Cheshire East Council

NHS Cheshire Clinical Commissioning Group

CHESHIRE EAST HEALTH AND WELLBEING BOARD
Reports Cover Sheet

Title of Report:	Better Care Fund End of Year report 2020 - 2021
Date of meeting:	23 November 2021
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Health & Wellbeing Board Lead:	Jill Broomhall Director of Adult Social Care

Executive Summary

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

Has the report been considered at any other committee meeting of the Council/meeting of the CCG board/stakeholders?	The following report has separately been distributed to the Better Care Fund Governance Group.
Has public, service user, patient feedback/consultation informed the recommendations of this report?	No
If recommendations are adopted, how will residents benefit? Detail benefits and reasons why they will benefit.	N/A

1 Report Summary

1.1 To highlight the performance of the Better Care Fund including the Improved Better Care Fund in Cheshire East in 2020/21.

2 Recommendations

2.1 That the Health and Wellbeing Board notes the Better Care Fund programme performance in 2020/21. Within this, that the Health and Wellbeing Board considers: Better Care Fund scheme overview, metric performance, the financial income and expenditure of the plan and individual scheme performance noted in Appendix one.

3 Reasons for Recommendations

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

4 Impact on Health and Wellbeing Strategy Priorities

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

5 Background and Options

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

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

5.3 For 2020-21, 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).

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

5.5 **Current schemes**

5.6 There were 26 Schemes funded through Winter pressures, iBCF and BCF during 2020-21:

Scheme number	Scheme name	Fund	Value
001	Winter Pressure Beds	Winter pressures	£195,684
002	Winter Rapid response	Winter pressures	£283,025
003	Winter Spot short stay beds	Winter pressures	£518,625
004	Winter Care at home hospital retainer	Winter pressures	£40,000
005	Winter Social work support (station house)	Winter pressures	£112,000
006	Winter Additional Social Care staff to prevent people from being delayed in hospital	Winter pressures	£301,124
007	Winter Cheshire east people helping people	Winter pressures	£0
008	Winter Care home flu vaccination scheme	Winter pressures	£0
009	iBCF 'Winter Schemes Cheshire CCG	iBCF	£500,000
010	iBCF Enhanced Care Sourcing Team (8am-8pm)	iBCF	£407,000
011	iBCF Improved access to and sustainability of the local Care Market	iBCF	£5,817,764

	(Home Care and Accommodation with Care)		
012	iBCF Social Work Team over Bank Holiday weekends	iBCF	£165,000
013	iBCF Live Well Cheshire East	iBCF	£109,527
014	BCF Safe Steps	Better Care Fund	£20,000
015	BCF Double handling care review	Better Care Fund	£268,000
016	BCF Trusted assessor service	Better Care Fund	£77,063
017	BCF Assistive Technology (AT)	Better Care Fund	£757,000
018	BCF British Red Cross Support at Home Service - Early Discharge Schemes	Better Care Fund	£229,133
019	BCF Combined Reablement Service	Better Care Fund	£4,700,813
020	BCF Social care act - Safeguarding Adults Board	Better Care Fund	£416,138
021	BCF Programme Management and Infrastructure*	Better Care Fund	£352,371
022	BCF 'Winter Schemes Cheshire CCG	Better Care Fund	£520,000
023	BCF Carers Hub	Better Care Fund	£722,000
024/025	BCF Home First Schemes Cheshire CCG	Better Care Fund	£17,753,023
026	BCF Disabled Facilities Grant (DFG)	Better Care Fund	£2,342,000

5.7 **Metric performance**

5.8 The Better Care Fund policy statement for 2020/21 noted that Health and Wellbeing Board areas were not expected to submit local trajectories for the BCF national metrics for 2020/21. It was noted that National reporting of Delayed Transfers of Care was suspended from 19 March 2020. The table below includes the BCF metrics and the performance for the 2020/21 period and an update for 2021/22.

Metrics	Period (April 2020 – March 2021)	2021/22 update
Non-elective admissions	75,525	Performance measure suspended Q1 2021/22
Admissions to residential care homes	395*	<530 permanent admissions
Effectiveness of reablement	Not available	Incomplete data

Delays transfers of care	Performance measure suspended	Performance measure suspended Q1 2021/22

*Provisional data

5.8 **Income and Expenditure**

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

Running balances	**Income**	**Expenditure**	**Balance**
1. DFG	£2,342,241	£2,342,241	£0
2. Minimum CCG contribution	£25,857,421	£25,857,421	£0
3. iBCF	£8,449,929	£8,449,929	£0
4. Additional LA contribution	£0	£0	£0
5. Additional CCG contribution	£0	£0	£0
Total	£36,649,591	£36,649,591	£0
Required spend	**Minimum required spend**	**Planned spend**	**Under spend**
6. NHS Commissioned Out of Hospital spend from the minimum CCG allocation	£7,347,945	£18,077,023	£0
7. Adult Social Care services spend from the minimum CCG allocations	£7,441,934	£7,780,398	£0

5.10 **COVID-19 impact**

5.11 We surveyed a range of providers who formed part of the winter pressure, improved better care fund and better care fund to better understand what impact COVID-19 has had on our commissioned services.

