CHESHIRE EAST HEALTH AND WELLBEING BOARD
Reports Cover Sheet

Title of Report:	Better Care Fund plan 2025/26
Report Reference Number	HWB77
Date of meeting:	18/03/2026
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Executive Summary

Is this report for:	Information ☐	Discussion ☐	Decision x
Why is the report being brought to the board?	The report is being brought to the health and wellbeing board for consideration and approval so that the BCF plan for 2025/26 can be implemented.		
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.	That the HWB endorse the Better Care Fund plan for 2025/26.
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 a summary of the BCF planning guidance for 2025/26 which includes a shift in focus from sickness to prevention and hospital to home. The report includes an overview of the plan finances, schemes, metric targets for 2025/26.

2 Recommendations

2.1 That the HWB endorse the Better Care Fund plan for 2025/26.

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

5.0 The 2025-2026 BCF aims to shift from sickness to prevention and hospital to home, with a focus on coordinated, community-based care. It emphasises:

Care closer to home
Prevention for independent living
Use of digital technology in care

For complex needs, care should be integrated, with a "home first" approach and multi disciplinary teams.

The following objectives, metrics and national conditions have been set:

Objective 1: Shift from sickness to prevention – Support independence, prevent escalating needs, and offer proactive care, home adaptations, and carer support.

Objective 2: Support independent living and shift from hospital to home – Prevent avoidable admissions, ensure timely discharge, and reduce long-term care home placements.

Metrics for 2025-2026

- Emergency hospital admissions for over 65s
- Average discharge delay
- Long-term care home admissions for over 65s
- Additional local metrics can be set to track overall policy outcomes.

National Condition 1: Jointly agree a plan – Local authorities and ICBs must create and approve a joint plan, addressing the 3 headline metrics, local goals and funding usage.

National Condition 2: Implement BCF objectives – Improve outcomes in prevention and independent living. Plans should address demand and capacity for intermediate care services to support independent living.

National Condition 3: Comply with funding conditions – Ensure NHS contributions to Social care are met and increased by 3.9%.

National Condition 4: Oversight and support – Local areas must engage with oversight, With enhanced support for underperforming areas. The focus will be on BCF alignment, risk management, and performance improvement.

Sign-off Process: A light-touch process will be implemented to approve, conditionally approve, or reject plans based on risk.

Reporting: Quarterly progress reports with simplified templates,

5.1 Better Care Fund priorities for 2025/26

The Cheshire East Better Care Fund programme has the following priorities for 2025/26:

1. Providing more care closer to home.
2. Increasing the focus on prevention so that people are living healthier and more independent lives.
3. Harnessing digital technology to transform care.
4. Providing stability through the winter period 2025/26.
5. Reviewing our approach to Discharge to assess.

6. Ensuring that our local programme provides value for money, good outcomes, are impactful and bring about meaningful change to people's lives.

5.2 Background information

1. Providing more care closer to home.

5.3 Better Care Fund

5.4 Through the Better Care Fund, we have re-focused investment into areas that provide more care closer to the person's home. This includes greater investment into: St Paul's extra miles, British Red Cross, Reablement, General Nursing Assistant service and Reablement services.
St Pauls - Extra Miles Hospital to Home Support service provides practical support for vulnerable people leaving hospital. Funded by Cheshire East Communities, Extra Miles delivers essential services through a strong partnership with Cheshire East Community Connectors. the service offers: transport home followed by 7 days of well-being checks, help with essential shopping, support with meal arrangements, advice with emergency pendants and key safes, help with applications for Attendance Allowance and other benefits, help with access to community activities.

5.5 British red cross - Support at Home Service offer short term practical and emotional support to anyone over the age of 18 with escalating health or care needs. Support Workers help with: Practical, emotional and wellbeing support, Shopping or help to organise the delivery of shopping or meals, collecting prescriptions or ensuring prescriptions can be delivered, help to attend key medical appointments, Signposting and referring to other agencies for further support.

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

5.7 General nursing assistants - GNAs provide care and support to patients at home. This means supporting the rehabilitation of a patient as they aim towards living independently again. Examples of support offered to a patient may include: assisting with personal care and getting dressed, assisting to maintain bowel and bladder health, working alongside a patient in the preparation of light meals like sandwiches or soup, promotion of use of equipment/mobility aids, medication reminders, assistance with bowel and bladder health, assistance with catheters or stomas, support and encouragement with rehabilitation exercises, as advised by therapists.

5.8 Right at home - The Right at home service provides support to facilitate hospital discharges for those people deemed medically fit, but whom have ongoing care and support needs. The service can be implemented quickly to ensure that care packages are put in place to provide an essential pathway to support the local health and social care infrastructure.

5.9 The service will seek to prevent readmission to hospital by ensuring wrap around services are in place in the first 48 hours following hospital discharge. The Service will also provide support to Service Users with complex health needs and end of life support at a level. Through the provision of 7 day working, the service will ensure a timely response to hospital discharge to reduce delayed transfers of care and create capacity and throughput for non-elective admissions.

5.10 System Home First Programme

5.11 A collection of services commissioned and delivered by Health, Social Care - including Physical and Mental Health - and the Voluntary Sector across Cheshire East place.

