CHESHIRE EAST HEALTH AND WELLBEING BOARD
Reports Cover Sheet

Title of Report:	Better Care Fund end of year analysis (2023-24) and plan for 2024-25
Report Reference Number	HWB61
Date of meeting:	24/09/2024
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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 x
Why is the report being brought to the board?	The following report provides an end of year overview of the Cheshire East Better Care Fund plan for the period 2023-24. In addition to this the report outlines the plan for 2024-25 which is a continuation of the plan agreed for 2023-25.		
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.	The Health and Wellbeing Board is asked to note the progress made during 2023-24 and agree the plan for 2024-25.		

Has the report been considered at any other committee meeting of the Council/meeting of the CCG board/stakeholders?	The following report has separately been distributed to the Better Care Fund Governance Group.
Has public, service user, patient feedback/consultation informed the recommendations of this report?	No
If recommendations are adopted, how will residents benefit? Detail benefits and reasons why they will benefit.	Not applicable.

1 Report Summary

1.1 The following report provides an end of year overview of the Cheshire East Better Care Fund plan for the period 2023-24. In addition to this the report outlines the plan for 2024-25 which is a continuation of the plan agreed for 2023-25.

1.2 The following report summarises the performance of the better care fund during 2023-24 with specific reference to the discharge fund. The report includes narrative from the 23-25 plan, better care fund priorities, notable achievements, scoring of schemes, schemes which have been cancelled, metric performance to date, new schemes, expenditure, and planned schemes for 2024-25.

2 Recommendations

2.1 That the Health and Wellbeing Board notes the performance for 2023-24 and approves the plan for 2024-25.

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 Strategic Outcomes

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

5 Background and Options

5.1 Narrative update from 23-25 plan

5.2 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, Cheshire and Merseyside 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 priorities.

5.3 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.

5.4 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.

5.5 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.

5.6 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.

5.7 **Better Care Fund priorities**

5.8 The Better Care Fund priorities are noted as follows:

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.

5.9 **Notable achievements from discharge fund**

5.10 Outlines the investment, objectives, impact and outcomes of each of the below schemes currently funded:

1. Assistive Technology & Gantry Hoists to reduce double handling care packages
2. East Cheshire NHS Trust ED/GP out of hours 7 Days per week
3. Carers Payments to Facilitate Rapid Discharge
4. Integrated Community for the Community and Discharge Support Team
5. Hospital Discharge Premium Payment & Prevention Scheme (Winter Support - Oct 2023 to Mar 2024)
6. Increased General Nursing Assistant Capacity care at home via Central Cheshire Integrated Care Partnership (CCICP)
7. Transfer of Care Hub, Nurses and additional Social Workers to support discharges out of ED and out of hospital
8. Approved Mental Health Professional Cover, evenings & weekends for ECT and MCHFT
9. Mental Health Rapid Response Outreach
10. Home First Occupational Therapist
11. CAH Investment Increase 2023/24 Non-Recurrent
12. Hospice Beds (Winter Support - Oct 2023 to Mar 2024)

5.11 **Scoring schemes from 2023-24**

5.12 The 2023/24 schemes scored were against criteria noted below, this follows the process undertaken in 2023 with respect to the winter schemes:

- BCF metrics
- Strategic Goals -Will project contribute to strategic goals
- Innovation - What level of innovation can be attributed to this service/proposal, to improve health outcomes.
- Strength of evidence. What is the strongest evidence that the proposed service / intervention has a positive effect?
- Magnitude of the clinical benefit to the individual patient (compared to existing provider if relevant)
- Numbers of people that will benefit (compared to existing provider if relevant)
- Patient Acceptability e.g., service location or method of treatment (compared to existing provider if relevant)
- Quality of Life e.g., disability reduction, independence, pain reduction, improving social relationships (compared to existing provider if relevant)
- Access & Equity - enables more equitable access to health care and/or reduces health inequalities (compared to existing provider if relevant)
- Prevention - the proposal significantly reduces ill health and/or need for further health and care services (compared to existing provider if relevant)
- Only treatment or alternative N/A
- Risk of not achieving target.
- Financial Risk what is the risk if the project does not go ahead.
- Political/Reputational risk, what is the risk if the project does not go ahead
- Clinical Risk what is the risk if this service is not implemented
- Impact on other services or provider/s if goes ahead.
- Rate of return - How quickly can the project be delivered.
- Resources - how many people will be engaged in delivering the project
- Resources - what is the estimated cost of delivery (pump priming, project costs, investment)
- Estimated savings - annual
- Return on Investment- how quickly will the initial investment be paid back

5.13 **Scheme cancelled from 2023-24**

5.14 As a result of underutilisation, the following 6 schemes have been cancelled which are as follows:

ID	Scheme Name	Brief Description of Scheme	Previously entered Expenditure for 2023-24 (£)
1	East Cheshire NHS Trust ED/GP out of hours 7 Days per week	These schemes will support facilitated discharge and the ongoing implementation of the Home First model of support.	£120,000
5	Carers Payments to facilitate rapid	These schemes will support facilitated discharge and the ongoing implementation of the Home First model of	£30,000

	discharge	support.	
7	Hospice Beds (East Cheshire Hospice). (Winter Support - Oct 2023 to Mar 2024)	These schemes will support facilitated discharge and the ongoing implementation of the Home First model of support.	£90,000
15	iBCF Rapid response	The Rapid Response Service will facilitate the safe and effective discharge of service users from hospital who have been declared as medically fit for discharge but who may still have care needs that can be met in the service users' own home.	£647,328
17	iBCF 'Winter Schemes	Additional capacity to support Additional capacity to support the local health and social care system to manage increased demand over the winter period.	£500,000
30	BCF Trusted assessor service	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.	£109,995

5.15 **Schemes added for 2024/25**

5.16 The following new schemes have been added for 2024-25:

5.17 **30. Care communities (£500,000)**

5.18 This funding is on a bid basis from each of the 8 Care Communities to rapidly mobilise local initiatives that support Place strategic Priorities. Conditions of the funding are as follows:

- Applications for Funding will align to the Frailty Agenda. This can be tailored to local population health need within each Care Community but must support improvements in care and wellbeing for residents living with frailty and aligned to one or more of the Priority Target areas below
- Applications will be submitted on the attached template
- Contribute to local systems in managing demand effectively and ensure people remain safe and well. Especially over Winter months
- Projects must have an evidence base and have a clear set of metrics that can demonstrate any improvements or impact.
- Projects must also be deliverable within 2024/25
- And where possible support the system to get up stream ahead of winter.
- Plans should not duplicate existing Commissioned services but provide additionality to what is already in place or support new ways of working to improve health outcomes.
- Priority Targets: admission avoidance, falls, social isolation, dementia
- Development of integrated holistic models of care within existing resources
- Enhanced Care in Care Homes, Virtual Wards, 2 Hour Urgent Crisis Response Programmes included
- Dying well

5.19 Care Community Managers and Clinical Leads are strongly encouraged to use your Care Community Dashboards to inform the development of your local plans and metrics. Care Communities can revisit any initial schemes submitted as part of Winter Pressures and consider their relevance in the context of the BCF asks.

5.20 **31. Accident and Emergency Department in reach (£220,584)**

5.21 The service will provide 168 hours per week of support:

5.22 12 hours of support daily in each A&E site over 7 days per week, between the hours of 8am and 8pm (this could be flexed after 3-month review depending on what is required once the service commences and agreed with commissioners)

5.23 The additional rapid response capacity will only be provided within the Cheshire East footprint.

5.24 The attending staff member will be a current/new ISL employee already working in mental health/crisis services. They will have all received their mandatory training and induction and all recruitment checks including enhanced DBSs will be in place. Attending staff will be Mental Health Support Workers with foundations in:

- Safeguarding
- Mental Health and Dual Diagnosis
- Learning disabilities
- Substance Misuse
- Managing behaviours that challenge
- Conflict resolution and De escalation
- Effective Communication

5.25 **32. Residential care home competence nurse (£48,451)**

5.26 In January 2023 Central Cheshire Integrated Care Partnership (CCICP) launched a 12-month secondment project for a Competency Nurse Role which was funded by the Cheshire East Better Care Fund. The project was for a whole-time band 6 registered clinician.

