

CHESHIRE EAST HEALTH AND WELLBEING BOARD
Reports Cover Sheet

Title of Report:	Better Care Fund Plan 2022/23
Date of meeting:	22 March 2022
Written by:	Alex Jones
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Health & Wellbeing Board Lead:	Helen Charlesworth-May, Executive Director – Adults, Health and Integration

Executive Summary

Is this report for:	Information <input type="checkbox"/>	Discussion <input type="checkbox"/>	Decision <input type="checkbox"/>
Why is the report being brought to the board?	This report describes the areas of activity and the proposed expenditure for the Better Care Fund covering Cheshire in 2022/23. It identifies a number of schemes and presents the rationale of how they meet the needs and demands of the local care and health economy in Cheshire East.		
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 <input type="checkbox"/> Improving the mental health and wellbeing of people living and working in Cheshire East <input type="checkbox"/> Enable more people to live well for longer x All of the above <input type="checkbox"/>		
Please detail which, if any, of the Health & Wellbeing Principles this report relates to?	Equality and Fairness <input type="checkbox"/> Accessibility <input type="checkbox"/> Integration <input type="checkbox"/> Quality <input type="checkbox"/> Sustainability <input type="checkbox"/> Safeguarding <input type="checkbox"/> 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 endorse the schemes and plan for 2022/23.		
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 That Health and Wellbeing Board endorses the BCF schemes and associated expenditure which is outlined in this plan.

2 Recommendations

- 2.1 That the Health and Wellbeing Board notes and endorses the Better Care Fund plan for 2022/23 which includes: vision for adult social care, priorities for 2022/23, governance changes, schemes for 2022/23, metric performance, income and expenditure.

3 Reasons for Recommendations

- 3.1 This 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 Vision for adult social care

- 5.4 Recently the government published the policy paper entitled 'People at the Heart of Care: adult social care reform white paper'. The white paper sets out a 10-year vision for adult social care and provides information on funded proposals that we will implement over the next 3 years.

- 5.5 The white paper has a particular focus on 3 key objectives: 1.How we will support people to have choice, control and independence. 2.How we will provide an outstanding quality of care. 3.How we will ensure that care is provided in a way that is fair and accessible to everyone who needs it.

- 5.6 Supporting social care reform there was an announcement made at the Spending Review in October 2021 detailing how £5.4 billion over 3 years would be deployed. £3.6 billion to pay for the cap on care costs, the extension to means test, and support progress towards local authorities paying a fair cost of care, which together will remove unpredictable care costs. £1.7 billion to improve social care in England, including at least £500 million investment in the workforce.
- 5.7 Some of these monies are in areas which are included within the Better Care Fund, with the Better Care Fund therefore growing over the next 3 years. One such area is more money being made available to support the Disabled Facilities Grant which will enable changes to be made to people's property so they can be discharged from hospital in a timely manner and continue to live independently in the community.
- 5.8 **Priorities for 2022/23**
- 5.9 A number of priorities have emerged throughout 2021-22 and into 2022-23:
- 5.10 Ensuring provider market risk management oversight – the council, CCG and hospital trusts have established a number of tools to appropriately manage the care home and domiciliary care market. These include the use of a quality dashboard, capacity tracker, bed vacancy management. Tangible results from this work to-date have included targeting low quality homes for intervention by deploying district nurses. There are strong relationships between partners to highlight and share system risk information and then to deploy appropriate resources. A narrative care market strategic overview is produced on a regular basis, strategic data is produced, and a live strategic risk register is maintained.
- 5.11 Increase collaborative commissioning – partners have come together to commission and procure services together and develop market strategy, this includes the carers hub, community equipment and assistive technology services. This collaborative commissioning approach also extends to the production of strategy for example jointly producing a Market Position Statement (MPS) and Live Well for longer strategy. The MPS provides key messages for Providers and summarises the supply and demand in a local authority area. The MPS brings together local information and analysis relating to commercial opportunities within the public health, health, and social care market in that area. The MPS also provides details of the Council's strategic commissioning approach, and how Commissioners and Provider can work together to achieve outcomes for local people.
- 5.12 Effective contract management - partners have also transferred responsibility for contract management and service delivery where appropriate. For example the sourcing and commissioning of Discharge to Assess, Pathways 1,2 and 3 placements has transferred from CHC nurses to the Cheshire East Borough Council Brokerage function. Further examples include the transfer of the responsibility for commissioning and contracting the British Red Cross services.
- 5.13 Increasing out of hospital resource - There has been an increased focus on ensuring greater community resource and step down capacity is in place to assist the system. For example a General Nursing Assistant service has been commissioned. This service provides an additional 7 GNA staff within the CCICP IPOCH team for a period of 12 months. These additional staff would be utilised across South Cheshire and the Congleton area of East Cheshire to support patients requiring domiciliary care that would normally be delivered by Local authority. Other community resources include; British Red Cross hospital avoidance and step-down services, Rapid response, community and mental health reablement.
- 5.14 Partners have worked more collaboratively on system planning - for example partners have produced the Cheshire East System Flow Plan for second half of the financial year 2021-22 (H2). It

