Cheshire East Council

Working for a brighter future together

Cheshire East Health and Wellbeing Board

Date of Meeting:	22/09/2020
Report Title:	Better Care Fund End of Year report 2019 - 2020
Portfolio Holder:	Cllr. Laura Jeuda (Adults Social Care and Health)
Senior Officer:	Linda Couchman, Acting Strategic Director of Adults Social Care & Health.

1. Report Summary

1.1. To highlight the performance of the Better Care Fund including the Improved Better Care Fund in Cheshire East in 2019/20.

2. Recommendations

2.1. That the Health and Wellbeing Board notes the Better Care Fund programme performance in 2019/20.

2.2. 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. Other Options Considered

4.1. Not applicable.

5. Background

5.1. **What is the BCF**

5.2. The BCF provides a mechanism for joint health and social care planning and commissioning, bringing together ring-fenced budgets from Clinical Commissioning Group 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.

5.3. 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.

5.4. National funding for the BCF in 2019-20 totalled £6.422bn.

Table 1 – BCF funding contributions in 2019-20

BCF funding contribution	**2019-20**
Minimum NHS (Clinical Commissioning Groups) contribution	£3.840bn
Disabled Facilities Grant (capital funding for adaptations to houses)	£0.505bn
Grant allocation for adult social care (improved Better Care Fund). Combined amounts were announced at Spending Review 2015 and Spring Budget 2017.	£1.837bn
Winter Pressures grant funding	£0.240bn
Total	£6.422bn

5.5. For 2019-20, 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 CCG 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).

5.6. 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.

5.7. **Current schemes**

5.8. The following table summarises the schemes, which comprise the iBCF, BCF and winter pressures.

Number	Scheme	Description
1	iBCF - Increased weekend capacity for social workers	To maintain Social Work assessments and advice services over 7-days per week. Based within the hospitals at Macclesfield and Leighton.
2	iBCF - Care Sourcing team model	The funding supports and expands the work of the Care sourcing team. The team undertakes 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 8am until 2pm / 2pm until 8pm, Monday to Sunday.
3	iBCF - Live well	'Live Well Cheshire East' is an online resource. It is designed to give people greater choice and control by providing easily accessible information and advice about care and support services in the region and beyond. This digital channel provides information and advice and a directory of local services in one place covering Adult, Children, Community and Public Health services.
4	iBCF - Funding for additional social care staff to support Discharge to Assess initiatives	Funding for additional Social Care staff (Locality Manager and Practice Manager) for each hospital team to implement and maintain 'Assessment Outside of Hospital' (previously known as 'Discharge to Assess) in a range of locations across Cheshire East. This includes bed-based services and within a person's own home to prevent admissions to hospital and facilitate timely discharge.
5	iBCF - Winter funding	Additional capacity to support the local health and social care system to manage increased demand over the winter period.
6	iBCF - Sustain the capacity, capability and quality within the social care market place	This funding supports and stabilizes the local social care market by offering fee uplifts for both 'Care at Home' (domiciliary care) and Accommodation with Care (Care Homes). The funding relates to the following: • Residential/nursing care – 1360 bed weeks which is 26 placements over the course of the year. • Domiciliary care – 380 new people until the end of the year.
7	iBCF - Electronic Call	The monitoring providers to ensure that individual level care calls meet planned activity as set out in care plans.

	Monitoring (ECM)	The electronic call monitoring system (ECM) will support the delivery of the recommissioned Care at Home service. ECM offers an automated solution to monitor care visits undertaken by the provider's staff, which will help to improve performance monitoring and safeguarding and improve the safety of staff. The ECM solution will also offer the potential to move towards the monitoring of outcomes for service users.
8	BCF Assistive Technology (AT)	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 personalized to each individual and is integrated within the overall support plan. This will entail: • Increasing the independence of people living with long term conditions and complex care. • Supporting Carers to maintain their caring role. • Improving access to the right service at the right time. The scheme supports the existing assistive technology service users. But will also involve piloting assistive technology support for adults with a learning disability (both living in supported tenancies and living in their own homes).
9	BCF Early discharge service – ECT is commissioned to provide an Early Discharge Co-ordinator also forming part of this scheme is the commission of the British Red Cross service.	Early discharge service – ECT is commissioned to provide an Early Discharge Co-ordinator, as part of this scheme there is also a commissioned element which supports the British Red Cross 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).
10	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.
11	BCF Statutory Social Care activities resulting from the Care Act including Safeguarding	The Care Act 2014 introduced and revised the statutory responsibilities of local authorities. The Partnership will ensure sustainable appropriate embedded solutions are in place to meet these responsibilities. The Partnership encompasses the duties of the Safeguarding Adults Board. This safeguarding scheme also includes the responsibilities which come from the Care Act which includes the following sub-schemes: Provider Quality Reports (BCF Social Care Act Allocation), Maintaining minimum care eligibility thresholds - Contribution towards maintaining care eligibility thresholds at critical and substantial, Continuity of care for people moving into areas - Additional social worker capacity, Assessment of Social Care in prisons - Additional social worker capacity, Disregard for armed forces Guaranteed Minimum Income - Allocated to care packages, Training social care staff in Social Care Act - Delivery of Care Act training to staff, Less reduction for savings from staff

		time and reduced complaints
12	BCF Disabled Facilities Grant (DFG)	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 will be administered by Cheshire East Council and will be delivered across the whole of Cheshire East.
13	BCF Carers hub	The Cheshire East Carers Hub is an 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 will support Carers who live in Cheshire East, along with those who live outside the area but care for a Cheshire East resident.
14	BCF Programme Management and Infrastructure	Overall responsibility for delivery of the principles and targets of the BCF and identifying barriers, risks and mitigation to ensure they are achieved. Staff employed and infrastructure required to support the management and governance arrangements for the BCF.
15	BCF Winter Schemes ECCCG	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.
16	BCF Homefirst ECCCG	'Home First' is the 'umbrella' term used to describe a collection of services commissioned by NHS Eastern Cheshire CCG and predominately delivered by East Cheshire NHS Trust
17	BCF Homefirst SCCCG	Home First is an ethos, to support patients to remain in their own homes. This scheme is delivered through a number of community health services predominately delivered by Central Cheshire Integrated Care Partnership.
18	Winter - rapid response	The Rapid Response Service facilitates 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.
19	Winter - additional beds	We have 60 short stay beds per week to support step down and step up per bed. Existing Commissioning resource will be used to procure these beds.
20	Trusted assessor service	The overall aim of this service is to develop and establish a trusted assessor service in Cheshire East; this service will provide a trusted assessment function through Independent Transfer of Care Coordinators. This service will initially work with existing care home residents who have been admitted to hospital and require assessment prior to transferring back to the care home. This service will in part help reduce patient length of stay as well as contributing to a reduction in Delayed Transfers of Care.

1.1. **Metric performance**

1.2. The following table describes the planned performance against the national metrics and the actual performance.

	2019/20 BCF Plan Target	**2019/20 Actual**
Non Elective Admissions	Quarter 4: 11,634 2019/20 Year Total: 45,685	Data up to March 2020 is due to be published on 14/05/20. As at Feb 2020 the total for the year was: 42,565
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population [3]	601	701

Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	83.3%	74.6%
Delayed Transfers of Care per day (daily delays) from hospital (aged 18+) [6]	24.4	47.9 (as at Feb 2020)

1.3. **The financial income and expenditure of the plan**

1.4. The following table describes the budget for the Better Care Fund the actual spend, the variance between the budget and the actual spend and the commitment carry forward to 2020/21.

