Cheshire East Council

NHS Cheshire Clinical Commissioning Group

CHESHIRE EAST HEALTH AND WELLBEING BOARD
Reports Cover Sheet

Title of Report:	Better Care Fund Plan 2023/24
Date of meeting:	27th June 2023
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 ☐	Discussion ☐	Decision ☐
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 2023/24. 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 ☐ 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 endorse the schemes and plan for 2023/24.		
Has the report been considered at any other committee meeting of the Council/meeting of the ICB 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 2023/24 which includes: vision for adult social care, priorities for 2023/24, governance changes, schemes for 2023/24, 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 **<u>Vision for adult social care</u>**

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 2023/24**

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, ICB 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 and the ICB's plan to consolidate and reconfigure existing pathway 2 bed-based 'step-down' and 'step-up' provision and create clusters across the Borough (with contract management and oversight by the local authority) to release funds to support alternative provision, to ensure people return directly to their homes thus improving outcomes and enhanced performance of service delivery.

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 7 day services - The Cheshire East Better Care Fund intends to implement a 7-day working plan to increase 7 day working across health and social care across the Cheshire Health and Wellbeing footprint. The refreshed national high impact change model notes in relation to seven-day working it can deliver improved flow of people through the system. For the seven-day working approach to be successful the model notes that it should consider the systems demand, capacity and bottlenecks, it should be pragmatic.

5.17 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.

5.18 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 ICB 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.

5.19 **Governance changes**

5.20 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.

5.21 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.

5.22 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.

5.23 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 ICB. 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)

5.24 **Schemes for 2023/24**

5.25 There are 22 schemes in total, of which 20 Schemes are funded through Winter pressures, iBCF and BCF for 2023-24. 2 schemes are funded directly by the local authority and the ICB:

BCF/iBCF 2023/24

Scheme ID	Scheme Name	Source of Funding	Expenditure (£)
1	**Adult Social Care Discharge Schemes from 1.1 to 1.13**		
1.1	ibcf - Increase General Nursing Assistant Capacity care at home via CCICP	iBCF	£125,000
1.2	ibcf - Transfer of Care Hub, Nurses and additional Social Workers to support discharges out of ED and out of hospital	iBCF	£300,000
1.3	ibcf - Mental Health Reablement – Rapid Response Service	iBCF	£25,000
1.4	ibcf - Assistive Technology & Gantry Hoists to reduce double handling care packages	iBCF	£50,000
1.5	Home First Occupational Therapist	iBCF	£63,000
1.6	ibcf - Carers Payments to facilitate rapid discharge	iBCF	£30,000
1.7	ibcf - St Pauls & Silk Life Hospital Discharge Support delivered via	iBCF	£120,000

	Community Voluntary Sector		
1.8	ibcf - Approved Mental Health Practitioners Cover, evenings & weekends for ECT and MCHFT	iBCF	£60,000
1.9	ibcf - Acute Visiting Service & GP out of hours	iBCF	£120,000
1.10	ibcf - Hospital Discharge Premium Payment & Prevention Scheme	iBCF	£125,000
1.11	Hospice Bed Capacity	iBCF	£90,000
1.12	Care Home Fee increase	iBCF	£1,220,549
1.13	Spot purchase beds and Cluster Model	iBCF	£1,200,000
2	iBCF Block booked beds	iBCF	£1,450,638
3	iBCF Care at home hospital retainer	iBCF	£47,250
4	iBCF Rapid response	iBCF	£613,000
5	iBCF Social work support	iBCF	£478,800
6	iBCF 'Winter Schemes	iBCF	£500,000
7	iBCF Enhanced Care Sourcing Team (8am-8pm)	iBCF	£1,025,592
8	iBCF General Nursing Assistant (within BCF Early Discharge scheme (with BRC)	iBCF	£315,000
9	iBCF Improved access to and sustainability of the local Care Market (Home Care and Accommodation with Care)	iBCF	£4,275,590
10	BCF Disabled Facilities Grant	DFG	£2,342,241
11	BCF Assistive technology	Minimum ICB Contribution	£757,000
12	BCF British Red Cross 'Support at Home' service / Early Discharge	Minimum ICB Contribution	£460,582
13	BCF Combined Reablement service	Minimum ICB Contribution	£5,084,860
14	BCF Safeguarding Adults Board (SAB)	Minimum ICB Contribution	£470,109
15	BCF Carers hub	Minimum ICB Contribution	£389,000
16	BCF Programme management and infrastructure	Minimum ICB Contribution	£968,429
17	BCF Winter schemes ICB	Minimum ICB Contribution	£588,903
18	BCF Home First schemes ICB	Minimum ICB Contribution	£19,116,250
19	BCF Trusted assessor service	Minimum ICB Contribution	£104,103
20	BCF Carers hub	Minimum ICB Contribution	£324,000
21	BCF Community Equipment service	LA Contribution ICB Contribution	£550,000 £2,112,086
22	VCFSE Grants	ICB Contribution	£182,860
			£45,684,842