was formerly known as the 'winter plan' but as a system we recognised that capacity and demand fluctuations occur across the year and can be planned for to safely and effectively manage the flow of patients throughout the Health & Social Care system. The system flow plan includes a number of schemes; primary care access, GP's aligned to care homes, community pharmacists, mental health crisis line, weekend escalation policy

- 5.15 A focus on reducing length of stay - A community LOS report is produced and reviewed with each acute Trust on a weekly basis where we review at our joint governance call each person and there identified exit – move on plan. In terms of hospital oversight for patients who are in hospital for over 14- 21 days a review of their length of stay is completed on a weekly basis with IDT, Bed Managers and the ward sisters to identify exit plans and unblock any obstacles that is preventing a discharge. An action plan is produced following on from the review, the most recent review identified the following actions: Clear communication plan to be rolled out over 4week period, Review current process, Ensure early identification of patients with a LOS 21days +, Escalation time frames to be agreed by all stakeholders, Using data to clearly identify themes, Test new processes/pathways using improvement methodology.
- 5.16 Transfer of care hubs – work is underway in the system to develop transfer of care hubs. A 'Transfer of Care Hub' is a single route for arranging all support for people leaving hospital and should facilitate access to long term support arrangements for those that require it. Agreed functions: The Hub would receive information about individual patients (on a Transfer of Care form) which will include a recommendation for the support required. There will be the option for more detailed MDT conversations where required due to complexity of need or risk. There will be pathways from the Hub to a range of short-term services which will allow the Hub to make the appropriate support arrangements for each individual leaving hospital. The care coordinator for each individual will be agreed at the Hub. The Hub will be supported by an IT system that allows for real time information to be accessed by all partners and to which they can all contribute. There will be pathways from the Hub to a range of long-term services for those assessed as requiring support following the period of assessment.
- 5.17 Age well – The age well programme is underway with an SRO appointed and project support in place. The draft terms of reference has been produced with identified leads to the attend the ageing well programme board with monthly meetings in place. Crucially in Cheshire East the CCG governing body agreed the Age well programme approach in Cheshire East and agreed that funding could be recurrent to support the intended aims of the project. Key components of the age well programme include the 2 hour response, enhanced health in care homes and anticipatory care. Its been noted that the anticipatory care framework is due to be published. The current pressures within the system have been noted for example those seen in the domiciliary care market. In respect of the enhanced health in care homes work which has taken place to date has focused on what providers need, what the gaps are, priority areas, what is realistic. Its noted that the individual projects in Cheshire East will be in place by the end of March 2022.
- 5.18 **Governance changes**
- 5.19 The Health & Care Act 2021 (currently at the bill stage) sets out reforms with the intention of delivering a more integrated provision for health and social care. The current position is that local authorities cannot have committees or arrangements with NHS bodies, other than in a limited way under S75 NHS Act 2006.
- 5.20 The new Act will provide a statutory framework for collaboration between NHS providers, local authorities and others, to enable them to form joint committees, pool funds and make joint arrangements for the discharge of functions.
- 5.21 Until we are able to legally set up a Joint Committee (other than our S75 committee) we will operate as a 'Committee in Common'. This is a committee of two or more organisations who meet for a

mutual purpose with a consistent agenda, but where each organisation makes its own decision under its own delegated authority, albeit ideally for the benefit of the overall Place.