5.27 The objective of the role was to reduce preventable skin damage and improve patient care to avoid unnecessary hospital admissions for elderly residents. Over the last 11 months the Competency Nurse has worked alongside care home managers and care staff to develop and deliver bespoke face-to-face training sessions providing clinical expertise and demonstrating evidenced based clinical skills and best practices to achieve this.

5.28 **33. Community Support Connectors In TOCH (£241,000)**

5.29 To provide recurrent funding for the following Communities staff, from BCF monies, in the continuance of their discharge work at Mid and East Cheshire Hospitals and support in avoidance of Adult Social Care services: 1x Senior Community Development Officer G10, 4x Community Connectors G7. The team have established themselves in each setting in September 2022, as a critical part of the Transfer of Care Hub (TOCH). With the support of the BCF funded Integrated Community Support Commission, and an array of VCSFE groups, the Community and Discharge Support Team enable discharge of patients from each location, leading to improved through put in the hospital. In addition, the wrap around support is provided in the Community leading to avoidance of readmission to hospital and increased care packages in the Community.

5.30 **34. Adult social workers linked to safeguarding (£496,717)**

5.31 The aim of this scheme will be to provide a dedicated social work function and social work assessments across a range of settings.

5.32 **35. Proportionate care (£135,134)**

5.33 The focus of this scheme is on those individuals already in receipt of double handed care, not those awaiting hospital discharge. However, it would be anticipated that NCtR would be reduced through the reduction of existing double handling packages, therefore releasing more home care hours and care agencies being better able to provide timely care for discharge. Following the anticipated delivery of savings from this scheme, it would be beneficial to capture the ongoing benefits on hospital discharge as a second phase of the scheme.

- Reduce the number of existing disproportionate packages of care with double handling, ensuring people are in receipt of proportionate care packages to meet needs safely. Reducing care packages will also release financial efficiencies for the council, contributing to the MTFS for 24-25.

- Drive the standards of manual handling up across domiciliary care agencies within Cheshire East footprint.

- Enable domiciliary care agencies to deliver single handed care competently and able to offer increased care provision with single handed care practice.

5.34 **36. Business case – Handyperson (£177,000)**

5.35 Since 2020/21 there has been on average a 10% increase in demand for the service year on year (see table below). If this trend in increased activity continues the projected total number of minor adaptations to be completed in 2024-25 is 2,523, based on a projected 10% increase on 2023/24 activity. This figure is approximate because it is based on the number of minor adaptations completed, in some cases there may be more than one minor adaptation completed for an individual.

5.36 Cheshire East residents who have minor adaptations installed within their home to enable them to live independently in their own home and/or enable safe discharge from hospital to home.

5.37 **37. HomeFirst social work support (£174,136)**

5.38 To support with the Home First programme and work alongside the care communities and virtual wards to enable people to remain at home. It is also to support those discharged home with reablement support to be reviewed quickly to ensure flow and capacity within the service.

5.39 Currently we have a bespoke reablement/ routes review team (RRTE) within Macclesfield Social work team which is 2.4 FTE Social Care Assessors and a short-term health funded Agency Social Worker. The remit grew with virtual wards having reablement input for 100 hours to support hospital avoidance and again assessment of needs for longer term care required after 72 hours.

5.40 This team are unable to meet the increased demands and are only based in one area. This proposal is to have a specific social worker for each team to increase capacity and flow. There would also be a spread of knowledge for the specific areas and closer working with the community teams. The need for qualified social workers rather than social care assessors has become apparent with the complexities of safeguarding and mental capacity issues.

5.41 **38. Reablement system investment (£420,000)**

5.42 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.

- Support Urgent Crisis Response and respond to paramedics to reduce hospital admission.
- Emergency Department discharge to home to avoid admission where identified.
- Support Frailty, Medical Assessment Unit & District Nurse Teams where a rapid response is required.

- Support Virtual Wards – frailty, palliative care, complex
- Continue with direct Reablement support, in-depth assessments, and reviews of long-term care packages.
- Work with system partners to support people by way of bridging care packages
- Increase referrals into Reablement where no care needs were previously required to maximize a return to full independence for people.
- Identify if assistive technology will benefit can be safely and effectively used to support people.
- Falls prevention – linking in with community therapy

5.43 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.

5.44 **39. Business case – Advice and signposting self-fund care (£83,281)**

5.45 Cheshire East has a high number of residents who are over the threshold in savings currently set at £23,000 to qualify for funding from the local authority for social care needs. Under the Care Act we have a duty to assess people who request an adult needs assessment to identify their eligible care needs. We also signpost and advice residents who approach the local authority for support. Additionally, we provide information on our Live Well site on available care and support. There are a significant number of residents and carers who ask for an assessment, and this does add to the demand on the operation teams. It is also an added pressure for hospital discharge where individuals and families are trying to make their own arrangements and are unfamiliar and unsure how to proceed hence resulting in delays to discharge.

5.46 The proposal would be for a grade 7 social care assessor and a grade 6 finance officer to pilot this concept for 12 months. This will be run as on an appointment basis either face-to-face, teams or telephone to minimise travel time and a timely response. This would be an effective and efficient use of staff time and as previously stated be beneficial for team waiting lists.

5.47 **40. Adult Contact Teams Service – CHC Administrator proposal (£32,432)**

5.48 An administrative worker to be within CEC CHC team working across our children and adult teams to be a main point of contact for CHC referrals and subsequent CHC assessments and outcomes.

5.49 The aims and objectives of this proposal are in line with those identified in the All Age CHC Care Review:

- Optimised timely pathways to reach care through appropriate assessments and effective partnership working within Cheshire East Council, ICB and other partner agencies including Secondary Care Services and Commissioned Providers
- Person-centred, inclusive of family, as an integral part of personalised care that includes effective and accessible communication in a timely way
- To work towards a more skilled sustainable workforce and leadership
- Continual improvement through audit, feedback received and responded to, qualitative (e.g. complaints/reviews) and quantitative measures (KPI's/performance reports)
- Care delivered within robust governance to ensure patient safety, consistent and high-quality care and provides assurance to the ICB
- Care provision to individuals is effective, affordable through right to have personalised care through best mechanisms available to ICB

5.50 **Programme activities for 2024/25:**

5.51 A number of activities are underway to improve the programme for 2024/25, this includes: Changeology support action plan project, improving the highlight report process, capacity and demand project, discharge to assess analysis project, scheme deep dive project & linking scheme performance to national metrics.

5.52 **Changeology support action plan project**

5.53 The national Better Care Support Programme commissioned Changeology to analyse capacity and demand planning capabilities across 21 Health and Social Care systems at Place level. Cheshire East Place was part of this commissioned support. The objective was to understand the barriers and identify opportunities to improve capacity and demand planning capability to enhance overall system resilience.

5.54 Changeology produced a report following a project in Cheshire East, the purpose of the report was to inform the system leaders on strategic decisions about enhancing capacity and demand planning capability to optimise and align resources with the system's operational requirements both now and in the future.

5.55 The following process was undertaken in Cheshire East: 1. Stakeholder interviews and an assessment of maturity in relation to "Managing Transfers of Care: A High Impact Change Model", (HICM). Stakeholder interviews were conducted, across senior leadership and frontline operations roles to gather insights into strengths, weaknesses, and opportunities for improvement. As part of the process, interviewee responses were also evaluated in two key areas: Firstly, their responses to interview questions were scored against key competencies related to capacity and demand planning criteria and a visual scoring matrix produced to depict the system's current resilience against what good looks like Secondly, participants were assessed on their maturity level in relation to a High Impact Change Model.

5.56 The project concluded with a range of recommendations and a action plan aligned to the following areas:

- Establishing Goals and Objectives That Align with the System Vision
- Enhancing Discharge Processes System-Wide
- The Need to Improve Resource and Utilisation Levels
- Ways of Working to Improve Communication
- Financial Understanding of Reduced Funding and Increased Demand
- IT Interoperability
- Early Discharge Planning
- Proactive Capacity and Demand Planning
- Care Transfer Hubs and Multi-Disciplinary Working to Coordinate Discharge
- Home First
- Discharge To Assess and Effective Intermediate Care
- Flexible working patterns
- Trusted assessments
- Engagement and Choice
- Improved Discharge to Care Homes
- Housing and related services

5.57 **Highlight reports**

5.58 A new highlight reporting template and reporting process has been put in place for new and existing schemes to ensure regular reporting of performance by schemes which form part of the Better Care Fund Porgramme. The highlight report considers in month spend, cumulative spend to date, in month activity, cumulative activity to date and the impact that the scheme has had.

