Cheshire East Council

Working for a brighter future together

Cheshire East Health and Wellbeing Board

Date of Meeting: 27 November 2017

Report Title: Better Care Fund and Improved Better Care Fund 2018/19 Quarter 2

Portfolio Holder: Cllr. Janet Clowes (Adults Social Care and Integration)

Senior Officer: Linda Couchman, Interim Director of Adult Social Care and Health

1. Report Summary

1.1. On the 19th October 2018, Cheshire East submitted the 2018/19 quarter 2 Better Care Fund and Improved Better Care Fund return. The return was signed-off by Linda Couchman, Interim Director of Adult Social Care and Health.

1.2. The purpose of this paper is to provide the Health & Wellbeing Board (HWB) with a summary of progress made during Quarter 2.

1.3. The paper will look at the following in turn:

- National conditions & s75 Pooled Budget (4.1)
- Programme progress during Q2 (4.2)
- Governance (4.5)
- Performance (4.10)
- High Impact Change Model (4.17)
- Spotlight on a BCF/iBCF scheme (4.20)
- Future configuration of the BCF programme (4.25)
- Next steps (4.29)

2. Recommendation

2.1. The Cheshire East Health and Wellbeing Board is asked to note Better Care Fund and Improved Better Care Fund performance during Quarter 2.

3. Reasons for Recommendation

3.1. The Cheshire East Health and Wellbeing Board is central to the Governance of the BCF, this report and recommendations form part of this ongoing governance.

4. Background

4.1. National conditions & s75 Pooled Budget

At the end of quarter 2 2018/19, the following national conditions were fully met in Cheshire East:

- Plans were jointly agreed
- There was a planned contribution to social care from the CCG minimum contribution; it has been agreed in line with the planning requirements.
- There is agreement to invest in NHS commissioned out of hospital services
- There is agreement on managing transfers of care
- Funds have been pooled via a s.75 pooled budget

4.2. Programme progress during Q2

As part of the Cheshire East BCF programme 19 schemes were included for 2018/19. These are a combination of BCF and iBCF funded elements. An additional 2 schemes were added to the programme during this previous quarter; Demand Capacity & End of Life Partnership Website/e-Paige.

4.3. Demand capacity

The aim of this scheme is to achieve a greater understanding of system wide capacity which in turn will allow for a better management of services in turn supporting the achievement and attainment of national metrics. Through analysis of demand and capacity for a service, it is possible to identify and apply good practice approaches to improve flow and decrease waiting times.

4.4. End of Life Partnership Website/ e-Paige

The e-Paige is a dynamic easy to use ‘one stop’ electronic tool available for use across all care settings. The e-Paige offers a unique approach to End of Life care, prognostication and management. It brings together resources tailored specifically to the needs of the patient, family or clinician at any given time. The information and resources gathered from a wide network of local, regional and national sources are aligned to individual stages of the patient pathway and placed into context via four individual management plans covering the assessment, ongoing management and discharge planning for a

patient with a prognosis of, months, weeks, or days. The final management plan covers the first hours and days after death and into ongoing bereavement care.

4.5. Governance

4.6. During the last quarter a number of activities have taken place, this includes a refresh of the Terms of Reference for the Better Care Fund Governance Group (BCFGG), the production and adoption of operating principles for the BCFGG and the production and adoption of a forward plan for the BCFGG.

4.7. Terms of Reference (TOR) – the terms of reference outlines; responsibilities, purpose, objectives, group composition/membership, code of conduct, meeting/quoracy arrangements and when the TOR should be re-reviewed.

4.8. Operating principles – The operating principles have been developed in order to explicitly set out how the organisations comprising of the BCFGG should operate in order to achieve the aims of the BCF plan in Cheshire East. For example the 2 year plan entitled: Delivering the Better Care Fund in Cheshire East 2017-19 set out the vision as follows: the “Delivery of a fully integrated health and social care commissioning function by 2020 supporting the delivery of Accountable Care across Cheshire”. The operating principles put forwards approaches towards achieving this vision.