5.12 These evidence-based interventions are 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.

5.13 The Home First service continues to bring together a range of professionals in our communities, including GPs, Nurses, Therapists, Medical Consultants, Support Workers, and third sector organisations, into a single integrated team working closely with families and carers. Aim is to prevent unnecessary or avoidable hospital admissions by working across the community and hospitals.

5.14 Home First priorities for 2025/26

- Care Communities, Urgent Community Response (UCR), NWAS See and Treat and pathways to UCR, Virtual Wards growth, Community Connectors and Third Sector Resilience, Carers support
- Palliative Care and End of Life Support. Understand the system offer including young people
- Dementia Support and developing community-based support models
- Care4CE Community Reablement, General Nursing Assistance and Care at Home provider growth
- Discharge to Assess scope of work
- Hospital flow – ED improvement SDEC pathways, NWAS (reducing turnaround times), NHS 111 and local Directory of Services
- Mental Health Intensive Support Team – Rehabilitation Offer, Development of a High Intensity User model of support , Community outreach including street triage and pathways
- Transfer of Care Hub and system workforce
- System Quality Improvement, Experience and Outcomes for people
- Governance, oversight, performance, and impact
- Keep Me Well care model – mapping of services and infrastructure

2. Increasing the focus on prevention so that people are living healthier and more independent lives.

5.15 Better Care Fund

5.16 Through the Better Care Fund we will be focusing on prevention so that people are living healthier and more independent lives, this work is demonstrated through our Care Communities and Neighbourhood integrated teams

5.17 The BCF funded Cheshire Care Communities schemes provide prime examples of how working collaboratively with primary care we can begin to support the three national shifts. With the additional resource, the existing platform for high intensity users can be enhanced and expanded to be able to support a wider cohort of patients across the East Cheshire care communities.

Eastern Cheshire Care Communities (Chelford, Handforth, Alderley and Wilmslow (CHAW),Bollington, Disley & Poynton (BDP), Congleton & Holmes Chapel (CHOC), Knutsford, Macclesfield)

Scope:	Proactive management of frailty within High Intensity Users HIUs and patients registered with a GP Practice with a frailty syndrome and within a Resource Utilisation Band RUB of 4 or 5
Aim:	• Reduce number of unplanned or crisis contacts, proactive case management through risk stratification. • Reduce LOS and emergency hospital admissions • Improved patient experience and quality of Care

Nantwich and Rural and Sandbach, Middlewich, Alsager, Scholar Green and Haslington (SMASH) Care Community BCF

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 a Multi-disciplinary Team (MDT) model of care by identifying caseload, setting up HIU MDTs, Establishing MDT model, medication optimisation.

Crewe Care Community BCF

Scope:	**T**he service will be delivered via a One Stop Shop frailty clinic for Crewe based on the principles of and successful delivery of the Crewe Leg Club Model of multi-disciplinary team working. All HIU will be registered 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

5.18 Objectives

Whilst each of the schemes identified a set of objectives they can be summarised in the following statements:

- The use of the risk stratification tool (resource utilisation band 4 or 5) to case find high intensity users registered with a GP* and at risk of 'progressive dwindling' including a focus on those associated with frailty and either are or will become high intensity users of health and social care resources including primary and social care.
- To proactively manage the above cohort of patients including initiation of a comprehensive assessment including a holistic approach which addresses patients wider social care needs.

5.19 Cheshire East Health and Wellbeing Board

The Cheshire East Joint Local Health and Wellbeing Strategy[1] was approved by the Cheshire East Health and Wellbeing Board in March 2023, setting out a vision 'To enable people to live a healthier longer life; with good mental and physical wellbeing; living independently and enjoying the place where they live'. The Strategy sets out a focus on:

- Tackling inequalities
- Prevention and early intervention
- Person centred actions
- Developing and delivering a sustainable, integrated health and care system

5.20 The 'Blueprint 2030' and the Care Communities operating model are key components of the aim to develop and deliver a sustainable, integrated health and care system. The 'Blueprint 2030' sets out three core components of the 2030 health and care system. These are:

5.21 Healthy Households: Our ambition for the people of Cheshire East is to live well for longer, starting within the household, where empowered and health literate individuals and families use evidence-based information and digital solutions that are readily accessible to them, to make the best choices and to support good physical and mental wellbeing in their everyday lives irrespective of age or affordability.

5.22 Healthy Neighbourhoods: Our ambition is to support neighbourhoods to build an asset-based approach, where we help people to help themselves. We want people to live as part of a community, connected to the people who are important to them and able to benefit from a range of local, flexible, high-quality services and support to help them live a good life together. This may require a radically different approach to how we work together as health and care organisations, the types of conversations we have and the willingness to distribute resources to local assets; for example our Voluntary Sector organisations are critical partners in developing healthy neighbourhoods.

5.23 Health and Care Services: Our ambition is for people to be in receipt of local provision when they require health and/or care services, creating a shift from traditional centralised provision. In so doing we will place the empowered person central to their health and care system, facilitating responses to people's urgent and planned care needs by bringing services together where traditionally they have been disparate and seeing the whole person rather than an individual condition or need.