5.26 **Metric performance**

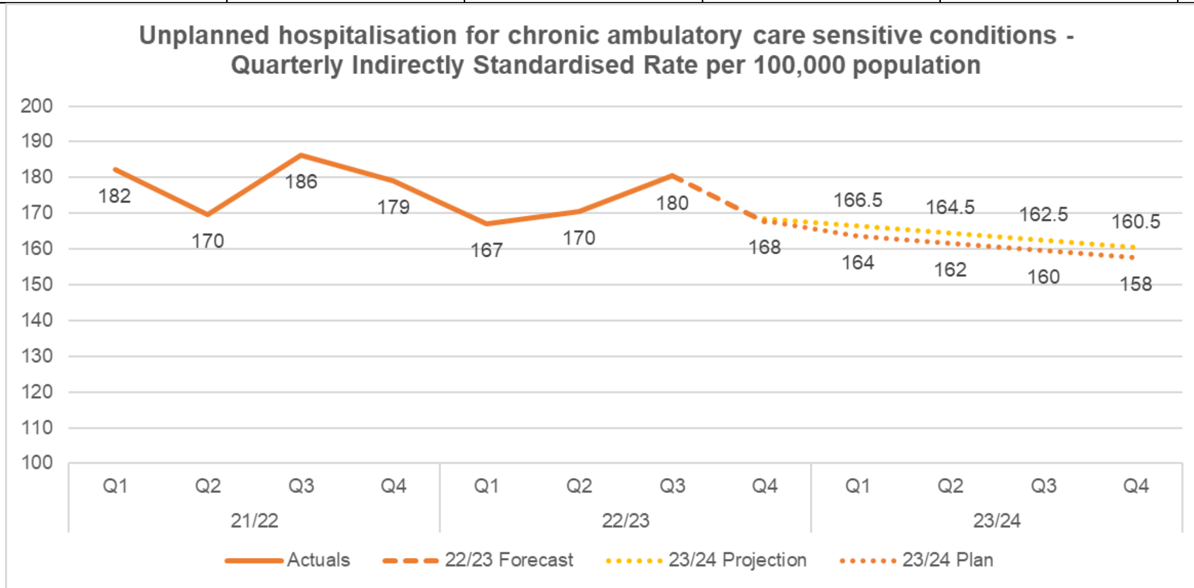
5.27 The table below includes the BCF metrics and expected performance for 2023-24:

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

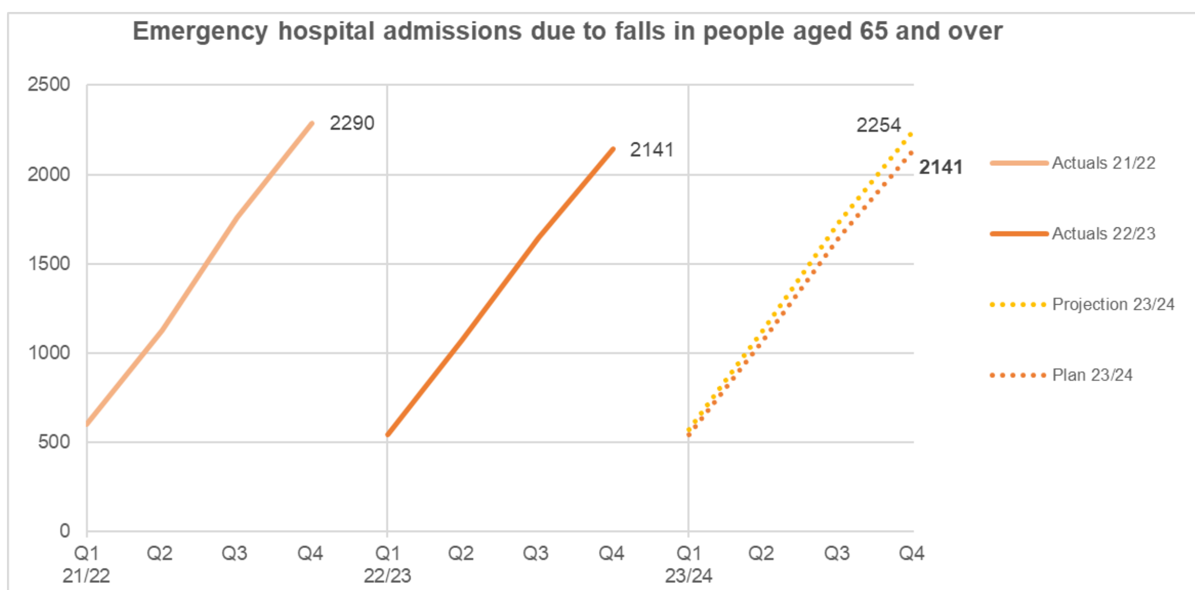
	23/24 Qtr 1	23/24 Qtr 2	23/24 Qtr 3	23/24 Qtr 4	Total

