HM Government

NHS England

# BCF narrative plan template

This is a template for local areas to use to submit narrative plans for the Better Care Fund (BCF). All local areas are expected to submit narrative BCF plans. Although the template is optional, we ask that BCF planning leads ensure that narrative plans cover all headings and topics from this narrative template.

These plans should complement the agreed spending plans and ambitions for BCF national metrics in your area's BCF Planning Template (excel).

There are no word limits for narrative plans, but you should expect your local narrative plans to be no longer than 25 pages in length.

Although each Health and Wellbeing Board (HWB) will need to agree a separate excel planning template, a narrative plan covering more than one HWB can be submitted, where this reflects local arrangements for integrated working. Each HWB covered by the plan will need to agree the narrative as well as their excel planning template.

**Cover**

Health and Wellbeing Board(s).

Cheshire East Health and Wellbeing Board

Bodies involved strategically and operationally in preparing the plan (including NHS Trusts, social care provider representatives, VCS organisations, housing organisations, district councils).

The BCF plan and priorities have been developed in collaboration with system partners and stake holders from Cheshire East Council Adult Social Care, Mental Health services, NHS Trusts, Integrated Care Board , Housing and Third Sector to ensure our plans are aligned across our organisations to support delivering the agreed shared priorities with our stakeholders to shape the way we deliver our agreed prioritise

Discharge performance data has been gathered from the Business Intelligence teams from Cheshire East Council and NHS Trusts who undertake performance reviews and attend the BCF governance group.

Finance colleagues from the Local Authority and Integrated Care Board have been instrumental in the agreed funding allocation for the various schemes

The Cheshire East Health and Wellbeing Board (HWB) retains responsibility for governance and oversight of the Better Care Fund and receives quarterly monitoring reports which is a continuation of the approach adopted in 2021/22.

How have you gone about involving these stakeholders?

BCF plans for this year have been reviewed through local planning processes along with consultation with the Better Care governance group which is made up of all system partners who have actively contributed to the design of the plan along with providing assurance that it supports the Cheshire East Health and Wellbeing strategy and is compliant with the national planning criteria.

Cheshire East BCF plan has been developed with contributions from the following partners,

Cheshire East Council (Adult Social Care, Housing and DFG Leads)

NHS Cheshire and Merseyside Integrated Care Board

East Cheshire NHS Trust

Mid Cheshire Foundation Trust

Business Intelligence Teams

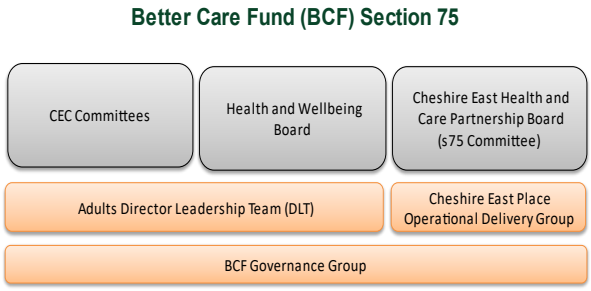
Cheshire and Wirral Partnership NHS Foundation Trust

Community Voluntary Sector

Carers Lead Officers

The BCF plan has been developed as a progression of previous plans but also builds on what worked well during 2022-23 in particular supporting our system partners and a number of the effective discharge schemes that were mobilised during 2022-23

## Better Care Governance and Oversight



**Governance**

Please briefly outline the governance for the BCF plan and its implementation in your area.

The Cheshire East Health and Wellbeing Board (HWB) retains responsibility for governance and oversight of the Better Care Fund and receives quarterly monitoring reports.

Responsibility for ongoing oversight is delegated to the Cheshire East Health and Care Partnership Board which meets monthly.

The core responsibilities of the Better Care Fund governance group in relation to the Better Care Fund are in the section 75 Agreement.

2023 – 25 Better Care Fund Plan approval timeline:

22nd May 2023 Adult Social Care and Health Department Leadership meeting

9th June 2023, Cheshire East Operational Delivery Group

16th June 2023 Cheshire East Leadership Team, Chaired by Integrated Care Board Place Director

27th June 2023 Health and Wellbeing Board for formal sign of by the HWB Chair

In addition to approval of the plan there is ongoing and regular stakeholder engagement. For example, with our providers in respect of discharge planning and monitoring, system performance, and at individual scheme level with HNS providers, private sector providers, Voluntary Community Sector providers, and housing to ensure these schemes remain effective.

**Executive summary**

This should include:

- Priorities for 2023-25
- Key changes since previous BCF plan.

Over the last twelve months Cheshire East system partners, including members of our operational teams have worked extensively to design, deliver and adopt an ambitious Home First model of support.

The whole Health and Social Care system , voluntary organisations and the faith sector have continued to develop trusted working relationships ,supporting people and building person centred support packages of care in partnership with the person and their support circles.

This Home First programme has continued to develop a care and support model that responds at the point of crisis, to offer more care at home and ensure we have the right amount and right type of resource to provide timely access to advice, treatment and support to help people spend more time in the place they call home, either by preventing an admission to hospital or supporting people to be discharged as soon as possible via the correct pathway.

Key priorities for the BCF plan are:

1. Integrated 'Transfer of Care Hubs' will be the single route for arranging timely discharges for people leaving hospital via Pathway 1 to 3 and will facilitate access to support arrangements for those that require it.

