

# Adult Social Care Transformation

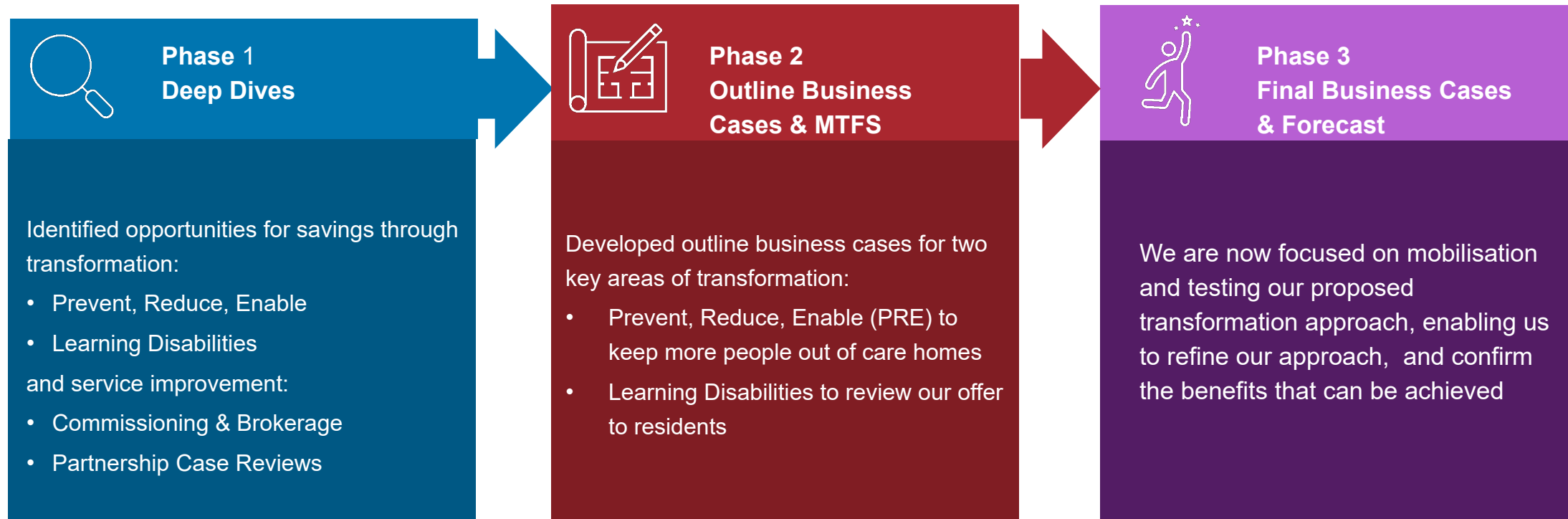
September 2025

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# Introduction | Summary of Progress

Adult Social Care has worked in collaboration with Cheshire East's transformation partner Inner Circle to design and deliver new transformation opportunities; in addition to continuing to progress existing service improvement activity.