5.12 In the first 6-7 months of the global pandemic there were occasions where it was identified that demand was falling, in particular in the Macclesfield area. It would appear that the reduction in demand was linked to the number of people presenting at the hospital had greatly decreased during this period. However, as hospitals and acute settings in Cheshire East began to see more people for non-Covid related issues then the demand for the services began to increase.

5.13 In particular as a result of covid-19 the rapid response contract was increased to provide additional capacity. The service was recommissioned during the pandemic to start in mid-December 2020. Initially 530 weekly hours were commissioned but through winter demand increased due to the addition of COVID 19 to a traditionally challenging period of the year. The service was designed to be flexible in times of need increasing and decreasing to meet demand. It was identified that there was need for additional capacity across Cheshire East and as such 200 additional hours were awarded to one of the commissioned providers. Currently there are 730 hours per week commissioned for the service and current statistics indicate that this level is still required to support health infrastructures.

5.14 Providers noted that they had challenges in relation to staffing and were unable to fulfil the capacity required of contracts in some instances this was noted across the commissioned rapid response services as well as the care at home service. Colleagues went onto note that across a range of winter pressure schemes that services were impacted by staff needing to self-isolate. Demand more broadly for non-bed-based services has continued to increase through the period of the pandemic. Other services also changed what they were able to offer through the pandemic, for example the Disabled Facilities Grant noted that during the first and subsequent lockdowns Occupational Therapy staff have prioritised urgent / critical referrals only and deprioritised non urgent cases until the lifting of lockdown restrictions, except where assessments can be completed by telephone.

5.15 As a result of changes in demand care at home providers delivered actual care and not planned care, during this period day services ceased to operate for a period of time which resulted in increased Direct Payment budgets and additional care being commissioned for people who were not accessing their planned day care service.

5.16 Colleagues highlighted that an issue observed during the pandemic was staff fatigue and wellbeing. Staff had worked a high volume of hours dealing with increased pressure. At the same time the council deployed a number of support offers for providers. There was a number of national interventions with increased funding to the social care sector during the pandemic with the aim of resolving issues and reducing pressure within the system.

6 Access to Information

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

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Appendix one – Aim of schemes

Scheme number	Scheme name	Fund
001	Winter Pressure 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.	Winter pressures
002	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.	Winter pressures
003	Winter Spot short stay beds Short Stay placements continue to be commissioned as and when required by the integrated discharge teams to support flow out of hospitals thus creating hospital bed capacity.	Winter pressures
004	Winter Care at home hospital retainer The hospital retainer is now well embedded across both hospitals and continues to support patient flow along with retaining existing care at home providers for known service users. The hospital retainer is funded for up to 14 days and offers effective impact for care restarts for people along with facilitating a timely discharge. he schemes continue to provide positive added value across the system.	Winter pressures
005	Winter Social work support (station house) There is one agency social worker in post covering Station House. There is also Social Care Assistants (x2) additional assessment and care management capacity to support the revised processes around hospital discharge using reablement exclusively for this purpose (East locality).	Winter pressures
006	Winter Additional Social Care staff to prevent people from being delayed in hospital 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	Winter pressures

	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.	
007	Winter Cheshire east people helping people This service is now live and fully operational across the Borough, the service continues to provide community based support across the Social Care system.	Winter pressures
008	Winter Care home flu vaccination scheme CEC contracts team continue to work with care provider managers to promote flu vaccination to front-line health and social care staff along with identifying a Flu champions in their organisations to highlight the immunize programme and encourage colleagues to participate in the voluntary programme to be immunised. A monthly flu vaccination report is produced via CCG colleagues confirming uptake of the vaccination. The schemes continue to provide positive added value across the system.	Winter pressures
009	iBCF 'Winter Schemes Cheshire CCG 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. There was a total of 38 services commissioned to assist with increased demand during winter.	iBCF
010	iBCF Enhanced Care Sourcing Team (8am-8pm) 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.	iBCF
011	iBCF Improved access to and sustainability of the local Care Market (Home Care and Accommodation with Care) 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.	iBCF
012	iBCF Social Work Team over Bank Holiday weekends To maintain Social Work assessments and advice services over 7-days per week. Based within the hospitals at Macclesfield and Leighton.	iBCF