2. To develop a community prevention model of support that supports people to remain at home and prevent a hospital admissions

3. Ensure there is sufficient community reablement provision to maximise the amount of people who are able to remain at home.

4. To ensure there is sufficient capacity across the system that continues to manage the ongoing demand to meet the needs of people.

Partners have collaboratively commissioned a range of services across the system, such as a Rapid Response service to support hospital discharge, and community prevention. In addition to our joint approach to commissioning the Local authority has been the lead commissioner in procuring the D2A bed base provision across the Borough. Going forward the NHS and Local Authority staffing structures have been aligned in a way that provides synergies and opportunities to continue in our joint approach to commissioning across the integrated care system.

The plan will continue building on our journey to date and what has been delivered so far, at a place level on our shared priorities, thus ensuring we continue to support the Health and Social Care system along with delivering positive outcomes for local people

**National Condition 1: Overall BCF plan and approach to integration**

Please outline your approach to embedding integrated, person centred health, social care and housing services including:

- Joint priorities for 2023-25
- Approaches to joint/collaborative commissioning
- How BCF funded services are supporting your approach to continued integration of health and social care. Briefly describe any changes to the services you are commissioning through the BCF from 2023-25 and how they will support further improvement of outcomes for people with care and support needs.

In Cheshire East the strategic priority for all stakeholders across Health ,Social Care and Housing is to support people to be discharged home or remain at home or their normal place of residence for as long as possible.

Our vision for person centred integrated care is as follows:

Care and support is planned and organised with people, partners, and communities in ways that ensures continuity in support

Strengths-based assessment approach that support an individual's independence, resilience and ability to make choices

People are supported to manage their own health and well-being, through health, access to self-management programmes and support within the community and have access to appropriate housing.

Ensure integrated care systems make the most of the expertise, capacity and potential of people, families and communities in delivering better outcomes and experiences

Reducing long length of stay remains a system joint priority. This involves community services working closely with hospital discharge teams to ensure that people can be discharged as soon as they are medically optimised.

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.

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 (GNA)service has been commissioned. This service provides an additional 7 GNA staff within the Central Cheshire Integrated Care Partnership 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.

Age well – The age well programme is underway with an Senior Responsible Officer 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 Cheshire  and Merseyside Integrated Care Board 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. It has 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 2024.

As part of the system joint prioritise we are progressing an a model of support via Community Reablement which would be, to operate on a hybrid multi-disciplinary model of service delivery. This would require building in other professional roles to facilitate a stream-lined approach in terms of the offer, ensuring each role fully maximises all opportunities both in the hospitals and within the community.

The aim of this investment and additional workforce infrastructure is to design a model of support that effectively responds within the first 72hours of a person experiencing an escalation of their health and social care needs.

The service will provide short-term social care rehabilitation, to support people to become or remain independent at home achieving the right outcome and work closely with the Care Communities.

In summary all partners and stakeholders are working towards developing an admissions avoidance  and prevention model of support and  early discharge to ensure people live independently at home or in their community for as long as possible.

**National Condition 2**

Use this section to describe how your area will meet BCF objective 1: **Enabling people to stay well, safe and independent at home for longer.**

Please describe the approach in your area to integrating care to support people to remain independent at home, including how collaborative commissioning will support this and how primary, intermediate, community and social care services are being delivered to help people to remain at home. This could include:

- steps to personalise care and deliver asset-based approaches
- implementing joined-up approaches to population health management, and proactive care, and how the schemes commissioned through the BCF will support these approaches
- multidisciplinary teams at place or neighbourhood level, taking into account the vision set out in the Fuller Stocktake
- how work to support unpaid carers and deliver housing adaptations will support this objective.

The Health and Wellbeing Board and the Cheshire East Health and Care Partnership recognise and acknowledge these challenges. Working together with our residents and other stakeholders is the only way that we can address and overcome them. Our over-arching goal is to improve population health and wellbeing whilst reducing health inequalities. This Strategy sets out our strategic objectives and areas of focus to achieve that over the next five years.

The Joint Local Health and Wellbeing Strategy sets out our high-level vision and aspirations to:

Reduce inequalities, narrowing the gap between those who are enjoying good health and wellbeing and those who are not

Improve the physical and mental health and wellbeing of all of our residents

Help people to have a good quality of life, to be healthy and happy.

There are a number of new processes that are in place to support safe, timely and effective discharge  include having appropriate pathways and support in place.

The principles that will underpin our work are to:

Put the voices of people and communities at the centre of decision-making and governance, at every level

Engage with and listen to the seldom heard, for example young carers, cared for children, care leavers, those living in poverty, rural residents and the LGBTQ+ community

Co-design services and tackle Cheshire East priorities in partnership with people and communities, building upon ‘Living Well for Longer’

Start engagement early when developing plans and feed back to people and communities how their engagement has influenced activities and decisions

Understand community needs, experience and aspirations for health and care, using engagement to find out if change is having the desired effect

Build relationships with excluded groups, especially those affected by inequalities

Work with Healthwatch and the voluntary, community, faith, and social enterprise (VCFSE) sector as key partners

Provide clear and accessible public information about vision, plans and progress, to build understanding and trust

Use community development approaches that empower people and communities, making connections to social action

Use co-design and production, insight and engagement to achieve accountable health and care services.