5.59 **Capacity and demand project**

5.60 A project is underway to more readily understand the demand that we have for services and the capacity that is required to meet that demand. The first step is to map our existing system capacity, with this in mind scheme leads have been asked to provide the following information:

- What is the capacity and demand
    - Expected number of service users per month
    - Capacity of the service per month
    - Average length of stay

- Cost avoidance
    - Expected number of bed days saved

- Source of referral
    - Community
    - Hospital

- Value for money (cost per unit)

- Number of units produced (hours, bed days)

- What are the outcomes
    - Those who go onto long term services
    - No further needs

- Benchmark -how does the service compare to
    - Customer journey
    - Cost per package

- How long does it take to access the service

- Cost to the service user of the service

5.61 **Discharge to assess bed analysis project**

5.62 The system has in place a number of discharges to assess beds which form part of Pathway 2 from hospital discharge. Discharges to a community bed-based setting which has dedicated recovery support. New or additional health and/or social care and support is required in the short-term to help the person recover in a community bed-based setting before they are ready to either live independently at home or receive longer-term or ongoing care and support.

5.63 A project is underway to asses current demand for discharge to assess beds and consider the current capacity that the system has in place to ensure there is sufficient capacity in place. The project will consider the current position, the demand requirements for discharge to assess, the capacity of current pathway 2 discharge services, any alternatives and finally recommendations, considerations and next steps.

5.64 **Scheme deep dive project**

5.65 A deep dive will be undertaken into a range of services to better understand performance and effectiveness, the deep dive will cover the following components:

1. Aim and overview of the service:
    a. The purpose of the service
    b. Who the service is focused on
    c. Budget of the service
    d. The number of staff

e. How the service is accessed
f. How the service links to strategy
g. How the service links to the rest of the system
h. Overview of customer journey, including time from referral, acceptance onto service, length of service provision.

2. Overview of performance
    a. Number of packages planned per year
    b. Cost per package
    c. Cost reduction to the system
    d. Outcomes
    e. Benchmark of performance
3. SWOT analysis

5.66 The following services are in scope for a deep dive:

Scheme
1. Disabled Facilities Grant
4. British red cross 5. Carers
6. Community equipment 7. Handyperson 8. Assistive Technology & Gantry Hoists to reduce double handling care packages 9. BCF Assistive technology
10. Combined reablement / 11. Reablement system investment 11. GNA / 12.iBCF General Nursing Assistant (within BCF Early Discharge scheme (with BRC)
12. VCFSE Grants 13. St Pauls Extra Miles 14. Community Support Volunteers 15. Community Support Connectors In TOCH
16. HomeFirst social work support 17. "Adult Contact Teams Service –CHC Administrator proposal" 18. Advice and signposting self-fund care
19. Mental Health Reablement – Rapid Response Service 20. AED in reach
21. Adult social workers linked to safeguarding 22. iBCF Social work support 23. Transfer of Care Hub, Nurses and additional Social Workers to support discharges out of ED and out of hospital

5.67 **Linking scheme performance to national metrics**

5.68 We are undertaking a process to better link our scheme performance to the national metrics which form part of the better care fund. The national metrics are as follows: avoidable admissions, falls, discharge to normal place of residence and admission to residential and nursing. As part of this we have reviewed schemes and remapped them against the metrics, we have also pulled out the narrative from each scheme linking them to metrics. The next step is then to attribute local scheme performance to the national metric to understand the level of impact they are having.

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 1 - Better Care Fund planned expenditure 2024-25

	2024-25		
Running Balances	Income	Expenditure	Balance
DFG	£2,554,801	£2,554,801	£0
Minimum NHS Contribution	£32,094,566	£32,094,566	£0
iBCF	£8,705,870	£8,705,870	£0
Additional LA Contribution	£550,000	£550,000	£0
Additional NHS Contribution	£182,860	£182,860	£0
Local Authority Discharge Funding	£2,034,249	£2,034,249	£0
ICB Discharge Funding	£3,297,743	£3,297,743	£0
Total	**£49,420,088**	**£49,420,089**	**-£1**

Required Spend

This is in relation to National Conditions 2 and 3 only. It does NOT make up the total Minimum ICB Contribution (on row 33 above).

	2024-25		
	Minimum Required Spend	Planned Spend	Under Spend
NHS Commissioned Out of Hospital spend from the minimum ICB allocation	£9,120,365	£22,475,652	£0
Adult Social Care services spend from the minimum ICB allocations	£9,237,025	£9,889,815	£0

Appendix 2 - Better Care Fund schemes 2024-25

Scheme ID	Scheme Name	New/ Existing Scheme	Updated Expenditure for 2024-25 (£)
1	Approved Mental Health Professionals Cover, evenings & weekends for ECT and MCHFT	Existing	£85,000
2	Assistive Technology & Gantry Hoists to reduce double handling care packages	Existing	£50,000
3	Care at Home Investment Increase	Existing	£2,034,249
4	Home First Occupational Therapist	Existing	£126,000
5	Hospital Discharge Premium Payment & Prevention Scheme	Existing	£125,000
6	Increase General Nursing Assistant Capacity care at home via CCICP	Existing	£133,000
7	Mental Health Reablement – Rapid Response Service	Existing	£90,000
8	Integrated Community for the Community and Discharge Support Team	Existing	£120,000
9	Transfer of Care Hub, Nurses and additional Social Workers to support discharges out of ED and out of hospital	Existing	£300,000
10	iBCF Care at home hospital retainer	Existing	£49,896
11	iBCF Rapid response	Existing	£647,328
12	iBCF Social work support	Existing	£505,613
13	iBCF Enhanced Care Sourcing Team (8am-8pm)	Existing	£870,000
14	iBCF General Nursing Assistant (within BCF Early Discharge scheme (with BRC)	Existing	£332,640
15	iBCF Improved access to and sustainability of the local Care Market (Home Care and Accommodation with Care)	Existing	£6,300,393
16	BCF Disabled Facilities Grant	Existing	£2,554,801
17	BCF Assistive technology	Existing	£757,000
18	BCF British Red Cross ‘Support at Home’ service / Early Discharge	Existing	£486,651
19	BCF Combined Reablement service	Existing	£5,372,663
20	BCF Carers hub	Existing	£389,000
21	BCF Programme management and infrastructure	Existing	£541,801
22	BCF Winter schemes ICB	Existing	£500,000
23	BCF Home First schemes ICB	Existing	£19,973,121
24	BCF Carers hub	Existing	£324,000
25	BCF Community Equipment service	Existing	£550,000
26	BCF Community Equipment service	Existing	£2,231,630
27	VCFSE Grants	Existing	£182,860
28	Spot purchase beds and cluster model	Existing	£1,200,000
29	Practice Development Nurse	Existing	£58,708
30	Care communities	New	£500,000
31	AED in reach	New	£220,584
32	Residential care home competence nurse	New	£48,451
33	Community Support Connectors In TOCH	New	£241,000
34	Adult social workers linked to safeguarding	New	£496,717
35	Proportionate care	New	£135,134
36	Handyperson	New	£177,000
37	HomeFirst social work support	New	£174,136
38	Reablement	New	£420,000
39	Advice and signposting self-fund care	New	£83,281

40	Adult Contact Teams Service	New	£32,432

Appendix 3 - Better care fund performance metrics 2024-25

8.1 Avoidable admissions

*Q4 Actual not

		2023-24 Q1 Actual	2023-24 Q2 Actual	2023-24 Q3 Plan	2023-24 Q4 Plan
Indirectly standardised rate (ISR) of admissions per 100,000 population (See Guidance)	Indicator value	186.3	177.1	159.6	157.6
	Number of Admissions	925	879	-	-
	Population	400,528	400,528	-	-
		2024-25 Q1 Plan	2024-25 Q2 Plan	2024-25 Q3 Plan	2024-25 Q4 Plan
	Indicator value	129.1	120.3	129.4	121.8

This target is based on avoidable admissions data provided by Cheshire and Merseyside ICB. As advised in guidance, 0 days lengths of stay are omitted. These figures differ from those provided within the national data pack. Clarification on what is being included in the national data pack was queried at the BCF Plan and Metrics drop-in session on 04/06/24. If clarification affects the figures provided by the ICB, then the plan figures may need to be amended. The ICB information provided for different scenarios. From these scenarios, a 3% cut in the number of avoidable admissions was set as a realistic ambition.