013	iBCF Live Well Cheshire East '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.	iBCF
014	BCF Safe Steps Safe Steps is a digital falls risk assessment tool, which is built to NHS digital standards and GDPR compliant. It is an easy-to-use app which prompts care staff to work through a dynamic set of questions with each resident once a month. 12 key areas based on NICE guidelines are assessed, to identify ways in which each resident is at risk of falls. The app then makes CQC-approved recommendations from a library of over 50 proven interventions, to create a personalised falls care plan.	Better Care Fund
015	BCF Double handling care review We are currently involved in a regional programme aimed at addressing the issue of 'double handling' which, as well as being an expensive way to deliver care, is also recognised as invasive and an intrusion on an individual's dignity. The programme aims to support the exploration of alternative ways of providing support (including the provision of training and equipment) that reduces the need for 'double handling'.	Better Care Fund
016	BCF 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.	Better Care Fund
017	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.	Better Care Fund

	• 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).	
018	BCF British Red Cross Support at Home Service - Early Discharge Schemes 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).	Better Care Fund
019	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.	Better Care Fund
020	BCF Social care act - Safeguarding Adults Board 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	Better Care Fund

	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.	
021	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.	Better Care Fund
022	BCF 'Winter Schemes Cheshire CCG 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. There were a total of 38 services commissioned to assist with increased demand during winter.	Better Care Fund
023	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.	Better Care Fund
024/025	BCF Home First Schemes Cheshire CCG 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.	Better Care Fund
026	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	Better Care Fund

	scheme will be administered by Cheshire East Council and will be delivered across the whole of Cheshire East.	

Appendix two – Individual scheme performance

Scheme number	Scheme name	Fund
001	Winter Pressure Beds	Winter pressures

The winter pressure beds are all operational and continue to be regularly used by hospital teams to support timely discharges and support flow across the system. Occupancy continues to fluctuate across the winter pressure beds due to some homes experiencing a Covid 19 outbreak.

Scheme number	Scheme name	Fund
002	Winter Rapid response	Winter pressures

Total number of service users (Jun – Dec)

	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
Cherished	3	6	7	6	12	11	6	51
Sylk	1	2	1	3	1	1	0	9
Affinity	9	13	11	11	13	15	7	79
Evolving	51	48	50	57	53	49	43	351
							Total	490

Total number of hours used (Jun – Dec)

	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
Cherished	88.25	123.25	106.5	131.5	163.5	136.25	73.5	822.75
Sylk	30	26.5	31	67.5	1.5	16	0	172.5
Affinity	175.25	157.25	195.5	213.75	343	246.75	112	1443.5
Evolving	908.25	1179.5	1168.75	1,001	1,220	1,051.25	856.75	7385.5
							Total	9824.25

Total number of service users (Jan – Mar)

	Jan	Feb	Mar	
Connected Health Plus	36	64	79	179
Extra Mile	11	12	15	38
Evolving	41	41	47	129
			Total	346

Total number of hours used (Jan - Mar)

	Jan	Feb	Mar	
Connected Health Plus	625	1,346.75	1234.25	3206
Extra Mile	334.5	292.25	395	1021.75
Evolving	1240.25	934.25	1,193.50	3368
			Total	7595.75

Scheme number	Scheme name	Fund
003	Winter Spot short stay beds	Winter pressures

Average bed occupancy (Apr – Mar)

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
Bentley Manor (1 bed)	47	0	3	42	61	73	94	60	71	97	25	100	56
Elm House (2 beds)	52	29	63	42	79	75	68	42	82	77	95	90	66

Leycester House (2 beds)	36	5	0	0	0	53	26	20	56	74	77	87	36
Mayfield House (1 bed)	100	100	93	74	32	100	32	87	48	35	0	77	65
Turnpike Court (2 beds)	82	34	17	13	0	60	56	55	95	68	36	87	50
												Av	55