In addition to the Joint Local Health and Wellbeing Strategy the BCF plan for Cheshire East aims to continue to build on the processes that were put in place during 2022/23.

The adopted Occupational Therapy and Reablement Home First Approach supporting people to return home quickly

A new approach to Discharge maximising the use of Community, Voluntary sector and universal services

Carers Payment to support rapid discharge and to remain at home

Mental Health In Reach support into Emergency Departments

The following Prevention / early intervention investment schemes have been commissioned to effectively support people to remain at home and prevent admission.

Community Rapid Response Service, Community Reablement, Mental Health Reablement, Dementia Reablement Services, Acute Visiting Service & GP out of hours, Mobile Night Support, Carers payment incentive, Community Equipment. Falls Coordinators Posts, Falls prevention and response equipment to Care Homes.

Community Connectors positioned within the Transfer of Care Hub promoting Community Voluntary sector services.

Data analysed to ensure that people are discharged from hospital via the correct pathway

Continue to work with the Transfer of Care Hubs and First Point of Contact teams at place which will include NHS Trusts , Care Communities, Primary Care, Social Care, Housing and voluntary are linked in order to coordinate care and support for people who require it during and following discharge and also to prevent a hospital admissions.

**National Condition 2 (cont)**

Set out the rationale for your estimates of demand and capacity for intermediate care to support people in the community. This should include:

- learning from 2022-23 such as
    - where number of referrals did and did not meet expectations
    - unmet demand, i.e. where a person was offered support in a less appropriate service or pathway (estimates could be used where this data is not collected)
    - patterns of referrals and impact of work to reduce demand on bedded services – e.g. admissions avoidance and improved care in community settings, plus evidence of underutilisation or over-prescription of existing intermediate care services);
- approach to estimating demand, assumptions made and gaps in provision identified

- where, if anywhere, have you estimated there will be gaps between the capacity and the expected demand?

how have estimates of capacity and demand (including gaps in capacity) been taken on board) and reflected in the wider BCF plans.

The Demand and Capacity  metrics are populated using a well-established local Cheshire & Merseyside Integrated Care System  out of hospital model. It utilises acute provider planning submission for 2023/24 and models predicted out of hospital activity based on the previous years trends and utilisation. A gap analysis has identified that we must collect additional data relating to Pathway 1 Reablement and Pathway 2 NHS commissioned beds. The complete data will be reviewed by commissioners and adjusted to take into account additional schemes and commissioning arrangements for 2023/24

**National Condition 2 (cont)**

Describe how BCF funded activity will support delivery of this objective, with particular reference to changes or new schemes for 2023-25, and how these services will impact on the following metrics:

- unplanned admissions to hospital for chronic ambulatory care sensitive conditions
- emergency hospital admissions following a fall for people over the age of 65

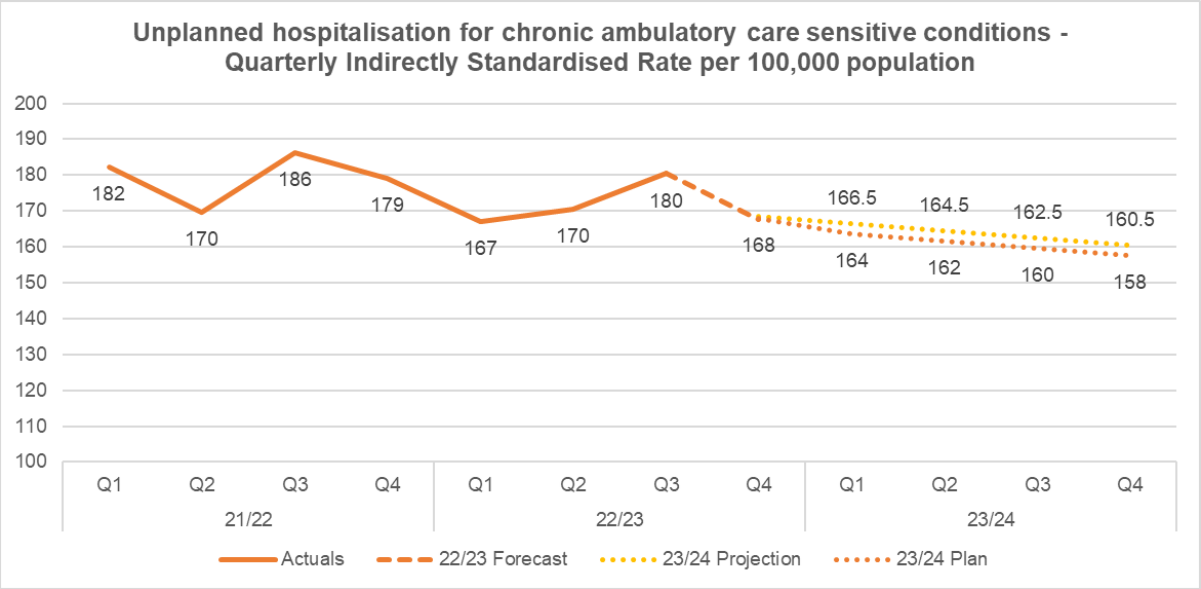
- the number of people aged 65 and over whose long-term support needs were met by admission to residential and nursing care homes, per 100,000 population.