4.9. Forward plan – The forward plan aims to explicitly set out the work due to be undertaken and discussed at future meetings of the BCFGG. It’s an aim to more clearly direct the work of the BCFGG ensuring that there is a strategy in meeting the objectives of the TOR.

4.10. Performance

4.11. The Integration and Better Care Fund Operating Guidance for 2017-19 sets out a number of metrics through which performance is judged, the measures are as follows:

- BCF Metric 1 - Emergency Admissions (All Age Groups)
- BCF Metric 2 - Long-term support needs of older people (aged 65 and over) met by admission to residential and nursing care homes (per 100,000)
- BCF Metric 3 - Proportion of older people (65 and over) who are still at home 91 days after discharge
- BCF Metric 4 - Delayed Transfers of Care Rate per 100,000 popn aged 18+
- BCF Metric 5 - Long stay patients

4.12. A breakdown of performance against these five metrics is shown in Appendix one.

4.13. The performance recorded presents the totality of health and social care performance for the Cheshire East Health and Wellbeing footprint area. In order to further improve performance a continued focus on the metrics has been built into the forward plan for the BCFGG. Each meeting of the BCFGG has a review of a particular metric. These focused reviews or 'deep dives' will try to establish;

- The system performance in relation to metric
- Any differences in performance within Eastern Cheshire between East and South
- Patterns/themes where greater resource can be targeted
- A series of recommendations to be implemented by organisations to improve performance.

4.14. In addition to this each scheme which comprises the BCF/iBCF in Cheshire East has a scheme descriptor which describes what the scheme is, what its due to achieve and in turn how this will impact on the five metrics outlined previously.

4.15. New nationally set targets have been introduced for the Delayed Transfers of Care (DTOC). The DTOC target for Cheshire East will be 733 and within this 498 delayed days will be attributable to the NHS and 235 delayed days will be attributable to Social Care. On a daily basis the DTOC expectation is that there will be a total of 24 delayed days, this is made up of 17 delayed days attributable to the NHS and 8 days attributable to Social Care.

4.16. There was also a new national ambition to reduce bed occupancy by reducing the number of long stay patients (and long stay bed days) in acute hospitals by 25%. The baseline accompanying the new target sets out that that beds occupied with long stay patients in Cheshire East was 165 , the ambition set which is the maximum number of beds to be occupied with long stay patients would be 122, this represents a local long stay reduction of 26.2%. As yet local information relating to actual performance hasn't been accessible from the Social Care Dashboard.

4.17. <u>High Impact Change Model</u>

4.18. The High Impact Change Model, as defined by the Local Government Association offers a practical approach towards managing transfers of care. The model identifies eight system changes which will have the greatest impact on reducing delayed discharge.

4.19. The model itself can be used to complete a self-assessment on how the local care and health systems are working now, it can also be used to help reflect on, plan for, and action improvements on reducing delays throughout the course of the year. An updated self-assessment against the HICM for Cheshire East is shown in Appendix two.

4.20. Spotlight on a BCF/iBCF scheme

4.21. Each Quarter we wanted to highlight a particular scheme and its performance. The Cheshire East Carers Hub - is a new information and support service designed to help carers of all ages fulfil their caring responsibilities and still enjoy a healthy life outside of their caring role. The Hub supports carers who live in Cheshire East, along with those who live outside the area but care for a Cheshire East resident.

4.22. The Hub was commissioned in May 2018 by Cheshire East Council, in partnership with the NHS, and is being delivered by N-compass Northwest. N-compass was selected following a competitive procurement process and is an organisation with experience of providing high-quality and innovative provision for carers. N-compass will work in partnership with Child Action North West, The Alzheimer's Society and other national and local organisations to ensure carers receive information and support which is tailored to their individual needs.

4.23. The Cheshire East Carers Hub provides a single point of access for carers, families and professionals. The Hub will ensure 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.

