CHESHIRE EAST HEALTH AND WELLBEING BOARD
Reports Cover Sheet

Title of Report:	Better Care Fund End of Year report 2022 - 2023
Date of meeting:	27 June 2023
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Health & Wellbeing Board Lead:	Helen Charlesworth-May, Executive Director – Adults, Health and Integration

Executive Summary

Is this report for:	Information ☐	Discussion ☐	Decision ☐
Why is the report being brought to the board?	The purpose of this paper is to provide the Health & Wellbeing Board (HWB) with a summary of progress made during 2021-22 of the Better Care Fund.		
Please detail which, if any, of the Health & Wellbeing Strategy priorities this report relates to?	Creating a place that supports health and wellbeing for everyone living in Cheshire East ☐ Improving the mental health and wellbeing of people living and working in Cheshire East ☐ Enable more people to live well for longer x All of the above ☐		
Please detail which, if any, of the Health & Wellbeing Principles this report relates to?	Equality and Fairness ☐ Accessibility ☐ Integration ☐ Quality ☐ Sustainability ☐ Safeguarding ☐ All of the above x		
Key Actions for the Health & Wellbeing Board to address. Please state recommendations for action.	The Health and Wellbeing Board (HWB) is asked to note the progress made during 2020/21 of the Better Care Fund.		
Has the report been considered at any other committee meeting of the Council/meeting of the ICB board/stakeholders?	The following report has separately been distributed to the Better Care Fund Governance Group.		

Has public, service user, patient feedback/consultation informed the recommendations of this report?	No
If recommendations are adopted, how will residents benefit? Detail benefits and reasons why they will benefit.	N/A

1 Report Summary

1.1 To highlight the performance of the Better Care Fund including the Improved Better Care Fund in Cheshire East in 2022/23.

2 Recommendations

2.1 That the Health and Wellbeing Board notes the Better Care Fund programme performance in 2022/23. Within this, that the Health and Wellbeing Board considers: Better Care Fund scheme overview, metric performance, the financial income and expenditure of the plan and individual scheme performance noted in Appendix one.

3 Reasons for Recommendations

3.1 This end of year report forms part of the monitoring arrangements for the Better Care Fund.

4 Impact on Health and Wellbeing Strategy Priorities

4.1 This report supports the Health and Wellbeing Priority of Ageing Well.

5 Background and Options

5.1 The BCF provides a mechanism for joint health and social care planning and commissioning, bringing together ring-fenced budgets from Clinical Commissioning Group (CCG) allocations, the Disabled Facilities Grant and the iBCF. Since 2015, the Government's aims around integrating health, social care and housing, through the Better Care Fund (BCF), have played a key role in the journey towards person-centred integrated care. This is because these aims have provided a context in which the NHS and local authorities work together, as equal partners, with shared objectives. During 2022, the CCG closed down on the 1st July 2022 and was replaced by the Integrated Care Board (ICB). Since the abolition of CCG's the s75 agreement was novated over to the ICB.

5.2 Local BCF plans are subject to national conditions and guidance. Local plans are monitored through NHS England and there are strict timelines regarding submission of plans for both regional and national assurance of plans to take place.

5.3 There were four National Conditions, in line with the BCF policy framework:

- Plans to be jointly agreed
- NHS contribution to adult social care to be maintained in line with the uplift to ICB Minimum Contribution
- Agreement to invest in NHS commissioned out-of-hospital services, which may include 7-day

services and adult social care
- Managing Transfers of Care: A clear plan for improved integrated services at the interface between health and social care that reduces Delayed Transfers of Care (DToC).

5.4 Beyond this, areas had flexibility in how the Fund was spent over health, care and housing schemes or services. Since June 2018, local health systems have been tasked with reducing the number of extended stays in hospital.

5.5 **Key changes from previous BCF plan**

5.6 The priorities noted for 2021/22 included: market risk management oversight, collaborative commissioning, effective contract management, increasing out of hospital resource, collaborative system planning, reducing length of stay, 7-day services, transfer of care hubs and Age Well. The priorities for 2022/23 reflect the development of the place and closer alignment between partners in respect of the problems and issues facing the system, this in turn has led to a closer focus on a fewer number of problems and issues. This has also been aided by joint appointments at director level and rationalisation of place governance.

5.7 The key priorities noted for the 2022/23 period are:
- Implementing the Home first programme
- Stabilising the care at home market
- Reducing the impact of the Cost-of-living crisis
- Having joined up winter planning

5.8 **Implementing the Home first programme**

Home First is an 'umbrella' term used to describe a collection of services commissioned and delivered by Health, Social Care, including Physical and Mental Health and the Voluntary Sector across Cheshire East place. These are evidence-based interventions designed to keep people at home (or in their usual place of residence) following an escalation in their needs and/or to support people to return home as quickly as possible with support following an admission to a hospital bed.

5.9 **Stabilising the care at home market**

The care at home market has faced a series of unprecedented pressures over the last 12-18 months, these include: recruitment and retention, financial pressures as well as the COVID pandemic. The local system has put in place a number of measures to try to stabilise the market including: an uplift for providers, assistance with recruitment and support through the pandemic through information and advice as well as protective equipment and grant funding.

5.10 **Reducing the impact of the Cost-of-living crisis**

The cost-of-living crisis is impacting upon residents, service users as well as providers by in Cheshire East. It represents an additional burden impacting upon daily life and for providers in continuing to operate. Mitigating actions taken by the local system include a dedicated phone line, winter warm places scheme and people helping people volunteer scheme.

5.11 **Having joined up winter planning**

Each partner develops plans on an annual basis to target increased pressure faced during the winter. Partners have continued to join up efforts through a single plan which identifies all of the schemes and funding to be deployed. This is with the aim of bringing greater efficiency and value and maximising possible outcomes

5.12 **Joint priorities for 2022/23**

Implementing the Home first programme

As noted, Home First is an ‘umbrella’ term used to describe a collection of services commissioned and delivered by Health, Social Care, including Physical and Mental Health and the Voluntary Sector across Cheshire East place

5.13 Objectives We will provide an equitable and fully integrated urgent and emergency care service for patients with physical, mental health or social care needs, via our Care Communities in conjunction with secondary care services. We will harness digital solutions, collaborative working and information sharing so that the population of Cheshire East will be able to access the right advice, care, or support in the right place, first time.We will reduce attendances to Emergency Departments and reduce the length of stay for those admitted to an acute hospital bed by enabling patients to self-care and recover through our Care Communities, underpinned by a philosophy of ‘home first’ wherever safe and appropriate.We will develop and deliver on system wide approaches to "growing" our workforce, developing skills and innovative/creative solutions as system providers, underpinned by the philosophy that working closely together will lead to sustainable future services.

5.14 **Programme aims**

5.15 Develop a care and support model that responds at the point of crisis, Offer more care at home and ensure we have the right amount of capacity and the right type to provide timely access to advice, treatment, and support to prevent a hospital admission and support people to remain at home. Develop an integrated workforce.Transform a sustainable model for step up and step-down beds.

5.16
- Share relevant data for patients who are currently delayed within the Mental Health wards and feed into place-based governance
- Provide a breakdown of individual needs of those waiting for discharge (triangulation of out puts from MADE, LA intelligence, CWP)
- Understand the care and support needs and whether these needs can be met by existing provision – also need to understand longer term needs based on population
- Increase bed base capacity and community support options for people living with Autism and Mental Health needs
- Develop service specifications that can be shared with care providers to test the market, such as specialist local bed-based provision and community capacity to support people with Physical and Mental Health needs.
- Some recent examples of progression within the Homefirst programme are around the rollout of the Transfer of Care (ToC) Hub.
- ToC hub currently operates Monday 8am– 5pm. Weekends are covered on a voluntary basis only. Community Crisis Response respond 7 days, 8am – 8pm.
- The Hub have a range of staff skill mix from Health and Social teams such as Social Workers, Therapy Staff, Nurses, Brokerage Officers and Care Providers
- A health professional/team leader acts as the single senior coordinator and ensures consistent procedures are in place and implements good practice and learning across all areas.
- IDT attend daily board rounds promoting and supporting ward staff with the Home First ethos.
- Patient Flow Support Workers carry out safety and wellbeing checks on all planned discharges, pathways 1, 2 and 3. They escalate any poor discharge, and a date is completed by either the ward or the ToC hub.
- Operate as a team without bureaucratic hand-offs and referral processes.
- A generic email address and a dedicated telephone number are in place, this has been shared inside the hospital and outside particularly amongst the care sectors.
- A case manager is allocated to every person coming through the hub on pathways 1-3 and a daily review of these patients takes place.
- Assessments are sent to providers prior to discharge to ensure they can meet the needs of the patient prior to transfer. Regular meetings are held with providers to ensure quality assurance. Family and friends are encouraged to complete the questionnaire on their discharge from the service.
- ECT uses Criteria to Reside as a daily reporting mechanism which escalates the number of patients who don’t meet the CtR what they are waiting for and how long they have been waiting.

- • We have a developed a discharge tracker which is used by all professionals, it tracks the journey of all people requiring supported discharge.