The table below includes the BCF metrics and expected performance for 2023-24:

Projections are based on historic trend and population projections. Plan figures take into account the projected impact from planned activity in 23/24.

1. **Indirectly standardised rate of unplanned hospitalisation for chronic ambulatory care sensitive conditions per 100,000 population**

| | 23/24 Qtr 1 | 23/24 Qtr 2 | 23/24 Qtr 3 | 23/24 Qtr 4 | Total |
|---|---|---|---|---|---|
| 23/24 Projection | 166.5 | 164.5 | 162.5 | 160.5 | 653.9 |
| 23/24 Plan | 163.6 | 161.6 | 159.6 | 157.6 | 642.4 |

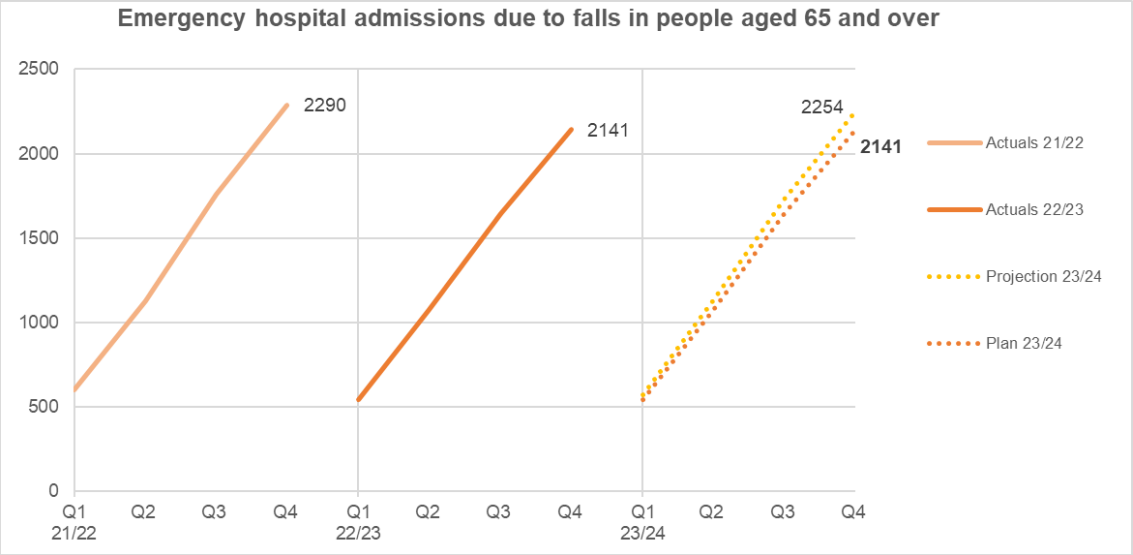



Please see the metrics sheet within the planning template for information on local plans to meet this ambition.

2. **Falls: Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000 population**

| | 23/24 Qtr 1 (cumulative) | 23/24 Qtr 2 (cumulative) | 23/24 Qtr 3 (cumulative) | 23/24 Qtr 4 (cumulative) |
|---|---|---|---|---|
| 23/24 Projection (Falls admissions) | 570 | 1133 | 1730 | 2254 |

| | | | | |
|---|---|---|---|---|
| 23/24 Plan (Falls admissions) | 542 | 1078 | 1645 | 2141 |




This is a new metric, from 2023/24, within BCF Plans. The figures above show a projection based on historic information of admissions due to falls by 5 year age bands combined with population forecasts for those same age bands. This would show an increase of 113 admissions due to falls in 23/24 compared to 22/23. Noting the increased population size for 2023-24, the ambition has been set not to increase the actual number of falls admissions in people aged over 65. This planned ambition reduces the falls rate by 4.8% for 2023/24 compared to 2022/23.

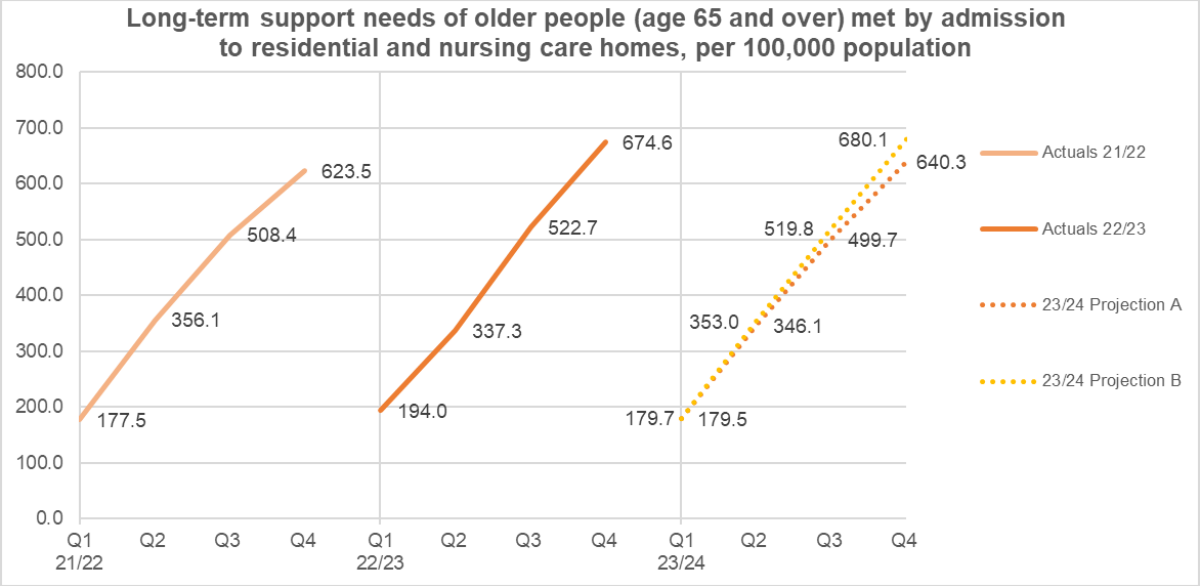
Please see the metrics sheet within the planning template for information on local plans to meet this ambition.