5.24 The Care Communities are geographically aligned, local teams of individuals drawn from general practice, community health, mental health, acute trusts, social care, Public Health, the VCSFE, local Healthwatch, optometry, dentistry, and community pharmacy to focus on the local population's health and well-being and their needs; helping people to stay in good health for longer (population health). They will be key to the 'Blueprint 2030' ambitions in relation to 'Healthy Neighbourhoods' and 'Health and Care Services'

5.25 The concept of the Care Community is to support people to be in good health and when needed, to arrange care, interventions and provide innovative personalised solutions. These solutions will be co-delivered and co-produced in partnership with the local community, drawing on local assets and engaging with services more widely than traditional health and care (eg local community organisations, housing, police, fire & rescue, schools). Working in partnership is the fundamental principle to delivering not only a successful Care Community but a community that cares. The Care Community is a "team of teams" based on a registered population footprint.

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[1] https://www.cheshireeast.gov.uk/pdf/council-and-democracy/health-and-wellbeing-board/joint-health-wellbeing.pdf
The Strategy is that of the Council and the NHS Integrated Care Board.

5.26 The ‘Blueprint 2030’ and the work of the Care Communities will, in the longer term, contribute to a clinically and financially sustainable health and care system. A key aspiration of the ‘Healthy Households’ and ‘Healthy Neighbourhoods’ is a focus upon empowerment, early intervention and prevention, with the aim of reducing demand over time as the population becomes healthier and people are supported to live independently at home for longer.

5.27 The Council’s Transformation Programme is similarly focussed upon creating a sustainable organisation with reduced demand. A Target Operating Model will be defined, which will consider the relationship between residents and the Council and provide a clear strategy for the transformation plan to be formed around. It will have a focus upon the demand management within Adult and Children’s services and the alignment of these programmes will be important where it is sensible and helpful to do so.

3. Harnessing digital technology to transform care.

Strategic context

5.28 Cheshire East Digital Strategy 2022 – 2024 - One of the aims of our digital strategy is to Improve health, wellbeing & inclusion, we aim to create an area where people (individuals and communities) live well for longer; independently and enjoying the place where they live. Where all residents have the opportunity to make the most of digital technology, giving them the access, awareness, skills and confidence to participate online safely.

4. Providing stability through the winter period 2025/26.

5.29 Winter planning is a statutory annual requirement to ensure that the local system has sufficient plans in place to manage the increased activity during the Winter period and plans have been developed in partnership with Cheshire East system partners across the place. The overall purpose of the Winter plan is to ensure that the system is able to effectively manage the capacity and demand pressures anticipated during the Winter period October 2025 to 31 March 2026.

5.30 Our system plans ensure that local systems are able to manage demand surge effectively and ensure people remain safe and well during the Winter months. The planning process considers the impact and learning from last Winter, as well as continued learning to the ongoing UEC system priorities. Plans will be developed on the basis of robust demand and capacity modelling and system mitigations to address system risk.

5.31 Our system ambition is to ensure a good Winter is delivered by supporting people to remain well and as healthy as possible at home, having responsive effective services, and a system that is resilient, resolution focused and has a shared vision to deliver meaningful positive Health and Wellbeing outcomes for the population of Cheshire East

5. Reviewing our approach to Discharge to assess.

Better Care Fund

5.32 The current approach is about assessment, therapy, and rehabilitation care where people are discharged from hospital as soon as they are medically ready. It means a long-term assessment can take place at or close to home instead of waiting to be assessed in hospital.

5.33 Discharge to assess (D2A) is about funding and supporting people to leave hospital, when safe and appropriate to do so, and continuing their care and assessment out of hospital. They can then be assessed for their longer-term needs in the right place so it’s important that we have it right in Cheshire East. The current Discharge to Assess Cluster model encompasses the community footprints of East Cheshire NHS Trust and Mid Cheshire Hospitals Foundation Trust

5.34 The current operating model is delivering:

- Centralised cluster of Discharge to Assess facilities strategically positioned across Cheshire East Place
- An environment for a period of Assessment, rehabilitation and Reablement for people.
- Removal of steps, processes, and delays in the discharge process
- A reduction in Length of Stay
- Transformation towards a financially sustainable model for step up and step-down beds.
- A reduction in the risk associated with people remaining in a hospital environment and deconditioning.
- A reduction in the number of people who have No Criteria to Reside in Hospitals
- Increased discharge rates on the wards and creating acute bed base capacity.
- Increased patient flow through the hospital
- Supporting people out of hospital, to streamline discharge to enable and recovery.
- Centralise the wraparound support: Nursing, Therapy, Social Work, and GP clinical resource into key locations, reducing staff travel time and creating staffing capacity to reinvest back into the system.
- A significant reduction in the spot purchasing of bed base placements.
- Improved Health & Wellbeing outcomes for people

5.35 Options Appraisal:

5.36 The system is continually reviewing and supporting the development of the discharge to assess model across Cheshire East Place. This ranges from mapping people flow, repurposing existing funding and understanding the now and future for improvement. One option to consider is the reconfiguration of Pathway 2 Capacity and in-source it via the Local Authority and NHS.