5.17 **Stabilising the care at home market**

5.18 The local context of the care at home marketplace is that providers were facing increasing cost pressures, the main area of cost was associated with staff and increases to wages to stay competitive within in the local employment market. From April 2022 national minimum wage and national insurance rises took effect. Whilst most care at home employers already paid the national minimum wage it was noted that they would still have to increase pay rates to remain competitive as well as increasing front line staff providers also increased pay rates for back-office staff to maintain wage differentials within their staff groups.

5.19 Other pressures faced by providers were recruitment and retention, across the sector there is a shortage of staff with increasing competition from other sectors which meant retention was also made more difficult. Care at home providers also noted pressure faced by the geographical variation in Cheshire East with an extensive mix of rural areas and urban hubs. Geographical variation created an increased cost between providing services in rural areas in comparison to urban hubs as a result of increased travel times. In order to bring about greater stability to the care at home market additional funding of £1,987,420 was provided to the market. Of this money £1,134,000 was provided by the Better Care Fund from monies carried forward from 2021/22. The funding has brought about sustained increased care being available in the marketplace

5.20 **Reducing the impact of the Cost-of-living crisis**

5.21 Recent winter scenario planning has included the impact that the crisis is having on residents/service users as well as providers. Care providers are being profiled to ascertain the level of market failure risk over the winter period. Scenario planning from 2021 is being re-visited to consider heightened risks around COVID, winter demand and the cost of living.

5.22 There will be the Winter Wellbeing campaign which has the aim of reducing excess winter deaths in Cheshire East, reduce the number of people who become so ill that they require admission to hospital and to provide information and advice to people on how to stay safe, well and warm during the colder weather. This will run from September/October 2022 – February 2023.

5.23 **Having joined up winter planning**

5.24 The local system has developed a joined-up approach - Warm Up for the Winter Plan – The planning group is to track the progress and fully understand each system partner plans on the approach to winter and what will be in place covering all areas of urgent care across Acute, Mental Health, Primary Care and Social Care services. The purposes of the planning meetings is to focus on operational concerns and emerging risks recognised as a system challenge and to identify any practical solutions that could be implemented ahead of winter.

5.25 This is an established forum made up of system leaders from Health & Social Care who will then be responsible for briefing their own organisations on the progress of the system Winter plan. In readiness for winter planning the ICB recently completed a winter readiness self-assessment. The council as part of the local system has developed a plan to focus on a number of priorities across adult social care in readiness for winter. The schemes cross the following areas: Care homes, voluntary sector, Mental health, Substance misuse, poverty and the cost of living, Direct payments, Domiciliary care, fire service and carers.

5.26 A Good Winter will be delivered by supporting people to remain well and as healthy as possible at home, having responsive effective services that offer choice, and a system that is resilient, resolution focused and has a shared vision to deliver meaningful positive Health and Wellbeing outcomes for the population of Cheshire East. System partners will support this through the

following methods:

5.27
- High uptake in the flu and covid vaccinations boosters with the 65+ year.
- Effective wellbeing & support for staff.
- Ability to access community provision unhampered by covid or other viral infections & Infection - Prevention Control restrictions.
- Utilisation of winter capacity provision to be 85% or above with high level throughput/flow..
- Patients deemed to no longer meet the criteria to reside in hospital have clear exit and support routes out.
- ED attendances reduced and no ambulance delays.
- Increased use of Voluntary Community Faith Sector
- Robust governance and system oversight

5.28 Winter Wellbeing campaign which has the aim of reducing excess winter deaths in Cheshire East, reduce the number of people who become so ill that they require admission to hospital and to provide information and advice to people on how to stay safe, well and warm during the colder weather. This will run from September/October 2022 – February 2023. Areas of focus will be;

5.29
- The cost-of-living crisis – food and fuel poverty and accessing benefits (September/October)
- Warm banks (September/October)
- Flu (November)
- Avoid being scammed on Black Friday (November)
- Preparing your home for winter (late November weather dependent)
- Ensuring you are accessing appropriate winter-related benefits to help pay for heating bills etc (November)
- Being a good winter neighbour including social isolation (November)
- 12 scams of Christmas (Early December)
- Using services appropriately (December)
- Staying Warm, including energy efficiency (January)
- Staying active (January)
- Nominated neighbour scheme

5.30 In addition to the annual Winter Wellbeing Campaign, the council's Stay Well Squad (formally Swab Squad) will be undertaking a tour of Cheshire East offering a range of information, advice and guidance with a focus on 'Winter Wellbeing' during the 2022-23 autumn/winter period. The tour will take place between October 2022 – February 2023. This will involve working with a range of partners with expertise in certain areas. The areas of focus will be:

5.31
- Winter ailments: Covid/Flu/Pneumonia
- Physical and mental health during winter
- Fuel poverty
- Food poverty
- Warm banks
- Accessing benefits
- Job hunting and CV writing advice
- Walking stick repairs/winter proofing

5.32 Cheshire Fire & Rescue Service - Safe and well visits, Cheshire Fire and Rescue Service offer a free 'Safe and Well Visit' for people who are aged over 65 and for people who are referred to us by partner agencies because they are considered to be a particular risk. Safe and Well Visits incorporate the traditional fire safety information (and smoke alarm fitting) but also offer additional advice on slips, trips, fall prevention, a heart check, bowel cancer screening as well as offering additional support to those who wish to stop smoking, taking drugs or reduce their alcohol consumption. During winter, winter warmth advice will also be discussed.

5.33 **Cheshire East Council**

5.34 Each year the council implements a winter plan in coordination with partners, the adult social care winter plan comprises of a number of schemes which will provide support through the following areas:

5.35
- Care homes
- Voluntary sector
- Mental health
- Substance misuse
- 0-19
- Poverty/ cost of living
- Public health campaigns
- Carers
- Direct payments
- Dome care
- Fire service support
- Winter scenario planning

5.36 The local authority is undertaking winter scenario planning, this process includes reviewing possible scenario's which could take place over winter: provider failure, increased demand, staff shortages, cost of living crisis and identifying action plans/mitigations which could take place in the event of them happening. Through this process a number of actions are underway which also include things such as: exploring how voluntary services could support the domiciliary care sector to provide low level support to clients, how and if students could be recruited and opportunities around additional dedicated care settings.

5.37 **Adult social care discharge fund**

5.38 Purpose of the funding - The Fund can be used flexibly on the interventions that best enable the discharge of patients from hospital to the most appropriate location for their ongoing care. It was noted that funding should prioritise those approaches that are most effective in freeing up the maximum number of hospital beds and reducing bed days lost within the funding available, including from mental health inpatient settings.

5.39 In total 30 schemes were developed. The list of schemes included as part of the fund are noted in appendix one. The list of schemes were endorsed by the Operational Delivery Group on 25/11/2022 as well the Place executive leaders group on 01/12/2022. National reporting is every couple of weeks. The list of schemes is found in Appendix three.

5.40 Project group meets weekly to discuss:
- Discharge scheme performance update including person centred outcomes
- Spend review and schemes highlight reports
- Recommendations for financial repurposing of any schemes underspent
- Reporting returns locally and nationally
- Risk review
- Items for escalation
- AOB.

5.41 We are tracking the following system performance measures:

- UEC metrics – Average daily type 1 A&E attendances – East and Mid trusts
- UEC metrics - Average daily non-elective admissions* - East and Mid Trusts
- UEC metrics – Average daily discharges – East and Mid trusts
- UEC metrics – Average daily number not meeting criteria to reside excluding discharges –
- East and Mid trusts
- UEC metrics – Average daily number of patients with 21+ day LoS – East and Mid trusts
- It should be noted that as of 16/01/2023 we are seeing positive performance against all of these system measures.

5.42 A separate paper will be coming to the health and wellbeing board to provide an update on the

schemes implemented.

5.43 **Current schemes**

5.44 There were 20 Schemes funded through Winter pressures, iBCF and BCF during 2022-23. The expenditure in the table results in a BCF carry forward for 2022/23 of £132,244 resulting in total headroom brought forward to 2023/24 of £184,790.

5.45

ID	Scheme Name	Source of Funding	Expenditure (£)
1	iBCF Block booked beds	iBCF	£1,450,638
2	iBCF Care at home hospital retainer	iBCF	£45,000
3	iBCF Rapid response	iBCF	£613,000
4	iBCF Social work support	iBCF	£456,000
5	iBCF 'Winter Schemes	iBCF	£500,000
6	iBCF Enhanced Care Sourcing Team (8am-8pm)	iBCF	£976,754
7	iBCF General Nursing Assistant	iBCF	£300,000
8	iBCF Improved access to and sustainability of the local Care Market	iBCF	£4,364,479
9	BCF Disabled Facilities Grant	DFG	£2,342,241
10	BCF Assistive technology	Minimum ICB Contribution	£757,000
11	BCF British Red Cross / Early Discharge	Minimum ICB Contribution	£724,364
12	BCF Combined Reablement service	Minimum ICB Contribution	£4,842,724
13	BCF Safeguarding Adults Board (SAB)	Minimum ICB Contribution	£447,723
14	BCF Carers hub	Minimum ICB Contribution	£307,415
15	BCF Programme management and infrastructure £227,368 plus Elmhurst £268,000 and MH SW's of £43,556	Minimum ICB Contribution	£538,924
16	BCF Winter schemes ICB	Minimum ICB Contribution	£557,673
17	BCF Homefirst schemes ICB	Minimum ICB Contribution	£20,091,176
18	BCF Trusted assessor service	Minimum ICB Contribution	£99,146
19	BCF Carers hub	Minimum ICB Contribution	£250,258
20	BCF Community Equipment service	Minimum ICB Contribution	£610,225

5.46 **Metric performance**

5.47 The following narrative on the performance on the BCF metrics is based on the latest available data which is up to the end of November 2022. Year end forecasts are purely based on performance to date and historic trends and do not take account of any operational or policy interventions that have been put in place since November 2022 or that may take effect in the future.