2019/20 Better Care Fund	Budget	Actual	Variance	Commitment c/fwd to 2020/21
Assistive technology - telecare	757,000	832,700	75,700	0
Early Discharge Schemes	222,942	220,677	-2,265	0
Combined Re-ablement	4,575,000	4,241,012	-333,988	0
Social Care Act	405,000	405,000	0	0
Programme Enablers	223,729	85,283	-138,446	0
MH Social Workers	40,000	40,000	0	
Trusted Assessor Scheme	75,000	6,500	-68,500	68,500
Winter pressures	510,000	500,000	-10,000	0
Carers Assessment and Support	722,000	701,662	-20,338	0
Addn Winter Pressures beds	128,000	128,000	0	0
Double Handling Project(incl. Training)	268,000	0	-268,000	268,000
Safe Steps	20,000	0	-20,000	20,000
Sub Total	7,946,671	7,160,834	-785,837	336,500
DFG	2,064,279	2,064,279	0	0
Homefirst South CCG	8,154,034	8,154,034	0	0
Homefirst East CCG	9,036,038	9,036,038	0	0
Total BCF	27,201,022	26,415,185	-785,837	336,500

2. Implications of the Recommendations

2.1. Legal Implications

2.1.1. This is in line with the Care Act 2014, and The Better Care Fund Policy Guidance and the Local Government Act 2003 for adult social care.

2.1.2. Under Section 75 of the National Health Service Act 2006, NHS bodies may enter into arrangements with local authorities in relation to NHS

functions and the health functions of local authorities. The Better Care Fund Governance Group continues to have oversight and responsibility for reviewing the delivery of the agreement.

2.1.3. S141 of the Care Act 2014 provides for the Better Care Fund Pooled Funds to be held under and governed by an overarching s75 National Health Service Act 2006 Partnership Agreement.

2.2. **Finance Implications**

2.2.1. Throughout the financial year the aim was to fully invest all the resources available to maximise performance against metrics. As any funds became available they were invested into new schemes and the table above demonstrates where these new schemes couldn't achieve a full year effect and therefore a commitment in 2020/21 is outlined. The year end position is a small variance at year-end (as there has been in the last couple of years), this will be ring-fenced and carried forward to 2020/21. This underspend results from two factors, firstly, the timing of new schemes commencing means part of their funding needs to be to carried forward and secondly, some small variances on existing schemes which came through late in the financial year (after third quarter review) As in previous years, the BCF Governance Group will then invest any carried forward monies in order to maximise performance against the BCF National Metrics.

2.3. **Policy Implications**

2.3.1. The ageing population in Cheshire East and associated pressures on the home care market is central to the planning behind the iBCF schemes and core Better Care Fund schemes, which have been developed for Cheshire East Better Care Fund.

2.4. **Equality Implications**

2.4.1. As the leaders for our local health and social care economy, all BCF partners in Cheshire East are conversant and complaint with the Equality Act 2010.

2.5. **Human Resources Implications**

2.5.1. Any impact for Cheshire East employees will be as a result of the need for greater integration in care delivery and commissioning in terms of restructures or changes to job roles. These will be dealt in accordance with the Councils policy and procedures. This could be due to a number of factors- seven day working policy, change in terms and conditions, geographical location of staff. Any identified implication will have a full

impact assessment completed and assurance that all employment legislation is adhered to.

2.6. **Risk Management Implications**

2.6.1. Risk of the consequence of failing to achieve proposed changes in activity levels and a plan to mitigate these with respect to the schemes in 2019-20.

2.7. **Rural Communities Implications**

2.7.1. There are no direct implications for rural communities.

2.8. **Implications for Children & Young People/Cared for Children**

2.8.1. There are no direct implications for children and young people.

2.9. **Public Health Implications**

2.9.1. There are no direct implications for public health.

2.10. **Climate Change Implications**

2.10.1. The following report encompasses an overview of the Better Care Fund schemes, the aim of these schemes include keeping people as independent as possible. Specifically the Live Well digital channel includes a range of information and advice to enable people to lead healthy lifestyles.

3. Ward Members Affected

3.1. The implications are borough wide.

4. Consultation & Engagement

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

5. Access to Information

5.1. 2017-19 Integration and Better Care Fund Policy Framework (DoH, DCLG 2017)

5.2. Delivering the Better Care Fund in Cheshire East 2017-19

5.3. Integration and Better Care Fund planning requirements for 2017-19

6. Contact Information

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

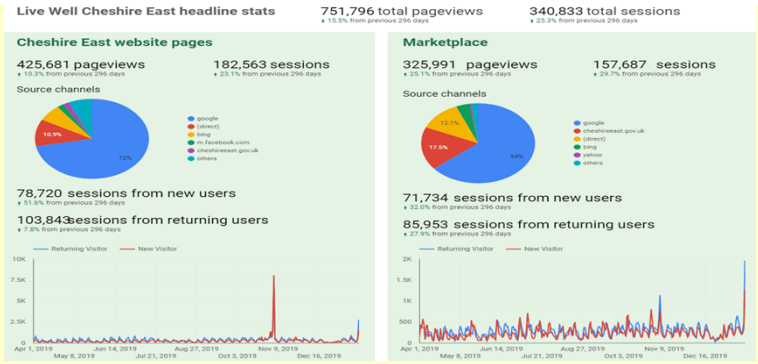
Name: Alex Jones

Job Title: BCF Programme manager

Email:

Appendix one – progress made to date

Number	Scheme	Description
1	iBCF - Increased weekend capacity for social workers	Services were provided over a 7 day week at Macclesfield and Leighton hospitals providing additional social work assessment capacity.
2	iBCF - Care Sourcing team model	The funding supports and expands the work of the Care sourcing team. The team undertakes 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 8am until 2pm/2pm until 8pm, Monday to Sunday. Progress made during 2019/20 was as follows: • Designated Hospital Workers for AWC & CAH • Weekly communication from Reablement • Daily Communication with Hospitals • Full Systems review with the project management team • Implemented Hospital escalation process & electronic early referral form using Liquid Logic. • Rural Contract incentive for set geographical locations • Implementation of the Winter Pressure Beds • Weekly meetings with hospital and reablement teams
3	iBCF - Live well	'Live Well Cheshire East' is an online resource. It is designed to give people greater choice and control by providing easily accessible information and advice about care and support services in the region and beyond. This digital channel provides information and advice and a directory of local services in one place covering Adult, Children, Community and Public Health services. Progress made during 2019/20 was as follows: Live Well page views and sessions, broken down to capture new and existing users



Top 10 frequently visited pages on Live Well Cheshire East and Live Well directory

Most popular pages on **cheshireeast.gov.uk/livewell (Cheshire East website)**

	Page Title	Pageviews	Sessions	Avg. Time on Page	Bounce Rate
1.	Live Well Cheshire East	25,010	13,818	00:00:35	26.71%
2.	Cheshire East Early years and Childcare Bulletin	24,451	16,700	00:02:46	11.97%
3.	Crewe Lions Bonfire and Firework Extravaganza - Queens Park - Crewe	21,998	18,785	00:03:09	86.9%
4.	Care and support for adults	12,495	3,720	00:00:31	28.84%
5.	SEND toolkit	10,661	4,582	00:03:10	21.74%
6.	Care and support for children	8,063	1,526	00:00:19	26.28%
7.	ChECS - Cheshire East Children's Consultation Service	7,164	3,303	00:01:58	74.99%
8.	Special Educational Needs and Disability	6,480	4,379	00:01:38	58.6%
9.	Local offer for children with SEN and disabilities	5,727	1,170	00:00:24	28.38%
10.	How to find childcare in Cheshire East	5,614	2,518	00:00:55	73.15%