004	Winter Care at home hospital retainer In certain circumstances there may be cases where a Service User is only a few days from being discharged from hospital and so to support a smooth transition a retainer fee may be paid for a nominal number of days. This is only in exceptional cases and needs authorising in partnership with Contracts and Operational Locality Managers.	Winter pressures
005	Winter Social work support (station house) There is one agency social worker in post covering Station House. Social Care Assistants (x2) additional assessment and care management capacity to support the revised processes around hospital discharge using reablement exclusively for this purpose (East locality).	Winter pressures
006	Winter Additional Social Care staff to prevent people from being delayed in hospital 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.	Winter pressures
007	Winter Cheshire east people helping people • Overall total number of people registered for support – 3263 • Number of people supported/matched with a volunteer – 3036 • Number of people awaiting urgent requests (48 hours) – 2 • Number of people awaiting support (triaged & deemed not urgent) – 50 • Number of people awaiting support (contacted awaiting volunteer) – 175 • Receiving ongoing support from a volunteer – 748 • Receiving ongoing support from a volunteer coordination network – 536 • Receiving ongoing support from other voluntary organisation – 112 • Receiving one-off support from a volunteer – 88 • Receiving one-off support from other voluntary organisation (van driver, emergency assistance etc) – 17 • Referral to CEC internal team i.e. Emergency Assistance, shared lives, Care4ce team - 40 • Referral to commissioned providers i.e. carers hub, AgeUK, Alzheimer's society – 12 • Doesn't need further help (started to receive a government food parcel) – 191 • Doesn't need further help (Phone info and advice sufficient) • Duplicates (or re-entered system) – 281 • Refused support and closed – 42 • Couldn't contact after 3 attempts and closed - 110	Winter pressures
008	Winter Care home flu vaccination scheme CEC contracts team continue to work with care provider managers to promote flu vaccination to front-line health and social care staff along with identifying a Flu champions in their organisations to highlight the immunize programme and encourage colleagues to participate in the voluntary programme to be immunised. A monthly flu vaccination report is produced via CCG colleagues confirming uptake of the vaccination. The schemes continue to provide positive added value across the system.	Winter pressures
009	iBCF 'Winter Schemes Cheshire CCG • Ward 11 suspected COVID Nurse & Therapy • Ward 12 Nurse, Therapy & Ward costs • COVID Swabbing	iBCF

	• COVID Medical Staffing • Psychological Support • GPOOH NHS 111 • Single point of Access • Therapies to support discharge to assess and rapid response • Flu Coordination • Community Beds • GP Costs for community beds • Advanced Nurse Practitioner • Community Therapy Beds • Same Day Emergency Care • Additional Registrar /Senior Reviews • Additional Discharge Doctor (F2) at weekend • A&E Doctor overnight • Medical Bank Hours to proactively support • Arrangements for medical staffing over the weekend • AVS GP and Pharmacy to cover Residential Homes • Extended Hours for the Discharge Lounge • Facilitate discharge of out of area delays • Deploy Matron to support discharges with senior review • Stretcher transport weekends (10am-7pm) • Critical Care Outreach • Additional Pharmacy Support for discharges 7 days to support flow and allow early discharge • Discharge Coordinator at weekend • Weekend OT & Physio • CWP Psychiatric Liaison in ED, additional clinician 7 days 8am-6pm and 2 days admin support • Frailty B7 Nurse, B6 Physio • Winter Pressure Beds • Winter Rapid response • Winter Spot short stay beds • Winter Care at home hospital retainer • Winter Social work support (station house) • Winter Additional Social Care staff to prevent people from being delayed in hospital • Winter Cheshire east people helping people • Winter Care home flu vaccination scheme	
010	iBCF Enhanced Care Sourcing Team (8am-8pm) Brokerage continued to provide a service that meets the needs of the service user with minimal to no disruption, we managed this by making a change to working from home within one day and executed our BCP. I think that the pandemic has affected service users when it has come to hospital discharges and in general finding care and support in the community – testing has become a barrier as Providers rightly so need to ensure safety of all – this has led to delays in Hospital and in getting care in a timely manner as some provider would not start care without test results even when providing care wearing PPE. We have always sourced the care; however, this was at times delayed due to above reasons. We have seen a huge rise in AWC vacancies – we now receive lots of offers through DPS for placement. In March 2020 demand was high – we then saw this drop as SU were hesitant around having provider come in their homes, more recently we are seeing this demand especially for CAH increase, the unmet demand as of today 16/04/2021 is sat at over 1200 hours which is the highest it has been in a year. We are seeing a huge demand for urgent care and care that needs to be put in place to prevent carer breakdown or where family are assisting. I believe that when PHP had a huge volunteer base this helped the Brokerage Team immensely – it was great to see community's stepping up and supporting which would leave us to source vital personal care, We do have to at times source care for non-personal care related needs which can take away capacity for those who need it.	iBCF
011	iBCF Improved access to and sustainability of the local Care Market (Home Care and Accommodation with Care) Services have continued to operate as safely and effectively as they possibly could whilst trying to be	iBCF