4.24. The Hub also offers groups and activities which carers will be familiar with along with introducing new support opportunities co-produced with local carers. Whilst the office base for the Hub is located in Congleton, a key feature of the new service will be regular outreach sessions in communities across the borough. Recent achievements include:

- Distributed Living Well funds to 117 carers
- Identified 364 hidden carers
- Facilitated 1010 support sessions
- Facilitated 36 support groups attended by 217 carers – 83% reported improved wellbeing
- Facilitated over 20 different briefings or presentations
- Launched the community grant scheme
- Working with the council to become trusted assessors

- Recruiting and inducting volunteers for the chat line
- Developed carer reference groups
- Developed list of GP Carer Advocates/Champions from within GP practices and build links/establish referral pathways
- Grew a network of young carer champions/link workers from within schools aligned to Emotionally Healthy Schools Programme
- Planning a range of positive, accessible and age appropriate activities/training that provide carers with a break/support in their caring role
- Carers Choice awards evening on 26th September where 13 projects were presented to carers for them to vote on which ones they liked. On the evening 34 carers voted and 10 projects were awarded £88,000 for them to deliver a range of carers services during the next 12 months, that complement the offer from the Carers Hub. A notable outcome of this was the vast majority supported the young carers projects.

4.25. Future configuration of the BCF programme

4.26. In the March 2017 Budget, the Conservative Government said that it would publish a Green Paper on social care, in order to allow a public consultation to be held. This followed the decision in July 2015 to postpone the introduction of a cap on lifetime social care charges and a more generous means-test that had been proposed by the "Dilnot Commission" and accepted in principle by the then Coalition Government. During the subsequent 2017 General Election campaign, the Conservative Party made a manifesto commitment to introduce the Green Paper.

4.27. The Government has said that the proposals in Green Paper will "ensure that the care and support system is sustainable in the long term". Other topics that the Government have said will be included include integration with health and other services, carers, workforce, and technological developments, among others. A Social care Green paper on older people and the future of BCF is due, there are a number of questions under consideration which include:

- What purpose should the BCF serve in the future
- What the funding model should be
- And what scope to improve the administration of the BCF

4.28. With this in mind there are a number of considerations with respect to the configuration of the BCF programme in Cheshire East and a options paper will be circulated to Cheshire East Council as well as Eastern Cheshire CCG and South Cheshire CCG outlining a number of proposals for 2019-20.

4.29. Next steps

4.30. In order to mitigate performance evidenced in Q2 the following next steps will be adopted and progressed:

- Implement metric improvement actions
- Carry out metric 'deep dives' and implement recommendations
- Produce programme recommendations for 2018/19

5. Implications of the Recommendations

5.1. Legal Implications

5.1.1. If an area is not compliant with any of the standard conditions of the BCF, or if the funds are not being spent in accordance with the agreed plan resulting in a risk to meeting the national conditions, the Better Care Support Team (BCST), in consultation with national partners, may make a recommendation to NHS England to initiate an escalation process. Any intervention will be appropriate to the risk or issue identified.

5.2. Finance Implications

5.2.1. The Integration and Better Care Fund Operating Guidance provides the option that where an area remains non-compliant, or performance remains poor, further intervention will be considered. If it becomes apparent that local implementation is resulting in one or more requirements of the BCF not being met in an area – the BCST will consider commencing an escalation process. The financial implications include withdrawal or redirection of grant funding and in turn, additional costs to be incurred locally by BCF partners. These include existing permanent costs no longer being funded and also, short term one off costs such as staff severance.

5.3. Policy Implications

5.3.1. Recent Better Care Fund guidance published 18th July 2018 stated the requirement to achieve a reduction in long stay in hospitals. The ambition is for long stays in hospital to be reduced by 25%. This is to be achieved in part through the continuing focus on delivery of the local DTOC expectations; this could have a policy implication on how resources are targeted to meet this ambition.