Pageviews
425,681
↑ 10.3%

Top 10 frequently visited pages on Live Well directory

Most popular pages on **livewellservices.cheshireeast.gov.uk (OCC Marketplace)**

	Page Title	Pageviews	Sessions	Avg. Time on Page	Bounce Rate
1.	Search results - Live Well Cheshire East	78,445	27,325	00:00:38	31.11%
2.	Eagle Bridge Health & Wellbeing Centre (Sexual Health Clinic) - Live Well Cheshire East	7,354	5,723	00:03:29	76.95%
3.	Congleton War Memorial Hospital (Sexual Health Clinic) - Live Well Cheshire East	2,457	1,846	00:03:40	78.49%
4.	Silklife Foodbank - Live Well Cheshire East	2,368	1,781	00:02:25	71.59%
5.	0 - 19 Health Visiting Service Cheshire East - Live Well Cheshire East	2,186	1,307	00:02:36	80.18%
6.	Talking Therapies - Live Well Cheshire East	1,999	1,583	00:01:50	87.43%
7.	Occupational Therapy Service - Live Well Cheshire East	1,834	1,457	00:03:06	83.6%
8.	Axess Sexual Health Macclesfield - Live Well Cheshire East	1,817	1,287	00:03:07	71.41%
9.	Cherubs Breastfeeding Support - Live Well Cheshire East	1,809	1,356	00:02:27	67.77%
10.	Service not found - Live Well Cheshire East	1,769	1,413	00:01:19	75.02%

1 - 100 / 3177

Pageviews
325,991
↑ 25.1%

New users vs returning visitors on Live Well Cheshire East and Live Well MarketPlace

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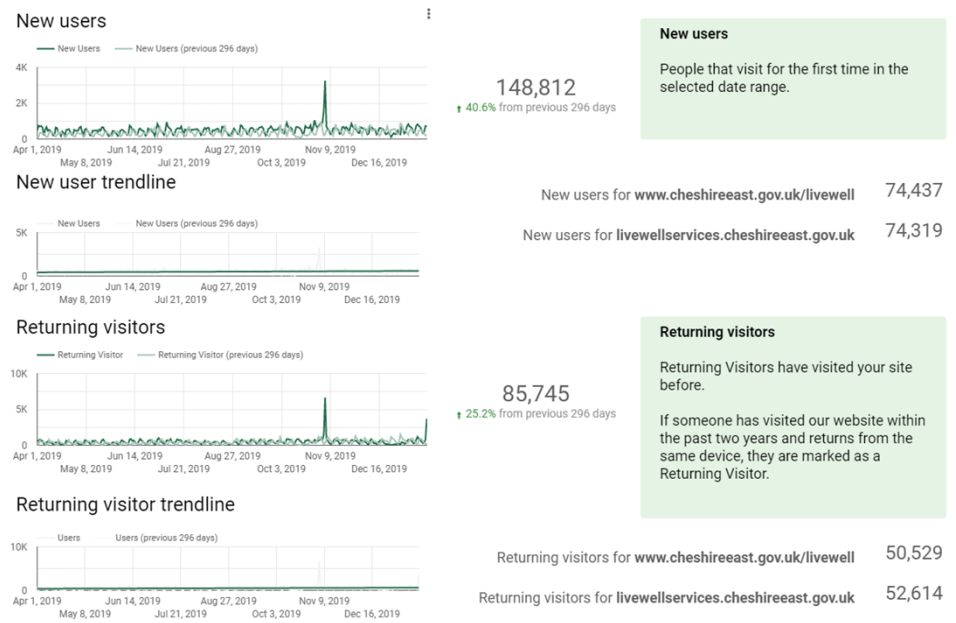

<u>Top 10 UK visitor location sessions originating within Cheshire East</u>

<table>
<tr><th></th><th>City</th><th>Country</th><th>Sessions ▾</th><th>Pageviews</th></tr>
<tr><td>1.</td><td>Crewe</td><td>United Kingdom</td><td>43,604</td><td>99,426</td></tr>
<tr><td>2.</td><td>Macclesfield</td><td>United Kingdom</td><td>18,871</td><td>45,895</td></tr>
<tr><td>3.</td><td>Wilmslow</td><td>United Kingdom</td><td>8,284</td><td>18,453</td></tr>
<tr><td>4.</td><td>Nantwich</td><td>United Kingdom</td><td>7,884</td><td>17,706</td></tr>
<tr><td>5.</td><td>Congleton</td><td>United Kingdom</td><td>7,028</td><td>17,031</td></tr>
<tr><td>6.</td><td>Sandbach</td><td>United Kingdom</td><td>1,404</td><td>3,257</td></tr>
<tr><td>7.</td><td>Knutsford</td><td>United Kingdom</td><td>1,244</td><td>2,679</td></tr>
<tr><td>8.</td><td>Alderley Edge</td><td>United Kingdom</td><td>199</td><td>439</td></tr>
<tr><td>9.</td><td>Holmes Chapel</td><td>United Kingdom</td><td>66</td><td>181</td></tr>
<tr><td>10.</td><td>Handforth</td><td>United Kingdom</td><td>21</td><td>63</td></tr>
<tr><td></td><td></td><td>Grand total</td><td>88,605</td><td>205,130</td></tr>
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<td>4</td>
<td>iBCF - Funding for additional social care staff to support Discharge to Assess initiatives</td>
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<td>iBCF - Winter funding</td>
<td>Additional capacity to support the local health and social care system to manage increased demand over the winter period. Progress made during 2019/20 was as follows:

• Reconfiguration of 21 surgical beds to medical beds.</td>
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		• Continued provision for medical outliers on Ward 1 (surgery). • Opening of Ward 5 for 13 in-patient beds. • Re-focusing on a home first approach to enable people to live independently with an emphasis on conditions with a high risk of hospital admission - respiratory, frailty and falls. • Additional social worker presence at the hospital to enable timely discharges in particular discharges from Stepping Hill (funded by Improved Better Care Fund (IBCF)). • Cheshire East Council – 10 block beds (3 Elderly Mental Illness and 7 Residential) across Cheshire East Council footprint. • Care at home (Domiciliary Care) rapid response service 250 hours per week for Eastern Cheshire. • Care at home (Domiciliary Care) rural modification scheme. • Social Care Assessor and Occupational Therapy Assistant rapid response to reablement • British Red Cross (2 week) support at home service (IBCF). • Maintenance of patient flow initiatives e.g. trusted assessor role, social prescribing, stranded reviews, early discharges, National Early Warning Signs (NEWS 2), safari pharmacy (weekdays). • North West Ambulance Service (NWAS) operational arrangements to manage predicted increased demand for both the patient emergency service and NHS 111. • Flu vaccination programme for staff and the local population for at risk groups. • Community beds (Block up to 30 Intermediate care beds & Spot Purchase Up to 12 Discharge to Assess) over and above the contracted 58 intermediate care beds at East Cheshire NHS Trust. • Implementation of the redesign of mental health services from November 2019, resulting in the provision of community beds, the increased investment into Home Treatment services, a staffed mental health crisis line that will provide a 24 hour response service to avoid people being signposted to Emergency Department (ED). • NHS Community Pharmacist Consultation Service (CPCS) from 29 October 2019 which will connect patients who have a minor illness or need an urgent supply of a medicine with a community pharmacy. • GP Practice Winter Plans including in hours flexibility to maximise access and extended access at evenings and weekends. • Eastern Cheshire Winter Campaign describes a range of internal and external communications, both analogue and digital, to reduce avoidable demand on urgent and emergency care by promoting self-care and informed use of NHS services.

<table>
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<td>6</td>
<td>iBCF - Sustain the capacity, capability and quality within the social care market place</td>
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Progress made during 2019/20 was as follows:

<u>Care Home providers</u>
• Since October 2018, the percentage of Cheshire East Care Home Providers rated as ‘good’ or ‘outstanding’ has gradually increased from 68% to the current figure of 72%. This does not however compare favourably to the national average (82.3%). To the North West average of (82.9%) and the national average of (82.1%).
• The percentage of Cheshire East Care Home Providers rated ‘inadequate’ gradually improved from a high of 10.2% in April 2018 to the current figure of 0%. This is significantly lower than the England (1.0%) and North West (1.1%) averages.