The following schemes support our ambition to reduce avoidable admissions - Care communities - All five care communities in East Cheshire have been engaged in working with high intensity users and frailer populations to a limited extent. Proactive management of frailty within HIUs and Pts registered with a GP Practice with a frailty syndrome and within a RUB of 4 or 5. Reduce number of unplanned or crisis contacts, proactive case management through risk stratification, Reduce LOS and emergency hospital admissions, Improved Pt experience and quality of Care.

Eastern cheshire care community - Scope: Proactive management of frailty within HIUs and Pts registered with a GP Practice with a frailty syndrome and within a RUB of 4 or 5. Reduce number of unplanned or crisis contacts, proactive case management through risk stratification. Reduce LOS and emergency hospital admissions. Improved Pt experience and quality of Care

Nantwich and Rural and SMASH Care Community Scope: All HIU will be registered with a Nantwich/SMASH GP. Focus will be on high intensity users: Acute Services (ED attends/NWAS callouts), Community Services, General Practice. Aim: To reduce the number of unplanned or crisis contacts by proactively case managing a cohort of patients using an MDT model of care by identifying caseload, setting up HIU MDTs, Establishing MDT model, medication optimisation.

Crewe Care Community Scope: Working in collaboration with colleagues in the frailty team in secondary care we will produce a framework for a high-quality unified service while recognising the value of continuity of care for the most vulnerable patients and their carers. The service will be delivered in the leg club model of multi-disciplinary team working. All HIU will be registered with a Nantwich/SMASH GP. Focus will be on high intensity users. Aim: Reduction in acute presentation or Emergency admission with Care Plan in place, Reduction in presentation in crisis to out of hours teams, Reduction in the number of falls which could have been prevented, Increasing Patient and Carer satisfaction rates, Continuity of care measures – District Nurse team and in Primary Care

8.2 Falls

		2023-24 Plan	2023-24 estimated	2024-25 Plan
Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.	Indicator value	2,188.5	2,291.5	2,223.5
	Count	2,141	2186	2121
	Population	94,555	91374	91374

The 24/25 Plan is based on a 3% cut in admissions. The population figures used for 23/24 estimated and 24/25 plan are consistent with population figures currently being used in the national data pack. It has been acknowledged that the national data pack population figures require updating but this has not been possible due to capacity issues but are due to be updated following the reporting round. When the updated figures are available, this may slightly change the Plan figure.

The following schemes are focused on meeting our ambition:

- Falls prevention classes - Our gentle exercise programme is suitable for anyone over 65, who is looking to improve strength, balance and mobility. the person will first attend an initial assessment with one of our qualified Health & Wellbeing Coaches before joining a class. The person will then work with them to learn exercises that will help the person feel more stable. The programme lasts for 26 weeks and are held once a week for 60 minutes. The simple exercises are designed for older adults and are adaptable to match all abilities and circumstances. Most of them can be done seated if required.
- Competency Nurse has worked alongside care home managers and care staff to develop and deliver bespoke face-to-face training sessions providing clinical expertise and demonstrating evidenced based clinical skills and best practices to achieve this.
- 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. This will entail: Increasing the independence of people living with long term conditions and complex care, supporting carers to maintain their caring role.Improving access to the right service at the right time. The scheme will continue to support the existing assistive technology services. But will also involve piloting assistive technology support for adults with a learning disability (both living in supported tenancies and living in their own homes). Assistive technology has predominately been focused on maintaining the independence of older people in a community setting.
- Finally a Joint Strategic Needs Assessment - A review of falls across Cheshire East Led by Cheshire East Council and the NHS was carried out in August 2023, this told us the following: Who is at risk of falling, Who and how many people might be at risk of falling in the future, What support services are in place to help stop people falling, What support services are needed but not yet provided, Which communities and organisations may be able to work together to fill the gaps.
- The support available in Cheshire East is as follows:
    - One You Cheshire East – Stand Strong classes for anyone looking to improve their strength, balance and mobility (https://oneyoucheshireeast.org/stand-strong/)
    - Medication reviews – To check that you are prescribed the most appropriate medicine
    - Home hazard assessments – Undertaken by occupational therapists who check for hazards in the home

- Free NHS eye tests – Available to all adults aged 60 and over
- Assistive technology – These include a range of electronic gadgets to help you live independently in your own home such as a pendant alarm
- Fire service safe and well checks – The fire service also provide advice on slips, trips and falls as part of wider health and fire safety checks. Must be referred to by a partner organisation and are available to all adults aged 65 and over
- Other NHS services (such as podiatry)

8.3 Discharge to usual place of residence

*Q4 Actual not

		2023-24 Q1 Actual	2023-24 Q2 Actual	2023-24 Q3 Actual	2023-24 Q4 Plan
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	Quarter (%)	89.0%	89.1%	89.0%	89.9%
	Numerator	7,540	7,543	7,416	7,153
	Denominator	8,474	8,469	8,333	7,957
		2024-25 Q1 Plan	2024-25 Q2 Plan	2024-25 Q3 Plan	2024-25 Q4 Plan
	Quarter (%)	89.4%	89.5%	88.8%	89.1%
	Numerator	7,997	8,028	8,057	7,976
	Denominator	8,950	8,973	9,078	8,952

Although there has been a small improvement on 22/23 performance. Cumulative performance in 23/24 is still 4.3 percentage points below the national position, which is the same as the gap last year. The plan is to improve the reporting rate which is currently below the C+M average (92.6%), currently expected to achieve 89.2% by March 2025 with a plan to reach 89.1% by March 2025.

The following services support our ambitions to increase discharge to usual place of residence:

- Assisted Discharge Service - From April 23 – December 23, 835 people were referred to the Assisted Discharge Service. 12 referrals were declined due to not meeting the referral criteria.
- Support at Home - From April 23 – December 23, 715 people have been referred to the Support at Home service. Some referrals were declined due to not meeting the criteria, some were declined by the service user and 37 were declined due to service capacity. 630 of the 715 people referred were accepted and received services. 106 individuals had previously received support from British Red Cross.
- Reablement - BCF Combined Reablement service - Community Reablement Service has worked on the Home First Agenda over the past 12 months to provide:
    - A concise assessment of people`s need using a person-centred, holistic approach and Reablement ethos.
    - To support Pathway.1 discharges to reable back to independence or complete an holistic care need assessment including Trusted Assessors to prescribe low level equipment to aid mobility and independence.
    - To help prevent hospital admission working with Urgent Community Response and Virtual Wards aimed at supporting someone in a health crisis reabling back to independence over a 72hour – 2-week period, working holistically to enable the person to access other services identified such as volunteers, Carers Scheme, Community Connectors. This also includes any long-term assessment of need.

- The service has aligned with the General Nursing Assistant and a joint competency training pack has been designed this includes staff now trained to provide low-level health tasks such as NEWS2, First line dressing.
- Worked with Leighton Pharmacy to develop a medication process and risk assessment for safe transfer of medication after discharge to reduce the delay in discharge when under extreme pressures and a competency framework for medication.
- Mobile Nights working with the Out of Hours District Nurse Teams and Emergency Department to respond to supporting people home overnight and emergency call outs overnight.
- Worked with people in pathway.2 in a bedded unit to prepare discharge home into reablement.
- Created a new senior role who works in the Transfer of Care Hub at Leighton Hospital to manage and facilitate hospital discharges into reablement, including Home Visits prior to discharge, introducing the service for a smooth transition home, ensuring any equipment and medication is ready to avoid any discharge delays.
- Worked with the End-of-Life Partnership to provide palliative care competencies
- Continued to develop the skills of the team in providing therapy exercises.

