manager in post

additional social care staff to support Discharge to Assess initiatives (iBCF)	• Practice Manager for hospital team in post • Weekends covered in February from existing staff group in both hospitals • Weekend referrals to reablement pilot commenced • Completion of MADE event with health colleagues & supported by NHSE
5. Increasing capacity in the Care Sourcing and Social Work Team over Bank Holidays and weekends (iBCF)	• Rota of volunteers from IDT & Intermediate Care team completed for December 2017 including Christmas and New Year period • Basis for weekend working agreed & shared with team • Information shared with health partners The Care Sourcing team has proven its value over the previous twelve months and has achieved the following:- • Increased productivity for front line social care staff due to them not having to spend time sourcing packages of care. • Has full oversight of the market place and the issues, blockages and capacity issues which are fed into the commissioners. • Held the contract price wherever possible when sourcing care. • Reduced care package costs as worked with the Local Area Co-Ordinators to find alternatives to traditional care services. • Has integrated and collaborated well with partners working within the Smart Teams, Community Mental Health Team (CHMT) and the Hospital integrated Health and Social Care team. • Facilitated prompt hospital discharges. Community and third sector links. • Developed the relationship between the Council and providers. Packages sourced: • January 2017 – 85 • February 2017 – 74 • March 2017 – 95 • April 2017 – 82 • May 2017 – 98 • June 2017 – 77 • July 2017 – 69 • August 2017 – 56 • September 2017 – 96 • October 2017 – 59 • November 2017 – 68 • December 2017 – 41 • January 2018 – 55

	Total: 955
6. Sustain the capacity, capability and quality within the social care market place (iBCF)	• Commenced Fair cost of care pricing review and consultation • Paper written on hard to serve areas and working up a pilot to try and improve capacity in these areas • Quality team putting a lot of input into a number of failing homes to ensure we can maintain admissions • Commenced market engagement on carers services and people with complex needs • Focused the care sourcing team on DTOCS • Joint approach to Preventing Lyme Green Nursing home from urgent closure • Commissioning of accommodation of care and care at home progressing well • Specification and advert for D2A beds for East CCG completed • Work has taken place with CCG colleagues around a number of joint posts. • Notice was received for Weston Park closure. • The Care fees review is coming to a closure • The final draft specification for care at home and accommodation with care.
7. The use of Live Well online information and advice resource (iBCF)	• Live Well CE currently has approximately 16,000 page views per week and 5,700 individual user sessions (session = a single user interaction). (In Sep 2017 the figures were approximately 10,000 pages views / 3,000 sessions). Since May 2017 to date there have been 48,000 new unique users to Live Well CE. In the same period there have been 140,000 user sessions. In November 2017 to January 2018: • 76% of traffic was on the CEC website and 24% on the OCC Marketplace. • 60% of source traffic to LWCE is from Google searches and a total of 67% of all traffic is now from all organic searches (Google/Bing/Yahoo etc). • Users are viewing 2.5 Pages per session on average. In this quarter, compare to the last: • Direct traffic has increased by 37%. • Page views have increased by 37%. • Social media traffic has increased by 182%.
8. Assistive Technology	• Meeting held with Community Equipment Service Partners where agreement took place that this service would be considered as part of a wider review of our offer to residents. • Ongoing research taking place as part of general review of the offer the service provides • Contract meeting to be held with Peaks and Plains to get their perspective on service provision • Initial data compiled on AT usage • Discussion with Peaks and Plains on service provision • New Manager appointed to support AT review • Falls prevention group held with CCGs which will also consider elements of AT • Review continuing of AT service • Core project group to consider current AT situation + review • Terms of reference agreed for core falls prevention group. Membership of wider group compiled. Audit completed by CCGs/LA of falls

provision at moment. Recommendations from falls group to feed into AT Strategy.

