CHESHIRE EAST HEALTH AND WELLBEING BOARD
Reports Cover Sheet

Title of Report:	Better Care Fund – Quarter 2 performance update
Report Reference Number	
Date of meeting:	23/01/2024
Written by:	Alex Jones
Contact details:	Alex.t.jones@cheshireeast.gov.uk
Health & Wellbeing Board Lead:	Helen Charlesworth-May

Executive Summary

Is this report for:	Information ☐	Discussion ☐	Decision x
Why is the report being brought to the board?	The purpose of this paper is to provide the Health & Wellbeing Board (HWB) with a summary of Quarter 2 performance for 2023/24 of the Better Care Fund.		
Please detail which, if any, of the Health & Wellbeing Strategic Outcomes this report relates to?	1. Cheshire East is a place that supports good health and wellbeing for everyone ☐ 2. Our children and young people experience good physical and emotional health and wellbeing ☐ 3. The mental health and wellbeing of people living and working in Cheshire East is improved ☐ 4. That more people live and age well, remaining independent; and that their lives end with peace and dignity in their chosen place 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.	Cheshire Health and Wellbeing Board notes and approves the performance against the following metrics: avoidable admissions, discharge to normal place of residence, falls, residential admissions, reablement. Alongside the metrics where appropriate the achievements and challenges have been noted. Finally, the report includes assumptions and supporting narrative around hospital discharge.		

Has the report been considered at any other committee meeting of the Council/meeting of the CCG board/stakeholders?	The report has been considered at the local 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.	Not applicable

1 Report Summary

1.1 The following report forms part of the monitoring arrangements for the Better Care Fund. The report notes that the system is on track to meet its targets in respect of: avoidable admissions, discharge to normal place of residence, falls, residential admissions and reablement.

2 Recommendations

2.1 Cheshire Health and Wellbeing Board notes and approves the performance against the following metrics: avoidable admissions, discharge to normal place of residence, falls, residential admissions, reablement. Alongside the metrics where appropriate the achievements and challenges have been noted. Finally, the report includes assumptions and supporting narrative around hospital discharge.

3 Reasons for Recommendations

3.1 The report forms part of the monitoring arrangements for the Better Care Fund.

4 Impact on Health and Wellbeing Strategic Outcomes

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

5 Background and Options

5.1 The following section contains the local performance against a range of national metrics: avoidable admissions, discharge to normal place of residence, falls, residential admissions and reablement.

1. <u>Avoidable admissions</u>

The following metric considers unplanned hospitalisations for those people where they have a chronic ambulatory care condition.

<u>Table 1 – Avoidable admissions</u>

Avoidable admissions-	For information – planned performance	For information – actual performance	Assessment of progress against the

Unplanned hospitalisations for chronic ambulatory care sensitive conditions (NHS outcome framework indicator 2.3i)	as reported in 2023-24 planning (Q1, 2, 3, 4)	for Q1	metric plan for the reporting period
	163.6, 161.6, 159.6, 157.6	180.1	On track to meet target.

Achievements - Quarter 1 actual is 16.5 (+10.1%) above the quarter 1 plan. The quarter 1 Cheshire East figure is, however, 5.3 (-2.9%) below the average of our comparator. authorities.

There has been initiatives to support avoidable admissions including carers payments to facilitate. discharge, GP out of hours support, there has been steady progress against the discharge to normal place of residence metric, falls pathway within the Urgent Community Response (UCR) service at Mid Cheshire Trust went live taking referrals for falls from North-West Ambulance Service (NWAS). The number of residential admissions is below the planned figure for the year and finally a greater proportion of people are still at home following reablement from hospital discharge.

Part of the Carers Payments to Facilitate Rapid Discharge scheme includes wellbeing. checks to the Carers via phone, email or face to face. These checks have prevented. hospital readmissions, by putting preventive services in place. A local performance dashboard shows the impact that this has had, it notes 165 referrals received across quarter 1 and quarter 2 with some 87 referrals closed during the period.

The GP Out of Hours support in ED enabling patients with primary care presentations to be streamed directly from the Emergency Department to GP Our of Hours/Urgent Treatment Centre (within hours). 6.61% of Friday to Sunday attendances in Q1 were streamed by the Out of Hours GP, this equated to a total of 343 streamed patients.

Challenges and any support needs - Quarter 1 is above the planned figure but is slightly. lower than Quarter 4. The following activities were identified as contributing to achieving. the planned reductions: Assistive technology and specialist equipment; GP out of hours 7 Days per week; Night Sitters; ARI Hubs - Alsager & Knutsford; and Additional Urgent Community Response capacity. There have been some operational challenges in the first. quarter with some of these schemes but plans to bring these back on track are in place and these should still have the anticipated impact on the metric.