5.48 **Unplanned hospitalisation for chronic ambulatory care sensitive conditions**

Data for this metric is only available on a quarterly basis. Cumulatively to quarter 2, the rate stands at 337.0. This is extremely close to the planned cumulative rate of 338.0. This is also 48.5 lower than the average rate for all local authorities and is in line with the average rate for Cheshire East's comparator authorities (Cheshire East is 4.6 higher). When comparing the cumulative position at Quarter 2 in 22/23 with the same cumulative position in 21/22, Cheshire East is 14.9 lower in 22/23. The current forecast year end performance is 675 against a full year plan figure of 689 (-2.0%).

5.49 **Discharge to usual place of residence**

In quarter 1, Cheshire East performance was at 88.5% against a quarter 1 plan of 88.3%. In quarter 2, performance was at 89.1% against a quarter 2 plan of 89.7%. In quarter 3 (to November), performance was at 88.2% against a quarter 3 plan of 90.0%. Cumulatively, to November 2022, performance was at 88.7%. This is broadly in line with performance over the same period in 21/22 (88.9%) which, given the challenges in the home care sector in 2022, should be viewed positively.

Cheshire East performance is lower than both national performance and the average for Cheshire East comparator authorities – an average gap of about 3-4 percentage points - which is the same gap seen in 21/22. The current forecast quarter 4 performance is 88.3% against a quarter 4 planned figure of 89.1%.

5.50 **Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population**

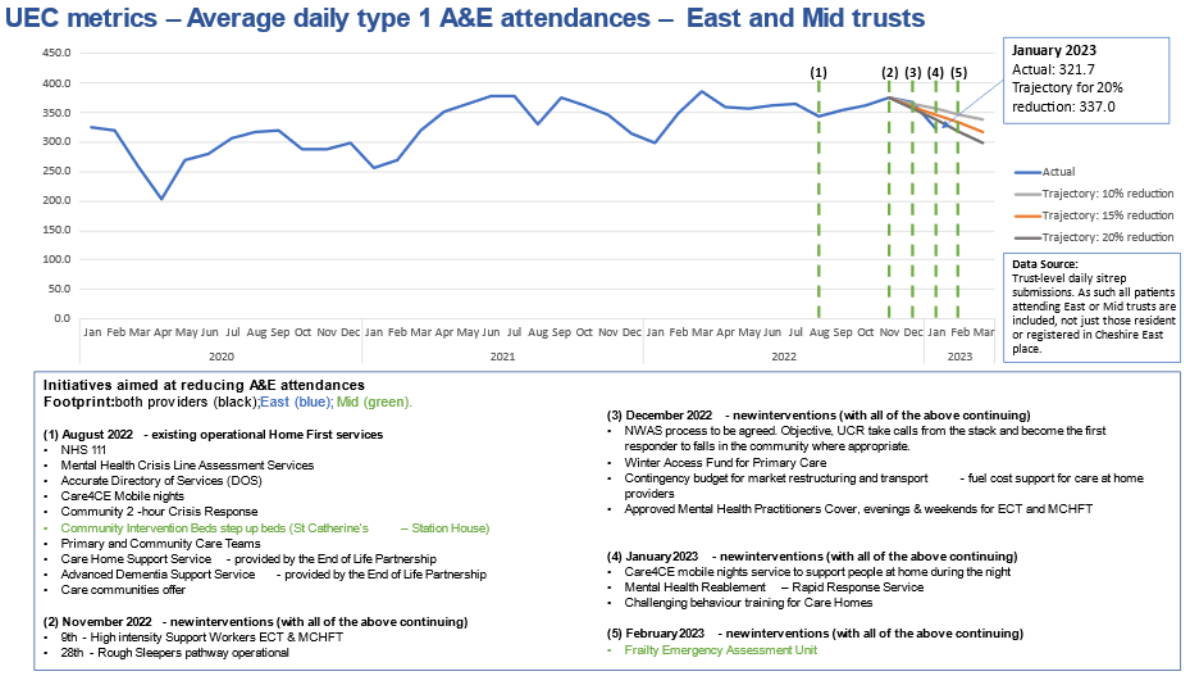
Please note that the latest actuals are estimated to take into account data lags.
The latest cumulative rate is at 453.7, which is 15.1 above the planned rate (+3.4%). This equates to 14 admissions above the planned number at this stage. This is currently in line with the rate seen in 21/22 at this point (455.8).

The current forecast year end performance is 626.5 against a full year plan figure of 657.4 (-4.7%). This is however, based on historic performance from 21/22 where a drop in admissions was seen in the final quarter. It is not clear whether this drop will be replicated in 22/23. A forecast, based solely on the trajectory of admissions in 22/23, however, would see a forecast end year rate as high as 684.4 (+4.1%).

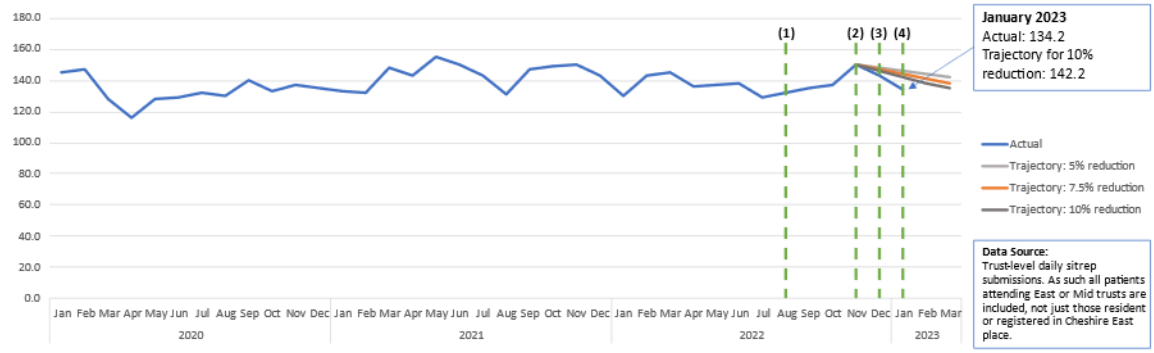
5.51 **Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services**

Please note that the figures below are estimates based on partial data.
In quarter 1, Cheshire East performance was at 82.2%. In quarter 2, performance was at 80.2%. In quarter 3 (to November), performance was at 85.6%. The current end year forecast performance is 83.7% against a planned figure of 82.2%.

5.52 The table below includes the BCF metrics and the performance for the for 2022/23 period.



UEC metrics - Average daily non- elective admissions* - East and Mid Trusts



*this specific data feed did not commence till January 2020 and from comparison to other sources we expect historic activity presented here to be lower than activity seen in 2018 -2019 due to COVID.

Initiatives aimed at reducing non-elective admissions
Footprint: both providers (black); East (blue); Mid (green).

(1) August 2022 - existing operational Home First services
- Frailty Service ECT
- React Service MCHFT
- Mental Health Crisis Response bed base
- Acute Visiting Service, GPOOH

(2) November 2022 - new interventions (with all of the above continuing)
- 21st - Co-locate Care4Ce Mobile Night & ECT Out of Hours District Nursing
- 21st - 200 Hours additional community capacity to positioned into ECT, ED Department linked to Frailty service and Urgent Community Response

(3) December 2022 - new interventions (with all of the above continuing)
- Hot Hub escalation expansion for non -elective and Paediatrics

(4) January 2023 – new interventions (with all of the above continuing)
- East Cheshire Hospice and St. Luke's Hospice bed capacity
- Co-locate Care4Ce Mobile Night & Mid Out of Hours District Nursing

UEC metrics – Average daily discharges – East and Mid trusts

Initiatives aimed at reducing total discharge volumes
Footprint: both providers (black); East (blue); Mid (green).