- GNA - Expand GNA service to continue to support bridging patients awaiting domiciliary care at home in the East locations of Cheshire East. Patients continue to be discharged earlier from acute settings via the GNA bridging scheme. Ongoing flow into long term services are efficient via MDT huddle working and effective links with the Brokerage Team. During Quarter 3, a total of 1573 hours of care and support were delivered, which continued to help enable and facilitate hospital discharges. During October, 572 hours of care were delivered and approximately 50% of patents go on to be independent with no long-term social care needs. In November, 564 hours of care was delivered and 33% of patients became independent after bridging package. In December, 437 hours of care was delivered and 48% went on to be independent with care needs; with a further 33% of patients became independent after bridging package. Within Quarter 3 a total of 156 patients were supported by this scheme.

8.4 Residential Admissions

		2022-23 Actual	2023-24 Plan	2023-24 estimated	2024-25 Plan
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	754.6	680.0	659.9	666.3
	Numerator	679	643	624	642
	Denominator	89,985	94,555	94,555	96,357

The estimated actual for 2023 has been analysed by single year of age and then the projected population change for each has been applied to give a starting position of 642 admissions in 24/25. In 2023/24, 76% of admissions were aged 80 or above (this was the same percentage as in 22/23). It is projected that the population for this age group will increase by 4.2% compared to last year.

We have the following services focused on meeting our ambition

- Reablement - Community Reablement Service - Reablement is a period of short-term, intensive support that is designed to help the service user manage independently following a period of illness or a fall, or if the service user have lost some of the skills, they need to maintain their independence. Support is provided in the service user's own home. Following support from the reablement service,

many people will not require any further assistance. However, if they do, a care and support plan will be developed to ensure that their needs are met.

- Mental Health Reablement Service - One in four people may experience mental health issues during their lives. Together with our health partners, the Council offers a Mental Health Reablement Service. The support focuses on coping techniques, promoting social inclusion, building self-esteem and goal setting. This may include providing support with housing, debt, low self-esteem and isolation, accessing social groups or voluntary work.
- Help people to stay at home longer through:
    - Supporting Carers so that they are able to continue in a caring role for as long as they want to and thereby decrease the number of admissions to residential care due to carer breakdown
    - Falls prevention to avoid post-fall deterioration that can lead to residential placements
    - Assistive technology that enables people to safely stay in their own home
    - Complementary Third sector offer that supports help at home tasks

Appendix 4 - Better Care Fund scheme performance 2023-24

Scheme ID	Scheme Name	New/ Existing Scheme	Updated Expenditure for 2024-25 (£)
1	Approved Mental Health Professionals Cover, evenings & weekends for ECT and MCHFT **Scheme Description** - Timely Mental Health Act assessments which will impact upon person, family/ carers, psychiatrists, CWP, ED departments, police, and other partnership agencies. **Spend** - In total, this scheme received an allocation of £60,000. Of this allocation £62,331.66 has been spent during 2023/24. **Impact** – The Approved Mental Health Professional is working 3 x 2-10 shifts in the week and Saturday and Sundays 10-6 to support these more challenging times. These assessments commence typically later in day from approx. 4pm and before EDT handover ensuring continuity in response from service from day to out of hours. During Quarter 3, this scheme has supported 28 cases. The AMHP continues to make a significant contribution to the delivery of MHA assessments on a timely basis. The average number of weekly assessments for 2023 was 16 which compares to the pre-covid average of 11, a percentage increase of 45%. Demand on the service remains high. The AMHP cover supports both the day time and evening/night/weekend service delivered by EDT. Between February 2023 and Dec 2023, the AMHP undertook 57 assessments.	Existing	£85,000
2	Assistive Technology & Gantry Hoists to reduce double handling care packages **Scheme Description** – To purchase additional gantry hoists to facilitate more rapid discharge from hospital. This provides an alternative to the provision of ceiling track hoists which are time consuming to deploy. **Spend** - In total, this scheme received an allocation of £50,000. **Objective** - Assistive Technology Service to promote more rapid discharge from hospital / to prevent admission. This funding will support out of hours delivery of the service through peripheral stores and will increase the range of devices that are available**.** **Impact** – The scheme has helped to decrease domiciliary care packages through the ability to use single-handed care, alongside the technology. The scheme has facilitated timely discharges from hospital for people. A Bariatric gantry was purchased to support patients with these needs when they are discharged from hospital. In Quarter 3, the scheme has assisted 26 people. The scheme will be funding key safes to support hospital discharges for	Existing	£50,000

	people, as this has been identified as area that can contribute towards delayed discharges. This is due to be rolled out shortly so an update can be provided in Q4 on its performance and impact.		
3	Care at Home Investment Increase **Scheme Description** – To ring fence the whole £1.2 million allocation of the Adult Social Care to provide a fee increase to Cheshire East Care at Home providers to ensure ongoing sustainability, growth and ongoing investment across the sector. **Spend** - In total, this scheme received an allocation of £1,200,000. This will contribute to a new pricing model for the commissioned Care at Home providers within the borough. This will also be used as an incentive to grow their customer base by 10% in the first six months of 2023/24. **Impact** – Hours delivered by Care at Home providers represented a growth of 15.46% during 2023/24. As of 20th December 2023, 12 people were awaiting Care at Home, compared to 63 on 10th April 2023. This equated to 151.25 hours of outstanding care, which demonstrates the impact the scheme has made. These figures exclude service users whose care is currently delivered by a provider who is not a Prime or Framework provider. The Council is in the process of transferring these care packages to Prime and Framework providers as the capacity becomes available.	Existing	£2,034,249
4	Home First Occupational Therapist **Scheme Description** – The role of the Occupational Therapist (OT) is a project which is part of the implementation of the Home First model across Cheshire East place and will have a primary focus on specific tasks to ensure that we continue to keep people at home following an escalation in their needs and/or to support people to return home as quickly as possible, with support. **Spend** - In total, this scheme received an allocation of £63,000. The full amount has been spent on the recruitment of this role. Which is a fixed term contract until 31st March 2024 (Full-time Band 6). **Impact** – During Quarter 3, 80 people have been supported through the scheme. Timely assessments that may not be able to reduce care however it quickly identifies long term care needs and refer on and provide assessment for social care team preventing delays in moving people in. There are now 76 General Nursing Assistants (GNA) and ongoing work to support with a rehab approach to care.	Existing	£126,000
5	Hospital Discharge Premium Payment & Prevention Scheme Hospital Discharge Premium Payment & Prevention Scheme	Existing	£125,000

	(Winter Support - Oct 2023 to Mar 2024) – Repurposed to: Cheshire East Council Community Support Connectors in TOCH (NHS Trusts) Scheme Description – The Community Support Connectors can provide community support packages around hospital and care at home for Pathway 0, 1 and 2 patients; located at Mid Cheshire Hospital Foundation Trust and East Cheshire NHS Trust. Spend - In total, this scheme received an allocation of £125,000. Of this allocation £59,622.00 has been spent in 2023/24. During Quarter 3, this scheme has received referrals for and supported 396 patients with their discharge. This equates to a cost saving of at least £213,218. This is based on 1 bed costing £500 per person supported.		
6	Increase General Nursing Assistant Capacity care at home via CCICP **Scheme Description** – Expand GNA service to continue to support bridging patients awaiting domiciliary care at home in the East locations of Cheshire East. **Spend** - In total, this scheme received an allocation of £125,000. Of this allocation £93,750.00 has been spent in half one of 2023/24. **Impact** - Patients continue to be discharged earlier from acute settings via the GNA bridging scheme. Ongoing flow into long term services are efficient via MDT huddle working and effective links with the Brokerage Team. During Quarter 3, a total of 1573 hours of care and support were delivered, which continued to help enable and facilitate hospital discharges. During October, 572 hours of care were delivered and approximately 50% of patents go on to be independent with no long-term social care needs. In November, 564 hours of care was delivered and 33% of patients became independent after bridging package. In December, 437 hours of care was delivered and 48% went on to be independent with care needs; with a further 33% of patients became independent after bridging package. Within Quarter 3 a total of 156 patients were supported by this scheme.	Existing	£133,000
7	Mental Health Reablement – Rapid Response Service Service will deliver 46 hrs per week; service is supporting on average 11 people per week., Individuals with mental health support needs. This service is available support individuals 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 intervention. The service will not provide any type of clinical interventions or physical restraint in the event of physical violence. The service will not provide personal care. Follow an acute stay, the service aims to support patients with mental health support needs who would benefit from some outreach support at home to support them with medication	Existing	£90,000