	creative during a very challenging situation. Quality areas that have been mainly impacted by covid are staffing levels, high numbers of staff self-isolating thus resulting in increased agency staffing usage which results in unfamiliar cohorts of staff not being fully familiar with service users needs, care plans and desired outcomes. The requirement for service users to self-isolate and not have contact with key family members has had a significant impact on people Health & Wellbeing. A reduction in the day to day activities that would have been delivered such as exercises groups, group quizzes, the opportunity to chat with friends, singing for the brain sessions all ceased thus resulting in an impact on the quality and offer for the resident. During the pandemic the was a decrease in referrals for Care Home placements and bed-based respite support. However, an increase for Care at Home and living in care arrangements was noted. Complex Care seen a small increase in referrals due to carer and placement breakdown. Service continued to operate and the only change that was agreed was for care at home. Care at Home providers delivered actual care and not planned thus ensuring people's needs continued to be met in a safe way. Day services ceased operating for a period which resulted in increased Direct Payment budgets and additional care being commissioned for people who were not accessing their planned day care service.	
012	iBCF Social Work Team over Bank Holiday weekends To maintain Social Work assessments and advice services over 7-days per week. Based within the hospitals at Macclesfield and Leighton.	iBCF
013	iBCF Live Well Cheshire East A summary of the Live Well monthly performance is as follows: **Cheshire East website pages** 18,529 pageviews (-28.8% from previous 32 days) 7,777 sessions (-30.1% from previous 32 days) Source channels: google 65.2%, (direct) 15.3%, bing, m.facebook.com, gov.uk, others 7.6% 4,305 sessions from new users (-32.1% from previous 32 days) 3,472 sessions from returning users (-27.5% from previous 32 days) New Visitor / Returning Visitor, 1 Dec 2020 – 29 Dec 2020 **Marketplace** 6,906 pageviews (760.0% from previous 32 days) 3,340 sessions (991.5% from previous 32 days) Source channels: No Data 1,741 sessions from new users (3,248.1% from previous 32 days) 1,599 sessions from returning users (529.5% from previous 32 days) New Visitor / Returning Visitor, 1 Dec 2020 – 29 Dec 2020 Most popular pages on **cheshireeast.gov.uk/livewell** (**Page Title** 1. Live Well Cheshire East 2. Cheshire East Early years and Childcare Bulletin 3. Care and support for adults 4. Covid-19 your health and well being 5. NHS App 6. SEND toolkit 7. live-well-search-results 8. ChECS - Cheshire East Children's Consultation Service 9. Concerned about an adult 10. Assessment of your care needs	iBCF
014	BCF Safe Steps Unfortunately, we have not been able to make progress with this project as the starting point is face-to-	Better Care Fund

<table>
<tr><td></td><td>face training with care home providers and we have not been able to deliver this because of the pandemic.</td><td></td></tr>
<tr><td>015</td><td>BCF Double handling care review

Unfortunately, we have not been able to make progress with this project as the starting point is face-to-face training with home care providers and we have not been able to deliver this because of the pandemic.</td><td>Better Care Fund</td></tr>
<tr><td>016</td><td>BCF Trusted assessor service

Number of patients – 617
Average length of stay – 11.2
Time of discharge: AM 82, PM 315, Out of hours 60, Not admitted 1, Deceased 114
Discharged W/A – IToCC 109, Care home 75, n/a 19, Not needed 120, Telephone 55, Deceased 41
Bed days saved – 422
Funding stream – Social care 80, CHC 55, Self-funded 24, COVID-19 71
Placement – Nursing 120, Nursing EMI 36, Residential 164, Residential EMI 35
Re-admission – 72 hours 13, 1-2 weeks 60, 2-4 weeks 80, 1 month+ 11, 6 months + 268

Case studies:

• As the first Lock down was coming to an end, the IToCC for Macclesfield was encouraging the Short-term care arranging team to request assessments within the first two days of discharge to ensure the package of care being received was adequate/appropriate. On completing the task herself, she discovered that the lady she was looking into who had been discharged on a 6 week reablement package had a long term heart condition, end stage terminal cancer, extremely high blood pressure and lived with dementia leading to her refusing to take her medication. After talking to the care provider, it quickly became apparent that the lady required palliative care and was unlikely to survive the 6 weeks let alone improve. The appropriate health professionals were involved and CHC took over the funding.

• In the Summer, a lady who was a full- time carer for her husband who had dementia, had an accident. The paramedics brought the husband too realising he was vulnerable and the IToCC met them both on the ward. The husband had been made comfortable by the ward staff because he had no other support apart from his wife. The lady required a rehabilitation bed and the IToCC managed to liaise with a provider who took both the husband and wife for the short duration.

• The IToCC was requested to complete an assessment for a lady who was bound for 24-hour residential care due to an increase in falls. There were no capacity concerns and the lady wished to go home. The IToCC went through all of the care needs, discovered the falls were due to UTIs causing confusion and a resistance to drinking to avoid the pain of passing water. Due to the IToCCs previous experience of running her own Domiciliary Care Agency, she explained the infection cycle to the lady who had never realised that her actions were causing the severity of her infections, talked about the assistive technology which was available along with brief care calls and pulled all the details together for the ASCT so the lady could return home.