5.4. Equality Implications

5.4.1. In respect of the Equality Act 2010, public bodies across Great Britain have an equality duty. All BCF partners in Cheshire East are conversant and compliant with the Equality Act 2010. The Equality Duty has three aims. It requires public bodies to have due regard to the need to:

- Eliminate unlawful discrimination, harassment, victimisation and any other conduct prohibited by the Act;
- Advance equality of opportunity between people who share a protected characteristic and people who do not share it; and
- Foster good relations between people who share a protected.

5.4.2. The implication of this Quarter 2 performance information is that we need to expressly collect and evidence we have satisfied that due regard has been given to the Equality duty. For example against each of the metrics we would show a breakdown of characteristics of services users/patients and whether these are protected.

5.5. **Human Resources Implications**

5.5.1. Poor performance against national metrics could see intervention and escalation process implemented which in turn could see funds directed differently, which in turn could bring with it human resource implications.

5.6. **Risk Management Implications**

5.6.1. Ongoing performance monitoring and management to ensure improving performance against the national metrics.

5.7. **Rural Communities Implications**

5.7.1. Where possible the national metrics are reported across Cheshire East Council footprint as well as Eastern Cheshire CCG footprint and Southern Cheshire CCG footprint. No specific impact across rural communities has been found across the national metrics.

5.8. **Implications for Children & Young People**

5.8.1. Some children and young people are classed as carers, and it is important that these individuals are recognised and supported through the existing better care fund.

5.9. **Public Health Implications**

5.9.1. The Better Care Fund has been created to improve the lives of some of the most vulnerable people in our society, placing them at the centre of their care and support, and providing them integrated health and social care services, resulting in an improved experience and better quality of life.

5.9.2. Health and care that supports better health and wellbeing for all, and a closing of health inequalities. There are no direct implications for public health.

6. Ward Members Affected

6.1. The implications will be borough wide.

7. Consultation & Engagement

7.1. Consultation and engagement with CCG partners through the BCF Governance Group has taken place and will continue to take place.

8. Access to Information

8.1. The Integration and Better Care Fund Operating Guidance For 2017-19 Published 18 July 2018

9. Contact Information

9.1. Any questions relating to this report should be directed to the following officer:

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Performance – Appendix one

Metric	National context	Regional context	Local context	Mitigating action
BCF Metric 1 - Emergency Admissions (All Age Groups)	Non-elective admissions (NEA) for year to date at August 2018 increased by 6.7% compared to year to date at August 2017. During the last quarter we have seen increases nationally in Non-Elective Admissions (NEAs) as shown from NHS Improvement provider performance information. Year to Date information suggests 200,000 additional admissions. The recent heatwave has contributed to the increase seen in Non-Elective Admission increases.	Commissioners in the NHS North region saw non-elective admissions for year to date at August 2018 increase by 8.1% compared to year to date at August 2017	At the end of Quarter 1, NEAs were 12% above planned target (10,635 compared to plan figure of 9,487). Due to the hot weather over the summer, there were system pressures across the whole health economy. Mid Cheshire Hospital Trust escalated to Operational Pressures Escalation Levels (OPEL) Twice during August and was consistently under pressure due to the hot weather, likewise, East Cheshire NHS Trust escalated to OPEL 4. OPEL helps to manage day to day variations in demand across the health and social care system as well as the procedures for managing significant surges in demand. NEAs from April to July 2018 are about 4% up on the same period last year (14,349 compared to 13,798). This, however, includes a spike in July where NEAs were about 7% up on the same month in 2017 (3,714 compared to 3,476) and a 6% increase on the previous month (3,714 compared to 3,501). July 2018 saw the highest number of NEAs in Cheshire East for at least 2 years. Some key areas contributing towards an increase in NEAs in Cheshire East are as follows: • Diagnosis Cellulitis of other parts of limb for 2017/18 was 37 incidents, and for 2018/19 was 78 incidents, the total change between 2017/18 and 2018/19 was 110.8%. • For a diagnosis of Urinary tract infection, site not specified for 2017/18 there were 105 incidents, and for 2018/19 there were 156 incidents, the total change between 2017/18 and 2018/19 was 48.6%. • Within this analysis Urology saw increased incidents increase from 76 in 2017/18 to 107 in 2018/19. Top 10 Diagnosis (Change in activity from previous year) (Summer - Jun to Aug Only)	
BCF Metric 2 - Long-term support needs of older	National data is only collected annually and not in-year. 2017/18 data is due to be published on 23rd October 2018. The latest national data	National data is only collected annually and not in-year. 2017/18 data is due to be published on 23rd October 2018. The latest national data	Cheshire East Quarter 2 is currently 308.2 (please note that this may rise as additional data is loaded).	