	management, establishing routines, connecting with other services, welfare checks, attending health or social care related appointments and reintegrating back into their local community.		
8	Integrated Community for the Community and Discharge Support Team **Scheme Description** – Hospital facilitated discharge and home support service provided by St Paul's. Support includes: • Home welfare and health & safety checks • Follow up where necessary • Settling in and linking up • Deliver 7-day support package • Bespoke or social support to ensure maximum benefit is realised in each case • Additional support to reduce hospital admission **Spend** - In total, this scheme received an allocation of £120,000. Of this allocation £82,602.48 has been spent in 2023/24. **Impact** – In Quarter 3 the service has helped facilitate 124 discharges. This has resulted in savings of approximately £70,275. This is based on 1 bed costing £500 per person supported. Savings broken down by month for Quarter 3 – • October - £24,658 • November - £28,581 • December - £17,036	Existing	£120,000
9	Transfer of Care Hub, Nurses and additional Social Workers to support discharges out of ED and out of hospital **Scheme Description** – Increase workforce to improve assessments and onward form completion for people who are ready for discharge. Review all patients over 14 days to reduce the length of stay. **Spend** - There was a total investment of £300,000 into this scheme for 2023/24 split into £75,000 for each of the following areas: • East Cheshire Trust Transfer of Care Hub Nurses • Short Term Service East Social Workers in ED • Mid Cheshire Hospital Foundation Trust Transfer of Care Hub Nurses • Short Term Service South Social Workers in ED. Of the allocation, the spend for 2023/24 half one is £213,510. **Impact** - During Quarter 3, the scheme supported 918 discharges from hospital. In Quarter 3, the average wait for a package of care (CEC social) was 5.13 days (increase), the	Existing	£300,000

<table>
<tr><td></td><td>average wait for a package of care (IPOCH) was 3.76 days (decrease) and the average total LOS from referral to TOCH to discharge was 8.17 days.</td><td></td><td></td></tr>
<tr><td>10</td><td>iBCF Care at home hospital retainer

In total some 21 individuals , were supported to retain their current Care at Home provider who required the retainer to be extended over the 14 days, which is over 14 different providers. The hospital retainer will support a timely hospital discharge as it reduces the requirement for the package to be resent to the long-term market alongside continuity of care for the individual. In addition, it supports with discharge to normal place of residence and reduces the number of care home admissions .</td><td>Existing</td><td>£49,896</td></tr>
<tr><td>11</td><td>Routes have been delivering the Rapid Response service to support hospital discharges from East Cheshire Trust (Macclesfield Hospital).

Number of people supported from April 23 – December 23 – 211

<table><tr><td>Start Year</td><td>2023</td></tr></table>
<table><tr><th>Start Month</th><th>Clients</th></tr><tr><td>April</td><td>16</td></tr><tr><td>May</td><td>15</td></tr><tr><td>June</td><td>15</td></tr><tr><td>July</td><td>30</td></tr><tr><td>August</td><td>34</td></tr><tr><td>September</td><td>33</td></tr><tr><td>October</td><td>17</td></tr><tr><td>November</td><td>23</td></tr><tr><td>December</td><td>28</td></tr><tr><td>Grand Total</td><td>211</td></tr></table>
Hours of support provided from April 23 – December 23 – 7235 hours

<table><tr><th>Month</th><th>Hrs</th></tr><tr><td>Apr</td><td>757.42</td></tr><tr><td>May</td><td>842.75</td></tr><tr><td>Jun</td><td>717.75</td></tr><tr><td>Jul</td><td>746.25</td></tr><tr><td>Aug</td><td>889.00</td></tr><tr><td>Sep</td><td>881.08</td></tr><tr><td>Oct</td><td>900.75</td></tr><tr><td>Nov</td><td>710.75</td></tr><tr><td>Dec</td><td>789.25</td></tr><tr><td>Grand Total</td><td>7235.00</td></tr></table></td><td>Existing</td><td>£647,328</td></tr>
<tr><td>12</td><td>iBCF Social work support

In total 11 staff (10 out of 11 were agency staff) were employed</td><td>Existing</td><td>£505,613</td></tr>
</table>

	via BCF funding, supporting to date 539 new cases (anticipated to be 660 by the end of the financial period), closing 577 down (anticipated to be 700 by the end of the financial period), completing 281 assessments (anticipated to be 350 by the end of the financial period) and supporting with 23 safeguarding concerns/ inquiries (anticipated to be 25-30 by the end of the financial period), additionally they have supported duty days and wider tasks which ASC / the local authority are required to complete. There has also been an increase in COP cases, which are due to their nature complex and time consuming. As above, this covers a number of settings which includes: Station house, Stepping Hill, Leighton Hospital, Macclesfield Hospital. In previous years this scheme also provided additional capacity at Macclesfield and Leighton hospital during core hours through the weekends,		
13	iBCF Enhanced Care Sourcing Team (8am-8pm) Referral Metrics: • Care at Home referrals - 1884 (732 hospital discharges to normal place of residence) • Pathway three referrals (East Cheshire Trust) - 72 • Pathway three referrals (Mid Cheshire Trust) - 179 • 30+ discharges in one day achieved at mid Cheshire trust December 23 (new record) • Residential referrals - 1391 • Complex Care referrals 251 Brokerage Team Targets: • To obtain a first reasonable offer for Care at Home within 24 Hours • Zero-hour Care at Home wait list – achieved December 2023 Brokerage forms within Liquid Logic have replaced SharePoint to provide much richer data: • Time taken to source packages of care (identifying where the delays sit in the system) • Cost avoidance activity through negotiations • Brokerage Dashboards – live case status • Performance monitoring • eBrokerage performance reports Relationship Management • We continue to co-locate with ICB colleagues in the Transfer of Care Hubs at both East Cheshire Trust and Mid Cheshire Trust, ensuring that we continue to develop as an integrated team • Provider engagement on the eBrokerage system – improvements established, and system re-launched • Brokers attend the Care at Home provider contract meetings • Brokers contact service users directly with offers of care at home, saving valuable SW time (we will expand this offer to residential placements in due course) • Brokers starting to visit residentials homes • Brokerage will manage the Carers Hub and Carers support payments moving forward	Existing	£870,000

	Peer Review Brokerage underwent a Peer Review from Staffordshire Brokerage to assist in the modelling for the re-structuring of the team. One significant outcome was the reporting aspect from which we have learned and adopted operationally in our new brokerage form and subsequent reporting suite. In addition, the team reported that they felt there was a divide between the East and South Community Teams, and this has been recognized in the proposed new team model by having one community team based in Macclesfield Town Hall where we can address and improve culture and efficiency to become a high performing team.		
14	iBCF General Nursing Assistant (within BCF Early Discharge scheme (with BRC) 6737 care calls were delivered during Q1 of 2023/24. 1965 hours of care and support were delivered during Q2. 1573 hours of care and support were delivered during Q3. Total of 156 patients were supported by this scheme during Q3.	Existing	£332,640
15	iBCF Improved access to and sustainability of the local Care Market (Home Care and Accommodation with Care) 20.6% growth in hours delivered by commissioned Care at Home providers, exceeding 10% growth target. Currently 18,124 hours compared to 15,030 in April 2023. 19.8% increase in number of service users receiving Care at Home from a commissioned care provider – currently 1,327 service users compared to 1,108 in April 2023. 90% reduction in number of people awaiting a Care at Home package – from 139 service users on 10th April 2023 to 14 service users on 17th January 2024 91.7% reduction in hours needed on Care at Home waiting list - from 1,721.5 hours on 10th April 2023 to 143.5 hours on 17th January 2024 Care providers now inform us that they have available capacity in some areas of the Borough – this situation was unimaginable prior to April 2023. The metrics above suggest a positive impact on discharge to normal place of residence and avoidable hospital admissions since more people are able to access the care and support they need in a more timely manner.	Existing	£6,300,393
16	BCF Disabled Facilities Grant In the year to date (01/04/2023 – 31/12/2023):	Existing	£2,554,801

- 382 new Occupational Therapy referrals have been received for people who will benefit from adaptations.
- 232 new grants have been approved.
- 71 referrals have been cancelled.
- 277 disabled people have benefited from adaptations being completed in their homes.
- The financial resource needed to meet all referrals currently in the DFG scheme stands at £5.67million.