<u>Care at Home Providers</u>
• The latest figures show that the percentage of Cheshire East Care at Home Providers rated as ‘good’ or ‘outstanding’ is 81.5%. This is slightly below the national average (85.3%) and the North West regional average (89.1%).
• Cheshire East has a significantly higher percentage of Providers rated as ‘outstanding’ (9.2%) than England (3.6%) and the North West (4.1%) region.

A breakdown of total service users at any one point in 2019/20 was as follows:
<table>
<tr><th></th><th>Total</th><th>Number where this service type was the only type they received</th></tr>
<tr><td>Direct Payments</td><td>686</td><td>455</td></tr>
<tr><td>Extra Care Housing</td><td>222</td><td>206</td></tr>
<tr><td>Home Care</td><td>1241</td><td>647</td></tr>
<tr><td>Residential and Nursing</td><td>1435</td><td>1376</td></tr>
<tr><td>Respite</td><td>15</td><td>1</td></tr>
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<td>7</td>
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		also offer the potential to move towards the monitoring of outcomes for service users. Progress made during 2019/20 was as follows: ECM was implemented across Cheshire East prime providers and the following information was collected: • Punctuality • Cheshire East - all agencies: punctual visits (excl. missed visits) • Cheshire East - by agency: punctual visits (excl. missed visits) • Cheshire East - all agencies: % punctual visits (excl. missed visits) against target • Cheshire East - by agency: % punctual visits (excl. missed visits) against target • Consistency of Carers* - single handling and double handling • All Clients: Consistency of Carers • Single Handling Clients: Consistency of Carers • Double Handling Clients - Consistency of Carers • Visit duration - Cheshire East - all agencies: total actual visit duration v s total planned visit duration (excl. missed visits) • Cheshire East - by agency: total actual visit duration v s total planned visit duration (excl. missed visits) • Cheshire East - all agencies: proportion of visits (excl. missed visits) by percentage of planned visit duration • Cheshire East - by agency: proportion of visits (excl. missed visits) by percentage of planned visit duration • Logging using ECM • Cheshire East - all agencies: visit validation breakdown
8	BCF Assistive Technology (AT)	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 personalized to each individual and is integrated within the overall support plan. This will entail: Increasing the independence of people living with long term conditions and complex care, Supporting Carers to maintain their caring role, Improving access to the right service at the right time.The scheme supports the existing assistive technology service users. But will also involve piloting assistive technology support for adults with a learning disability (both living in supported tenancies and living in their own homes). Progress made during 2019/20 was as follows: Narrative update:

- Demand on the service remains high and performance in the service continues to improve, following implementation of the new structure.
- The Task and Finish group is continuing to review current processes in order to identify potential efficiencies and cost reductions going forward.
- Welbeing staff that have been co-located at different venues i.e. Leighton Hospital, Macclesfield Hospital, Contact centres have been well received by front line staff and feel this is a positive step forward in supporting the referral process and their understanding of AT equipment.

Summary of performance:

- Installations - URGENT to completed within 24 hours ie Hospital
  discharges- 100%
- Installations - STANDARD to be completed within 5 working days - 91%
- Maintenance/Faults – CRITICAL within 24hours -100%
- Maintenance/Faults – NON-CRITICAL within 7 working days - 92%
- Withdrawals - STANDARD within 7 working days - 99%
- Response – Calls answered within 60 seconds - 98.0%
- Response – Calls answered within 30 seconds - 91%
- Response – When a mobile response is required it will be within 45 minutes of the initial call. Also captured from July response within 60 minutes of the initial call. - 72%, 84%
- Total number of Telecare clients – 3275

Summary of survey

A survey of AT service users was carried out by an independent third party research company. The survey was conducted in July 2019 with a sample size of 308 people. The Respondents were as follows: 85% user / 13% carer. 31% Men / 69% Female.

Question	Yes (%)	No (%)
Did the telecare installer explain how the lifeline worked?	95	5
Did installer show identification?	96	4
When you last contacted Welbeing was your call answered promptly?	93	7

Was the operator polite and helpful?	100	-

Overwhelmingly users feel the service is beneficial to them and their family

Question: Would you say you…	Yes (%)	No (%)
Feel safer as a result of having lifeline?	98	2
It provides reassurance to other people?	99	1
You find it easy to use?	99	1
It means you are able to continue living at home?	97	3
Would recommend the service?	99	1

- 15% said they would welcome improvements to the service
- Many comments saying the pendant is too sensitive and results in false alarms.
- Several comments on issues with strap (uncomfortable, different material, adjustable, colour). Also louder speaker, want more than one unit.
- Few comments on service: cheaper, would like a call checking service, ambulance took too long to arrive.

Mobile response

- 95 people answered questions about the last time they used the mobile response service
- 76% pressed pendant as needed help, 24% because of equipment failure.
- Of those that needed help: 58% needed emergency services, 20% social services and 27% friends/family.
- 98% said call was answered promptly
- 100% said operator was helpful
- 93% were able to get everything sorted in first call
- 92% were satisfied how quickly they were able to get hold of

		contact • 96% rated service very good/good. **Testimonials** • I've told relatives about it; thinks it's marvelous; my relatives have had to use it in an emergency so I'm glad I suggested it. Even if I did have to pay, I'd still keep it. It's a brilliant service. • The family are very pleased with it. There couldn't be any improvements. The customer is very impressed that when Lifeline was called, they came the same morning. • Customer keeps calling by accident - she has never needed it for help. The equipment is too sensitive. – this issue came up a lot • The customer said she "wouldn't be without it". • Unsatisfied with how long it took for Lifeline to get hold of the nominated contact - it took 40 minutes.
9	BCF Early discharge service – ECT is commissioned to provide an Early Discharge Co-ordinator also forming part of this scheme is the commission of the British Red Cross service.	Early discharge service – ECT is commissioned to provide an Early Discharge Co-ordinator, as part of this scheme there is also a commissioned element which supports the British Red Cross 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). Progress made during 2019/20 was as follows: Quarter 3 performance of referrals by location: • Crewe - 46 • Holmes Chapel- 4 • Nantwich- 23 • Middlewich - 5 • Sandbach - 15 • Congleton - 7 • Macclesfield- 18 • Poynton/Disley- 3

- Wilmslow/Alderley Edge - 5
- Alsager - 7
- Knutsford- 7
- Out of area- 7

Case study one

Social circumstances

Mrs G is a 81 year old lady who resides alone in a privately owned house in the Chelford area. She has no family locally, and her daughter was on holiday at the time of the referral.

Reason for referral

Mrs G has previously been admitted to hospital following a fall. Mrs G discussed that prior to the fall she felt confident and independent. However, following the fall Mrs G discussed feeling nervous and losing her confidence when mobilising, and does not feel confident to drive without someone being with her. She privately employs a cleaner, who will also undertake food shopping, but this person was away on holiday at the time of the referral. Mrs G self-referred to the Support at Home team having used the service on a previous occasion.

Red Cross involvement

A Red Cross worker visited Mrs G at home for an initial assessment of her needs. A risk assessment was also carried out. Mrs G discussed her initial feelings of anxiety regarding managing her food shopping whilst her cleaner was on holiday, along with completing a few other tasks. The support worker reassured her all efforts would be made to achieve this her thereby preserving and maintaining her personal choices and ensuring continuation of a healthy diet. The support worker reassured her and it was therefore agreed a worker would visit Mrs G for an agreed period of time to carry out her food shopping along with supporting her to complete other tasks, for example putting the items away and throwing away old food from her fridge, taking rubbish to the outside bin and posting letters.

During the first visit, Mrs G was relieved to be supported with her food shopping, therefore encouraging her daily living activities and encouraging her wellbeing. She was also encouraged to contact the Social Care team to discuss her long-term practical requirements, as she had recently lost a lot of weight and was only

able to walk with a frame, and she could not foresee being able to manage certain tasks by herself for the near future.