5.22 Implementation of the Act has been delayed until 1 July 2022, but we are working to have shadow arrangements in place from April 2022 (the original proposed implementation date). This will take the form of a 'Committee in Common' as well as our S75 Joint Committee with the CCG. Any further integration beyond the existing activities included in the BCF would be subject to the normal Cheshire East Council governance procedures for approval, including whether the existing S75 agreement is widened or whether a new separate additional S75 agreement is created. (this is importance given that the S75 outlines key issues such as risk sharing)

5.23 **Schemes for 2022/23**

5.24 There are 19 Schemes funded through Winter pressures, iBCF and BCF for 2022-23:

5.25 The exact scheme amounts are based on 2021/22 original budgets – the amounts for 2022/23 are yet to be fully confirmed. We are awaiting the national guidance on the Minimum amounts to be Pooled (the amount of uplift is mandated) and in addition, the Local Government Pay Award for 2021/22 is still to be formally finalised and this is used as the measure for uplifting the relevant schemes (for example, the BCF Reablement scheme where the vast majority of expenditure incurred is staffing related). It is also noted that the scheme 19 is added to the plan for 2022/23 which will impact the expenditure of the plan noted in section 5.28.

Scheme ID	Scheme Name	Source of Funding	Expenditure (£)
1	ibcf Block booked beds	iBCF	£363,297
2	ibcf care at home hospital retainer	iBCF	£40,000
3	ibcf rapid response	iBCF	£797,473
4	ibcf social work support, ibcf Winter Additional Social Care staff to prevent people from being delayed in hospital, iBCF Social Work Team over Bank Holiday weekends	iBCF	£578,124
5	iBCF 'Winter Schemes	iBCF	£500,000
6	iBCF Enhanced Care Sourcing Team (8am-8pm)	iBCF	£440,463
7	iBCF Improved access to and sustainability of the local Care Market (Home Care and Accommodation with Care)	iBCF	£5,764,035
8	BCF Disabled Facilities Grant	DFG	£2,342,241
9	BCF Assistive technology	Minimum CCG Contribution	£757,000
10	BCF British Red Cross 'Support at Home' service	Minimum CCG Contribution	£297,570
11	BCF Combined Reablement service	Minimum CCG Contribution	£4,771,325
12	BCF Safeguarding Adults Board (SAB)	Minimum CCG Contribution	£422,380
13	BCF Carers hub	Minimum CCG Contribution	£398,000
14	BCF Programme management and infrastructure	Minimum CCG Contribution	£411,558
15	BCF Winter schemes CCG	Minimum CCG Contribution	£527,800
16	BCF Homefirst schemes CCG	Minimum CCG Contribution	£18,693,933
17	BCF Trusted assessor service	Minimum CCG Contribution	£94,000
18	BCF Carers hub	Minimum CCG Contribution	£324,000
19	Community Equipment	Minimum CCG	£1,400,000

5.26 Metric performance

5.26 The tables below include the BCF metrics and expected performance for 2021/22. Once at year-end the anticipated performance for 2022/23 will be set in collaboration with partners. To set planned 22/23 performance in April 2022 will be based on information up to February 2022 (available mid-April).

8.1 Avoidable admissions

Latest Data as at: **March 2020 (from February 2021 Release)**

Data source: NHS Digital - NHS Outcomes Framework Indicators - February 2021 Release	19-20 Actual	20-21 Actual	21-22 Plan	21-22 Actual	Comments
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	776.9	770.3 (estimated)	765.5	See comments	The results for this metric are published annually. The next publication is due to be in February 2022 but this will be for the figures for 2020/21. 2021/22 figures will not be published until February 2023. NHS England are looking into accessing more recent data for local authorities.

8.2 Length of Stay

Latest Data as at: **October 2021**

Data source: NHS England SUS time series data (via Better Care Exchange)		21-22 Q3 Plan	21-22 Q4 Plan	Latest Month	Previous Month	Comments
Percentage of in patients, resident in the HWB, who have been an inpatient in an acute hospital for: i) 14 days or more ii) 21 days or more As a percentage of all inpatients (SUS data - available on the Better Care Exchange)	Proportion of inpatients resident for 14 days or more	15.8%	16.5%	13.1%	14.6%	14+ LOS is 1.5 percentage points lower than last month and is 2.7 percentage points below the Qtr 3 Plan. It is, however, 1.5 percentage points higher than the England figure.
	Proportion of inpatients resident for 21 days or more	7.7%	8.0%	8.4%	9.1%	21+ LOS is 0.7 percentage points lower than last month but is 0.7 percentage points higher than the Qtr 3 Plan. It is also 2.2 percentage points higher than the England figure.