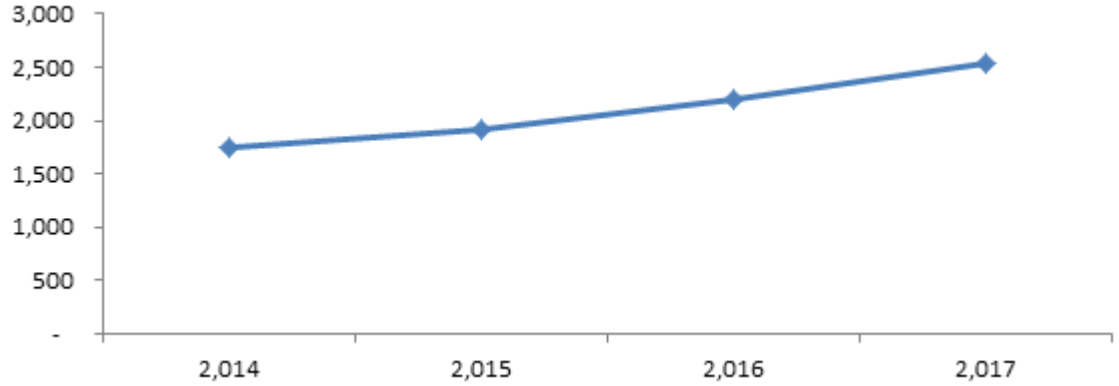
- Review continuing of AT service. Needs assessment once complete to be followed by AT Strategy.

Table 2: Telecare Usage over time

	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEPT	OCT	NOV	DEC
2014				1,503	1,520	1,554	1,590	1,631	1,644	1,652	1,707	1,749
2015	1,756	1,743	1,817	1,837	1,862	1,862	1,881	1,919	1,912	1,936	1,929	1,925
2016	1,926	1,927	1,917	1,929	1,940	1,994		2,032	2,061	2,105	2,161	2,193
2017	2,228	2,259	2,057	2,306	2,135	2,384	2,407	2,406	2,466	2,594	2,531	2,531

There has been a general trend of increased telecare usage over time although numbers have increased relatively steadily. This is illustrated in the graph below which show numbers of telecare users in December each year.

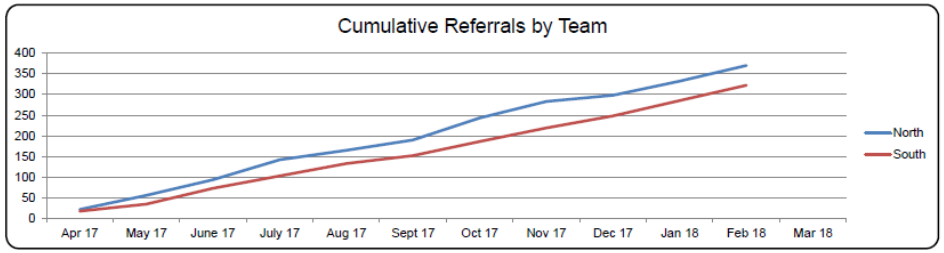
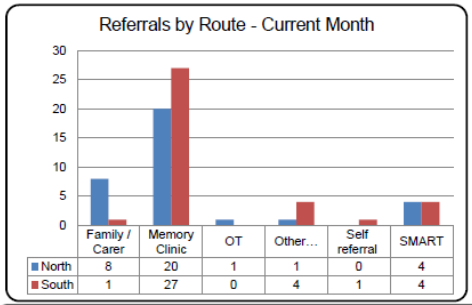
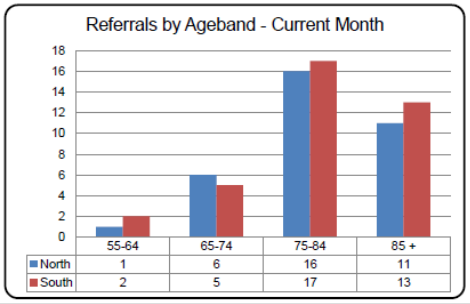
Graph 1: Telecare Take Up



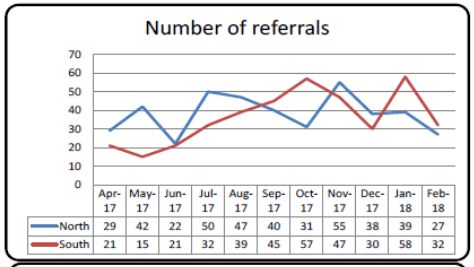
9. Carers Breaks /	• Total number of carers wellbeing budgets confirmed for this period = 872