Metric	National context	Regional context	Local context	Mitigating action
people (aged 65 and over) met by admission to residential and nursing care homes (per 100,000)	available is for 2016/17. In 2016/17, the year-end rate nationally was 610.7. Assuming admissions were broadly consistent over the year, the national performance at the end of Quarter 2 would have been 305.4.	available is for 2016/17. In 2016/17, the year-end rate for the North West region was 769.0. Assuming admissions were broadly consistent over the year, the national performance at the end of Quarter 2 would have been 384.5	Quarter 2 actual performance is currently forecast to be around 15% below the Quarter 2 target. Individual monthly spikes in admissions seen in the first half of the year in the previous years have not happened in 2018/19 and there has been a more consistent level of admissions.	
BCF Metric 3 - Proportion of older people (65 and over) who are still at home 91 days after discharge	National data is only collected annually and not in-year. 2017/18 data is due to be published on 23rd October 2018. The latest national data available is for 2016/17. Please note that national performance is only measured for those people who were discharged from hospital between 1st October and 31st December) The national percentage achieved in 2016/17 was 82.5%. For the 85+ age group it was 80.3%. 45% of the cohort for this measure, nationally, were aged 85+	National data is only collected annually and not in-year. 2017/18 data is due to be published on 23rd October 2018. The latest national data available is for 2016/17. Please note that national performance is only measured for those people who were discharged from hospital between 1st October and 31st December) The regional percentage achieved in 2016/17 was 81.8%. For the 85+ age group it was 79.9%. 42% of the cohort for this measure, regionally, were aged 85+	In Quarter 1 18/19 (Intermediate Care Only), the percentage achieved was 70.5%. For the 85+ age group it was 64.1%. 52% of the cohort for this measure, in Cheshire East, were aged 85+ Recording process issues relating to Reablement following discharge. In Quarter 1, just over 12% of people discharged to Intermediate Care (38 out of 302) sadly passed away before the 91 days after discharge. We are still awaiting full Quarter 2 data and Reablement data, Quarter 1 (Intermediate Care only) was significantly below plan (18.4 percentage points). To meet the target, a further 59 on top of the 213 people would have needed to be still at home at the 91 day point. If the numbers who passed away were excluded, the shortfall against plan would be 9.1 percentage points. Partial data for Quarter 2 indicates some potential improvement though still not at the planned level. The handbook of definitions for 2018/19 which includes this metric suggests that future of this performance measure could include consideration of Reablement packages delivered in the community.	In mitigation of this information the following actions will be taken: • Re-validation of data including Reablement packages, Intermediate Care beds and Intermediate Care Packages. • We will increase the scope of data collection to include those Reablement packages offered in the community.
BCF Metric 4 - Delayed Transfers of Care Rate per 100,000 popn aged 18+	Nationally, DTOC beds in August 2018 were 19% lower than at August 2017. By June 2018, DTOC beds were at their lowest number since May 2015. There has, since June 2018, been an increase of 5% as at August 2018 (+10% for social care delays and +3% for NHS delays). At August 2018, nationally, the top 3 reasons for all delays were: Awaiting care package in own home (22%); Awaiting further non-acute NHS care (17%); and Awaiting nursing home placement or availability (16%)	In the North West region, DTOC beds in August 2018 were 24% lower than at August 2017. There has, since June 2018, been an increase of 8% as at August 2018 (+6% for social care delays and +9% for NHS delays). At August 2018, regionally, the top 3 reasons for all delays were: Awaiting care package in own home (22%); Awaiting nursing home placement or availability (15%); and Awaiting completion of assessment (15%) At August 2018, regionally, the top 3 reasons for	In Cheshire East, DTOC beds in August 2018 were 22% lower than at August 2017. There has, since June 2018, been an increase of 12% as at August 2018 (+4% for social care delays and +23% for NHS delays). At August 2018, in Cheshire East, the top 3 reasons for all delays were: Awaiting further non-acute NHS care (26%); Awaiting care package in own home (23%); and Awaiting nursing home placement or availability (20%) At August 2018, in Cheshire East, the top 3	In mitigation of this information the following actions will be taken: • Recommendations produced as a result of the 'deep dive' conducted through the BCF GG will be implemented. • The Health and Social Care secretary has announced an additional £240m will be allocated to Social Care in England in order to ease pressure on the NHS this winter by enabling a greater number of elderly people to be cared for at home. The additional money is being targeted at reducing Delayed Transfer of Care.