(1) August 2022 - existing operational Home First services
- Mental Health Reablement
- Community Equipment
- Community Reablement
- Raid Response Care Via Routes and Evolving Care Support Hospital Discharge
- General Nursing Assistants Hospital Discharge
- D2A Community beds
- Resilience Beds to support P1 discharges
- Virtual Wards Home Oximetry
- British Red Cross discharge to home service
- Personal Health Budgets to support discharges
- Carers Payments to facilitate rapid discharge
- St Pauls Hospital Discharge Support delivered via Community Voluntary Sector

(2) September 2022 - new interventions (with all of the above continuing)
- 1st - 4-week assistive technology offer at the point of discharge
- 5th - Community Connectors deployed into Transfer of Care Hub
- 5th - Reablement Workers deployed into Transfer of Placements
- 5th - Bridging Placements of Care packages GNA & Reablement
- 12th - Home First OT Therapist & Reablement 72 discharges
- 14th - Community Voluntary Services St Michaels & St Pauls support
- ISL in reach support for MH patients contract extended

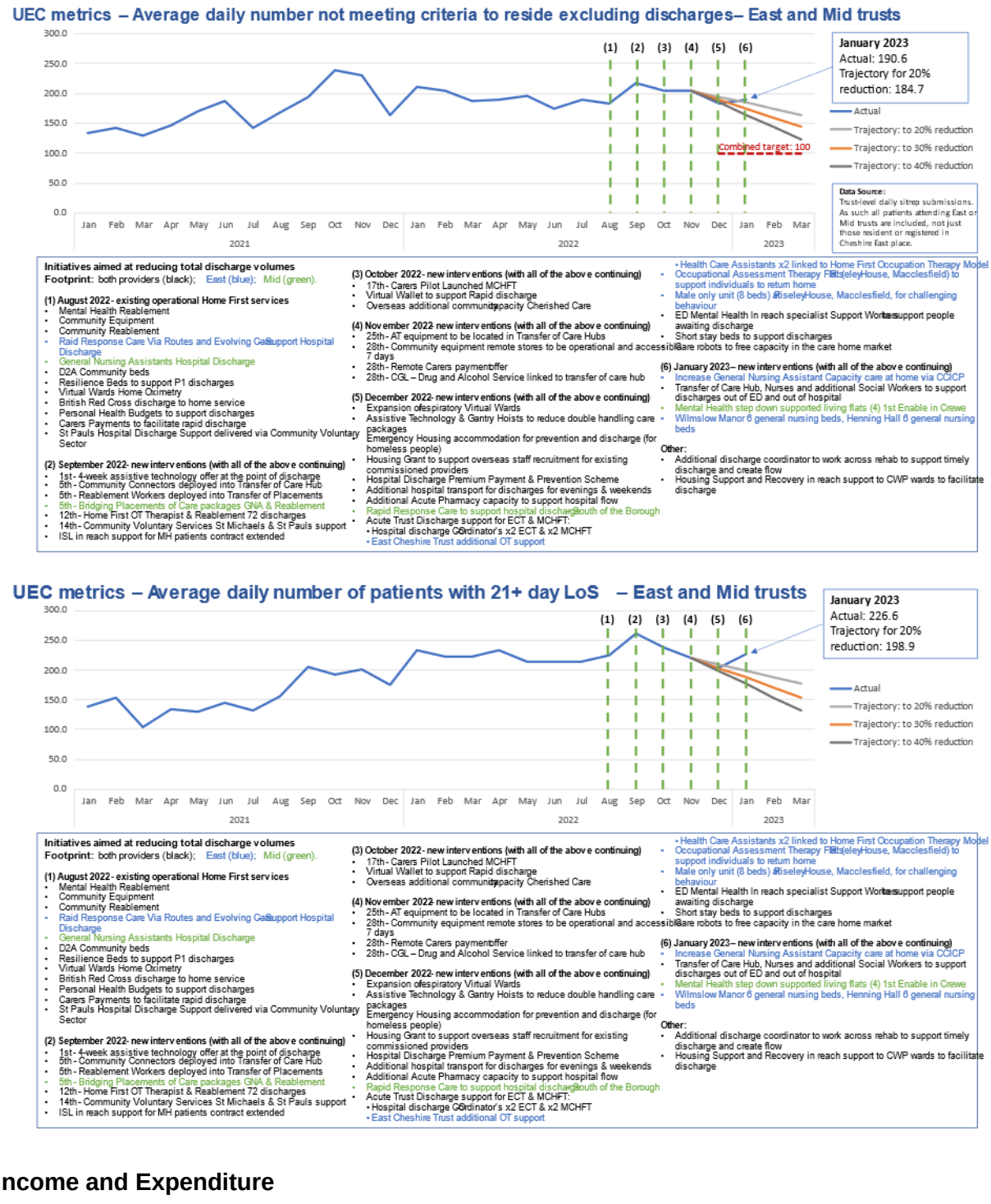
(3) October 2022 - new interventions (with all of the above continuing)
- 17th - Carers Pilot Launched MCHFT
- Virtual Wallet to support Rapid discharge
- Overseas additional community capacity Cherished Care

(4) November 2022 - new interventions (with all of the above continuing)
- 25th - AT equipment to be located in Transfer of Care Hubs
- 28th - Community equipment remote stores to be operational and accessible 7 days
- 28th - Remote Carers payment offer
- 28th - CGL – Drug and Alcohol Service linked to transfer of care hub

(5) December 2022 - new interventions (with all of the above continuing)
- Expansion of respiratory Virtual Wards
- Assistive Technology & Gantry Hoists to reduce double handling care packages
- Emergency Housing accommodation for prevention and discharge (for homeless people)
- Housing Grant to support overseas staff recruitment for existing commissioned providers
- Hospital Discharge Premium Payment & Prevention Scheme
- Additional hospital transport for discharges for evenings & weekends
- Additional Acute Pharmacy capacity to support hospital flow
- Rapid Response Care to support hospital discharge South of the Borough
- Acute Trust Discharge support for ECT & MCHFT:
  - Hospital discharge Coordinator's x2 ECT & x2 MCHFT
  - East Cheshire Trust additional OT support
  - Health Care Assistants x2 linked to Home First Occupation Therapy Model
- Occupational Assessment Therapy Fitzsley House, Macclesfield) to support individuals to return home
- Male only unit (8 beds) @ Risley House, Macclesfield, for challenging behaviour
- ED Mental Health In reach specialist Support Workers to support people awaiting discharge
- Short stay beds to support discharges
- Care robots to free capacity in the care home market

(6) January 2023 – new interventions (with all of the above continuing)
- Increase General Nursing Assistant Capacity care at home via CCICP
- Transfer of Care Hub, Nurses and additional Social Workers to support discharges out of ED and out of hospital
- Mental Health step down supported living flats (4) 1st Enable in Crewe
- Wilmslow Manor 6 general nursing beds, Henning Hall 6 general nursing beds

Other:
- Additional discharge coordinator to work across rehab to support timely discharge and create flow
- Housing Support and Recovery in reach support to CWP wards to facilitate discharge



5.53 Income and Expenditure

The following table describes the budget for the Better Care Fund the actual spend, the variance between the budget and the actual spend.

Running Balances	Income	Expenditure	Balance
DFG	£2,342,241	£2,342,241	£0
Minimum ICB Contribution	£28,748,176	£28,748,176	£0
iBCF	£8,705,870	£8,705,870	£0
Additional LA Contribution	£610,225	£610,225	£0
Additional ICB Contribution	£0	£0	£0
Total	£40,406,512	£40,406,512	**£0**

5.54 Access to Information

5.55 The background papers relating to this report can be inspected by contacting the report writer:

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Designation: Better Care Fund Programme Manager
Tel No: 07803846231
Email: Alex.t.jones@cheshireeast.gov.uk

Appendix one – Aim of schemes

Scheme ID	Scheme Name	Expenditure (£)
1	iBCF Block booked beds Direct award of short-term contracts for 8 winter pressure beds to support Covid-19 pressures, winter pressures, supporting hospital discharges or preventing admission. The rationale for completing a direct award was as follows: an anticipated second wave of Covid-19, non Covid-19 related elective surgery and procedures which were cancelled/postponed are currently being reinstated in hospitals which will increase demand, residents have avoided accessing primary care services and we anticipate a surge in demand on these beds due to people's conditions deteriorating due to lack of treatment, we are now seeing the demand on A & E services in our hospitals rapidly increasing, Covid-19 is likely to be with us for the foreseeable future, we will need to access these beds to prevent hospital admissions as well as support hospital discharges and Care home providers do not have available capacity and would not be inclined to complete a standard tendering process due to the short term nature of these contracts during normal circumstances. We know the enormous pressures that care homes are under at present due to Covid-19, therefore, there is an even great need to award these contracts via a direct award.	£1,450,638
2	iBCF Care at home hospital retainer Since the implementation of the new Care at Home contract in November 2018 the Council does not pay a retainer fee for the first 7 days for hospital admission or respite; however, the provider is contractually obligated to hold open the care packages for this time. In order to assist with service continuity there may be instances upon agreement from the Contracts Manager where a retainer fee will be paid for up to the following 7 days. (i.e. day 8 to 14). In certain circumstances there may be cases where a Service User is only a few days from being discharged from hospital and so to support a smooth transition a retainer fee may be paid for a nominal number of days. This is only in exceptional cases and needs authorising in partnership with Contracts and Operational Locality Managers.	£45,000
3	iBCF Rapid response The Rapid Response Service will facilitate the safe and effective discharge of service users from hospital who have been declared as medically fit for discharge but who may have still have care needs that can be met in the service users own home. The service will seek to prevent readmission to hospital by ensuring wrap around services are in place in the first 48 hours following hospital discharge. The Service will also provide support to Service Users with complex health needs and end of life support at a level. Through the provision of 7 day working, the service will ensure a timely response to hospital discharge to reduce delayed transfers of care and create capacity and throughput for non-elective admissions.	£613,000
4	iBCF Social work support Social Worker (x1) dedicated to the Discharge to assess beds at Station House, Crewe. Social Care Assistants (x2) additional assessment and care management capacity to support the revised processes around hospital discharge using reablement exclusively for this purpose (East locality). Funding of additional staff to support a 'Discharge to assess' model. Funding is continuing to provide a team manager, social worker and occupational therapist. Increased capacity in the Social Work Team over Bank Holidays and weekends. This is to ensure patient flow and assisting in reducing the pressure on the NHS can be maintained over a seven-day period. Cheshire East will provide 2 social workers and 2 care arrangers (split between the 2 hospitals) that cover the weekends and bank holidays. This support would be 124 days for the weekends and another 8 days for bank holidays giving 132 days each per year.	£456,000
5	iBCF 'Winter Schemes	£500,000