• Two days before Christmas a lady was assessed by the IToCC. She required ventilation equipment to support her recovery. The IToCC requested the equipment was organised before discharge and suggested a delay. This did not happen, the lady was discharged, the home did not receive the equipment because of the time of year and the lady was readmitted shortly after.</td><td>Better Care Fund</td></tr>
<tr><td>017</td><td>BCF Assistive Technology (AT)

<table>
<tr><th></th><th>Apr</th><th>May</th><th>Jun</th><th>Jul</th><th>Aug</th><th>Sep</th><th>Average/ Total</th></tr>
<tr><td>Installations - Urgent to completed within 24 hours i.e. hospital discharges</td><td>75</td><td>100</td><td>100</td><td>100</td><td>100</td><td>83.33</td><td>93</td></tr>
<tr><td>Installations - Standard to completed within 5 working days</td><td>100</td><td>97.5</td><td>98.7</td><td>93.33</td><td>100</td><td>94.2</td><td>97</td></tr>
<tr><td>Maintenance/Faults - Critical within 24 hours</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td></tr>
<tr><td>Maintenance/Faults - Non-critical within 7 working days</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>93.33</td><td>99</td></tr>
</table>
</td><td>Better Care Fund</td></tr>
</table>

Maintenance - Annual checks or in line with manufacturers guidelines	160	189	5	55	36	54	83
Withdrawals - Standard within 7 working days	94.74	65.31	89.19	85.37	86.49	90	85
Response - Calls answered within 60 seconds	97.42	98.02	98.43	98.53	98.52	98.57	98
Response - Calls answered within 30 seconds	90	91	91	91	91	90	91
Number of calls	6345	6720	6845	6591	7078	7012	40591
Response - when a mobile response is required within 45 minutes	72.54	88.82	90.91	93.96	93.71	94.7	89

018

BCF British Red Cross Support at Home Service - Early Discharge Schemes

Macclesfield DGH

	Q1	Q2	Q3	Q4	Annual
Number of service users waiting to access this service at the end of the quarter	0	0	0	0	0
Number of service users supported by the service to facilitate discharge	42	62	39	52	143
Number of service users supported by the service in the community to avoid admission	62	59	60	47	228
Number of Service Users Supported who have an identified Carer	0	4	5	0	0

Leighton hospital

	Q1	Q2	Q3	Q4	Annual
Number of service users waiting to access this service at the end of the quarter	0	0	0	0	0
Number of service users supported by the service to facilitate discharge	21	18	18	8	65
Number of service users supported by the service in the community to avoid admission	57	52	41	57	207
Number of Service Users Supported who have an identified Carer	0	6	10	0	16

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019

BCF Combined Reablement Service

Community reablement

Number of packages delivered	
	YTD Total
No. Referrals in the month	1526
No. Closed in the month	1439

Time between referral & assessment	
	YTD Average
Average days between referral and 1st visit	3

Average package delivered	
	YTD Average
Average days between 1st and last visit	25

Outcome of Reablement	
	YTD Total
1.NHS/Palliative/Died	11
2.NHS/other-admitted to hosp	192

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3.NHS/leading to Support	5
4.LTsupport any setting agency	436
5.NSP N.Ident S-Fund	11
6.Ongoing Assistive Tech	6
7.Short Term Support[other]	4
8.NSP N.Ident declined	69
9.Universal Signposted	3
10.NSP- no needs identified	266
11.No Availability	655

Mental health reablement

Number of packages delivered	
	YTD Total
No. Referrals in the month	2351
No. Closed in the month	1854
Time between referral & assessment	
	YTD Average
Average days between referral and 1st visit	19

Average package delivered	
	YTD Average
Average days between 1st and last visit	53

Outcome of Reablement	
	YTD Total
Early cessation of service (not leading to long-term support)	123
No services provided - No identified needs	6
No services provided - Universal services / signposted to other service	1483
Long-Term Support (Community)	0
Early cessation of service 100% NHS funded care/End of Life/deceased	1
Short-Term support (other)	2
Ongoing low level support	2
Blank	35

Dementia reablement

Number of packages delivered	
	YTD Total
No. Referrals in the month	960
No. Closed in the month	536

Time between referral & assessment	
	YTD Average
Average days between contact and 1st visit	13

Average package delivered	
	YTD Average

Average days between 1st and last visit	53

Outcome of Reablement

	YTD Total
Early cessation of service (not leading to long term support) - 100% NHS funded care/End of Life/deceased	0
Early cessation of service (not leading to long-term support)	1
Early cessation of service (leading to long-term support) (Residential)	1
Long-Term Support (Community)	4
Long-Term Support (Nursing)	9
Long-Term support (Residential)	4
No services provided - Needs identified but self-funding	8
No services provided - Needs identified but support declined	0
No services provided - No identified needs	20
No services provided - Universal services / signposted to other service	381
On-going low-level support	8
Short-Term support (other)	2