Referrals:

There has been a 15% reduction in the number of referrals from the Occupational Therapy (OT) service compared to the same period last year. The reduction in referrals can be attributed to staff vacancies in the OT service.

Approved grants:

There has been a 20% reduction in the number of approved grants compared to the same period last year, and a 12% reduction in the value of grants approved. The principal reasons for the reduction in approved grants are:

- Delays receiving permissions and asbestos management information from social landlords
- An increase in the number of extensions that require planning permission
- A shortage in capacity in the technical staff team for designing and facilitating the adaptations work

The average value of grants that have been approved is £5,357, compared to £4,868 last year and £5,558 in 2021-22.

Childrens' cases remain a small percentage of the number of referrals, but the financial impact is greater. 5.6% of approved grants year to date were for children, while expenditure was 30.5% of the budget.

Cancelled referrals:

The attrition rate for the year to date is 18.6%, compared to 20.5% in the same period last year. The reasons for attrition remain similar to previous years – principally connected to the financial assessment (either individuals not qualifying for a grant due to their financial circumstances or refusing to undertake the financial assessment).

Completed adaptations:

There is a 10% reduction in the number of completed adaptations compared to the same period last year. The reduction in the number of referrals and approved grants are both impacting on this metric.

Financial pressure:

The financial pressure has continued to build year on year, and for several years the demand has exceeded the available budget. The principal reasons for this are:

- the increased demand for adaptations with an ageing

	population and improvements in healthcare meaning people are living at home for longer; • the complexity of individuals' needs that we are meeting with higher value adaptations; • the continued inflationary increases in the construction sector; and • a reduction in the voluntary contributions received from social landlords (£303,217 year to date, compared to £530,909 in the same period last year). Summary: Delivery of the Disabled Facilities Grant scheme continues at pace, and while the metrics above would indicate a decline in performance, the metrics are restoring to a more normal level following 2 years of significant increased demand. There is still latent demand in the system, demonstrated by the financial pressure on the scheme. We don't envisage demand reducing to a level that would be within the scheme budget and we continue to highlight this to the Council as part of the MTFS process.		
17	BCF Assistive technology The provider is Livity Life – After Millbrook rebranded their Technology Enable Care service the contract was novated over. Demand for the service has continued to be high with the average number of referrals a month at 225 with installations averaging 188 per month. The below KPI's are the average from April-December 2023 • Installations - URGENT to completed within 24 hours i.e. Hospital discharges – 96% within this KPI • Installations - STANDARD to be completed within 5 working days – 98% within this KPI • Maintenance/Faults – CRITICAL within 24hours - 100% on this KPI • Maintenance/Faults – NON-CRITICAL within 7 working days – 98% within this KPI • Withdrawals - STANDARD within 7 working days - 100% on this KPI • Response – Calls answered within 180 seconds – 95% within this KPI • Response – Calls answered within 60 seconds – 86% within this KPI • Response – When a mobile response is required it will be within 45 minutes of the initial call – 96% on this KPI • Total number of Telecare clients – 2,936 at the end of December 2023	Existing	£757,000
18	BCF British Red Cross 'Support at Home' service / Early Discharge **Assisted Discharge Service** From April 23 – December 23, 835 people were referred to the Assisted Discharge Service. 12 referrals were declined due to not meeting the referral criteria.	Existing	£486,651

	Support at Home From April 23 – December 23, 715 people have been referred to the Support at Home service. Some referrals were declined due to not meeting the criteria, some were declined by the service user and 37 were declined due to service capacity. 630 of the 715 people referred were accepted and received services. 106 individuals had previously received support from British Red Cross.		
19	BCF Combined Reablement service Community Reablement Service has worked on the Home First Agenda over the past 12 months to provide: • A concise assessment of people`s need using a person-centred, holistic approach and Reablement ethos. • To support Pathway.1 discharges to reable back to independence or complete an holistic care need assessment including Trusted Assessors to prescribe low level equipment to aid mobility and independence. • To help prevent hospital admission working with Urgent Community Response and Virtual Wards aimed at supporting someone in a health crisis reabling back to independence over a 72hour – 2-week period, working holistically to enable the person to access other services identified such as volunteers, Carers Scheme, Community Connectors. This also includes any long-term assessment of need. • The service has aligned with the General Nursing Assistant and a joint competency training pack has been designed this includes staff now trained to provide low-level health tasks such as NEWS2, First line dressing. • Worked with Leighton Pharmacy to develop a medication process and risk assessment for safe transfer of medication after discharge to reduce the delay in discharge when under extreme pressures and a competency framework for medication. • Mobile Nights working with the Out of Hours District Nurse Teams and Emergency Department to respond to supporting people home overnight and emergency call outs overnight. • Worked with people in pathway.2 in a bedded unit to prepare discharge home into reablement. • Created a new senior role who works in the Transfer of Care Hub at Leighton Hospital to manage and facilitate hospital discharges into reablement, including Home Visits prior to discharge, introducing the service for a smooth transition home, ensuring any equipment and medication is ready to avoid any discharge delays. • Worked with the End-of-Life Partnership to provide palliative care competencies. • Continued to develop the skills of the team in providing therapy exercises.	Existing	£5,372,663
20	BCF Carers hub Following a recommission the new contracted provider of the Carers Hub is Making Space and the contract commenced 1st January 2023. Performance data – Jan to December 2023.	Existing	£389,000

	• 6289 adult carers & 823 young carers registered with the Hub • 1419 adult, 254 parent & 183 young carer referrals received • 652 adult statutory carers assessments completed • 370 contingency card & plans provided • The biggest sources of referrals are from carers themselves via self-referrals, also Adult Social Care, Dementia Reablement, Cheshire & Warrington Carers Trust and Health sources including social prescribers. • Adult Carers accessing support - % of interaction type: • Info & Advice Only – 1% Low – 36% Moderate – 56% High – 5% Intensive – 1% • Parent Carers accessing support - % of interaction type: • Info & Advice Only – 0.8% Low – 40% Moderate – 56% High – 3% Intensive – 0.9% • Young Carers accessing support - % of interaction type: • Info & Advice Only – 0.2% Low – 60% Moderate – 36% High – 3% Intensive – 0.4% • Outcomes following review – based on needs assessment: • 51% of adult carers showed improvement in being able to get out into the community, 41% indicated improvements in being able to maintain their home, 56% noted an improvement in being able to take part in leisure, cultural or spiritual activities, 28% indicated an improvement to their mental wellbeing and 38% to their physical health. • 116 adult and parent carers provided with a break with the Take a Break service • 165 adult and parent carer group sessions delivered – providing 730 carers with a break • 124 young carer sessions delivered – providing 523 young carers with a break • 15 training courses delivered to carers – providing them with skills in emergency first aid, infection prevention and control, safe handling of medication, basic food safety and manual handling. Hospital Discharge Scheme – Between April 23 – December 2023, 152 carers were referred to the Carers Hub for support through the Hospital Discharge Scheme. These carers were then able to support the cared for person to be able to return to their home from hospital.		
21	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. • Additional commissioning capacity might be required to support the review of existing contract and schemes and the procurement of alternative services. • To provide enabling support to the Better Care Fund programme, through programme management and other support, as required. • To develop and maintain adherence to governance	Existing	£541,801

	arrangements including the s75 agreement and commissioning capacity. • The delivery of the Better Care Fund relies on joint commissioning plans already developed across the Cheshire East Health and Social Care economy. • Submission of all financial information on time of all NHSE and other central returns. • Financial support for remedial action / development of new initiatives where needed to maximise the impact of the BCF investment (including performance against the national metrics). • Financial administration to support the BCF, invoicing etc. • Financial advice and support to scheme managers as required. • Contribution to budget papers and other reporting to governing bodies/committee as required. • Contribution to governance mechanism's such as S75 statements, BCF Governance Group. • Production of year-end information, notes to the accounts etc.		
22	BCF Winter schemes ICB This winter funding supports the systems winter flow plan. As a system we recognise that capacity and demand fluctuations occur across the year and can be planned for to manage the flow of patients safely and effectively throughout the Health & Social Care system. The Challenges noted in recent years include: unprecedented urgent care demand, new urgent care standards to achieve whilst continuing to manage the effects of the COVID pandemic, increasing issues with workforce availability, elective care backlogs and recovery trajectories, predictions of high flu circulation, Respiratory Syncytial Virus (RSV) in children and increased Mental Health demands, as well as pressures from neighbouring areas, winter illnesses and weather effects. Please note a deep dive of the following scheme is underway.	Existing	£500,000
23	BCF Home First 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. Please note a deep dive of the following scheme is underway.	Existing	£19,973,121
24	BCF Carers hub	Existing	£324,000
25/26	BCF Community Equipment service	Existing	£550,000