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

| | **23/24 Qtr 1** | **23/24 Qtr 2** | **23/24 Qtr 3** | **23/24 Qtr 4** |
|---|---|---|---|---|
| Projection A | 179.5 | 346.1 | 499.7 | 640.3 |
| Projection B | 179.7 | 353.0 | 519.8 | 680.1 |

Projection A is based on the trend of both 2021/22 and 2022/23

Projection B is based on the trend of 2022/23




Projection A would equate to 605 permanent admissions in the year
Projection B would equate to 643 permanent admissions in the year

Please see the metrics sheet within the planning template for information on local plans.

**National Condition 3**

Use this section to describe how your area will meet BCF objective 2: **Provide the right care in the right place at the right time.**

Please describe the approach in your area to integrating care to support people to receive the right care in the right place at the right time, how collaborative commissioning will support this and how primary, intermediate, community and social care services are being delivered to support safe and timely discharge, including:

- ongoing arrangements to embed a home first approach and ensure that more people are discharged to their usual place of residence with appropriate support, in line with the Government's hospital discharge and community support guidance.

- How additional discharge funding is being used to deliver investment in social care and community capacity to support discharge and free up beds.

- Implementing the ministerial priority to tackle immediate pressures in delayed discharges and bring about sustained improvements in outcomes for people discharged from hospital and wider system flow.

. Priorities for 2023/24: Home First remains a strategic priority across our Integrated Care System in Cheshire East Place and a clear set of associated Home First work programme priorities have been set in line with the NHS Urgent and Emergency Care Operational Planning Guidance for 2023-24 and NHS England delivery plan for recovering Urgent Emergency Care Services January 2023. The key principals of the Home First Model of support are to: Prevent unnecessary or avoidable hospital admissions by working across the community and hospital Facilitate safe discharge from local hospitals in a timely manner to the most appropriate setting to meet people's needs and maintain their independence Design and build a person-centred support package in partnership with the person and there, strengthens and support circles. Ensure people are supported in the community post discharge to reduce readmissions Implement National guidance on discharge requirements As part of our Home First programme of work the system vision is to implement the Home First model of discharge to assess, to maximise the potential for providing more integrated care and support across community-based Health and Social Care. A number of additional schemes have been funded that will create additional Care at Home, Rapid Response Care, support for carers, workforce capacity that will support facilitated discharge, Hospital Prevention and support system flow. The transfer of care hub is works with system partners to ensure that delayed discharges are managed effectively on a daily basis and discharges plans are designed in a way that provides positive outcomes for people.

**National Condition 3 (cont)**

Set out the rationale for your estimates of demand and capacity for intermediate care to support discharge from hospital. This should include:

- learning from 2022-23 such as
    - where number of referrals did and did not meet expectations
    - unmet demand, i.e. where a person was offered support in a less appropriate service or pathway (estimates could be used where this data is not collected)
    - patterns of referrals and impact of work to reduce demand on bedded services – e.g. improved provision of support in a person's own home, plus evidence of underutilisation or over-prescription of existing intermediate care services);
- approach to estimating demand, assumptions made and gaps in provision identified
- planned changes to your BCF plan as a result of this work.
    - where, if anywhere, have you estimated there will be gaps between the capacity and the expected demand?
    - how have estimates of capacity and demand (including gaps in capacity) been taken on board ) and reflected in the wider BCF plans.

The demand and capacity analysis has indicated with have a shortage of Care at Home and Bed base across the Borough. Care at Home Capacity, our investment plan shows  a

significant financial investment in Care at Home, Rapid Response Care, Community Reablement and General Nursing assistants.

A proportionate of funding will also fund a small number of step down resilience beds that will support step up and down along with carer breakdown.

To support the identified capacity gap an investment proposal is being taken forward that which would enhance the delivery for Community Reablement which would be, to operate on a hybrid multi-disciplinary model of service delivery. This would require building in other professional roles to facilitate a stream-lined approach in terms of the offer, ensuring each role fully maximizes all opportunities both in the hospitals and community.

The aim of this investment and additional workforce infrastructure is to design a model of support that effectively responds within the first 72hours of a person experiencing an escalation of their health and social care needs.

The service will provide short-term social care rehabilitation, to support people to become or remain independent at home achieving the right outcome and work closely with the Care Communities.