5.37 To fully consider and understand this option, a deep dive exercise will need to be executed to explore the options and costs for bringing the model in-house. Assets and operational structure and costs would need to be considered, as part of a cost modelling exercise. This would set out the costed options of an in-house discharge to assess model vs an external operating model and demonstrate which option would offer the most effective investment, best value for money and achieve the best outcomes for people.

6. Ensuring that our local programme provides value for money, good outcomes, are impactful and bring about meaningful change to people's lives.

5.38 Better Care Fund

5.39 For all of the schemes forming part of our better care fund we will continue to collect information on: the money we have spent, the impact that this has had, the activity that has been generated and the outcomes for service users. This will help us to understand and refine our approach to ensure that schemes provide value for money. Key to this is that we understand the

unit cost for all of our local investments and what changes these have made for local people. Each scheme will provide a monthly highlight report which captures all of the key information, this will be shared with the Better Care Fund Governance Group and in-turn form part of our monitoring arrangements through the Health and Wellbeing Board and the national Better Care Fund team.

5.39 BCF finances

Cheshire East

	2025-26		
Running Balances	Income	Expenditure	Balance
DFG	£2,906,341	£2,906,341	£0
NHS Minimum Contribution	£35,754,872	£35,754,872	£0
Local Authority Better Care Grant	£10,740,119	£10,740,119	£0
Additional LA contribution	£550,000	£550,000	£0
Additional NHS contribution	£182,860	£182,860	£0
Total	**£50,134,192**	**£50,134,192**	**£0**

Required Spend

This is in relation to National Conditions 3 only. It does NOT make up the total NHS Minimum Contribution (on row 10 above).

	2025-26		
	Minimum Required Spend	Planned Spend	Unallocated
Adult Social Care services spend from the NHS minimum allocations	£9,599,588	£9,599,588	£0

5.40 BCF schemes

Scheme ID	Activity	Description of Scheme	Primary Objective	Area of Spend	Provider	Source of Funding	Expenditure for 2025-26 (£)
1	Home-based intermediate care (short-term home-based rehabilitation, reablement	Reablement	5. Reducing the need for long term residential care	Social Care	Local Authority	NHS Minimum Contribution	£ 5,752,665
2	Assistive technologies and equipment	Supporting care homes	2. Home adaptations and trusk	Social Care	Local Authority	NHS Minimum Contribution	£ 187,153
3	Housing related schemes	AT & Community equipment & Handy person	2. Home adaptations and trusk	Social Care	Local Authority	NHS Minimum Contribution	£ 334,888
4	Other	NEW business case: falls (£48k), system winter plan (£588k), falls prevention	4. Preventing unnecessary hospital admissions	Social Care	Local Authority	NHS Minimum Contribution	£ 715,888
5	Support to carers, including unpaid carers	Carers	3. Supporting unpaid carers	Social Care	Local Authority	NHS Minimum Contribution	£ 715,888
6	Wider local support to promote prevention and independence	Proportionate care	1. Provision care in those with complex needs	Social Care	Local Authority	NHS Minimum Contribution	£ 155,154
7	Home-based intermediate care (short-term home-based rehabilitation, reablement	British red cross	5. Timely discharge from hospital	Social Care	Local Authority	NHS Minimum Contribution	£ 636,651
8	Home-based intermediate care (short-term home-based rehabilitation, reablement	CHA	5. Timely discharge from hospital	Social Care	NHS Acute Provider	NHS Minimum Contribution	£ 565,384
9	Bed-based intermediate care (short-term bed-based rehabilitation, reablement	Beds short and long term	5. Timely discharge from hospital	Other	Local Authority	NHS Minimum Contribution	£ 1,288,888
10	Wider local support to promote prevention and independence	Mental health support	1. Provision care in those with complex needs	Other	Private Sector	NHS Minimum Contribution	£ 388,584
11	Wider local support to promote prevention and independence	Mental health professionals	1. Provision care in those with complex needs	Other	NHS Acute Provider	NHS Minimum Contribution	£ 85,888
12	Discharge support and infrastructure	Social workers	5. Timely discharge from hospital	Other	Local Authority	NHS Minimum Contribution	£ 246,888
13	Discharge support and infrastructure	Transfer of care hub	5. Timely discharge from hospital	Other	NHS Acute Provider	NHS Minimum Contribution	£ 388,888
14	Discharge support and infrastructure	Occupational therapists	5. Timely discharge from hospital	Other	NHS Acute Provider	NHS Minimum Contribution	£ 126,888
15	Wider local support to promote prevention and independence	Care + communities	1. Provision care in those with complex needs	Other	NHS	NHS Minimum Contribution	£ 588,888
16	Wider local support to promote prevention and independence	Volunteers	4. Preventing unnecessary hospital admissions	Other	Charity / Voluntary Sector	NHS Minimum Contribution	£ 458,153
17	Home-based intermediate care (short-term home-based rehabilitation, reablement	Homefirst	5. Timely discharge from hospital	Community Health	NHS Acute Provider	NHS Minimum Contribution	£ 28,757,855
18	Housing related schemes	Community equipment	2. Home adaptations and trusk	Social Care	Local Authority	Additional LA Contribution	£ 558,888
19	Other	Grants	4. Preventing unnecessary hospital admissions	Social Care	Charity / Voluntary Sector	Additional NHS Contribution	£ 182,858
20	Enablers and enabling integration	Programme management	1. Provision care in those with complex needs	Social Care	Local Authority	Local Authority Better Care Grant	£ 245,888
21	Other	Social workers	1. Provision care in those with complex needs	Social Care	Local Authority	Local Authority Better Care Grant	£ 1,845,175
22	Short-term home-based social care (including rehabilitation, reablement	Care at home	1. Provision care in those with complex needs	Social Care	Local Authority	Local Authority Better Care Grant	£ 8,577,348
23	Discharge support and infrastructure	Care planning	5. Timely discharge from hospital	Social Care	Local Authority	Local Authority Better Care Grant	£ 878,888
24	Disabled Facilities Grant related schemes	Disabled Facilities Grant	2. Home adaptations and trusk	Social Care	Local Authority	DFG	£ 2,906,341
25	Housing related schemes	Community equipment	2. Home adaptations and trusk	Community Health	Local Authority	NHS Minimum Contribution	£ 2,855,548