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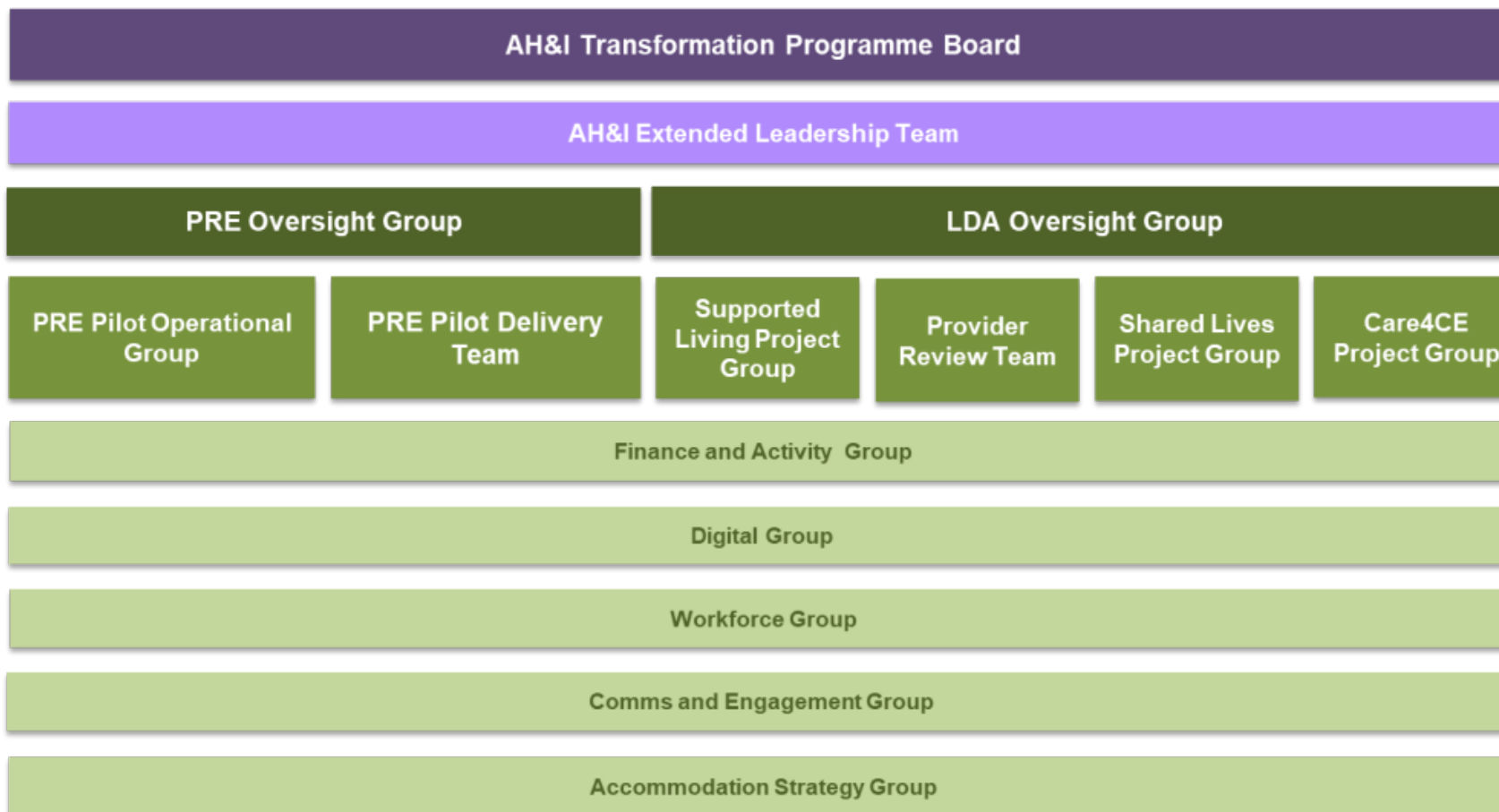


# Introduction | Ambition of the Programme

Our transformation programme will deliver better outcomes whilst delivering significant savings.

Workstream Title	Financial Benefits					Outcomes
	25/26		26/27	27/28	28/29	
	MTFS	Forecast	MTFS	MTFS	MTFS	
<b>Prevent, Reduce, Enable</b>	£1.5m	£0.65m	£2.83m	£2.83m	£2.83m	<ul style="list-style-type: none"> <li>• More people enabled to live independently at home for as long as possible</li> <li>• Fewer people entering care homes</li> </ul>
<b>LD Programme</b>	£2.5m	£1.0m	£2.5m			<ul style="list-style-type: none"> <li>• More people enabled to live in home-based settings, either with families or in their own homes</li> <li>• The offer to residents is fit-for-purpose for the needs of residents in Cheshire East</li> </ul>
<b>Commissioning &amp; Brokerage</b>	£0.5m	£0.5m	£0.25m			<ul style="list-style-type: none"> <li>• Market management is strengthened</li> </ul>
<b>Partnership Case Reviews</b>	£2.5m	£2.5m				<ul style="list-style-type: none"> <li>• Legal requirements around joint funding are upheld by all parties</li> </ul>