Integrated Carers Hub	Carers Living Well statistics Nov 2017 to March 2018 inclusive:- • Total spend East CCG: £152,250 • Total Budgets completed East CCG: 364 qty • Total spend South CCG : £233,000 • Total Budgets South CCG: 508 qty • Total Spend to date= £385,250.
10. Disabled Facilities Grants	• 318 disabled people enabled to live independently in 2017-18 • Grants ranged from £836 to £30,000 – average of £4,384 per grant
11. Home First (NHS Eastern Cheshire CCG)	• Short term action group established on behalf of the operational resilience group to agree and implement the initiatives to support the Home First Winter plan – key commissioners and operational leads from across Eastern Cheshire • At the Transforming Older People's Service Steering Group on Monday 27 November 2017 it was agreed that a joint commissioner and provider meeting would be established. The focus of this meeting is to bring together the CEC and CCG commissioners and provider organisations to: • Review the transformation work underway; • Identify any gaps in delivery (based on the Fusion48 final report); and • Reduce duplication across Eastern Cheshire. • The joint commissioner and provider meeting has been planned for Monday 18 December 2017. The Short Term Action Group members have been invited to this meeting.
12. Home First (NHS South Cheshire CCG)	• Redesign of Community Matron role and function complete. New role and pathway agreed by CCICP Partnership Board. • Review of Complex Case Practitioner and Care Facilitator roles complete • Alignment of community services staff to Care Communities complete. • Care Communities senior management structure complete. All vacancies appointed • Roll out of Advanced Community Practitioner complete. Community Matrons in all areas now working as Advanced Community Practitioners, delivering the rapid response pathway • Vision for frailty developed, based on national framework. Test site for community frailty pathway live • Rockwood Score being recorded by Advanced Community Practitioner, Complex Care Practitioners and as part of the Social Care assessment • Work commenced to combine the function of Intermediate Care therapy and community therapy into one coordinated rehab service /function, to support patients both within intermediate bed based services and at home • Falls Rapid Response pilot live. The 'Green Car' is operational 7 days a week, with AHPs from community rehab involved as part of the rapid response • Intermediate care accepting forms 1 & 2 to support discharge to assess pathway • "Community redesign • Redesign of Community Matron role and function complete. New role and pathway agreed by CCICP Partnership Board.

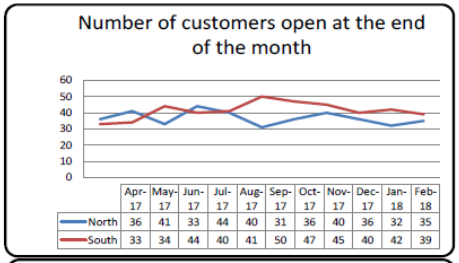
	• Review of Complex Case Practitioner and Care Facilitator roles complete • Alignment of community services staff to Care Communities complete. • Care Communities senior management structure complete. All vacancies appointed • Roll out of Advanced Community Practitioner complete. Community Matrons in all areas now working as Advanced Community Practitioners, delivering the rapid response pathway • Vision for frailty developed, based on national framework. Test site for community frailty pathway live • Rockwood Score being recorded by Advanced Community Practitioner, Complex Care Practitioners and as part of the Social Care assessment • Work commenced to combine the function of Intermediate Care therapy and community therapy into one coordinated rehab service /function, to support patients both within intermediate bed based services and at home • Falls Rapid Response pilot live. The 'Green Car' is operational 7 days a week, with AHPs from community rehab involved as part of the rapid response • Intermediate care accepting forms 1 & 2 to support discharge to assess pathway • Hone first steering group in place • Community Matrons covering the care communities • Initial scoping of intermediate care completed • MSK triage commenced 1/2/18 • OOHrs and primary care streaming now linked more closely with CCICP
13. Support at Home Service – (British Red Cross to provide practical and emotional support at home over 7 days) NHS Eastern Cheshire CCG	• Service Specification developed • Service specification agreed with the Red Cross. • Demand and capacity modelling has been completed with the Red Cross. • Additional models for Winter Resilience have been shared. • Service Specification agreed by CCG representatives and The British Red Cross • Service Specification developed • Agreement regarding revised specification now in place. Previous activity 272 people per year. • Agreement to establish data capture for the revised specification in place.
14. Programme Enablers	• Q2 LGA monitoring is completed and was submitted on the 2oth of October 2017 • Implement recommendations • Cabinet report