5.41 BCF metric targets

8.1 Emergency admissions

		Apr 24 Actual	May 24 Actual	Jun 24 Actual	Jul 24 Actual	Aug 24 Actual	Sep 24 Actual	Oct 24 Actual	Nov 24 Actual	Dec 24 Actual	Jan 25 Actual	Feb 25 Actual	Mar 25 Actual	Rationale for how local goal for 2025-26 was set. Include how learning and performance to date in 2024-25 has been taken into account, impact of demographic and other demand drivers. Please also describe how the ambition represents a stretching target for the area.
Emergency admissions to hospital for people aged 65+ per 100,000 population	Rate	1,498	1,536	1,471	1,466	1,503	1,390	1,525	1,525	n/a	n/a	n/a	n/a	Locally the ambition is to reduce the number of admissions, we have a number of schemes focused on admission avoidance. Community connectors - 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
	Number of Admissions 65+	1390	1,425	1,365	1,360	1,395	1,290	1,415	1,415	n/a	n/a	n/a	n/a	
	Population of 65+*	92,798	92,798	92,798	92,798	92,798	92,798	92,798	92,798	n/a	n/a	n/a	n/a	
		Apr 25 Plan	May 25 Plan	Jun 25 Plan	Jul 25 Plan	Aug 25 Plan	Sep 25 Plan	Oct 25 Plan	Nov 25 Plan	Dec 25 Plan	Jan 26 Plan	Feb 26 Plan	Mar 26 Plan	
	Rate	1,614	1,655	1,585	1,579	1,620	1,498	1,643	1,643	1,605	1,605	1,605	1,605	
	Number of Admissions 65+	1497.877	1535.593	1470.937	1465.549	1503.265	1390.116	1524.817	1524.817	1489.122	1489.122	1489.122	1489.122	
	Population of 65+	92,798	92,798	92,798	92,798	92,798	92,798	92,798	92,798	92,798	92,798	92,798	92,798	

8.2 Discharge Delays

*Dec Actual onwards are not available at time of publication

	Apr 24 Actual	May 24 Actual	Jun 24 Actual	Jul 24 Actual	Aug 24 Actual	Sep 24 Actual	Oct 24 Actual	Nov 24 Actual	Dec 24 Actual	Jan 25 Actual	Feb 25 Actual	Mar 25 Actual	Rationale for how local goal for 2025-26 was set. Include how learning and performance to date in 2024-25 has been taken into account, impact of demographic and other demand drivers. Please also describe how the ambition represents a stretching target for the area.
Average length of discharge delay for all acute adult patients (this calculates the % of patients discharged after their DRD, multiplied by the average number of days)	n/a	n/a	n/a	n/a	n/a	0.41	0.98	0.59	n/a	n/a	n/a	n/a	We have a number of schemes aimed at improving our delayed discharges: A demand and capacity review of the Discharge to assess bed base model will be completed as part the wider options appraisal review, Ensure we have full recruitment for our reablement services, Increase our general nursing assistant investment, Recommission British red cross and St Pauls extra miles services whilst increasing investment, Review our discharge to assess services and implement changes agreed by leaders, Continue to develop and manage our services through our HomeFirst programme. Discharge delays - Rapid response - The Rapid Response Care at Home service provides support to facilitate hospital discharges for those people deemed medically fit, but whom have ongoing care and support needs. The
Proportion of adult patients discharged from acute hospitals on their discharge ready date	n/a	n/a	n/a	n/a	n/a	94.2%	90.2%	90.5%	n/a	n/a	n/a	n/a	
For those adult patients not discharged on DRD, average number of days from DRD to discharge	n/a	n/a	n/a	n/a	n/a	7.0	10.0	6.2	n/a	n/a	n/a	n/a	
	Apr 25 Plan	May 25 Plan	Jun 25 Plan	Jul 25 Plan	Aug 25 Plan	Sep 25 Plan	Oct 25 Plan	Nov 25 Plan	Dec 25 Plan	Jan 26 Plan	Feb 26 Plan	Mar 26 Plan	
Average length of discharge delay for all acute adult patients	0.41	0.98	0.57	0.55	0.62	0.62	0.62	0.62	0.62	0.62	0.62	0.62	
Proportion of adult patients discharged from acute hospitals on their discharge ready date	94.2%	90.2%	90.5%	93.2%	92.2%	92.2%	92.2%	92.2%	92.2%	92.2%	92.2%	92.2%	
For those adult patients not discharged on DRD, average number of days from DRD to discharge	7.00	10.00	6.00	8.00	8.00	8.00	8.00	8.00	8.00	8.00	8.00	8.00	