8.3 Discharge to normal place of residence

Latest Data as at: **October 2021**

Data source: NHS England SUS time series data (via Better Care Exchange)	21-22 Plan	Latest Month	Previous Month	Comments
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence	89.0%	89.9%	89.2%	The latest month is 0.7 percentage points higher than last month and is 0.9 percentage points higher than the 21-22 plan. This month, however, is 2.9 percentage points lower than the England figure.

8.4 Residential Admissions

Latest Data as at: **October 2021**

Data source: Cheshire East Council Adults case management system	19-20 Plan	19-20 Actual	20-21 Actual	21-22 Plan	Latest Month (Plan)	Latest Month (Actual)	Comments	
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	600.9	761.2	496.9	580.7	338.9	381.3	The annual rate, as at the latest month, is 42.4 higher than the planned rate. This equates to 39 more admissions than expected at this point in the year. 48% of admissions were admissions to nursing care. N.B. In year figures are provisional and may change following data validation for annual data returns
	Numerator	530	672	443	530	309	348	
	Denominator	88,205	88,280	89,148	91,265	91,265	91,265	

Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population (aged 65+) population projections are based on a calendar year using the 2018 based Sub-National Population Projections for Local Authorities in England:

8.5 Reablement / Rehabilitation

		19-20 Plan	19-20 Actual
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	83.3%	74.6%
	Numerator	320	182
	Denominator	384	244

21-22 Plan	Latest Month	Previous Month	Comments
	See Comments		Due to the Coronavirus, hospital staff involved in the data collection and processing for this metric were diverted to other tasks and, therefore, the necessary data to derive this metric was not submitted in 2020/21. This meant that we could not submit this data as part of our 2020/21 annual returns to NHS Digital. This is also the case in 2021/22 to date. Discussions with NHS Trusts have taken place to identify new staffing resource to support this in the new year and recommence reporting.
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5.28 Income and Expenditure

5.29 The following table describes the budget for the Better Care Fund and the anticipated expenditure:

Running Balances	Income	Expenditure
DFG	£2,342,241	£2,342,241
Minimum CCG Contribution	£27,208,192	£27,208,192
iBCF	£8,449,929	£8,449,929
Additional LA Contribution	£0	£0
Additional CCG Contribution	£0	£0
Total	£38,000,362	£38,000,362

	Minimum Required Spend	Planned Spend
NHS Commissioned Out of Hospital spend from the minimum CCG allocation	£7,731,796	£19,317,933
Adult Social Care services spend from the minimum CCG allocations	£7,830,695	£7,966,459

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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Sch eme ID	Scheme Name	Brief Description of Scheme	Expenditure (£)
1	ibcf Block booked beds	Direct award of short-term contracts for 8 winter pressure beds to support Covid-19 pressures, winter pressures, supporting hospital discharges or preventing admission. The rationale for completing a direct award was as follows: an anticipated second wave of Covid-19, non Covid-19 related elective surgery and procedures which were cancelled/postponed are currently being reinstated in hospitals which will increase demand, residents have avoided accessing primary care services and we anticipate a surge in demand on these beds due to people's conditions deteriorating due to lack of treatment, we are now seeing the demand on A & E services in our hospitals rapidly increasing, Covid-19 is likely to be with us for the foreseeable future, we will need to access these beds to prevent hospital admissions as well as support hospital discharges and Care home providers do not have available capacity and would not be inclined to complete a standard tendering process due to the short term nature of these contracts during normal circumstances. We know the enormous pressures that care homes are under at present due to Covid-19, therefore, there is an even great need to award these contracts via a direct award.	£363,297
2	ibcf care at home hospital retainer	Since the implementation of the new Care at Home contract in November 2018 the Council does not pay a retainer fee for the first 7 days for hospital admission or respite; however, the provider is contractually obligated to hold open the care packages for this time. In order to assist with service continuity there may be instances upon agreement from the Contracts Manager where a retainer fee will be paid for up to the following 7 days. (i.e. day 8 to 14). In certain circumstances there may be cases where a Service User is only a few days from being discharged from hospital and so to support a smooth transition a retainer fee may be paid for a nominal number of days. This is only in exceptional cases and needs authorising in partnership with Contracts and Operational Locality Managers.	£40,000
3	ibcf rapid response	The Rapid Response Service will facilitate the safe and effective discharge of service users from hospital who have been declared as medically fit for discharge but who may 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.	£797,473
4	ibcf social work support	<p>Social Worker (x1) dedicated to the Discharge to assess beds at Station House, Crewe. Social Care Assistants (x2) additional assessment and care management capacity to support the revised processes around hospital discharge using reablement exclusively for this purpose (East locality).</p> <p>ibcf Winter Additional Social Care staff to prevent people from being delayed in hospital - Funding of additional staff to support a 'Discharge to assess' model. Funding is continuing to provide a team manager, social worker and occupational therapist.</p> <p>iBCF Social Work Team over Bank Holiday weekends - Increased capacity in the Social Work Team over Bank Holidays and weekends. This is to ensure patient flow and assisting in reducing the pressure on the NHS can be maintained over a seven-day period. Cheshire East will provide 2 social workers and 2 care arrangers (split between the 2 hospitals) that cover the weekends and bank holidays. This support would be 124 days for the weekends and another 8 days for bank holidays giving 132 days each per year.</p>	£112,000