020

BCF Social care act - Safeguarding Adults Board

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Type of abuse	Mar	Feb	Jan	Dec	Nov	Oct	Sep	Aug	Jul	Jun	May	Apr	
Discriminatory	1		0	5	1	3	5	0	4	0	0	6	25
Domestic Abuse	33	24	26	23	27	17	22	16	13	21	23	15	260
Emotional/ Psychological:	74	51	38	81	81	53	67	55	63	64	40	59	726
Financial	48	50	43	52	36	37	66	89	37	37	29	43	567
Neglect	146	116	89	155	112	111	113	89	107	102	95	97	1332
Organisational	11	7	10	15	19	16	7	12	12	13	17	16	155
Physical	93	65	56	73	72	67	69	67	76	73	62	71	844
Self-Neglect	72	47	45	56	40	57	72	65	34	34	26	37	585
Sexual	16	12	7	10	13	6	9	10	11	5	5	8	112
Modern Slavery:	0	1	1	0	1	2	0	0	1	2	1	1	10
Sexual Exploitation	0	1	1	2	2	2	1	1	2	1	1	1	15
												Total	4631

021

BCF Programme Management and Infrastructure

The BCF Programme management function had the responsibility for producing the following reports: BCF end of year report 2020/21, BCF plan report 2021/22 as well as coordinating the winter schemes and the winter plan for the local authority for 2021/22 and finally the coordination and implementation of a number of 7 day working schemes.

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022

BCF 'Winter Schemes Cheshire CCG

- Ward 11 suspected COVID Nurse & Therapy
- Ward 12 Nurse, Therapy & Ward costs
- COVID Swabbing
- COVID Medical Staffing
- Psychological Support