	The below are some of the main KPI's the provider has achieved from April-December 2023 with average compliance over this period. Actual projected spend is £5M p.a. for all partners (CEC, CWAC and CCCG) or £2.5M for just the CE area. The total spend across East Cheshire for the Council & ICB in this period - £1,915,279. Projected council spend at the end of the financial year - £520,000. • Deliveries within 1 Day (urgent) – 99% • Deliveries within Same Day (4 hours) (Critical) – 95% • Deliveries within 5 Days (standard) – 96% • Items collected within 5 Days (standard) – 95% • Items collected within 1 Day (urgent) – 87% • All routine repairs shall be completed within 5 Days – 98% • Percentage of equipment that has been recycled – 79% (generating an average £118k/month in credits) • Equipment Issue Codes – As indicated by the prescriber (cost of equipment and associated activities) • Hospital Discharge – 19.9% (cost £526,842) • Maintain without Care Package – 6.1% (cost £161,585) • Prevent Placement – 7.3% (cost £192,142) • Reduce Care Package – 0.5% (£11,908) • Maintain/Enable Independence – 21.5% (cost £569,169) • Support Formal Carers – 24.3% (cost £642,026)		/£2,231,630
27	VCFSE Grants **Mental Health Support and Interventions** Healthbox CIC - £9,221 Early intervention mental health and counselling service. It will comprise of 1 trained counsellor working part time (2 days per week) as a mental health lead and 5 placement counsellors providing 1-2-1 counselling sessions as required. This service will be targeted towards adult (18+) Cheshire East residents with low level mental health issues. Number of service users: 29, Number of volunteer hours contributed: 43. Knutsford Together - £10,000 A service to connect all those in need in Knutsford with the help they require and, when necessary, being their advocate. 100 new individuals across Knutsford will benefit up to 1st April 2024. Number of service users: 82. Time Out Group - £11,679 Together Time, is a project that improves the mental health and emotional wellbeing of adults with learning disabilities and/or autism. Together Time is a bespoke programme that helps people to explore how they feel	Existing	£182,860

	and to develop the skills they need to cope with life's challenges. Together Time will be attended by 50 adults in Wilmslow. providing 51 full day sessions, over 250 hours of contact time and 24 hours of 1-on-1 counselling. Number of service users: 234, Number of volunteer hours contributed: 197. Wilmslow Youth - £19,951 Oversight and coordination of a multi-organisational approach to referral and support for young people experiencing mental ill-health, offering three levels of support. This project will benefit 200 young people aged 11-18 living within the CHAW footprint. Number of service users: 164, Number of volunteer hours contributed: 1213. The Dove Service - £15,665 Specialist 1:1 counselling and group support across Cheshire East, with outreaches in Crewe, Congleton and Macclesfield to support those of any age, experiencing issues around grief and loss. Number of service users: 244, Number of volunteer hours contributed: 439. **Physical Health and Wellbeing** Petty Pool College - £20,000 Supporting those young people living with LD to access additional activities in Macclesfield and surrounding area to improve skills linked to Education and Health Care Plans. Number of service users: 10. Number of volunteer hours contributed: 35 Community and Voluntary Services Cheshire East - £19,965 Engaging with VCFSE Organisations in 20% Most deprived areas. This will support 20 Groups to access support and to develop walking groups in the areas to help improve health of population within these areas. Number of service users: 12 Number of volunteer hours contributed: 195. Everybody Health and Leisure - £14,339 Junior Activity Referral Scheme will target young people aged 12-18 years in Crewe and surrounding areas with long term health conditions to engage them in 12-week programme to encourage and facilitate exercise. Number of service users: 38. Down Syndrome Cheshire - £3,203 Providing opportunities for people living with Downs Syndrome in Macclesfield and surrounding areas to take part in regular, accessible, and inclusive dance classes. Number of service users: 350, Number of volunteer hours contributed: 20. Crewe Central Table Tennis Club CIC - £3,500 Deliver tailored sessions for people with long term health conditions and to expand provision to young people. This will work to support people with a range of conditions including Dementia, Parkinson’s, and physical disabilities to help manage and alleviate symptoms, enjoy achievements and raise activity levels and improve confidence. Number of service users: 20, Number of volunteer hours contributed: 214. Connecting Chelford - £4,570 Working with Care Community to engage older people to reduce isolation and loneliness. Activities including weekly friendship groups, developed a Digital Friends Scheme, First Aid in the community, Dementia Carers Support Group. Number of service users: 459, Number of volunteer hours		

	contributed: 612. Cheshire Deaf Society - £9,922.90 Health, Advice 'n' Deafness-HAnD Project- will provide support and improve engagement to reduce health inequalities experiences by the deaf community across Cheshire East. Number of service users: 23, Number of volunteer hours contributed: 4. Cheshire Young Carers - £7,982 Delivering 70 activities across 5 schools in Cheshire East to improve health of young carers to improve activity levels and develop support networks. Number of service users: 51. Central Cheshire Buddies Scheme - £7,982 CCBS supports children and young people living with a disability and their siblings delivering a range of activities to increase confidence and self-esteem and reduce social isolations through shared activities with friends and siblings. Number of service users: 56, Number of volunteer hours contributed: 324. Audlem and District Community Action - £12,310 ADCA aims to make Audlem 'dementia friendly' by delivering targeted activities, raising awareness and supporting carers. Number of service users: 48 Number of volunteer hours contributed: 540 Visual Impairments Hopes and Beams - £14,600 A peer-support and social group for young adults across South Cheshire who have sensory issues, including visual impairments and hearing loss. 50 potential users through partnership work with Cheshire East Council's Sensory Support and Communities teams. A mixture of structured and unstructured sessions within the group, allowing the users to socialise with each other, access support or learn new skills such as cooking or art. Number of service users: 8 Number of volunteer hours contributed: 63. Wishing Well - £7,000To provide additional support services to the growing drop-in sessions that are now based at Jubilee House in Crewe. Working in partnership with IRIS. To provide specialist support, particularly for those who have little to no vision. This project will benefit a minimum of 60 people across South Cheshire. Number of service users: 103, Number of volunteer hours contributed: 476.		
28	Spot purchase beds and cluster model • Centralised cluster of D2A facilities strategically positioned across Cheshire East Place have ensured that people are discharged to a D2A bed as near to their local community as possible. • 158 beds have been added to the system to ensure people are discharged from hospital for a period of further treatment, assessment, and rehabilitation. • Seamless discharge and transition to D2A beds has been achieved with the removal of unnecessary authorisation processes. • A reduction in Length of Stay has been achieved. • Transformation towards a financially sustainable model for step up and step-down beds.	Existing	£1,200,000

	• 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, creating acute bed base capacity. • Increased patient flow through the hospital. • Supporting people out of hospital, to streamline discharge to enable 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. • People require lower levels of formal care on return home due to successful period of rehabilitation. • Optimisation prior to return home increases the success rate of discharges and reduces the risk of re-admission.		
29	Practice Development Nurse	New	£58,708
30	Care communities	New	£500,000
31	AED in reach	New	£220,584
32	Residential care home competence nurse	New	£48,451
33	Community Support Connectors In TOCH	New	£241,000
34	Adult social workers linked to safeguarding	New	£496,717
35	Proportionate care	New	£135,134
36	Handyperson	New	£177,000
37	HomeFirst social work support	New	£174,136
38	Reablement	New	£420,000
39	Advice and signposting self-fund care	New	£83,281
40	Adult Contact Teams Service	New	£32,432