Outcomes

The weekly visits continued until the end of the agreed service period. Mrs G was given information to contact outside agencies to offer future support and was encouraged to maintain her independent lifestyle she enjoyed prior to her recent ill health. She was also given the contact details of another British Red Cross service to enquire whether they could assist her to attend her upcoming medical appointments.

Professional involvement/feedback

Mrs G thanked the Red Cross for their involvement and the support and encouragement she had received. She was clearly relieved the Red Cross was able to visit and provide emotional and practical support.

			Q1	Q2	Q3	Q4	
No.	**Outcome measure**	**Evidence** What evaluation tools have been used to gather this evidence, for example surveys, individual interviews etc.	**Outcome**	**Outcome**	**Outcome**	**Outcome**	**Additional Information** Including any issues that may have affected achievement or reporting of outcomes
1	Feeling safe and secure	Service user questionnaires individual interviews and data collection	60	60	63		
2	Making	Service user questionnaire	1	9	14		

			more meaningful use of time	s individual interviews and data collection						
		3	Improved ability to manage paperwork and finances	Service user questionnaires individual interviews and data collection	0	0	1			
		4	Improved ability to manage day to day activities	Service user questionnaires individual interviews and data collection	69	65	29			
		5	Increased satisfaction with home environment	Service user questionnaires individual interviews and data collection	0	10	3			
		6	Improved awareness of the access to further services	Service user questionnaires individual interviews and data collection	56	112	116			

		7	Improved social networks and friendships	Service user questionnaires individual interviews and data collection	0	6	12		
		8	Improved ability to cope in caring role	Service user questionnaires individual interviews and data collection	0	5	3		
					186	267	241		
10	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. Progress made during 2019/20 was as follows: Community reablement **Number of packages delivered** No. Referrals in the month: 1326 No. Closed in the month: 1353 **Time between referral & assessment**								

Average days between referral and 1st visit	9

Average package delivered

Average days between 1st and last visit	23

Outcome of Reablement

1.NHS/Palliative/Died	10
2.NHS/other-admitted to hosp	140
3.NHS/leading to LT support	9
4.LTsupport any setting agency	414
5.NSP N.Ident S-Fund	19
6.Ongoing Assistive Tech	25
7.Short Term Support[other]	10
8.NSP N.Ident declined	73
9.Universal Signposted	18
10.NSP- no needs identified	228
11.No Availability	406

Mental health reablement

Number of packages delivered

	Total
No. Referrals in the month	2674
No. Closed in the month	2404

Time between referral & assessment

Average days between referral and 1st visit	25

Average package delivered

Average days between 1st and last visit	46

Outcome of Reablement

Early cessation of service (not leading to long-term support)	204
No services provided - No identified needs	1
No services provided - Universal services / signposted to other service	2046

		Long-Term Support (Community) 134 Dementia reablement **Number of packages delivered** Total No. Referrals in the month 1071 No. Closed in the month 551 **Time between referral & assessment** Average days between contact and 1st visit 26 **Average package delivered** Average days between 1st and last visit 67 **Outcome of Reablement** Early cessation of service (not leading to long term support) - 100% NHS funded care/End of Life/deceased 3 Early cessation of service (not leading to long-term support) 5 Long-Term Support (Community) 15 Long-Term Support (Nursing) 26 Long-Term support (Residential) 1 No services provided - Needs identified but self-funding 98 No services provided - Needs identified but support declined 6 No services provided - No identified needs 99 No services provided - Universal services / signposted to other service 74 On-going low level support 196 Short-Term support (other) 28
11	BCF Statutory Social Care activities resulting from the Care Act including Safeguarding	The Care Act 2014 introduced and revised the statutory responsibilities of local authorities. The Partnership will ensure sustainable appropriate embedded solutions are in place to meet these responsibilities. The Partnership encompasses the duties of the Safeguarding Adults Board. This safeguarding scheme also includes the responsibilities which come from the Care Act which includes the following sub-schemes:

Provider Quality Reports (BCF Social Care Act Allocation), Maintaining minimum care eligibility thresholds - Contribution towards maintaining care eligibility thresholds at critical and substantial, Continuity of care for people moving into areas - Additional social worker capacity, Assessment of Social Care in prisons - Additional social worker capacity, Disregard for armed forces Guaranteed Minimum Income - Allocated to care packages, Training social care staff in Social Care Act - Delivery of Care Act training to staff, Less reduction for savings from staff time and reduced complaints.

Progress made during 2019/20 was as follows:

Total number of safeguarding concerns: 1,450. Abuse types for those cases where this has been recorded (as will not have been recorded for all cases that are open):

- Discriminatory: 9
- Domestic abuse: 66
- Emotional/Psychological abuse: 221
- Financial abuse: 219
- Modern Slavery: 8
- Neglect: 525
- Organisational: 53
- Physical: 362
- Self-neglect: 77
- Sexual: 49
- Sexual Exploitation: 6

Notes regarding the data

- A safeguarding concern is either a contact that has been recorded as a safeguarding concern or a contact where safeguarding issues have been identified.
- More than one abuse type can be chosen for each concern/enquiry

Classification and definition of abuse types

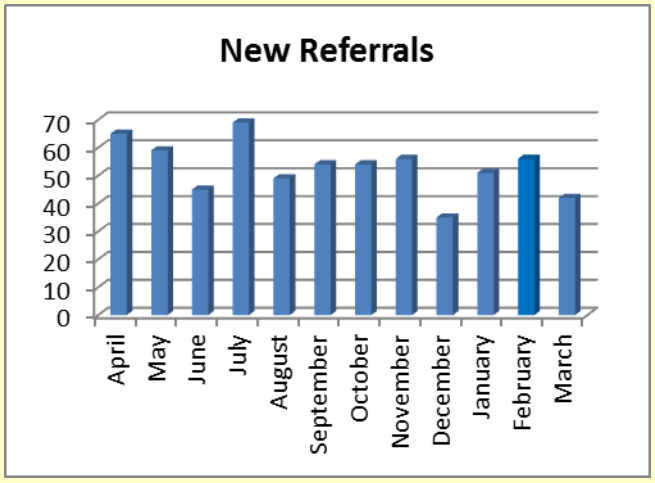
Classificat	Definition
Physical	Includes hitting, slapping, pushing, kicking, and misuse of medication, restraint or inappropriate sanctions.
Sexual	Includes rape and sexual assault, sexual acts to which the adult has not consented, could not consent or was pressured into consenting.
Psycholo	Includes emotional abuse, threats of harm or

gical	abandonment, deprivation of contact, humiliation, blaming, controlling, intimidation, coercion, harassment, verbal abuse, isolation or withdrawal from services or supportive networks.
Financial	Includes theft, fraud, exploitation, pressure in connection with wills, property or inheritance or financial transactions, or the misuse or misappropriation of property, possessions or benefits.
Neglect and acts of omission	Includes ignoring medical or physical care needs, failure to provide access to appropriate health, social care or educational services, the withholding of the necessities of life, such as medication, adequate nutrition and heating
Discriminatory	Includes abuse based on a person's race, sex, disability, faith, sexual orientation, or age; other forms of harassment, slurs or similar treatment or hate crime/hate incident.
Organisational	Includes poor care practice within an institution or specific care setting like a hospital or care home. This may range from isolated incidents to continuing ill-treatment.
Domestic Abuse	An incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse by someone who is or has been an intimate partner or family member regardless of gender or sexuality. It can include psychological, physical, sexual, financial, emotional abuse; 'honour' based violence; Female Genital Mutilation; forced marriage.
Sexual Exploitation	Involves exploitative situations and relationships where people receive 'something' (e.g. accommodation, alcohol, affection, money) as a result of them performing, or others performing on them, sexual activities.
Modern Slavery	Encompasses slavery, human trafficking, and forced labour and domestic servitude. Traffickers and slave masters use whatever means they have at their disposal to coerce, deceive and force individuals into a life of abuse, servitude and inhumane treatment
Self-Neglect	Covers a wide range of behaviour; neglecting to care for one's personal hygiene, health or surroundings and includes behaviour such as hoarding.