Metric	National context	Regional context	Local context	Mitigating action
	At August 2018, nationally, the top 3 reasons for NHS delays were: Awaiting further non-acute NHS care (27%); Patient/family choice (18%); and Awaiting nursing home placement or availability (14%) At August 2018, nationally, the top 3 reasons for Social Care delays were: Awaiting care package in own home (36%); Awaiting residential home placement or availability (24%); and Awaiting nursing home placement or availability (14%)	NHS delays were: Awaiting further non-acute NHS care (24%); Patient/family choice (18%); and Awaiting nursing home placement or availability (15%) At August 2018, regionally, the top 3 reasons for Social Care delays were: Awaiting care package in own home (42%); Awaiting residential home placement or availability (18%); and Awaiting completion of assessment (16%)	reasons for NHS delays were: Awaiting further non-acute NHS care (39%); Awaiting nursing home placement or availability (20%); and Patient/family choice (10%) At August 2018, in Cheshire East, the top 3 reasons for Social Care delays were: Awaiting care package in own home (47%); Awaiting nursing home placement or availability (21%); and Awaiting residential home placement or availability (20%). The latest data suggests that it will be very challenging to meet the revised target, significant reductions have been achieved over the last year. Delayed days are down 36% from April to July 2018, compared to the same period 2017. Out of area delays: between January and July 2018 almost a third of delayed days (32%) were at Hospital Trusts outside of the Cheshire East area. Some recent issues regarding availability of residential/nursing placements. In comparison to Cheshire East Geographical neighbours we compare favourably against Cheshire West & Chester, Stockport, Manchester, Staffordshire and Trafford	
BCF Metric 5 - Long stay patients	At the time of writing the information wasn't available from the Long stay patient dashboard.			

8 High Impact Changes for Delayed Transfers of Care – Appendix two

CCG - Assessment of action against the 8 High Impact Changes for Delayed Transfers of Care

8 High Impact Changes for Delayed Transfers of Care		
Change 1	Early D*i*scharge Planning In elective care, planning should begin before admission. In emergency/ unscheduled care, robust systems need to be in place to develop plans for management and discharge, and to allow an expected date of discharge to be set within 48 hours.	• SAFER Bundle delivered within East Cheshire NHS Trust • Frailty approach - CGA and 'Expected Discharge Date' within 6-hours for admissions via A&E (non-elective) • 'Expected Discharge Date' set within 48-hours on all wards • Pre assessment clinics prior to admission include discharge planning (electives)
Change 2	Systems to Monitor Patient Flow Robust patient flow models for health and social care, including electronic patient flow systems, enable teams to identify and manage problems (for example, if capacity is not available to meet demand) and to plan services around the individual.	• 'Full Capacity Protocol' in place and operational (as part of OPEL Framework) • Weekly 'stranded' and 'super stranded' patient reviews and database for all 7+ day length of stay patients (with reasons and actions, as per the national expectations). For all acute beds, non-acute beds and for people at home still receiving intermediate care • Prioritisation and proactive management of DTOC led by the Integrated Discharge Team (IDT) including daily action-focused bed management meetings • Multi-agency evaluation complete of Winter 17/18 and plans in development for Winter 18/19 • Ambulance Response Programme (ARP) - Improvement Plan signed off and monitored via County-wide Clinical Quality and Assurance