5	iBCF 'Winter Schemes	Additional capacity to support the local health and social care system to manage increased demand over the winter period. Evidence-based interventions designed to keep people at home (or in their usual place of residence) following an escalation in their needs and/or to support people to return home as quickly as possible with support following an admission to a hospital bed.	£500,000
6	iBCF Enhanced Care Sourcing Team (8am-8pm)	The scheme sees the continuation of funding for the Care Sourcing Team following on from a successful pilot; the service provides a consistent approach to applying the brokerage cycle and in turn, makes best use of social worker time. The Care sourcing team undertake all aspects of the Brokerage cycle: enquiry, contact assessment, support planning, creation of support plan, brokering, putting the plan into action as well as monitor and review of the support. The service operates Monday to Sunday. The Care Sourcing Team comprises of a range of employees including team and deputy manager, admin, care sourcing officers as well as a social care assessor. This funding is to enable an 8 till 8 operation. The model is fully compliant with the Care Act 2014 as it provides information and advice, prevention, assessment, review, safeguarding, carers, market management and shaping, charging, support planning, personalisation and arranging care and support.	£440,463
7	iBCF Improved access to and sustainability of the local Care Market (Home Care and Accommodation with Care)	Cheshire East Council has a duty under Section 5 of the Care Act to promote the efficient and effective operation and sustainability of a market in services for meeting the care and support needs of individuals. There are increasing financial pressures on the social care market, for example National Living Wage, recruitment and retention issues, which is resulting in a rise in care costs. This scheme contributes towards the cost of care home and home care fees as well as supporting the delivery of additional care packages within the marketplace.	£5,764,035
8	BCF Disabled Facilities Grant	The Disabled Facilities Grant provides financial contributions, either in full or in part, to enable disabled people to make modifications to their home in order to eliminate disabling environments and continue living independently and/or receive care in the home of their choice. Disabled Facilities Grants are mandatory grants under the Housing Grants, Construction and Regeneration Act 1996 (as amended). The scheme is administered by Cheshire East Council and is delivered across the whole of Cheshire East.	£2,342,241
9	BCF Assistive technology	Assistive technologies are considered as part of the assessment for all adults who are eligible for social care under the Care Act where it provides greater independence, choice and control and is cost-effective for individuals. The provision of assistive technology is personalised to each individual and is integrated within the overall support plan. The scheme will continue to support the existing assistive technology services. The scheme also involves piloting assistive technology support for adults with a learning disability (both living in supported tenancies and living in their own homes).	£757,000
10	BCF British Red Cross 'Support at Home' service	Cheshire East 'Support At Home' Service is a 2-week intensive support service with up to 6 Interventions delivered within a 2-week period for each individual. The aim is to support people who are assessed as 'vulnerable' or 'isolated' and who are at risk of admission to hospital or becoming a delay in hospital. Service users have been identified as requiring additional support that will enable them to remain independent at home, or to return home more rapidly following a hospital admission. The interventions may include: A 'safe and well' phone call. A 'follow-up visit' within 1 working day. Help with shopping. Signposting and referring to other agencies for specialist support. The main focus of the service is on supporting people to remain at home (preventing unnecessary hospital admissions by increasing intensive support at home).	£297,570