8.3 Residential Admissions

		2023-24 Actual	2024-25 Plan	2024-25 Estimated	2025-26 Plan Q1	2025-26 Plan Q2	2025-26 Plan Q3	2025-26 Plan Q4		Rationale for how the local goal for 2025-26 was set. Include how learning and performance to date in 2024-25 has been taken into account, impact of demographic and other demand drivers. Please also describe how the ambition represents a stretching target for the area.
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Rate	680.0	691.8	627.2	166.0	331.9	497.9	663.8		The estimated actual for 2024 (based on data at Jan 25) has been analysed by single year of age and then the projected population change has been applied to give a starting position of 616 admissions in 25/26 (if nothing changes). In 24/25 74% of admissions were aged 80 or above.
	Number of admissions	631	642	582	154	308	462	616		
	Population of 65+*	92,798	92,798	92,798	92,798	92,798	92,798	92,798		

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 – BCF schemes 2025/26

1. Care communities

Eastern Cheshire Care Communities (CHAW, CHOC, Knutsford, Macclesfield, BDP)

- Scope: Proactive management of frailty within High Intensity Users HIUs and patients registered with a GP Practice with a frailty syndrome and within a Resource Utilisation Band RUB of 4 or 5
- Aim: Reduce number of unplanned or crisis contacts, proactive case management through risk stratification, Reduce LOS and emergency hospital admissions, Improved patient experience and quality of Care

Nantwich and Rural and SMASH Care Community BCF Application

- 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 a Multi-disciplinary Team (MDT) model of care by identifying caseload, setting up HIU MDTs, Establishing MDT model, medication optimisation.

Crewe Care Community BCF Application

- Scope: The service will be delivered via a One Stop Shop frailty clinicc for Crewe based on the principles of and successful delivery of the Crewe Leg Club Model of multi-disciplinary team working. All HIU will be registered 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

2. Volunteers and grants

VCFSE Grants - Health and Wellbeing Grants

The Health and Wellbeing Grants Programme was developed in partnership (ICB & CE) and was to help reduce health inequalities and to support the creation of a sustainable health and care system in Cheshire East.

Applications from VCFSE organisations were accepted for up to £20,000 under the following categories:

- Mental Health support and interventions - focussing on improving the mental health of the population. Proposals were to complement local provision (formal and informal support and services) and work with local services to direct to more specialist support where appropriate.
- Physical Health and Wellbeing - supporting the priority areas defined for each Place. Proposals were to complement local provision (formal and informal support and services) and work with local services to direct to more specialist support where appropriate.
- Visual Impairments – supporting those living with visual impairments by providing emotional and peer support.

The fund supported the high-level vision and aspirations of the Joint Local Health and Wellbeing Strategy to:

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

- Improve the physical and mental health and wellbeing of all of our residents.
- Help people to have a good quality of life, to be healthy and happy.

Community connectors

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.

3. Disabled Facilities Grant

The Disabled Facilities Grant provides financial contributions, either in full or in part, to enable disabled people to make modifications to their home in order to eliminate disabling environments and continue living independently and/or receive care in the home of their choice.

Disabled Facilities Grants are mandatory grants under the Housing Grants, Construction and Regeneration Act 1996 (as amended). The scheme will be administered by Cheshire East Council and will be delivered across the whole of Cheshire East.

4. AT & Community equipment & Handy person

Assistive technology

Assistive technologies are considered as part of the assessment for all adults who are eligible for social care under the Care Act where it provides greater independence, choice and control and is cost-effective for individuals. The provision of assistive technology is personalised to each individual and is integrated within the overall support plan. 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.

Community equipment

The Cheshire Integrated Community Equipment Service (ICES) provides equipment in discharge of the Council and Health's statutory duties to meet the needs of individuals. This will be delivered by commissioning a single equipment provider. Equipment is provided to adults and children when, by reason of a temporary or permanent disability or health needs, they require the provision of equipment on a temporary or permanent basis for independent living.

This includes equipment for rehabilitation, long term care and support for formal and informal carers. It is also vital for hospital discharge, hospital admission avoidance, and nursing need. Equipment is provided to Cheshire East council and Cheshire registered GP population. There are a small proportion of customers who live outside of Cheshire. The population of Cheshire is approximately 727,223 (taken from the mid-2019 ONS Population Estimates).

Handyperson

The Minor Adaptations Service (known as the Handy person service) is currently delivered by Orbitas (Bereavement Service), the Council-owned organisation (Alternative Service Delivery Vehicle). The current contractual arrangement has been in place since May 2015.

The Handyperson Service supports Cheshire East Council in meeting its statutory requirements under the Care Act 2014 for providing minor adaptations up to a maximum of £1,000 free of charge to the end user. Minor adaptations include the installation of items such as grab rails, stair rails, chair raisers.