12	BCF Disabled Facilities Grant (DFG)	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 will be administered by Cheshire East Council and will be delivered across the whole of Cheshire East. Progress made during 2019/20 was as follows: Narrative update: • Spend has been managed well, with the budget fully committed to adaptation schemes without the need to implement any legislative provisions to delay approvals or payments. The full budget allocation of £2,064,279 was spent in 2019-20. • There was a 17% reduction in referrals from Occupational Therapists, due to recruitment and retention difficulties, and the impact of Covid-19 in March 2020. • 335 new grants have been awarded. 74% had a value of less than £5,000; 19% £5,000 to 10,000; and 7% over £10,000. • 370 adaptation schemes were completed. This is a 19% reduction (88 schemes) compared to 2018-19. This reflects the 17% reduction in referrals, the impact of Covid-19 in March 2020 as well as reduced staffing due to long term sickness within the Strategic Housing team. • 25% of referrals that were initiated through the Disabled Facilities Grant programme went on to be completed without grant assistance. Case Study • Mrs S is a wheelchair user and has Multiple Sclerosis, needing assistance with all mobility. This was creating a high risk of carer breakdown, as formal carers were unable to assist safely, and Mr S was providing all mobility assistance, including transferring on and off a stair lift. As Mrs S's illness has progressed, this has become unsafe so a different method of enabling Mrs S to access her bedroom and bathroom was needed. A Disabled Facilities Grant was awarded for a vertical passenger lift, and for ceiling track hoists to assist safe transfers. The adaptations had a huge impact: "The adaptation has made our lives much easier, no more lifting or trying to get S off the floor. A lot easier for carers and family. It has made a massive improvement to our

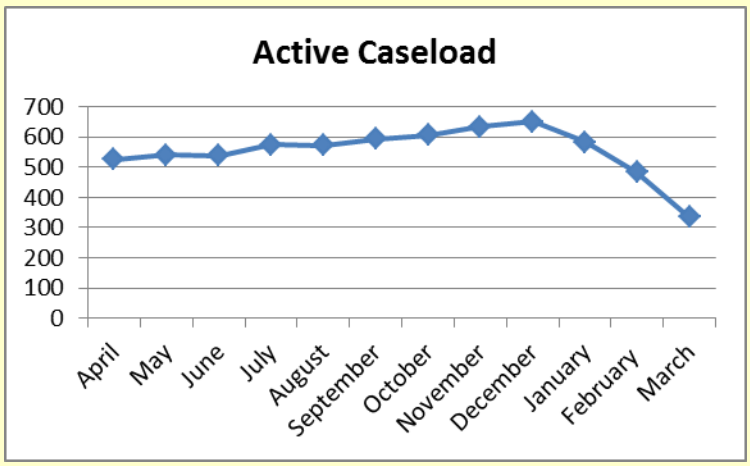
day to day lives". The adaptation means that single handed care can be delivered effectively, and carer breakdown is avoided. Costs associated with an increased care package have been avoided.

The number of referrals



Referrals are received into the Disabled Facilities Grant programme following a functional assessment by an Occupational Therapist / Social Care Assessor of how the disabled person manages activities of daily living in the home environment. The average number of referrals per month in 2019/20 is 53.

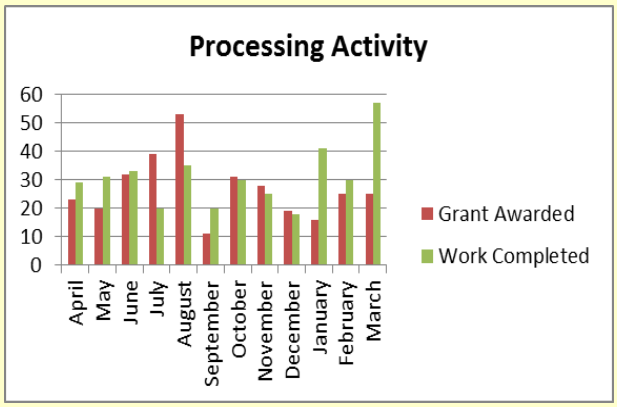
The number of grants awarded



This chart shows the number of active cases that are in the Disabled Facilities Grants programme at any one time; the number of cases has steadily risen over the year as capacity has not been able to keep up with demand for the service. The active caseload at 31.03.2020 is 334, a 36% reduction from 31.03.2019 as a result of the reduction in new referrals from Occupational Therapists and

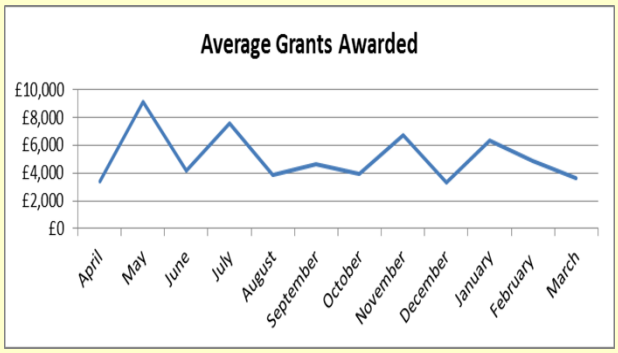
improved case management.

Grant processing activity



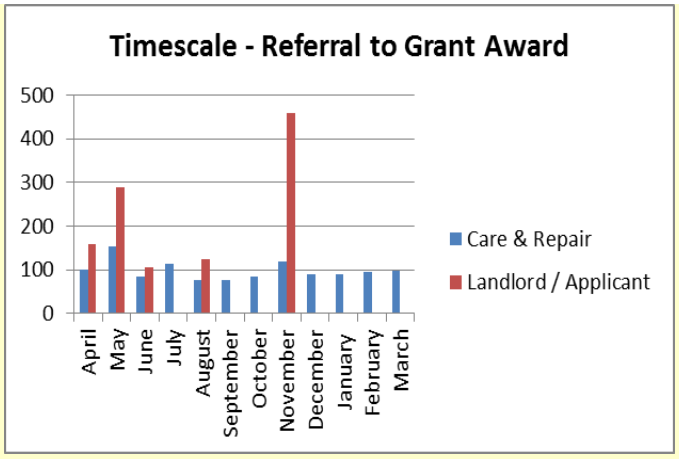
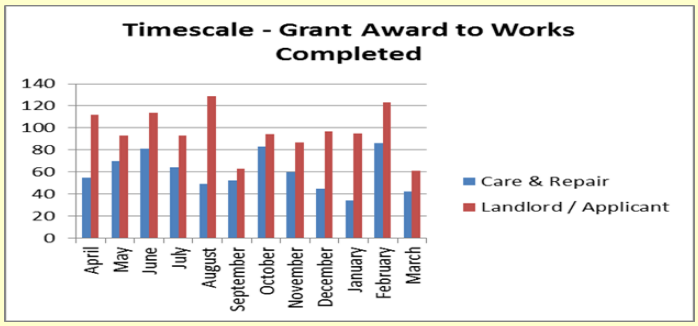
The graph shows the number of grants that are awarded and the number of completed schemes of work. There appears to be a spike in August and a significant drop in September; when these two months are averaged out it shows a more consistent line with the other months. 25 new grants were awarded in March 2020 and 57 adaptations schemes were completed.

The average grant value approved



The average grant awarded in 2019-20 is £5,118; the peaks on the graph represent where more complex and expensive schemes have been approved. 25 grants were awarded in March 2020 at an average of £3,653; 19 of the grants were for less than £5,000.