**National Condition 3 (cont)**

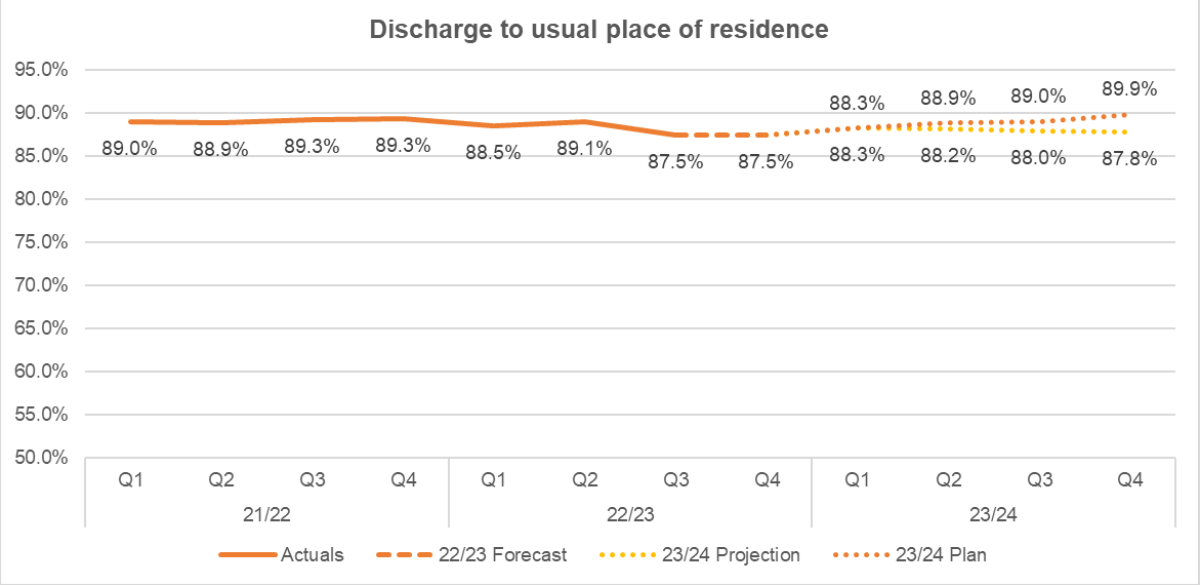
Set out how BCF funded activity will support delivery of this objective, with particular reference to changes or new schemes for 2023-25 and how these services will impact on the following metrics:

- Discharge to usual place of residence

Projections are based on historic trend and population projections. Plan figures take into account the projected impact from planned activity in 23/24.

**4. Discharge to usual place of residence**

| | 23/24 Qtr 1 | 23/24 Qtr 2 | 23/24 Qtr 3 | 23/24 Qtr 4 | Total |
|---|---|---|---|---|---|
| 23/24 Projection | 88.3% | 88.2% | 88.0% | 87.8% | 88.1% |
| 23/24 Plan | 88.3% | 88.9% | 89.0% | 89.9% | 89.0% |




Please see the metrics sheet within the planning template for information on local plans to meet this ambition.

**National Condition 3 (cont)**

Set out progress in implementing the High Impact Change Model for managing transfers of care, any areas for improvement identified and planned work to address these.

On going work continues to implement the high impact  change model on supporting timely and effective discharge through joint working across the Adult Social Care and Health system are continued to be adopted through the transfer of care hub.

As part of our planning for 2023-24 there is a number of work streams that the system is focusing on via the Home First programme of work which is as follows:

Centralised cluster of D2A facilities strategically positioned across Cheshire East Place. The plan is to consolidate and reconfigure existing pathway 2 bed-based ‘step-down’ and ‘step-up’ provision and create clusters across the Borough to ensure people return directly to their homes thus improving outcomes and enhanced performance of service delivery.

The new Model of care will deliver:

An environment for a period of Assessment, Rehabilitation and Reablement for people.

Removal of steps, processes, and delays in the discharge process

A reduction in Length of Stay

Transformation towards a financially sustainable model for step up and step-down beds.

A reduction in the risk associated with people remaining in a hospital environment and deconditioning

A reduction in the number of people who have No Criteria to Reside in Hospitals

Increased discharge rates on the wards and creating acute bed base capacity

Increased patient flow through the hospital

Supporting people out of hospital, to streamline discharge to enable and recovery.

Centralise the wraparound support:  Nursing, Therapy, Social Work, and GP clinical resource into key locations, reducing staff travel time and creating staffing capacity to reinvest back into the system

A significant reduction in the spot purchasing of bed base placements

Improved Health & Wellbeing outcomes for people

Home First Admissions Avoidance/ Community Prevention Planning: The objective of this work stream is to design Develop a care and support model that responds at the point of crisis, -Offer more care at home and ensure we have the right amount of capacity and the right type to provide timely access to advice, treatment and support to prevent a hospital admission and support people to remain at home -Develop an integrated workforce - Transform a sustainable model for Discharge to Assess across the Borough via cluster of beds in set localities.

High Intensity Users Programme of Work: To develop a test model to enable local health and social care systems proactively identify and work with high intensity users and empower service users to better manage their own health and social care needs.