	Additional capacity to support the local health and social care system to manage increased demand over the winter period. Evidence-based interventions designed to keep people at home (or in their usual place of residence) following an escalation in their needs and/or to support people to return home as quickly as possible with support following an admission to a hospital bed.	
6	iBCF Enhanced Care Sourcing Team (8am-8pm) The scheme sees the continuation of funding for the Care Sourcing Team following on from a successful pilot; the service provides a consistent approach to applying the brokerage cycle and in turn, makes best use of social worker time. The Care sourcing team undertake all aspects of the Brokerage cycle: enquiry, contact assessment, support planning, creation of support plan, brokering, putting the plan into action as well as monitor and review of the support. The service operates Monday to Sunday. The Care Sourcing Team comprises of a range of employees including team and deputy manager, admin, care sourcing officers as well as a social care assessor. This funding is to enable an 8 till 8 operation. The model is fully compliant with the Care Act 2014 as it provides information and advice, prevention, assessment, review, safeguarding, carers, market management and shaping, charging, support planning, personalisation and arranging care and support.	£976,754
7	iBCF General Nursing Assistant Provide an additional 7 GNA staff within the CCICP IPOCH team for a period of 12 months. An evaluation of effectiveness will be undertaken during this period subsequent to discussion and agreement regarding permanent funding. These additional staff would be utilised across South Cheshire and the Congleton area of East Cheshire to support patients requiring domiciliary care that would normally be delivered by Local authority. It is expected that whilst this proposal will reduce the current pressure it is not expected to eliminate the pressure and further work would be required in order to ensure sufficient and timely access to pathway 1 care.	£300,000
8	iBCF Improved access to and sustainability of the local Care Market (Home Care and Accommodation with Care) Cheshire East Council has a duty under Section 5 of the Care Act to promote the efficient and effective operation and sustainability of a market in services for meeting the care and support needs of individuals. There are increasing financial pressures on the social care market, for example National Living Wage, recruitment and retention issues, which is resulting in a rise in care costs. This scheme contributes towards the cost of care home and home care fees as well as supporting the delivery of additional care packages within the marketplace.	£4,364,479
9	BCF Disabled Facilities Grant The Disabled Facilities Grant provides financial contributions, either in full or in part, to enable disabled people to make modifications to their home in order to eliminate disabling environments and continue living independently and/or receive care in the home of their choice. Disabled Facilities Grants are mandatory grants under the Housing Grants, Construction and Regeneration Act 1996 (as amended). The scheme is administered by Cheshire East Council and is delivered across the whole of Cheshire East.	£2,342,241
10	BCF Assistive technology Assistive technologies are considered as part of the assessment for all adults who are eligible for social care under the Care Act where it provides greater independence, choice and control and is cost-effective for individuals. The provision of assistive technology is personalised to each individual and is integrated within the overall support plan. The scheme will continue to support the existing assistive technology services. The scheme also involves piloting assistive technology support for adults with a learning disability (both living in supported	£757,000

	tenancies and living in their own homes).	
11	BCF British Red Cross 'Support at Home' service Cheshire East 'Support At Home' Service is a 2-week intensive support service with up to 6 Interventions delivered within a 2-week period for each individual. The aim is to support people who are assessed as 'vulnerable' or 'isolated' and who are at risk of admission to hospital or becoming a delay in hospital. Service users have been identified as requiring additional support that will enable them to remain independent at home, or to return home more rapidly following a hospital admission. The interventions may include: A 'safe and well' phone call. A 'follow-up visit' within 1 working day. Help with shopping. Signposting and referring to other agencies for specialist support. The main focus of the service is on supporting people to remain at home (preventing unnecessary hospital admissions by increasing intensive support at home). The commissioning responsibility for the British Red Cross services has transferred from the ICB to the local authority.	£724,364
12	BCF Combined Reablement service The current service has three specialist elements delivered across two teams (North and South): 1. Community Support Reablement (CQC-registered) - provides a time-limited intervention supporting adults with physical, mental health, learning disabilities, dementia and frailty, from the age of 18 to end of life, offering personal care and daily living skills to achieve maximum independence, or to complete an assessment of ongoing needs. 2. Dementia Reablement - provides up to 12-weeks of personalised, post-diagnostic support for people living with dementia and their carers. The service is focused on prevention and early intervention following a diagnosis of dementia. 3. Mental Health Reablement - supports adults age 18 and over with a range of mental health issues and associated physical health and social care needs, focusing on coping strategies, self-help, promoting social inclusion and goal-orientated plans.	£4,842,724
13	BCF Safeguarding Adults Board (SAB) The overarching objective of a SAB is to assure itself that local safeguarding arrangements and partners act to help and protect adults in its area who: have needs for care and support (whether or not the local authority is meeting any of those needs) and; are experiencing, or at risk of, abuse or neglect; and as a result of those care and support needs are unable to protect themselves from either the risk of, or the experience of abuse or neglect.	£447,723
14	BCF Carers hub The Cheshire East Carers Hub provides a single point of access for carers, families and professionals. The Hub ensures that carers have access to information, advice and a wide range of support services to help them continue in their caring role and to reduce the impact of caring on their own health and wellbeing. Carers can registered directly with the Hub or referrals can be made by professionals, any agency or organisation, relatives or friends. The Hub offers groups and activities which carers will be familiar with along with introducing new support opportunities co-produced with local carers. Through the period of 2022/23 the carers service is being recommissioned as part of the developments a carers apprentice has been recruited to support the work being carried out.	£307,415
15	BCF Programme management and infrastructure	£538,924

	The delivery of the Better Care Fund relies on joint commissioning plans already developed across the health and social care economy. The scheme covers the following: Programme management, Governance and finance support to develop s75 agreements; cost schemes and cost benefit analysis, Financial support, and amongst other things additional commissioning capacity might be required to support the review of existing contract and schemes and the procurement of alternative services.	
16	BCF Winter schemes ICB The proposed schemes specifically support the achievement and maintenance of the four-hour access standard, admission avoidance, care closer to home and a continued compliance with the DTOC standard. Schemes cover: discharge to assess, British Red Cross transport, non-emergency transport, additional acute escalation ward and additional ED staffing amongst others. Each of the partners will be developing winter plans which will then form part of a place-based plan.	£557,673
17	BCF Homefirst schemes ICB They are evidence-based interventions designed to keep people at home (or in their usual place of residence) following an escalation in their needs and/or to support people to return home as quickly as possible with support following an admission to a hospital bed. The Home First schemes mainly support older people living with frailty and complex needs to remain independent, or to regain their independence following deterioration in their medical, social, functional or cognitive needs.	£20,091,176
18	BCF Trusted assessor service Delays are caused in the hospital by service users/patients waiting for nursing & residential homes to assess their needs. This scheme deploys a trusted assessor model by commissioning an external organisation to employ Independent Transfer of Care Co-ordinator's (IToCC's) to reduce hospital delays. The trusted assessment model is a key element of the eight High Impact Changes in order to support the timely transfer of patients to the most appropriate care setting and to effect a reduction in the number of delayed transfers of care. The model is being supported nationally by the emergency Care Improvement Programme. Through the period 2022/23 the trusted assessor service is being recommissioned with the aim that the new provider is in place for 1st January 2022.	£99,146
19	BCF Carers hub The Cheshire East Carers Hub provides a single point of access for carers, families and professionals. The Hub ensures that carers have access to information, advice and a wide range of support services to help them continue in their caring role and to reduce the impact of caring on their own health and wellbeing. Carers can registered directly with the Hub or referrals can be made by professionals, any agency or organisation, relatives or friends. The Hub offers groups and activities which carers will be familiar with along with introducing new support opportunities co-produced with local carers. Through the period of 2022/23 the carers service is being recommissioned as part of the developments a carers apprentice has been recruited to support the work being carried out.	£250,258
20	BCF Community Equipment service	£620,225

Appendix two – Individual scheme performance

ID	Scheme Name
1	iBCF Block booked beds

Care Home	No. of Beds	Total Nights Used	Total Commissioned Nights	Cost Per Commissioned Night	Cost Per Night Utilised	%
Bentley Manor	1 (res dem)	105	189	£117.57	£211.63	56
Brookfield House	8 (2 res dem, 6 res)	1196	2443	£105.83	£216.17	49
Corbrook Park	3 (res/nurs)	608	938	£172.86	£266.68	65
Cypress Court	3 (res)	699	938	£103.72	£139.18	75
Elm House	4 (res)	599	1239	£104.55	£216.25	48
Leycester House	5 (res)	1017	1540	£105.06	£159.08	66
Mayfield House	1 (res dem)	207	336	£106.68	£173.17	62
The Elms	3 (res)	610	938	£103.72	£159.48	65
Turnpike Court	4 (2 res, 2 res dem)	774	1239	£104.55	£167.36	62
Twyford House	5 (res/res dem)	859	1540	£168.09	£301.35	56
Total/Average	36	6674	10871	£124.46	£202.73	60