The service supports some of Cheshire East's most vulnerable residents, including older adults and those with a disability, enabling people to live independently in their own homes for longer, in greater levels of safety.

The Handyperson Service supports the Home First Programme aim of empowering people to receive the right level of care and treatment within the comfort and familiarity of their own homes, as well as wider health and social care system priorities of helping and supporting people to age well and live independently for as long as possible through: Enabling timely and safe discharge from hospital to home, creating capacity within the acute hospital system. Enabling people to remain in their own homes for longer, therefore reducing and/or delaying the need for costly care packages, preventing the need for permanent residential care placements, and creating home care and care home capacity. Preventing unplanned hospital admission, particularly through falls.

5.Supporting care homes

Residential care home competence nurse

The objective of the role was to reduce preventable skin damage and improve patient care to avoid unnecessary hospital admissions for elderly residents.

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.

Practice development nurse

This role will focus on staff competency development and the delivery of training and education to a wide range of staff with varying experiences.

We have worked diligently to form strong collaborative relationships with care homes and elevate the standard of care for residents throughout East Cheshire.

6.Mental health support

Mental Health Reablement – Rapid Response Service

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 management, establishing routines, connecting with other services, welfare checks, attending health or social care related appointments and reintegrating back into their local community.

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.

AED in reach

To support the needs of vulnerable patients and provide resilience and support to the staff in the of Macclesfield and Leighton, it is proposed that Cheshire & Wirral Partnership NHS Foundation Trust offer additional Mental Health practitioners into both Emergency Departments and Macclesfield Section 136 suite.

Approved mental health professionals

The AMHP responds to ED assessments as a priority to alleviate wait time and pressure on the department when the day service has been unable to respond due to high volume of assessments required. Or when requests are made out of hours where a delay could occur in the wait for day time service AMHP to be allocated following a weekend admission.

8. Carers

Carers

The Cheshire East Carers Hub provides a single point of access for carers, families, and professionals. The Hub will ensure that carers have access to information, advice, and a wide range of support services to help them continue in their caring role and to reduce the impact of caring on their own health and wellbeing. Carers can registered directly with the Hub or referrals can be made by professionals, any agency or organisation, relatives, or friends.

The Hub will offer groups and activities which carers will be familiar with along with introducing new support opportunities co-produced with local carers.

9. Proportionate care

Proportionate care

The aims of this scheme are to: 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.

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.

10. GNA

General Nursing Assistant

Older people who do not meet the criteria to reside, It can be evidenced that the patients occupying this additional acute hospital capacity do not require continued Acute bed based care and do not meet the national “reason to reside” criteria. It can be further evidenced, through comparison with the recommendations set out in the paper on Achieving Quality Flow in Acute Care, that patients in parts of Cheshire are not accessing the appropriate pathway at the appropriate time. Patients who could be managed with domiciliary care packages are being cared

for in beds whilst they wait for longer term arrangements to be put in place by partners including Cheshire East Council.

The use of the £300K from the Cheshire East Better Care Fund would provide a total of 7 GNA staff with adequate clinical and managerial support and would reduce the number of patients awaiting Pathway 1 discharge by 8 patients at any one time.

Increased GNA

These additional staff would be utilised across South Cheshire and the Congleton area of East Cheshire to support patients requiring domiciliary care that would normally be delivered by Local authority.

11.Reablement

Combined reablement service

The current service has three specialist elements delivered across two teams (North and South): Community Support Reablement (CQC-registered) - provides a time-limited intervention supporting adults with physical, mental health, learning disabilities, dementia and frailty, from the age of 18 to end of life, offering personal care and daily living skills to achieve maximum independence, or to complete an assessment of ongoing needs.

Dementia Reablement - provides up to 12-weeks of personalised, post-diagnostic support for people living with dementia and their carers. The service is focused on prevention and early intervention following a diagnosis of dementia.

Mental Health Reablement - supports adults age 18 and over with a range of mental health issues and associated physical health and social care needs, focusing on coping strategies, self-help, promoting social inclusion and goal-orientated plans.

Reablement system investment

This proposal will outline the future direction of service delivery for Community Reablement which would be, to operate on a hybrid multi-disciplinary model of service delivery. This would require building in other professional roles to facilitate a stream-lined approach in terms of the offer, ensuring each role fully maximizes all opportunities both in the hospitals and community.

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

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

12.British red cross

This contract is for two services:

Cheshire East ‘Support At Home’ Service is a 2-week intensive support service with up to 6 Interventions delivered within a 2-week period for each individual. The aim is to support people who are assessed as ‘vulnerable’ or ‘isolated’ and who are at risk of admission to hospital or becoming a delay in hospital. Service users have been identified as requiring additional support that will enable them to remain independent at home, or to return home more rapidly following a

hospital admission. The interventions may include: A ‘safe and well’ phone call. A ‘follow-up visit’ within 1 working day. Help with shopping. Signposting and referring to other agencies for specialist support. The main focus of the service is on supporting people to remain at home (preventing unnecessary hospital admissions by increasing intensive support at home).