Mental Health Services - Develop adequate admission avoidance options including crisis beds, with a focus on earlier intervention and prevention in communities and  put in place system wide agreement to combat delays in moving patients from acute to rehab bed provision

## National Condition 3 (cont)

Please describe how you have used BCF funding, including the iBCF and ASC Discharge Fund to ensure that duties under the Care Act are being delivered?

The Care Act 2014 requires local authorities to ensure the provision or arrangement of services, facilities or resources to help prevent, delay or reduce the development of needs for care and support.

The main principles of the  funded investment schemes through BCF, iBCF, ASC discharge fund that have been mobilised  are to support people to improve people's independence and wellbeing , support carers  and to promote a person-centred approach to the care and support they provide.

The range of schemes and support options demonstrates that our duties and responsibilities are working inline with the Care Act and remaining complaint in the offer of servcies and diverse ramge f services that will be delivered across the people for people

**Supporting unpaid carers**

Please describe how BCF plans and BCF funded services are supporting unpaid carers, including how funding for carers breaks and implementation of Care Act duties in the NHS minimum contribution is being used to improve outcomes for unpaid carers.

Cheshire East Carers Hub (All Age Carers Hub) work in partnership with 'Making Space' who are the provider who works with Carers to find solutions and identify support and resources available to you in Cheshire East.The provider provides physical and emotional support and will explore how to support carers in there caring role now and in the future.The support will be personalised and holistic and will consider all the areas of your life and what is important to and for you. This could include:

- Benefits advice and guidance
- A statutory carers assessment
- One to one support
- Peer support and groups
- Activities and carer breaks
- Access to respite
- Training relevant to your caring role
- Volunteering opportunities
- Befriending support
- Referrals and signposting to our partners
- Opportunities to shape the service we provide

The Carers Hospital Discharge to Home Scheme

A newly introduced Carer Hospital Discharge to Home Scheme has been introduced which provides a one off incentive payment that can be paid to an unpaid Carer (family/friend) to support carers in their caring role at the point of discharge. The scheme is aimed at patients who are ready for hospital discharge but need some support to recover or recuperate, which could be met through informal care, either entirely or alongside reduced formal support. The vision of the schemes is to reduce delayed discharges and free up hospital bed capacity.

Help to reduce the need for formal care at home support and short stays.

Support Reablement packages and help to reduce their input.

Support the Transfer of Care Hub in designing holistic packages of care by way of briging support via the carer

Support informal Carers in their role by paying them a one off incentive payment.

Offer another support pathway to enable patients to be discharged from hospital once ready

**Disabled Facilities Grant (DFG) and wider services**

What is your strategic approach to using housing support, including DFG funding, that supports independence at home?

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), with a discretionary top-up of £20,000 under the housing renewal policy in accordance with the Regulatory Reform (Housing Assistance) (England & Wales) Order 2002. The scheme will be administered by Cheshire East Council and will be delivered across the whole of Cheshire East.

Assessment and support - Occupational therapists and social care assessors across health and social care are engaged in the delivery of Disabled Facilities Grants, carrying out an holistic assessment of health, care and housing needs including a functional assessment of how people are managing in their homes. Occupational therapists are engaged with continuing healthcare, equipment services and assistive technology, bringing together a range of services to provide a holistic response to meet the needs of disabled people. Occupational therapists are working across health settings to facilitate hospital discharge with the use of home adaptations as appropriate, and utilising the Regulatory Reform Order to facilitate more efficient adaptations for hospital discharge and to support palliative care. In 2022/23 we used a discretionary fast track grant on 59 occasions to support hospital discharge and facilitate care at home for people on palliative care pathways. Occupational therapists' assessments and recommendations take an incremental approach, and where there is need for temporary solutions to facilitate hospital discharge while longer term arrangements can be put in place, they work in collaboration with the service user and the Housing service to implement appropriate solutions.

We have a focus on early intervention for admissions avoidance and preventing inappropriate or unnecessary use of health and social care services. In 2022/23 we delivered adaptations to 123 people as part of this prevention agenda. The predominant support provided was to meet bathing needs and falls prevention. Early intervention officers are employed within the Housing service to identify and support people who do not have eligible care needs but need some form of practical support to be able to maintain independent living. The objective is to provide interventions that support people to maintain their wellbeing at home, such as bathing, access in and out of the home, or being able to move around the home, at an early enough stage that negates or delays the need for them to access health and social care services.

Care and Repair - improving homes, improving lives - We have a care and repair service in Cheshire East which is aimed at helping people to adapt or repair their home. The service is aimed at those over state pension age, or those that have a disability. Care and Repair is a

service for older, disabled and vulnerable people, guiding them through the often complex or daunting process of carrying out repairs and adaptations in their own home. We offer help with many types of work around the home, from replacing a window to building an extension. In 2022-23 the service facilitated 97% of the Disabled Facilities Grants that were completed, and provided advice and guidance to the 3% of service users who arranged adaptations themselves. The service has proved effective at facilitating adaptations in a more timely manner than service users have been able to do for themselves; the average timescale for completion of adaptations by Care & Repair is 4 months, compared to 9 months for adaptations arranged by service users.

The service scope covers those that can afford to pay for work themselves or for those that need help with the cost of repairs and adaptations or finally those people that may just want advice. The following services are offered: technical advice and information about repairs and adaptations, helping the person to find ways to pay for the home repairs and adaptations, and checking your entitlement to benefits, assisting the person with filling in forms for funding applications, providing the person with information about other service to help them live independently within their own home.