ID	Scheme Name
2	iBCF Care at home hospital retainer

Average number of days the retainer was deployed for	**10.02**
Minimum period the retainer was deployed for	2 days
Maximum period the retainer was deployed for	67 days
Total number of days the retainer was deployed for	361
Number of instances where the retainer was deployed	36

Reason For Retainer:	
Best Interest Meeting	2
Care Planning Meeting	1
Covid Positive	2
Discharge Planning	15
Due to medically fit next week	10
House Clean or Building Work ongoing at home	2
Increase in POC and awaiting MFFD.	1
Med fit awaiting transport to be arranged	1
Not Medically Fit- Awaiting Further Assessment	5
Retainer Authorised to facilitate discharge	4
Safeguarding Investigation	1

ID	Scheme Name
3	iBCF Rapid response

	Total hours contracted and people supported Month / Block hours / Number of people supported Jan 903.25 20 Feb 1,159 33 Mar 1,292.25 42 Apr 1,227.50 35 May 967.5 33 Jun 1197.75 37 Jul 1,194.50 36 Aug 1,130 36 Sep 1,118.25 36 Oct 905.5 31 Nov 700.25 25 Dec 779.75 34 Total 12575.5 398
4	iBCF social work support Social Work staff supporting approximately 650 cases collectively in addition to duty actions/ safeguarding tasks. This covers a number of settings which includes: Station house, Stepping Hill, Leighton Hospital, Macclesfield Hospital. The scheme also provided additional capacity at Macclesfield and Leighton hospital over the course of the weekend. Combined Short Term Services East and South supported: 1429 new contacts 1090 referrals were progressed 358 support plan reviews took place 91 reablement reviews took place 83 new safeguarding referrals were received 70 S.42 inquiries were completed Agency staff directly supported: 720 new allocations 292 assessments completed 308 support plans 106 STP's (Short Term plans)
5	iBCF 'Winter Schemes

Programme	SRO
Hospital support scheme family and friends to enable family and friends to provid informal care and payment for up to 6 weeks	Operational
Community Connectors positioned in the two Transfer of Care Hubs promoting Community Voluntary Sector services	Operational
Personal Health Budgets to support Rapid Hospital Discharge	Operational
Capacity for Pathway 1– 36 System resilience beds	Operational
Capacity for Pathway 2– 39 block beds are funded via the ICB up to 31st March 2023	Operational
November – January 2023	
C/o locate Care4CE Mobile Nights service and East Cheshire Trust Out of Hour District Nursing Teams thus increasing overnight care, support and resilience	November 2022
Help Force volunteer Programme	November 2022
Nursing Dementia beds x 6	November 2022
ED In reach support for Mental Health patients	November 2022
Additional 200 hours per week, Rapid Response Care linked to East Cheshire Frailty team. November to March 2023	Nov / Dec 2022
Complex Dementia 18 Step up/step down beds	Nov / Dec 2022
Supported Living– Mental Health step down self contained apartments x 6	December 2022
Housing pathway agreed for rough sleepers	December 2022
Increase of the General Nursing Assistant service capacity UNCLASSIFIED	Dec / Jan 2022

Winter Schemes	Budget Allocation
Proposed Additional Discharge Capacity	
ED Mental Health In reach Support Workers	£45,000
Approved Mental Health Practitioners Cover, Evenings & Weekends	£60,000
Mental Health Reablement Support Workers x 4	£100,000
Hospital discharge CoOrdinator's x 4	£110,000
Transfer of Care Hub, Nurses and Social Workers to support weekend discharges	£80,000
Increase General Nursing Assistant Capacity via CCICP	£250,000
Health Care Assistances x 2 linked to the Home First Occupation Therapy Model	£48,000
Personal Health Budgets	£15,000
Carers Payments to facilitate rapid discharge	£15,000
Assistive Technology & Gantry Hoists to reduce double handling care packages	£50,000
Hospice at Home Support and bed base capacity	£85,000
8 Care Communities supporting priorities and Winter	£160,000
Extra Care Housing– step down assessment flats	£40,000
Contingency budget for market restructuring and transport fuel cost support for domiciliary care Staff	£80,000
Total Investment	**£1,138,000**

6 iBCF Enhanced Care Sourcing Team (8am-8pm)

Referral type	Number of Referrals	Hours
Care at Home - Hospital	524	8194.75
Care at Home - Community	405	4627
Rapid Response	113	1103.75
Hospital Home First	377	4476.25
Hand Back	125	1263
Care at Home - Total	1544	19664.75
Accommodation with Care - Hospital	633	
Accommodation with Care - Community	1149	
Pathway 3	437	
Carer Respite - Block Booked Beds	358	
Carer Respite - Spot Purchase	80	
Accommodation with Care - Total	2657	
Complex Care - Hospital	42	
Complex Care - Community	235	
Day Opportunities (started 05/08/2022)	21	
Complex Care - Total	298	
Total	4499	19664.75

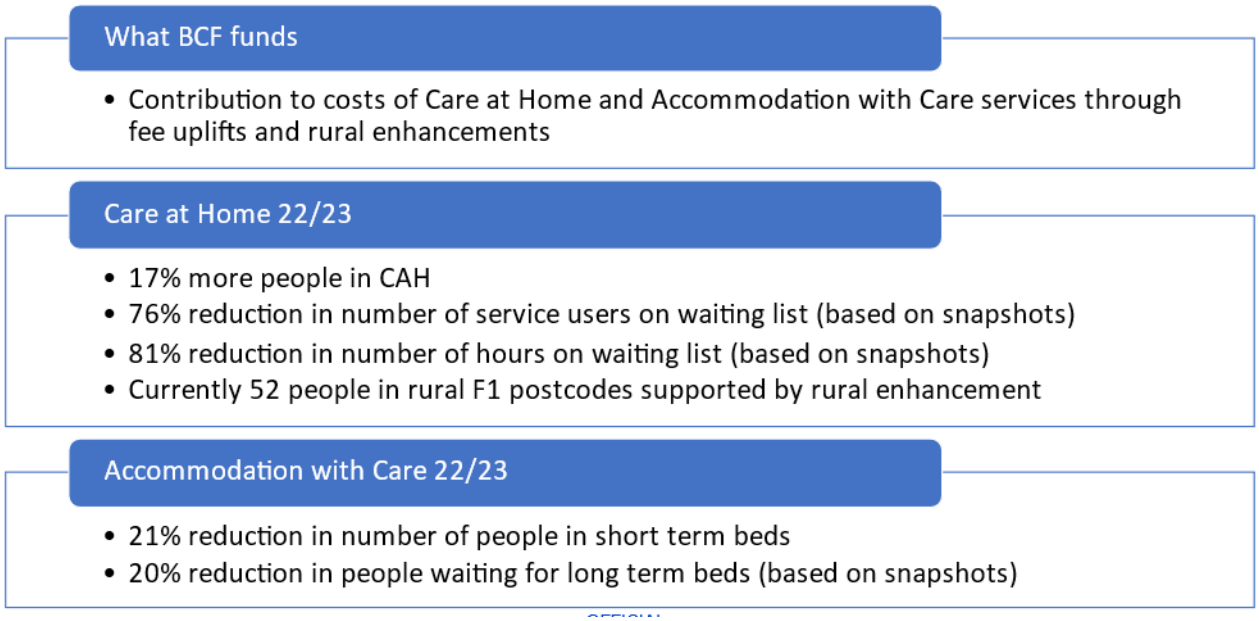
7 iBCF General Nursing Assistant

April 2022 - Dec 2022

- 96 referrals were received - 89 service users accessed the service
- Source of referrals – Hospital, NWAS, GP, Care Community
- 3339 Visits were made & 1743 clinical hours of care were delivered

Row Labels	2022-04	2022-05	2022-06	2022-07	2022-08	2022-09	2022-10	2022-11	2022-12	Grand Total
Double										
Visits	10	23	20	14	38	94	40	7	37	283
Visit Total Hours	5.0	11.5	10.0	7.8	21.0	49.5	20.0	4.0	26.5	155.3
Single										
Visits	100	98	189	353	644	504	384	456	327	3055
Visit Total Hours	50.0	50.5	97.8	188.8	345.3	262.5	199.0	229.5	164.0	1587.2
Triple										
Visits						1				1
Visit Total Hours						0.7				0.7
Total Visits	110	121	209	367	682	599	424	463	364	3339
Total Visit Total Hours	55.0	62.0	107.8	196.5	366.3	312.8	219.0	233.5	190.5	1743.2

8 iBCF Improved access to and sustainability of the local Care Market



9 BCF Disabled Facilities Grant

- The number of grants awarded to disabled people has increased in 2022-23, with 374 new grants approved (compared to 313 in 2021-22).
- The number of grants be completed in 2022-23 was 438 (compared to 298 in 2021-22). Last year we reported a major issue with the failure of the level access shower contract; the performance of the new contractor from April 2022 has enabled us to improve performance and complete more grants. There is still considerable work to do, particularly around bedroom and bathroom extensions, as we are experiencing major issues with our Domestic Build Works Framework, where contractors on the framework have insufficient capacity to meet our demand.
- The average grant awarded to date in 2022-23 is £4,888, compared to £5,558 in 2021-22. This contrasts with inflation, but will be a reflection of the smaller, lower cost adaptations that have been recommended by OTs as part of the enhanced scrutiny of referrals.
- 22.2% of referrals have led to cancellation. There has been a sharp increase in grants being declined by the applicant; reasons cited can be summarised as changing their mind about having works done, refusing the financial assessment, or disengaging from the process without giving a reason.