2. Discharge to normal place of residence

The following metric considers how effective we are at discharging people to their normal place of residence.

Table 2 – Discharge to normal place of residence

Discharge to normal place of residence - Percentage of people who are discharged from acute hospital to their normal place of	For information – planned performance as reported in 2023-24 planning (Q1, 2, 3, 4)	For information – actual performance for Q1	Assessment of progress against the metric plan for the reporting period

residence			
	88.3% 88.9% 89.0% 89.9%	88.98%	On track to meet target.

Achievements - July performance is 89.7% which is above target. There has been steady improvement on this metric over the past 12 months helped by investment in the Care at Home market which has seen a significant increase in capacity: as at the end of August, there had been a 21% increase in the number of hours delivered compared to the same point in the previous year. Wait Lists for Home Care have also been vastly reduced.

Challenges and any support needs - The domiciliary care market is a fragile resource, Providers have informed local authorities of their concerns regarding financial sustainability with major challenges including Workforce issues recruitment & retention, Rurality of the Cheshire footprint - Rising fuel costs

3. Falls

The following metric considers hospital admission as a result of a fall for those aged 65 and over.

Table 3 – Falls

Falls - Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000	For information – planned performance as reported in 2023-24 planning	For information – actual performance for Q1	Assessment of progress against the metric plan for the reporting period
	2,188.5	564.50	On track to meet target.

Achievements - The falls pathway within the Urgent Community Response (UCR) service at Mid Cheshire Trust went live taking referrals for falls from North-West Ambulance Service (NWAS). Falls Awareness week held 18-24 September 2023. Community therapy CPD Falls session completed.

4. Residential admissions

The following metric considers the rate of admissions to residential care.

Table 4 – Residential admissions

Residential admissions - Rate of permanent admissions to residential care per 100,000 population (65+)	For information – planned performance as reported in 2023-24 planning	For information – actual performance for Q1	Assessment of progress against the metric plan for the reporting period
	680	662.60	On track to meet target.

Achievements - The annual rate, as at the latest month, is 1.0 below the planned rate. This equates to 1 admission below the planned number. The current projected end year rate is 662.6

Challenges and any support needs - Demographic changes in Cheshire East that are seeing an increasing older population compared to the national picture, particularly in the upper age bands who are more likely to require their needs to be met via a permanent placement.

5. Reablement

The following metric considers effectiveness of a reablement/rehabilitation intervention following hospital discharge.

Table 5 – Reablement

Reablement - Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/ rehabilitation services.	Q2 performance	Assessment of progress against the metric plan for the reporting period
	83.9%	On track to meet target.

Achievements - Performance is 3.8 percentage points above the same quarter last year and is above the 23/24 plan percentage. Local performance information shows that the reablement service has seen the following demand: community reablement year to date referrals 803, mental health reablement 1464 referrals and dementia reablement 454 referrals.

Work completed over the past 8 months in preparation of the go-live date for Urgent Crisis Response, Virtual Ward, End of Life, Emergency Department discharge is as follows:

- Actively engaged in the integrated steering group/workshops including the Big Conversation working with partners across the wider system of the delivery model to establish next steps.
- Task & Finish Group to align the General Nursing Assistants in the Integrated Partnership of Care Hub [IPOCH] competencies with Reablement Workers and East Cheshire Health Care Assistants providing a more streamlined integrated model.
- Complete Train the Trainer Competency training for Reablement Seniors who cascaded the competencies and observe/sign off in practice all Reablement & Mobile Night Workers.
- Seniors trained in Trusted Assessor to prescribe and order low level OT equipment.
- Procure and have End of Life Partnership deliver End of Life training.
- Procure and train all staff on NEWS2 medical equipment including a written Service Level Agreement for the calibration of the equipment.
- Reviewed and updated in-house reporting system to streamline data capture.
- Reviewed customer brochure and amended to fit rapid response.
- Reviewed and updated the portal referral process into Liquid Logic.
- Referrals have doubled in quantity into the Reablement Service and the service covers all areas of East Cheshire.
- Retrained all staff in the Reablement ethos and delivery of support.

6. Capacity and demand

The following tables detail the hospital discharge capacity of the system.