**Additional information (not assured)**

Have you made use of the Regulatory Reform (Housing Assistance) (England and Wales) Order 2002 (RRO) to use a portion of DFG funding for discretionary services? (Y/N)

Yes

If so, what is the amount that is allocated for these discretionary uses and how many districts use this funding?

£500,000

**Equality and health inequalities**

How will the plan contribute to reducing health inequalities and disparities for the local population, taking account of people with protected characteristics? This should include

- Changes from previous BCF plan
- How equality impacts of the local BCF plan have been considered
- How these inequalities are being addressed through the BCF plan and BCF funded services
- Changes to local priorities related to health inequality and equality and how activities in the document will address these
- Any actions moving forward that can contribute to reducing these differences in outcomes
- How priorities and Operational Guidelines regarding health inequalities, as well as local authorities' priorities under the Equality Act and NHS actions in line with Core20PLUS5.

It is an essential priority for Cheshire East to significantly reduce health inequalities. Cheshire East is one of the most polarized boroughs in the country, with some of the most affluent and some of the most deprived local areas, generating significant inequalities among community groups. Our local health and care system is committed to the reduction of inequalities. The Cheshire East Health and Wellbeing Board oversees our BCF activity. The Board has a focus on reducing inequalities and established an Increasing Equalities Commission to review service provision to ensure it is equitable. The Cheshire and Merseyside Health and Care Partnership have placed the reduction of health inequalities as a key aim for our local system. It gave a commitment for the sub-region to become a "Marmot Community" - committed to tackling health inequalities throughout people's lives through a determined and joint effort to true integration across a number of sectors to achieve common goals. Cheshire East Council has put fairness as one of the three aims at the heart of its Corporate Plan (2021–2025) - "We aim to reduce inequalities, promote fairness and opportunity for all and support our most vulnerable residents"

BCF projects will contribute to our new Joint Local Health and Wellbeing Strategy as part of a comprehensive plan to reduce health inequalities and help people live well for longer.

Inequalities are seen across Cheshire East. Most starkly, these area based, with our most deprived electoral wards in central Crewe (and to a lesser extent Macclesfield) seeing poor health outcomes across the life course. We are ensuring that our BCF projects are active in these areas and will benefit these residents. This includes provision of nursing assistants and the work of our Carer's Hub. We are funding a third sector organisation to work with residents in central Crewe and Macclesfield.

Cheshire East is becoming increasingly diverse, with significant increases in ethnic minority populations seen in Crewe. Our schemes are accessible in those from ethnic minority groups and we ensure that they are appropriate for those who do not have English as a first language.

In addition to deprivation in our central urban areas, we also have a dispersed rural population, experiencing issues around access to services and social isolation. Our BCF projects are designed to be accessible for our residents in rural and remote areas.

Specific work for those living with disabilities is discussed above.

Further work is needed to explore provision of services to those in the boating community and those who are Gypsy or Roma travellers. We work closely with our Homelessness Team to support those with urgent housing needs.

Our BCF initiatives will Make Every Contact Count and take opportunities to promote prevention and healthy lifestyles to our residents. Smoking cessation is a cross-cutting priority in the reduction of avoidable deaths and health inequalities from cardiovascular diseases, respiratory diseases and cancers, as per the Core20PLUS5 approach.

A consensus building process has been undertaken to identify 12 key outcome indicators to inform action to reduce healthcare inequalities at both national and system level. These indicators will form the first of two parts of a Joint Outcomes Framework. The second part of the Framework will focus on additional indicators to monitor local progress in relation to the Cheshire East Five-Year Health and Care Service Delivery Plan.

The Joint Outcomes Framework as a whole, will continue to evolve over the coming years, influenced by: emergent findings within the Joint Strategic Needs Assessment; community insights; Cheshire and Merseyside intelligence; progress in relation to the Delivery Plan; and developments in what we are readily able to measure. Importantly, the purpose of the Outcomes Framework is not to monitor and evaluate all core activity and transformation across the health and care system. However, there is a recognition across Cheshire East Place, that sustained focus on the above 12 specific outcomes, and inequalities across these, is required in order to demonstrate progress towards achieving the overarching vision outlined in this strategy Our approach to reducing inequalities in Cheshire East will be led through the Increasing Equalities Commission.

Addressing health inequalities and equality in line with the Equality Act for people with protected characteristics through commissioning

A number of schemes are currently in place to support discharge for people with mental health support needs in Cheshire East which range from

Mental Health Step Down – Up Crisis, step down beds to provide a step-down support and overnight accommodation as a planned, safe and sustainable discharge from hospital settings.

Mental Health A&E In Reach at Macclesfield and Leighton Hospitals – this provides a staff member to both A&E departments to support the ward staff in managing and keeping safe those patients who have been assessed as requiring/awaiting an acute bed, and those awaiting discharge.

Rapid Response Reablement Service - support individuals living in Cheshire East with mental health support needs who are fit for discharge and are delayed due to awaiting care package and would benefit from a short-term community intervention. Two2 Mental Health Crisis Cafes Services are open to offer people (18+) a safe space if they are struggling with

emotional and psychological distress and considering themselves to be in a self-defined crisis