		Committee and NWAS Strategic Partnership Board
Change 3	Multi-Disciplinary/Multi-Agency Discharge Teams Co-ordinated discharge planning based on joint assessment processes and protocols, and on shared and agreed responsibilities, promotes effective discharge and good outcomes for patients	• Multi-disciplinary health and social care IDT in place and working across 7-days when required • Daily Meetings/Board Rounds including Commissioners (10am daily) • Proactive management approach to delays (in line with OPEL Framework) • WTE Nurse within IDT focused on out-of-area delays to improve repatriation and discharge (including newly agreed protocol with North Staffs CCG)
Change 4	Home First/Discharge to Assess Providing short-term care and Reablement in people's homes or using 'step down' beds to bridge the gap between hospital and home means that people no longer need wait unnecessarily for assessments in hospital. In turn, this reduces delayed discharges and improves patient flow.	• Local model in place for 'Assessment Outside of Hospital' including Continuing Healthcare (CHC) assessments (flexible capacity based on demand) • Spot purchase of beds in different locations to support assessment and offer localised care (linked to future Care Communities) • Whole system demand and capacity modelling is underway (to be reported to ORG in September 2018). • Review of bed-based care (17/18 and future state) underway.
Change 5	Seven-Day Service Successful, joint 24/7 working improves the flow of people through the system and across the interface between health and social care, and means that services are	• NHS 111 'Clinical Assessment Service' (CAS) in place • NHS 111 'online' in place by 31st July 2018 • NHS 111 'Acute Patient Advisory Service' (APAS) - Go Live in Sept 2018

	more responsive to people's needs.	• Frailty approach working across 7 days, including Single Point of Access. • Increased weekend working - 1 x Social Worker 10am-4pm Saturday and Sunday and Intermediate Care Nurses provide additional cover (further work is needed on the wards) • Extended Primary Care - an additional 104 hours per week in General Practice to 'Extend Access' to the Service by 1st Oct 2018 • Enhanced Primary Care Acute Visiting Service (in-hours) to manage urgent demand – additional 50 hours per week is commissioned above core GMS
Change 6	Trusted Assessors Using trusted assessors to carry out a holistic assessment of need avoids duplication and speeds up response times so that people can be discharged in a safe and timely way.	• Primary Care Streaming model at the 'front door' (A&E). Regular monitoring in place ('zero tolerance on minor breaches') • IDT proactively working with Care Homes to continue the development of Trusted assessor • Care Home collaborative Trusted Assessor model funding agreed and due to be implemented (based on Lincoln model)
Change 7	Focus on Choice Early engagement with patients, families and carers is vital. A robust protocol, underpinned by a fair and transparent escalation process, is essential so that people can consider their options, the voluntary sector can be a real help to patients in considering their choices and reaching decisions about their future care.	• Supporting Patient Choices to Avoid Long Hospital Stays – policy/protocol written and implemented April 2017 • Out of area visit complete to identify learning and new protocol agreed • Support at Home Service commissioned across Cheshire East footprint, joint service specification agreed and service delivered by the British Red Cross

Change 8	Enhancing Health in Care Homes Offering people joined-up, co-ordinated health and care services, for example by aligning community nurse teams and GP practices with care homes, can help reduce unnecessary admissions to hospital as well as improve hospital discharge.	• Enhanced primary care proactive medical services in place in all nursing homes • Additional proactive Dietetics and Speech and Language services in place • Database of all emergency attendances and non-elective admissions from residential and nursing homes • Low standardised rates of admission from Nursing Homes • Work to be developed in residential homes