10 BCF Assistive technology

- The Assistive Technology service (also known as Technology Enabled Care) was recommissioned,

and a new provider Millbrook Healthcare commenced delivering this service from 1st July 2022. The previous provider was Careium (formerly known as Welbeing) delivered the service since December 2018.

- Following the transfer of data from the previous provider in June the total number of service users noticeably reduced from approx. 3600 down to 2612 in July based on data provided by Millbrook. We believe this was due to Careium private clients also being included in our activity data.
- At the end of December 2022, the total number of AT users was approx. 2400.
- During the mobilisation of the service a 4-week free period for hospital discharges was introduced where NHS staff could refer into the provider to support urgent discharges.
- Referrals have been received from the following hospitals, where a Lifeline, Pendant and Key Safe (if required) have been provided to the patients:
- Macclesfield District General Hospital & Leighton Hospital – Majority of the referrals.
- Knutsford District and Community Hospital & Congleton War Memorial Hospital – Also referred.
- Total Hospital referrals have increase month on month from 15 to 30 – With 130 referrals July-Dec.
- There are currently approx. 65 difference LA staff that refer into the service each month.
- From July-Dec there has been approx. 670 installations completed
- Most of the equipment issued out by the provider has been Digital Lifeline Units, Pendants, Vibby Falls Detectors and Key Safes. Other equipment includes sensors and smoke/CO2 detectors.
- Future pilot planned in 2023 include the issuing of equipment (Ownfone) through peripheral stores in hospitals to the Urgent Community Response teams in preventing hospital admissions and supporting discharges out of normal hours ie up to 8pm in the evenings and weekends.

11 BCF British Red Cross

Assisted Discharge Service:

Description	Target per quarter	April to June 2022	July to September 2022	October to December 2022
Number of referrals	240	215	226	182
Number of referrals accepted		202	219	176
% of referrals accepted	90%	94%(avg)	96.69% (avg)	96.33% (avg)
Referral source:	%			
Macclesfield Hospital		89.3%	91.15%	98.35%
CEC Adult Social Care		3.26%	0.90%	1.1%
Congleton War Memorial Hospital		0.47%	0.45%	
Lawton House		0.47%		
No data		6.5%	7.5%	0.55%

Support at Home:

Description	Target per quarter	April to June 2022	July to September 2022	October to December 2022
Number of referrals	150	166	165	155
Number of referrals accepted		163	151	147
% of referrals accepted	90%	98% (avg)	91.67% (avg)	95.67% (avg)
Referral source:	%			
BRC charity		33.3%	4,6%	7.1%
Self referral		27.2%	37.7%	30.3%
Hospital Ward		21.1%	32.5%	45.8%
Internal referral		9.4%	6.6%	
Family/friend		2.8%	7.9%	5.8%
CEC Adult Social Care		2.8%	2%	1.9%
Hospital A&E		1.4%	0.8%	1.4%
Other / GP		2%	7.9%	7.7%

12	BCF Combined Reablement service

Community Reablement Summary

Number of packages delivered - *Referrals in the month relates to Liquidlogic Action Plans and Portal Referrals, these may not be accepted therefore the number will be higher than closed Reablement Plans*

	April	May	June	July	August	September	October	November	December	January	February	March	YTD Total
No. Referrals in the month	186	175	142	133	116	127	123	145	119				1266
Completed Reablement Plans	69	79	103	105	105	98	153	171	135				1018

Mental Health Reablement Summary

Number of packages delivered

	April	May	June	July	August	September	October	November	December	January	February	March	YTD Total
No. Referrals in the month	203	252	197	242	265	219	251	270	193				2092
No. Closed in the month	178	240	206	202	198	213	245	246	180				1908

Dementia Reablement Summary

Number of packages delivered

	April	May	June	July	August	September	October	November	December	January	February	March	YTD Total
No. Referrals in the month	111	85	75	74	81	62	75	73	83				719
No. Closed in the month	64	57	53	52	66	56	57	26	82				513

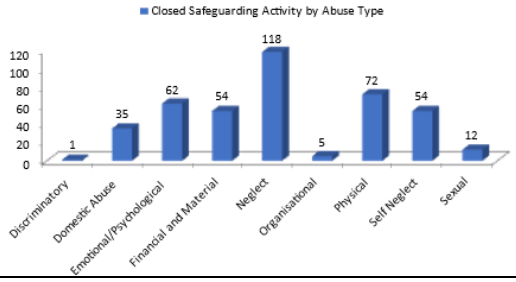
13	BCF Safeguarding Adults Board (SAB)

Closed safeguarding activity by Abuse Type

The chart below shows all safeguarding activity (safeguarding concerns and enquiries) concluding in December 2022.

Neglect and Acts of Omission accounts for the greatest proportion with 29%; followed by Physicalabuse with 17% and Emotional abuse with 15%.

Closed safeguarding activity by Abuse Type

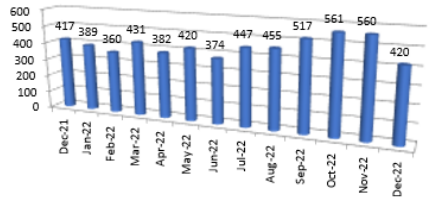


Number of new safeguarding concerns

A safeguarding concern is either a contact where safeguarding issues have been identified, or a contact that has been recorded as a safeguarding adults concern. The total number of safeguarding concerns received during December 2022 was 420.

This represents an increase of 3 concerns (1%) compared with December 2021 and 22 concerns less than the average of the last 12 month period (442).

Safeguarding Concerns



14	BCF Carers hub

- 7183 adult carers & 786 young carers registered with the Hub
- 1039 adult & 141 young carer referrals received
- 693 adult & 101 young carers assessments
- Source of referrals– self referrals are biggest source of referrals, followed by Cheshire East adult social care and then health including GPs.
- Number and type of intervention delivered
  - Low – 3% Moderate – 94% Intensive – 3%
- Outcome following service:
  - 56% of adult carers felt they had improved quality of life, 99% had improved physical health, 100% had improved emotional wellbeing, 100% had increased choice, control & independence.
  - 84% of young carers have an improved positive outlook, 67% had improved relationships, 79% had improved self esteem, 81% had improved resilience
- 2392 adult & 147 young carers provided with a break
- 302 adult carers reporting that service has prevented a carer break down or prevented them / cared from needing residential care

15	BCF Programme management and infrastructure

- Adult Social Care Discharge Fund
  - National submission of plan
  - Implementation, 30 schemes, £3,754,168.
  - Monitoring and tracking of scheme performance
- Better Care fund
  - National submission of plan
  - Implementation and ongoing business as usual for 20 schemes, £39,145,856
- Adult social care winter schemes
  - Submission of plan
  - Implementation, 23 schemes at no cost
  - Monitoring and tracking of scheme performance
- Place development
  - Maturity matrix

- S75 development
- Mapping of governance
- Supporting new enabler workstreams

Reports

- Adult social care winter plan
- BCF end of year 2022/23
- BCF plan 2023/24
- Crewe winter proposals
- Expansion of s75 agreement
- BCF beds paper
- Adult social care discharge evaluation paper

16 BCF Winter schemes CCG

Programme	SRO
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Extra Care Housing– step down assessment flats	£40,000
Contingency budget for market restructuring and transport fuel cost support for domiciliary care Staff	£80,000
Total Investment	**£1,138,000**

17 BCF Homefirst schemes CCG

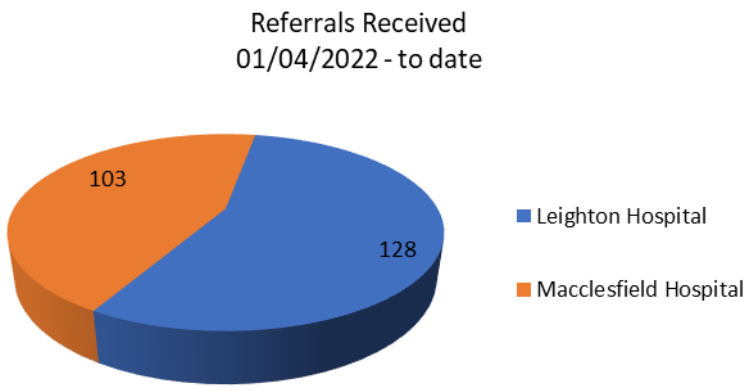
Community Support Connectors – Transfer of Care Hub (TOCH) The Community Support Connectors have been deployed to Macclesfield and Leighton Hospitals to operate and support within the Transfer of Care Hub. The Connectors support has proved to be an essential and integral part of the TOCH.