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



2. **Emergency hospital admissions due to falls in people aged 65 and over (directly age standardised rate per 100,000 population)**
   This is a new BCF metric for 23/24.

	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

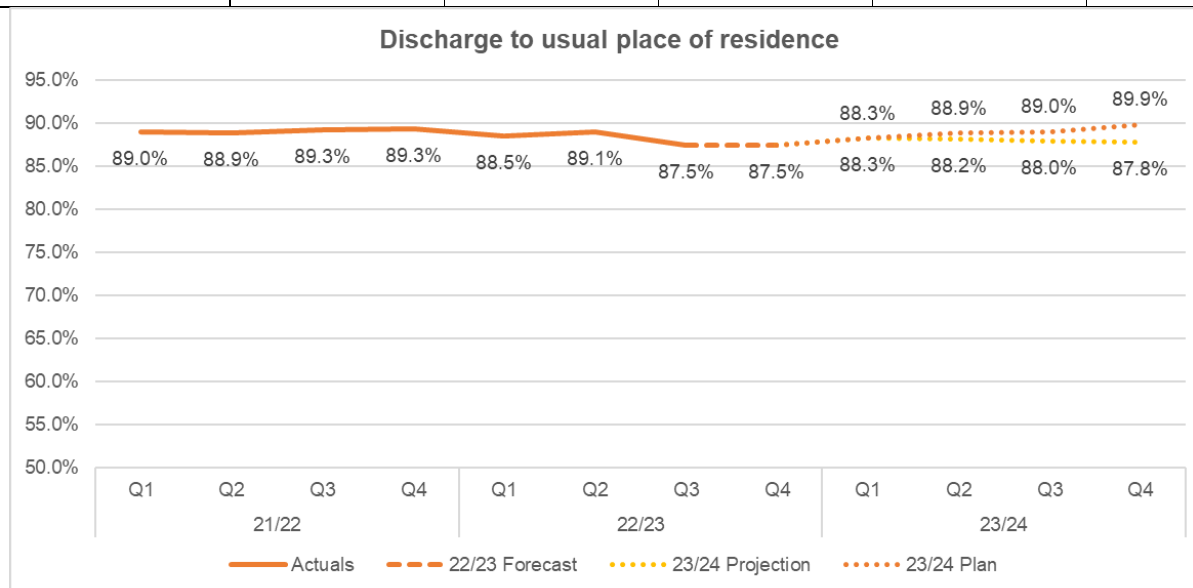


23/24 Projection – Annual directly age standardised rate per 100,000 population: **2,301.6**

23/24 Plan – Annual directly age standardised rate per 100,000 population: **2,188.5**