	• IBCF Cabinet report • End of year report for HWB • Finalise s75
15. Reablement Services	• Weekly meetings now operational to take forward reablement redesign • Proposals, based on best practice from Norfolk and Wolverhampton underpinned by NICE guidelines are being brought together as part of a Business Case that will be taken to Cabinet and CCG Governing Body's. • The Business Case will focus on a model which brings together reablement with intermediate care, and will involve a number of partners namely, Cheshire East Council, NHS South Cheshire CCG, NHS Eastern Cheshire CCG, East Cheshire Trust, CCICP, Macclesfield District General Hospital and Mid-Cheshire Hospitals Foundation trust. • High level paper has now been drafted which has been shared with all operational partners (CCGs and acute trusts). **Dementia Reablement**    Between April 16 and February 17 640 referrals were recieved for the DRS, this has increased in the period April 17 to February 18 to 692. The largest source for referrals in February 2017 was the memory clinic and this remains the same in 2018. People in the 75-84 age group were the most frequently referred in February 2017 and this is the same in February 2018.

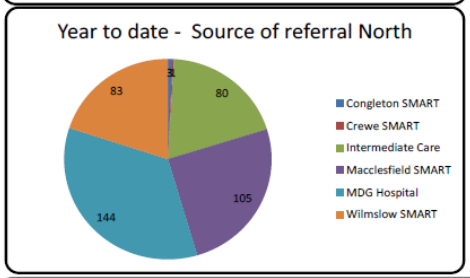
Domiciliary Care/ Community Support Reablement

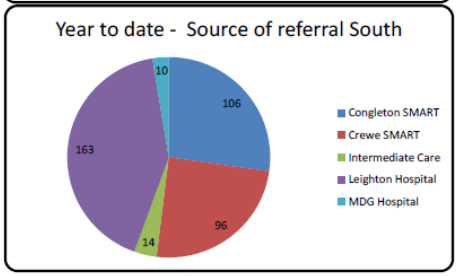


	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18
North	29	42	22	50	47	40	31	55	38	39	27
South	21	15	21	32	39	45	57	47	30	58	32



	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18
North	36	41	33	44	40	31	36	40	36	32	35
South	33	34	44	40	41	50	47	45	40	42	39





Across the 2 teams in February 2017 43 referrals were recieved, this has increased to 57 for February 2018. At the end of February 2017 69 customers were open to Reablement and this slightly higher with 74 in February 2018. At this point last year Intermediate Care was the largest referral source for the North, MDG Hospital is the biggest referral source this year. The largest referral source for the South was the Crewe SMART team, so far this year Leighton Hospital is the largest referral source.

16. Care Act

Performance and activity Information 2016-17

SAFEGUARDING CONCERNS

3175 concerns were received by the local authority

Of which 1030 were section 42 enquiries.

An enquiry is what needs to be looked at to confirm a person is safe

COMPLETED ENQUIRIES (S42)

Types of abuse

31% Neglect
28% Physical
15% Emotional
15% Financial
6% Organisational

RESULT OF ACTION TAKEN

Reduced Risk 71%
Removed Risk 19%
Risk remained 10%

RATIO OF CONCERNS RECIEVED

FEMALE	MALE
64%	36%
Age	Age
26% 18-64	36% 18-64
66% 65-84	62% 65-84
8% 95 over	2% 95 over

COMPLETED ENQUIRIES (S42)

Location of abuse

43% Own home
32% Care home
13% Nursing home
8% Community
4% Hospital

'Hospital' includes community hospitals, acute hospitals and mental health inpatient

During 2016/17 the Board received 3 referrals for a Safeguarding Adults Review (SAR), none fulfilled the threshold for a full SAR but one did result in a Reflective Review.

33 cases were referred to the Board's High Risk Self-Neglect Forum – 16 cases were heard at the Forum and 8 were referred to the Medium Risk Hoarding group

Data comparisons to the North West England figures for 2016/17 available on request