The average time between referral and grant

		 The timescale is measured from receipt of the referral from the occupational therapist, to when the grant is awarded. The graph demonstrates that using the Care & Repair service to manage the grant application process is consistently more efficient that than applicants / landlords managing the grant themselves. <u>The average time between grant award and works completed</u>  The timescale from when the grant is awarded to when the works are completed is also measured. The graph illustrates the benefit of the Care & Repair service managing the building works, as timescales for completion of works is considerably quicker than where applicants / landlords manage the process.
13	BCF Carers hub	The Cheshire East Carers Hub is an 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 will support Carers who live in Cheshire East, along with those who live outside the area but care for a Cheshire East resident. Progress made during 2019/20 was as follows: • Identified and supported 1,798 new adult and young carers. • 1:1 sessions with carers 2,266

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99% of carers reported increased choice, control and independence.
Distributed 1,083 living well fund grants.

<u>Testimonials</u>

“Yes I have had useful information from the support service, not just information about Mum’s diagnosis but about other things. You always do what you say you will do. Always answer the phone and are available to speak it has made it easier knowing someone is listening. “

“Thank you to all at the Carers Hub for your help, support and assistance it has been a good source of support for me just in the short time I have been aware of the carers’ hub.”

“You and your service make my life more bearable. You are always there for me to talk to it helps me to cope as a carer, in what are sometimes difficult situations.”
</td></tr>
<tr><td>14</td><td>BCF Programme Management and Infrastructure</td><td>
Overall responsibility for delivery of the principles and targets of the BCF and identifying barriers, risks and mitigation to ensure they are achieved. Staff employed and infrastructure required to support the management and governance arrangements for the BCF.

Progress made during 2019/20 was as follows:

The production of a number of reports and plans: Quarterly reports, Winter plan, BCF plan 2019/20, End of year review BCF 2018/19
End of year review 2019/20, Terms of reference, Minutes, Agenda
Action log, Highlight report, Forward plan, Business case production.
DMT, CLT, HWB, Cabinet, CCG and Overview and Scrutiny reports

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<tr><td>15</td><td>BCF Winter Schemes ECCCG</td><td>
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.

Progress made during 2019/20 was as follows:

<table>
<tr><td>Scheme</td><td>Increase in ED health care and registered nursing staff</td></tr>
<tr><td>Value of investme</td><td>499k</td></tr>
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nt	
Period Active	Recruitment commenced in May 2019
Implementation lead	MCHFT
Summary Detail	Additional workforce necessary within the emergency department to support with the increasing demand and maintain patient safety

Scheme	**ED clinical co-ordinator**
Value of investment	51k
Period Active	Oct-19
Implementation lead	MCHFT
Summary Detail	Increased clinical leadership required to ensure 24/7 senior nursing support for the emergency department

Scheme	**ED clinical fellow**
Value of investment	17k
Period Active	Jan-20
Implementation lead	MCHFT
Summary Detail	Further medical support is required to allow for an increase in shift patterns to cover increasing attendances throughout the evening and weekend in the emergency department

Scheme	**EN ENP (VIN)**
Value of investment	16K
Period Active	Jan-20
Implementation lead	MCHFT
Summary Detail	Victoria Infirmary Northwich continues to experience high level of attendance; additional

	workforce is required to support the current team

Scheme	Acute consultant
Value of investment	30k
Period Active	Jan-20
Implementation lead	MCHFT
Summary Detail	An increase in senior clinicians to support the flow through ED into the admission and assessment units.

Scheme	Additional Streaming Appointments
Value of investment	95k
Period Active	Jul-19
Implementation lead	MCHFT
Summary Detail	Increased support from GP's / primary care to allow for the provision of evening and weekend cover. The additional appointments for the GP will support the demand in ED and ensure that patients suitable for primary care / UTC have increased availability of appointments.

Scheme	Discharge co-ordinators
Value of investment	34k
Period Active	Sep-19
Implementation lead	MCHFT
Summary Detail	Further support for the assessment areas in the Trust to support with complex discharges. The discharge coordinators are integral to work closely with social care and the integrated discharge team to allow for safe discharge for patients into their homes with additional support

	or another care setting.

Scheme	Weekend OT/ physio - core wards
Value of investment	35k
Period Active	Sep-19
Implementation lead	MCHFT
Summary Detail	There is a very limited provision of OT and physiotherapy across the core wards at the weekend. The increased support across winter will assist with weekend discharges and 7 day flow across the system

Scheme	Increase in pharmacy
Value of investment	34k
Period Active	Already in place from last winter
Implementation lead	MCHFT
Summary Detail	Increase in pharmacy to support the wards and early discharge across winter

Scheme	Ward 19 shortfall
Value of investment	234k
Period Active	Oct-19
Implementation lead	MCHFT
Summary Detail	Additional funding is required for ward 19 to ensure the ward remains in place permanently, due to shortages of nursing staff, the ward has a high use of agency - as such, and additional funding is required. The ward is multi-disciplinary and led by the GP's, undertaking daily wards and support the safe discharge of medically optimised

	patients from the hospital

Scheme	British Red Cross - patient transport
Value of investment	79k
Period Active	Oct-19
Implementation lead	MCHFT
Summary Detail	The British Red Cross currently provide supportive discharge to the system. For winter 19/20 we will pilot the stretcher transfer services to assist with the more complex discharges.

Scheme	Packages of care
Value of investment	100k
Period Active	Oct-19
Implementation lead	CCICP
Summary Detail	This scheme will allow for increased community provision to reduce the delayed transfer of care and allow for increased community services to support patients in their own home.

Scheme	Spot Purchase beds
Value of investment	50
Period Active	Oct-19
Implementation lead	CCG
Summary Detail	Throughout winter, there is an increased need for nursing home placement and support. Spot purchase beds will be attained in conjunction with CCG colleagues to allow for increase provision outside of the acute setting to maintain flow and

		safe and timely discharge

Scheme	Repeat Prescriptions
Value of investment	30k
Period Active	Oct-19
Implementation lead	CCG
Summary Detail	Throughout the bank holidays this scheme will ensure that provision is in place for patients with on-going medication needs across primary avoiding hospital attendance

Scheme	ED / CDU decant
Value of investment	50k
Period Active	Oct-19
Implementation lead	MCHFT
Summary Detail	The Trust has supported an increase in physical estate to allow for additional majors cubical in ED. This will support with the increasing demand and reduce the need for corridor care. In order to allow for this work, CDU will be decanted to another area of the hospital. As this clinical decision unit will not be co-located with ED, additional staffing is required to manage the patient group safely

16-17	BCF Homefirst ECCCG/ SCCCG	'Home First' is the 'umbrella' term used to describe a collection of services commissioned by NHS Eastern Cheshire CCG and South Cheshire CCG. Progress made during 2019/20 was as follows: 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. 1. <u>Proactive:</u> • Risk stratification to target services to the most 'at risk' groups • A single assessment focused on lifestyle, goals and care needs using a joint assessment across health and social care • An identified care co-ordinator from within the integrated community team • A care plan created jointly with the person to include goals, required and interventions. For less complex needs, a 'crisis plan' will be agreed • Proactive case management approach • Education and training across all care settings and involving the whole workforce in a rolling evidence-based training and mentoring programme • Single Point of Access for all GPs and professional referrals <u>BCF funded services already commissioned and in place:</u> • Dedicated staff to support Nursing Home MDT - Dietician and Speech and Language Therapist (based on an assessment of admissions from Nursing Homes) • NIMO medicines support • Community Matrons case-managing highest risk and frail patients' • Telehealth • Evidence-based frailty training programme delivered on a rolling programme for all staff (including frailty champions and trainers) <u>2. Responsive:</u> • Comprehensive assessment on attendance at A&E or admission to Acute Assessment Unit (Acute Frailty Approach). People are assessed and supported to return home (if not possible, the service will minimise inpatient stay) • Link to existing care plans via Cheshire Care Record and 'real-time' access to Primary, Community and Social Care records. • Rapid support to return home via increased nursing and therapy support to A&E and outreach into community. • Transport service and support to 'settle back home'. • Community (home-based) intermediate care service (independently clinically reviewed). Working jointly with Social Care colleagues) to enable recovery at home – both to prevent admissions and support people following an admission to