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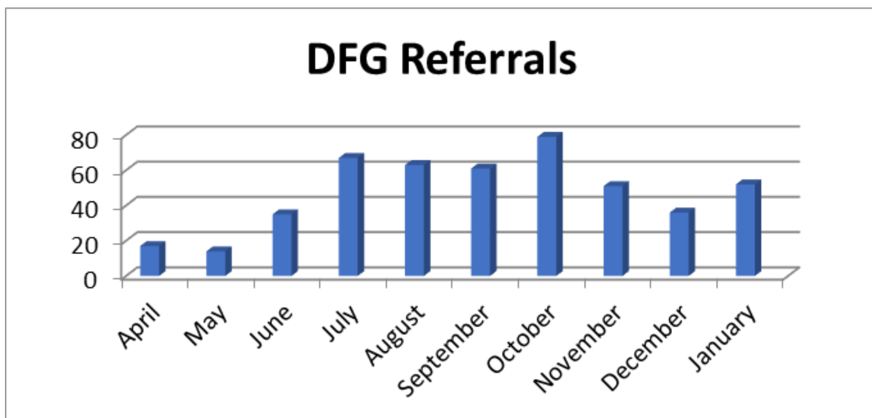
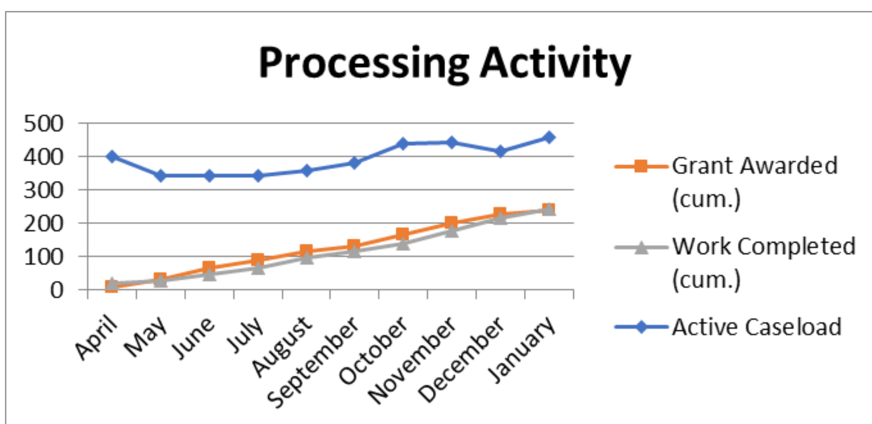
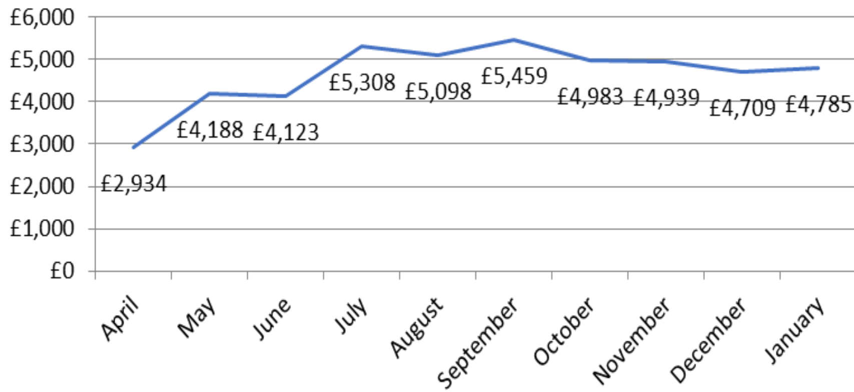
	• GPOOH NHS 111 • Single point of Access • Therapies to support discharge to assess and rapid response • Flu Coordination • Community Beds • GP Costs for community beds • Advanced Nurse Practitioner • Community Therapy Beds • Same Day Emergency Care • Additional Registrar /Senior Reviews • Additional Discharge Doctor (F2) at weekend • A&E Doctor overnight • Medical Bank Hours to proactively support • Arrangements for medical staffing over the weekend • AVS GP and Pharmacy to cover Residential Homes • Extended Hours for the Discharge Lounge • Facilitate discharge of out of area delays • Deploy Matron to support discharges with senior review • Stretcher transport weekends (10am-7pm) • Critical Care Outreach • Additional Pharmacy Support for discharges 7 days to support flow and allow early discharge • Discharge Coordinator at weekend • Weekend OT & Physio • CWP Psychiatric Liaison in ED, additional clinician 7 days 8am-6pm and 2 days admin support • Frailty B7 Nurse, B6 Physio • Winter Pressure Beds • Winter Rapid response • Winter Spot short stay beds • Winter Care at home hospital retainer • Winter Social work support (station house) • Winter Additional Social Care staff to prevent people from being delayed in hospital • Winter Cheshire east people helping people • Winter Care home flu vaccination scheme	
023	BCF Carers Hub • Number of adult Carers registered with the Hub • Number of NEW individual adult Carers accessing provision of support - 386 • Number of adult Carers receiving Live Well Fund - 240 • Number of adult Carers receiving support – low - 16 • Number of adult Carers receiving support – moderate - 365 • Number of adult Carers receiving support – Intensive - 5 • Number of referrals received (could be new or re-referrals) - 650 • Number of referrals and signposts on to other organisations - 366 • Number of statutory Carers Assessments completed - 237 • Number of support plans completed - 237 • Number of support plan reviews undertaken - 71 • Number of planned exits - 65 • Number of Carers taken up Emergency Card and Plan during the reporting period - 91 • Number of Group sessions delivered - 99 • Number of Carers provided with a break - 933 • Number of Carer volunteers doing hrs each month supporting Cheshire East Carers' Hub - 7.3 • Number of volunteers (non-Carers) doing hrs supporting Cheshire East Carers' Hub - 60 • Number of calls to the CHAT Line - 91 • Number of calls to Carers from volunteers for the CHAT Line - 69 • Non-Elective admissions (General and Acute) - 27 • Admissions to residential care homes (prevented Carer Breakdown **) - 99 • Delayed Transfers of Care (from Hospital) - 1	Better Care Fund
024/025	BCF Home First Schemes Cheshire CCG	Better Care Fund

	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.	
026	BCF Disabled Facilities Grant (DFG) 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. Referrals have reduced since October; this is being attributed to the Covid restrictions that have been in place throughout November into January which has led to lower demand as people are unwilling to invite people into their homes, and adapted methods of working to reduce contact has reduced assessments.  The graph shows the cumulative number of grants that are awarded and the number of completed schemes of work. Contractors are fully operational and working in accordance with Covid-19 Secure guidance. The most recent lockdown together with a transition to a new level access showers contract during December and January has resulted in a reduced forecast for completed works. Our revised forecast for 2020-21 is for 300 adaptations schemes to be completed, a 19% decrease on 2019-20. Active caseloads have risen from an average of 109 cases per 1.0fte caseworker in October to 113 in January.  The average grant awarded to date in 2020-21 is £4,785, compared to £5,279 in 2019-20 (-9.4%). Appointment of a new supplier for level access showers in December 2020 has secured an estimated 12% savings compared to the previous installer (subject to surveys). This will drive down the average value of grants and secure better value for money.	Better Care Fund



The timescale is measured from receipt of the referral from the occupational therapist, to when the grant is awarded. The majority of grant awards are for less than £5,000 and are generally for simpler works. The timescale increases exponentially for more complex works (£15-50k) where architectural designs, planning application and building regulations consents are needed, together with the greater emotional investment and decision making by the service user when making significant changes to their home.

Covid has had a significant impact on landlord permissions this year due to furloughed staff and/or restricted home visits. The anomaly for January (£5-£15k) was caused by an applicant managing their own application, which took them in excess of 2 years despite offers of support.