Table 6. Hospital discharge

Hospital Discharge	Previous plan					Refreshed capacity surplus. Not including spot purchasing					Refreshed capacity surplus (including spot puchasing)				
Capacity - Demand (positive is Surplus)	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Social support (including VCS) (pathway 0)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Reablement & Rehabilitation at home (pathway 1)	-5	-4	6	5	15	-5	-4	6	5	15	-5	-4	6	5	15
Short term domiciliary care (pathway 1)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Reablement & Rehabilitation in a bedded setting (pathway 2)	-34	-28	-10	-12	-10	-34	-28	-10	-12	-10	0	0	0	0	0
Short-term residential/nursing care for someone likely to require a longer-term care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Table 7. Capacity hospital discharge

Capacity - Hospital Discharge		Prepopulated from plan:					Refreshed planned capacity (not including spot purchased capacity					Capacity that you expect to secure through spot purchasing				
Service Area	Metric	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Social support (including VCS) (pathway 0)	Monthly capacity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Reablement & Rehabilitation at home (pathway 1)	Monthly capacity. Number of new clients.	60	60	60	60	60	60	60	60	60	60	0	0	0	0	0
Short term domiciliary care (pathway 1)	Monthly capacity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Reablement & Rehabilitation in a bedded setting (pathway 2)	Monthly capacity. Number of new clients.	114	114	114	114	114	114	114	114	114	114	34	28	10	12	10
Short-term residential/nursing care for someone likely to require a longer-term care	Monthly capacity. Number of new clients.	23	21	19	19	19	23	21	19	19	19	0	0	0	0	0

Capacity and Demand Assumptions

1. We have reviewed the most recent demand levels from hospital discharge this indicates very little variation from the previous months with Cheshire Trusts overall position reduced by 1.6% against position when initial plans were developed. No refresh of C&D figures as no significant changes in demand.

2. Demand: We have predicted demand by utilising the well-established Cheshire & Mersey model. A piece of software called Stella Architect reworks 2023/24 acute planned discharges into predicted demand for Place Community Intermediate Care services. Assumptions are then applied using a 2022/23 baseline for discharge pathway utilisation, step-up activity and turnaround within community services.

3. Capacity: An assessment is then made of the predicted demand vs the capacity in caseload/occupancy as opposed to activity/demand. This is particularly useful as we can scenario plan reduced LOS and identify additional capacity. There is further opportunity to reverse engineer the model into activity. After the merge into ICB we are reviewing the methodology of modelling and aim to provide a consistent review across Cheshire & Mersey ICB for the next financial year.

4. The additional discharge funded schemes continue to make an impact to facilitated discharge and hospital preventions across the system. 10 of the 12 ADF schemes are now operational and the other 2 are planned for the Winter period. The Adult Social Care schemes have had a positive improvement on the NCTR and Length of Stay performance figures within each hospital, which is evidenced through the UEC metrics.

5. The outcome from our acute bed base modelling is forecasting that there is insufficient acute bed capacity at Mid Cheshire Hospital foundation Trust (MCHFT)and East Cheshire Trust (ECT). The acute bed base short fall is due to the ongoing RACC issues at MCHFT and the return of Maternity at ECT. It should be noted that the BCF and Local Authority are not able to financially mitigate the identified acute bed base shortfall. The system is also experiencing capacity gaps within Primary Care and ongoing congestion challenges within our ED departments. Ongoing planning and mitigation work continues with system partners to identify how the system can pragmatically address the capacity gaps going forward.

6. Overall gaps in information across C&M linked to national data recording of discharge pathway routes from hospitals. C&M wide dataset for intermediate care currently being developed.

7. For pathway 1 where demand exceeds capacity the General Nursing Assistant service will bridge the gap. in addition to this for pathway 2 demand will be met by using additional spot purchase beds via the Integrated Care Board funding stream as allocated through the BCF plan. Some additional

system mitigations focused on avoidable admissions to hospital or to enable discharges are as follows: Weekend discharges – staffing contingency fund allocated to support weekend discharges at times of increased system pressure to ensure capacity and flow, additional consultant-led discharge team in the acute providers. Where there is a lack of acute hospital beds the following mitigations have been identified: cancellation of lowest risk elective procedures to release bed capacity, enact spot purchasing of discharge to assess bed capacity across existing d2a cluster model, deployment of winter ward escalation capacity.

There are a number of schemes and plans focused on the winter period to add resilience these include: adult social care investment fund, better care fund winter schemes, local authority urgent and emergency care support grant, Cheshire and Wirral partnership mental health plans, east Cheshire trust winter plan, mid-Cheshire trust winter plan, we are also supporting discharge through a range of third sector schemes: British Red Cross. Finally, we have been exploring how virtual wards can support care homes, the homes would have access to experienced consultants with direct access to them for 7 day, alongside this we are also strengthening the use of the Urgent Care Response Service.

6 Access to Information

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

Name: Alex Jones
Designation: Better Care Fund Programme Manager
Tel No: 07803846231
Email: Alex.t.jones@cheshireeast.gov.uk