		hospital (and prevent readmission). • Comprehensive step-up and step-down short-term bed-based rehabilitation and assessment service (independently clinically reviewed). People in this service are more dependent than those being supported at home and have a greater number of morbidities and risk factors. Barthel score available on admission and discharge to evidence improvements in independence. Full tracking database in place to track all admissions, interventions delivered, LoS and discharge. • In-hours acute GP home visiting service (independently clinically reviewed) to prevent admissions due to escalating needs (visit within 4-hours of request). The majority of referrals are received from NWAS. The independent clinical review evidenced that the majority of people seen are older people living with frailty and they remained at home for >30 days following the visit. <u>Services already commissioned and in place (BCF and Core CCG Funding)</u> • Single Point of Access • Community Intermediate Care Service • Bed-based Intermediate Care Service (64 core beds plus seasonal additional capacity and including 12 CHC DTA beds) • Additional evening staffing in A&E (based on an assessment of times people arrive) • Frailty Approach multi-disciplinary team with Consultant clinical lead and 'GPs with Special Interest in Frailty,' additional Nursing and Therapy support in A&E to provide rapid reablement/Home First approach • Transport home from A&E at night • Acute Visiting Service (three GP teams with an interest in managing complex needs and frailty).
18	Winter - rapid response	The Rapid Response Service facilitates 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.

		Progress made during 2019/20 was as follows: The current Rapid Response service commenced on 1st October 2019 as a direct follow on from the previous service that ran from January 29th 2019 to September 30th 2019. As with the previous incarnation of Rapid Response, the new service is not based on a rota model. Each provider is aligned to the terms and conditions of the Prime Provider Contract where payment is made for delivered care and that any capacity gaps are compensated for only in the event of lack of service demand. The current Rapid Response contract runs for a period of 6 months (end date 31st March) with the potential for 2 further incremental increases of 2 months. Previously, the areas that providers covered were aligned to the Eastern and Southern CCG footprints. However, for this version of the service the decision was taken to further break down the areas covered by providers to match up with the 6 Care at Home Lots. The primary driver for this was the previous difficulties faced by a single provider in servicing both Lots 1 and 2 effectively. A provider could not be found for all of Lot 1's provision and 2 providers currently cover 60% of the lot's 100-hour allocation and each cover specific postcode areas. Initially, management of the referral process, as well as capacity and flow, remained with the Brokerage team. However, all referrals that originate from Macclesfield and Leighton Hospitals are now managed by the Social Work based within these hospitals. This decision was taken further aide faster but safe discharges from hospital for those requiring support at home. All referrals that originate from any other source continue to be managed directly by the Brokerage team. . Referrals can be made out of hours, weekends and Bank Holidays by EDT as providers are required to be able to respond between 6am and 11pm. The brokerage team now operates The current providers are: • Cherished Care Services 50 hours (50% of Lot 1 provision) • Sylk Care Limited (10% of Lot 1 provision) • Affinity Homecare (Cheshire) Ltd 130 hours (100% of Lot 2 provision) • Evolving Care Crewe 370 Hours (100% Lots3,4,5 and 6 provision)

Cumulative total

Provider	Lot(s)	Block hours per week	Total Hours delivered during winter period	Average number of days spent under Rapid Response	Total Number of people using Rapid Response during winter period
Cherished	1 (covering specific postcodes)	50	2,997	92.18	104
Sylk	1(covering specific postcodes)	10	1,092	110.3	26
Affinity	2 (Cover whole lot as sole provider)	130	1,367	91.24	62
Evolving	3-6 (Cover whole of each lot as sole provider)	370	5,507	81.045	254
			10,962	374.765	446

19	Winter - additional beds	We have 60 short stay beds per week to support step down and step up per bed. Existing Commissioning resource will be used to procure these beds. Progress made during 2019/20 was as follow: Period covers November 2019 to March 2020

Location	Total days used	Days available	%
Leycester house 1	87	154	56
Leycester house 2	72	154	47
Leycester house 3	66	154	43
Elm House 1	136	154	88
Elm house 2	100	154	65
Mayfield 1	118	154	77
Park Lane	71	154	46
Turnpike 1	90	154	58
Turnpike 2	76	154	49
Bentley Manor	78	898	59

20	Trusted assessor service	The overall aim of this service is to develop and establish a trusted assessor service in Cheshire East; this service will provide a trusted assessment function through Independent Transfer of Care

		Coordinators. This service will initially work with existing care home residents who have been admitted to hospital and require assessment prior to transferring back to the care home. This service will in part help reduce patient length of stay as well as contributing to a reduction in Delayed Transfers of Care. Progress made during 2019/20 was as follows: • Number of Patients - 46 • Average LOS - 13.6 • Days saved - 48 • Estimated Financial savings £33,750

Appendix two – scheme funding

Scheme ID	Scheme Name	Scheme Type	Provider	Source of Funding	Expenditure (£)	New/ Existing Scheme
1	Ibcf - Increased weekend capacity for social workers	HICM for Managing Transfer of Care	Local Authority	iBCF	£161,862	Existing
2	Ibcf - Care Sourcing team model	Other	Local Authority	iBCF	£407,200	Existing
3	Ibcf - Live well	Prevention / Early Intervention	Local Authority	iBCF	£107,908	Existing
4	Ibcf - Funding for additional social care staff to support Discharge to Assess initiatives	HICM for Managing Transfer of Care	Local Authority	iBCF	£295,220	Existing
5	Ibcf - Winter funding	Other	NHS Acute Provider	iBCF	£510,000	Existing
6	Ibcf - Sustain the capacity, capability and quality within the social care market place	Personalised Care at Home	Private Sector	iBCF	£5,415,301	Existing
7	Ibcf - Electronic Call Monitoring (ECM)	Other	Private Sector	iBCF	£101,800	Existing
8	BCF Assistive Technology (AT)	Assistive Technologies and Equipment	Private Sector	Minimum CCG Contribution	£757,000	Existing
9	BCF Early discharge service – ECT is commissioned to provide an Early Discharge Co-ordinator also forming part of this scheme is the commission of the British Red Cross service.	Community Based Schemes	Local Authority	Minimum CCG Contribution	£222,942	Existing
10	BCF Combined Reablement Service	Community Based Schemes	Local Authority	Minimum CCG Contribution	£4,575,000	Existing
11	BCF Statutory Social Care activities resulting from the	Care Act Implementation Related Duties	Local Authority	Minimum CCG Contribution	£405,000	Existing

	Care Act including Safeguarding					
12	BCF Disabled Facilities Grant (DFG)	DFG Related Schemes	Local Authority	DFG	£2,064,279	Existing
13	BCF Carers hub	Carers Services	Local Authority	Minimum CCG Contribution	£722,000	Existing
14	BCF Programme Management and Infrastructure	Enablers for Integration	Local Authority	Minimum CCG Contribution	£404,088	Existing
15	BCF Winter Schemes ECCCG	Other	NHS Acute Provider	Minimum CCG Contribution	£510,000	Existing
16	BCF Homefirst ECCCG	HICM for Managing Transfer of Care	NHS Acute Provider	Minimum CCG Contribution	£9,036,038	Existing
17	BCF Homefirst SCCCG	HICM for Managing Transfer of Care	NHS Acute Provider	Minimum CCG Contribution	£8,154,034	Existing
18	Winter - rapid response	Community Based Schemes	Private Sector	Winter Pressures Grant	£613,212	Existing
19	Winter - additional beds	Other	Private Sector	Winter Pressures Grant	£837,426	Existing
20	Trusted assessor service	HICM for Managing Transfer of Care	Local Authority	Minimum CCG Contribution	£75,000	Existing