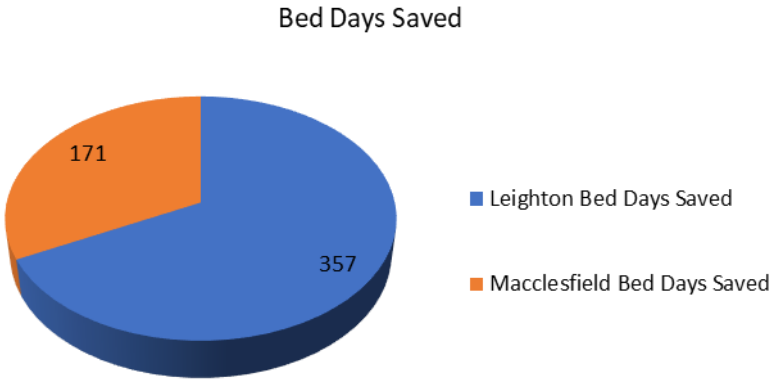
Primary Care Developments

Access

- Increase access through Enhanced Access and Winter pressures Funding.
- Rollout of APEX – Access, Capacity and Demand reports

	• Development of a winter pressures alert system (OPEL) for General Practice (Due April 23)
	
	Acute Respiratory Hubs
	• Mobilised in Alsager and Knutsford
	GP Confederation
	• Development of a GP Confederation to provide coordinated representation & Engagement of General Practice at Place and in the wider system, as well as shaping the future sustainable delivery model of General Practice
	Mental Health
	• Crewe Winter Pressures Funding (highlight report available upon request)
	Everybody Support and Recreation (ESAR) Falls Prevention
	• Less NWAS Call outs
	• Lower impact to A&E and primary Care
	Asylum Seeker Outreach
	• Ease pressures at A&E through reduced attendance. Asylum seekers attending practices as opposed to A&E
	• Self Care pack translations can be used/adapted to target other non-English speaking patients/other projects
	
	Mental Health Developments – Crisis Cafes: 2 Mental Health Crisis Cafes went live in March 2021 - They are the Crewecial Café in Crewe and Weston Hub in Macclesfield.
	
	Mental Health Developments – Community Crisis Beds: 4 Mental Health Crisis Beds across Cheshire East. Occupancy across the beds is currently high ranging from 67-88% over the last 3 months, with a total of 283 bed days utilised
	
	Care at Home:
	• Overseas recruitment has given 1,100 extra hours capacity per week
	• Increased care package hospital retainer to 21 days
	• Rapid Reablement response service to support Mental Health patients –
	• 80 hours per week
	• Care at Home financial investment to support hospital discharge
	• Carers Payments to facilitate rapid discharge
	• Investment of £250,000 into the General Nursing Assistant via Central Cheshire Integrated Care Partnership.
	• Increase in Rapid Response care and positioned at the hospital front door – East Cheshire Trust
	• Virtual ward domiciliary care growth will be explored in the following way:
	  ○ Combined Cheshire East Council Community Reablement team and General Nursing Assistant service via CCICP
	  ○ Increased external capacity via Routes Healthcare

18	BCF Trusted assessor service 



19 BCF Carers hub

A performance update – insight into performance metrics

- 7183 adult carers & 786 young carers registered with the Hub
- 1583 adult & 189 young carer referrals received
- 871 adult & 126 young carers assessments
- Source of referrals– self referrals are biggest source of referrals, followed by Cheshire East adult social care and then health including GPs, including the hospital discharge scheme for carers
- Number and type of intervention delivered
  - Low – 3% Moderate– 94% Intensive- 3%
- Outcome following service:
  - 56% of adult carers felt they had improved quality of life, 99% had improved physical health, 100% had improved emotional wellbeing, 100% had increased choice, control & independence.
  - 84% of young carers have an improved positive outlook, 67% had improved relationships, 79% had improved self esteem, 81% had improved resilience
- 2630 adult & 178 young carers provided with a break. 183 YC supported by Cheshire Young Carers through Living Well Funding.
- 302 adult carers reporting that service has prevented a carer break down or prevented them / cared for from needing residential care

20 BCF Community Equipment service

	Dec-22			Nov-22			Oct-22			Sep-22			Aug-22			Jul-22			Jun-22			May-22			Apr-22		
Description																											
Deliveries within 5 Days (standard), as indicated, on receipt of the Requisition.	381	380	99.7%	432	427	98.8%	415	410	98.8%	440	437	99.3%	414	412	99.5%	399	394	98.7%	413	409	99.0%	394	388	98.5%	390	386	99.0%
Deliveries within 1 Day (urgent), as indicated, on receipt of the Requisition.	232	232	100.0%	212	209	98.6%	196	195	99.5%	216	214	99.1%	221	221	100.0%	186	184	98.9%	161	160	99.4%	201	199	99.0%	172	172	100.0%
Deliveries within Same Day (4 hours) (Critical), as indicated, on receipt of the Requisition.	103	96	93.2%	94	93	98.9%	107	107	100.0%	126	126	100.0%	101	100	99.0%	108	108	100.0%	108	108	100.0%	99	99	100.0%	77	76	98.7%
A minimised number of multiple deliveries - % of service users receiving more than one delivery per order	941	5	0.5%	1015	5	0.5%	992	6	0.6%	1050	9	0.9%	1016	8	0.8%	944	10	1.1%	942	8	0.8%	973	7	0.7%	867	9	1.0%
Special items to be ordered within 5 Days of receipt of Requisition, unless instructed otherwise.	67	67	100.0%	55	55	100.0%	56	56	100.0%	49	49	100.0%	70	70	100.0%	84	84	100.0%	58	58	100.0%	57	57	100.0%	45	45	100.0%
Items collected within 5 Days (standard) of request as indicated, on receipt of the Requisition.	335	335	100.0%	372	372	100.0%	452	449	99.3%	386	380	98.4%	405	402	99.3%	409	402	98.3%	419	415	99.0%	440	435	98.9%	371	365	98.4%
Items collected within 1 Day (urgent), as indicated, on receipt of the Requisition.	25	24	96.0%	15	15	100.0%	33	33	100.0%	29	29	100.0%	34	34	100.0%	20	19	95.0%	25	24	96.0%	24	24	100.0%	24	24	100.0%
Community Equipment recycled (% of total items collected) TO BE DEFINED	795	589	74.1%	1,341	860	64.1%	1,362	942	69.2%	1,355	998	73.7%	1,098	780	71.0%	1,324	958	72.4%	1,325	980	74.0%	1,332	1,021	76.7%	1,040	783	75.3%
All routine repairs shall be completed within 5 Days	67	61	91.0%	90	88	97.8%	70	70	100.0%	69	69	100.0%	89	87	97.8%	95	95	100.0%	79	78	98.7%	82	82	100.0%	84	83	98.8%

Appendix three – Adult Social Care Discharge Fund schemes

	Scheme name	Budget allocation
1	1. Assistive Technology & Gantry Hoists to reduce double handling care packages	50,000
2	2. Emergency Housing accommodation for prevention and discharge (for homeless people)	10,000
3	4. Housing Grant to support overseas staff recruitment for existing commissioned providers	40,000
4	5. Winter Access Fund for Primary Care	250,000
5	6. Contingency budget for market restructuring and transport - fuel cost support for care at home providers	80,000
6	7. Acute Visiting Service & GP out of hours	120,000
7	8. Hot Hub escalation expansion for non-elective and Paediatrics	60,000
8	9. Hospice Beds (East Cheshire Hospice & St Lukes Hospice).	85,000
9	11. Personal Health Budgets to support discharges	15,000
10	12. Carers Payments to facilitate rapid discharge	15,000
11	13. St Pauls Hospital Discharge Support delivered via Community Voluntary Sector	30,000
12	14. Hospital Discharge Premium Payment & Prevention Scheme	180,000
13	15. Additional hospital transport for discharges for evenings & weekends	40,000
14	16. Additional Acute Pharmacy capacity to support hospital flow	70,000
15	18. Acute Trust Discharge support for ECT & MCHFT	300,000
16	19. Increase General Nursing Assistant Capacity care at home via CCICP	250,000
17	20. Transfer of Care Hub, Nurses and additional Social Workers to support discharges out of ED and out of hospital	80,000
18	21. Approved Mental Health Practitioners Cover, evenings & weekends for ECT and MCHFT	60,000
19	22. Mental Health step down supported living flats (4) 1st Enable in Crewe	115,140
20	23. Mental Health Reablement – Rapid Response Service	12,500
21	24. Challenging behaviour training for Care Homes	5,000
22	27. ED Mental Health In reach specialist Support Workers to support people awaiting discharge	45,000
23	28. Short stay beds to support discharges	1,000,000
24	29. Care robots to free capacity in the care home market	80,000
25	31. £40k to support the Feebris proposal in team CHAW	40,000
26	32. £2k to BDP which will provide transport	2,000
27	33. £70K to provide GP support to Wilmslow Manor	75,000
28	34. PCN Community Pharmacy Link	2,100
29	37. Routes rapid response	476,067
30	38. Carers support in hospital	166,361
	Total spend	3,754,168