		The commissioning responsibility for the British Red Cross services has transferred from the CCG to the local authority.	
11	BCF Combined Reablement service	<p>The current service has three specialist elements delivered across two teams (North and South):</p> <ol style="list-style-type: none"> 1. Community Support Reablement (CQC-registered) - provides a time-limited intervention supporting adults with physical, mental health, learning disabilities, dementia and frailty, from the age of 18 to end of life, offering personal care and daily living skills to achieve maximum independence, or to complete an assessment of ongoing needs. 2. Dementia Reablement - provides up to 12-weeks of personalised, post-diagnostic support for people living with dementia and their carers. The service is focused on prevention and early intervention following a diagnosis of dementia. 3. Mental Health Reablement - supports adults age 18 and over with a range of mental health issues and associated physical health and social care needs, focusing on coping strategies, self-help, promoting social inclusion and goal-orientated plans. 	£4,771,325
12	BCF Safeguarding Adults Board (SAB)	The overarching objective of a SAB is to assure itself that local safeguarding arrangements and partners act to help and protect adults in its area who: have needs for care and support (whether or not the local authority is meeting any of those needs) and; are experiencing, or at risk of, abuse or neglect; and as a result of those care and support needs are unable to protect themselves from either the risk of, or the experience of abuse or neglect.	£422,380
13	BCF Carers hub	<p>The Cheshire East Carers Hub provides a single point of access for carers, families and professionals. The Hub ensures that carers have access to information, advice and a wide range of support services to help them continue in their caring role and to reduce the impact of caring on their own health and wellbeing. Carers can registered directly with the Hub or referrals can be made by professionals, any agency or organisation, relatives or friends. The Hub offers groups and activities which carers will be familiar with along with introducing new support opportunities co-produced with local carers.</p> <p>Through the period of 2021/22 the carers service is being recommissioned as part of the developments a carers apprentice has been recruited to support the work being carried out.</p>	£398,000
14	BCF Programme management and infrastructure	The delivery of the Better Care Fund relies on joint commissioning plans already developed across the health and social care economy. The scheme covers the following: Programme management, Governance and finance support to develop s75 agreements; cost schemes and cost benefit analysis, Financial support, and amongst other things additional commissioning capacity might be required to support the review of existing contract and schemes and the procurement of alternative services.	£411,558
15	BCF Winter schemes CCG	<p>The proposed schemes specifically support the achievement and maintenance of the four-hour access standard, admission avoidance, care closer to home and a continued compliance with the DTOC standard. Schemes cover: discharge to assess, British Red Cross transport, non-emergency transport, additional acute escalation ward and additional ED staffing amongst others.</p> <p>Each of the partners will be developing winter plans which will then form part of a place-based plan.</p>	£527,800
16	BCF Homefirst schemes CCG	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	£18,693,933

		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.	
17	BCF Trusted assessor service	<p>Delays are caused in the hospital by service users/patients waiting for nursing & residential homes to assess their needs. This scheme deploys a trusted assessor model by commissioning an external organisation to employ Independent Transfer of Care Co-ordinator's (IToCC's) to reduce hospital delays. The trusted assessment model is a key element of the eight High Impact Changes in order to support the timely transfer of patients to the most appropriate care setting and to effect a reduction in the number of delayed transfers of care. The model is being supported nationally by the emergency Care Improvement Programme.</p> <p>Through the period 2021/22 the trusted assessor service is being recommissioned with the aim that the new provider is in place for 1st January 2022.</p>	£94,000
18	BCF Carers hub	<p>The Cheshire East Carers Hub provides a single point of access for carers, families and professionals. The Hub ensures that carers have access to information, advice and a wide range of support services to help them continue in their caring role and to reduce the impact of caring on their own health and wellbeing. Carers can registered directly with the Hub or referrals can be made by professionals, any agency or organisation, relatives or friends. The Hub offers groups and activities which carers will be familiar with along with introducing new support opportunities co-produced with local carers.</p> <p>Through the period of 2021/22 the carers service is being recommissioned as part of the developments a carers apprentice has been recruited to support the work being carried out.</p>	£324,000
19	Community Equipment	<p>The Cheshire Integrated Community Equipment Service (ICES) will provide equipment in discharge of its statutory duties to meet the needs of individuals. This will be delivered by commissioning a single equipment provider. Equipment is provided to adults and children when, by reason of a temporary or permanent disability or health needs, they require the provision of equipment on a temporary or permanent basis for independent living. This includes equipment for rehabilitation, long term care and support for formal and informal carers. It is also vital for hospital discharge, hospital admission avoidance, and nursing need. Equipment is provided to Cheshire East council and Cheshire registered GP population. There are a small proportion of customers who live outside of Cheshire. The population of Cheshire is approximately 727,223 (taken from the mid-2019 ONS Population Estimates)</p>	£1,400,000