Assisted Discharge Service – Includes supported transport home from Macclesfield Hospital (or an intermediate care centre) for patients unable to utilise other modes of transport. On arrival at the individual’s home, the service will ensure that the individual is able to access their home and is able to settle within their property. This dovetails with the service above.

13.Care at home

Care at home investment increase

The funding has been used to contribute to the introduction of a new 3-tiered pricing structure for Care at Home services which reflects the differential cost of delivering services in more rural or hard to serve areas of the Borough. The new pricing structure includes financial incentives to encourage growth in community provision.

The scheme aims to increase capacity in the Care at Home sector which in turn supports the Home First approach and the Council’s aim to support people to maintain their independence for as long as possible.

Improved access to and sustainability of the local Care Market (Home Care and Accommodation with Care)

This scheme is essential in helping to manage demand, maintain Care Act compliance, protect existing key services, maintain the adult care statutory duties, whilst also enhancing NHS community and primary care services to facilitate hospital discharge. The scheme will help to promote the sustainability of adult social care and other care services.

In order to sustain and stabilise both the ‘Care at Home’ and ‘Accommodation with Care’ markets. This means transforming the care and support provided to ensure Cheshire East has greater capacity and an improved range of services to meet current and future demand.

Right at home service

The Right at home service provides support to facilitate hospital discharges for those people deemed medically fit, but whom have ongoing care and support needs. The service can be implemented quickly to ensure that care packages are put in place to provide an essential pathway to support the local health and social care infrastructure.

The service will seek to prevent readmission to hospital by ensuring wrap around services are in place in the first 48 hours following hospital discharge. The Service will also provide support to Service Users with complex health needs and end of life support at a level.

Through the provision of 7 day working, the service will ensure a timely response to hospital discharge to reduce delayed transfers of care and create capacity and throughput for non-elective admissions.

14.Beds short and long term

Spot purchase beds and cluster model

Centralised cluster of D2A facilities strategically positioned across Cheshire East Place.

Ensure that people can leave hospital within 24 hours of being identified as having no criteria to reside against the national definition.

15.Homefirst

Homefirst

'Home First' is the 'umbrella' term used to describe a collection of services commissioned by the ICB and predominately delivered by East Cheshire NHS Trust and Mid Cheshire Trust It is not currently possible to confirm the number of people supported.

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.

16.Social workers

Homefirst social workers

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.

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.

Social work support

The following scheme provides social work capacity for a number of settings which includes Station house, Stepping Hill, Leighton Hospital, Macclesfield Hospital.
The aim of this scheme will be to provide a dedicated social work function and social work assessments across a range of settings.

Advice and signposting

We have a significant number of people requesting that CEC pick up the funding costs when their savings drop below £23,000 on a weekly basis. In order to be able to forecast these demands more accurately we would benefit from getting further details from these people and our providers in Cheshire East at earlier stage.

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.

Adult contact team

An area challenge is responding in a timely and efficient way to CHC referrals for both DSTs and D2A which is growing in volume. These referrals currently are received in the Contact Teams in East and South, since October these teams have loaded 273 CHC forms and processed these as stated below the volume of requests would be higher and triaged. The initial information and if

unknown an unknown person a new case is loaded on to Liquid Logic and the referral for is passed to the appropriate operational teams. It is often complex identifying which team the most appropriate and has capacity to take this forward which is both time consuming and can lead to delays.

We have a small CHC team (1 Social Worker Grade 9, 2 Social Workers Grade 8, 1 Social Care Assessor Grade 7) under the management of the Learning Disability team practice manager which whilst effective has limited capacity so prioritises the more complex referrals. This team is currently temporary due to being an additional extra to the staffing establishment.

17.Programme management

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 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/cabinet/OSC as required.
- Contribution to governance mechanism’s such as S75 statements, BCF Governance Group.
- Production of year-end information, notes to the accounts etc.

18.Care sourcing

Care sourcing team

The service provides a consistent approach to applying the brokerage cycle and makes best use of social worker time.

The Care Brokerage team work on a rotational basis and undertake all aspects of the Brokerage cycle: from referral to awarding the care. The process is instrumental to the management of the care market by driving down rates through negotiation and the use of business intelligence data and therefore ensuring we achieve value for money services.

The Care Brokerage Team comprises of a range of employees including Integrated Commissioning Manager, Resource Manager, Senior Brokerage Officers, Brokerage Officers, and a Commissioning Support Officer.

19.Transfer of care hub

Transfer of care hub

The aim of this scheme will be to provide a dedicated social work function and social work assessments across a range of settings to support hospital discharges and to in reach into A&E/ / FPAU AMU/MAU to avoid unnecessary admissions to hospital.

20.Occupational therapists

Occupational therapists

The role of the Occupational Therapist (OT) is part of the Home First model with a primary focus on ensuring 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. The OT does this by facilitating graded leave and discharge home visits. The OT educates colleagues and teams on risk management and using specialist equipment.

They work in collaboration an engages with community teams, including community connectors, and provides training. They promote a positive approach to embracing independence. In addition, the OT reviews care packages in the community with a view of reducing the care need and therefore enabling recycling of care to help meet the demand of others. This initiative has reduced the cost of prescribed care.