3. 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%

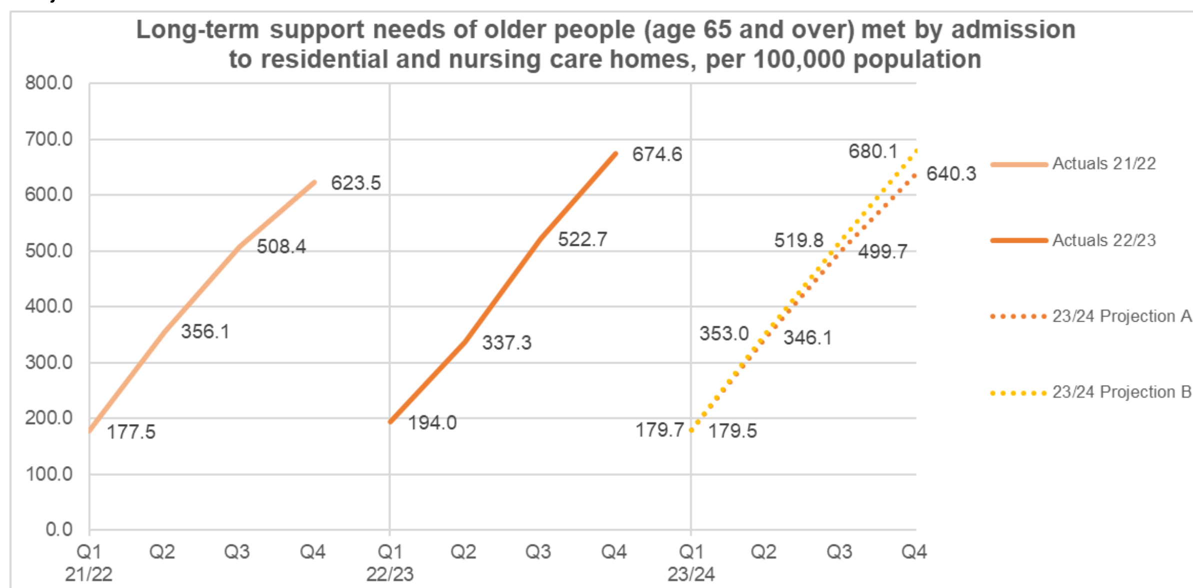


4. Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population

	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

5. Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services

Due to only having complete data for only a small part of 21/22 and 22/23, it is difficult to project forward for 23/24. An equivalent performance to the current estimated year end forecast of 83.9% is suggested. This metric is to be dropped from the Adult Social Care Outcomes Framework (ASCOF) and 2023-24 will be the last year that this data is collected in its current form.

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 ICB Contribution	£30,375,322	£30,375,322
iBCF	£8,705,870	£8,705,870
Additional LA Contribution -CES	£550,000	£550,000
Additional LA Contribution – Discharge Funding	£1,220,549	£1,220,549
Additional ICB Contribution – Discharge Funding	£2,308,000	£2,308,000
Additional ICB Contribution – Grants	£182,860	£182,860
Total	**£45,684,842**	**£45,684,842**

	Minimum Required Spend	Planned Spend
NHS Commissioned Out of Hospital spend from the minimum ICB allocation	£8,631,805	£19,758,530
Adult Social Care services spend from the minimum ICB allocations	£8,742,215	£9,141,792

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 ID	Scheme Name	Brief Description of Scheme	Expenditure (£)
1	Adult Social Care Discharge Fund 1.1 to 1.13	These schemes will support hospital prevention, facilitated discharge and the ongoing implementation of the Home First model of support and transition to the Cluster Model for bed based support A proportion of the funding will provide investment to the Care at Home market to ensure sustainability and ongoing growth.	£2,308,000 plus £1,220,549
2	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.	£1,450,638
3	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.	£47,250
4	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 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.	£613,000
5	ibcf social work support	Social Worker (x1) dedicated to the Discharge to assess beds at Station House, Crewe. Social Care Assistants (x2) additional assessment and	£478,800

		care management capacity to support the revised processes around hospital discharge using reablement exclusively for this purpose (East locality). 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. 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.	
6	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
7	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.	£1,025,592
8	iBCF General Nursing Assistant	Provide an additional 7 GNA staff within the CCICP IPOCH team for a period of 12 months. An evaluation of effectiveness will be undertaken during this period subsequent to discussion and agreement regarding permanent funding. 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. It is expected that whilst this proposal will reduce the current pressure it is not expected to eliminate the pressure and further work would be required in order to ensure sufficient and timely access to pathway 1 care.	£315,000
9	iBCF Improved access to and sustainability of the local Care Market (Home Care and	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.	£4,275,590

	Accommodation with Care)		
10	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
11	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
12	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). The commissioning responsibility for the British Red Cross services has transferred from the ICB to the local authority.	£460,582
13	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 aged 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.	£5,084,860
14	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.	£470,109

15	BCF Carers hub	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 register 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. 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.	£389,000
16	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. At this planning stage this project includes any funds yet to be allocated (approx. £500k)	£968,429
17	BCF Winter schemes ICB	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. Each of the partners will be developing winter plans which will then form part of a place-based plan.	£588,903
18	BCF HomeFirst schemes ICB	They are evidence-based interventions designed to keep people at home (or in their usual place of residence) following an escalation in their needs and/or to support people to return home as quickly as possible with support following an admission to a hospital bed. The Home First schemes mainly support older people living with frailty and complex needs to remain independent, or to regain their independence following deterioration in their medical, social, functional or cognitive needs.	£19,116,250
19	BCF Trusted assessor service	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. 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.	£104,103
20	BCF Carers hub	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	£324,000

		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. 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.	
21	Community Equipment	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)	£2,662,086 (CEC £550,000 and ICB £2,112,086)
22	VCFSE Grants	An integrated Place Based VCFSE Grant process to led by the Council building on exiting good practice and mechanisms within the Council. Aligned to Care Communities in partnership with the VCFSE sector.	£182,860