# Introduction | Overview of Programme



# Prevent, Reduce, Enable (PRE)

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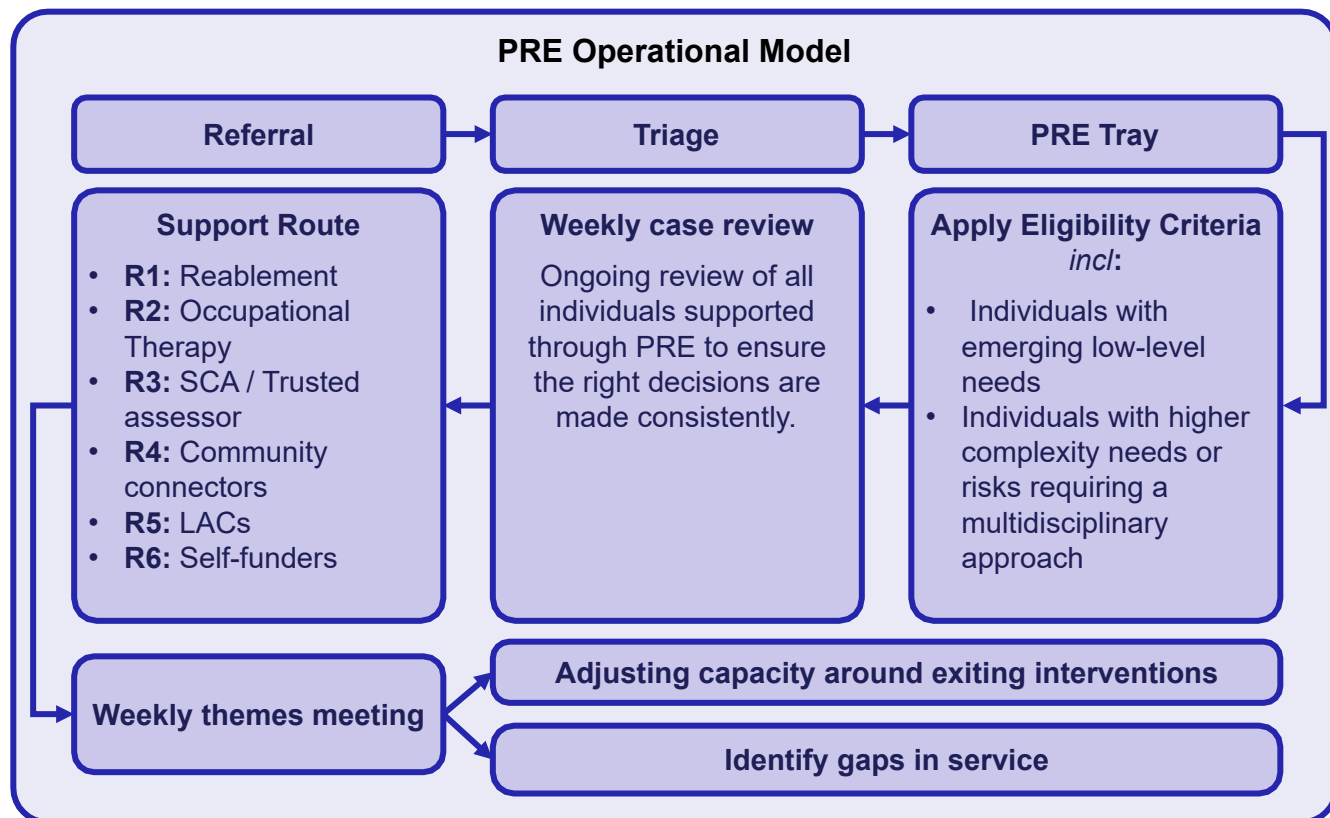
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# PRE | Plan

	2024				2025								2026						
Month	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
<b>Phase 2</b>																			
Phase mobilisation																			
Staff engagement																			
Data analysis and triangulation																			
Outline business case development																			
Financial model development																			
Outline business case approved																			
Phase 3 pre-design																			
<b>Phase 3</b>																			
Phase mobilisation																			
Pilot planning and set up																			
Launch and run pilot																			
Formal review of pilot																			
Pilot end / extension / reformat																			
Full business case development																			
Refreshed financial model development																			
Submit full business case for approval																			
Prepare for full scale roll out																			

# PRE | Overview of Approach

The PRE pilot went live in **June** following a data-led review of interventions based in Macclesfield. A review will take place in **September** to assess progress and to extend the scope to include hospitals.



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The PRE Operational Model focuses on early identification of preventative interventions for residents who come through the Adults front door in the pilot area.

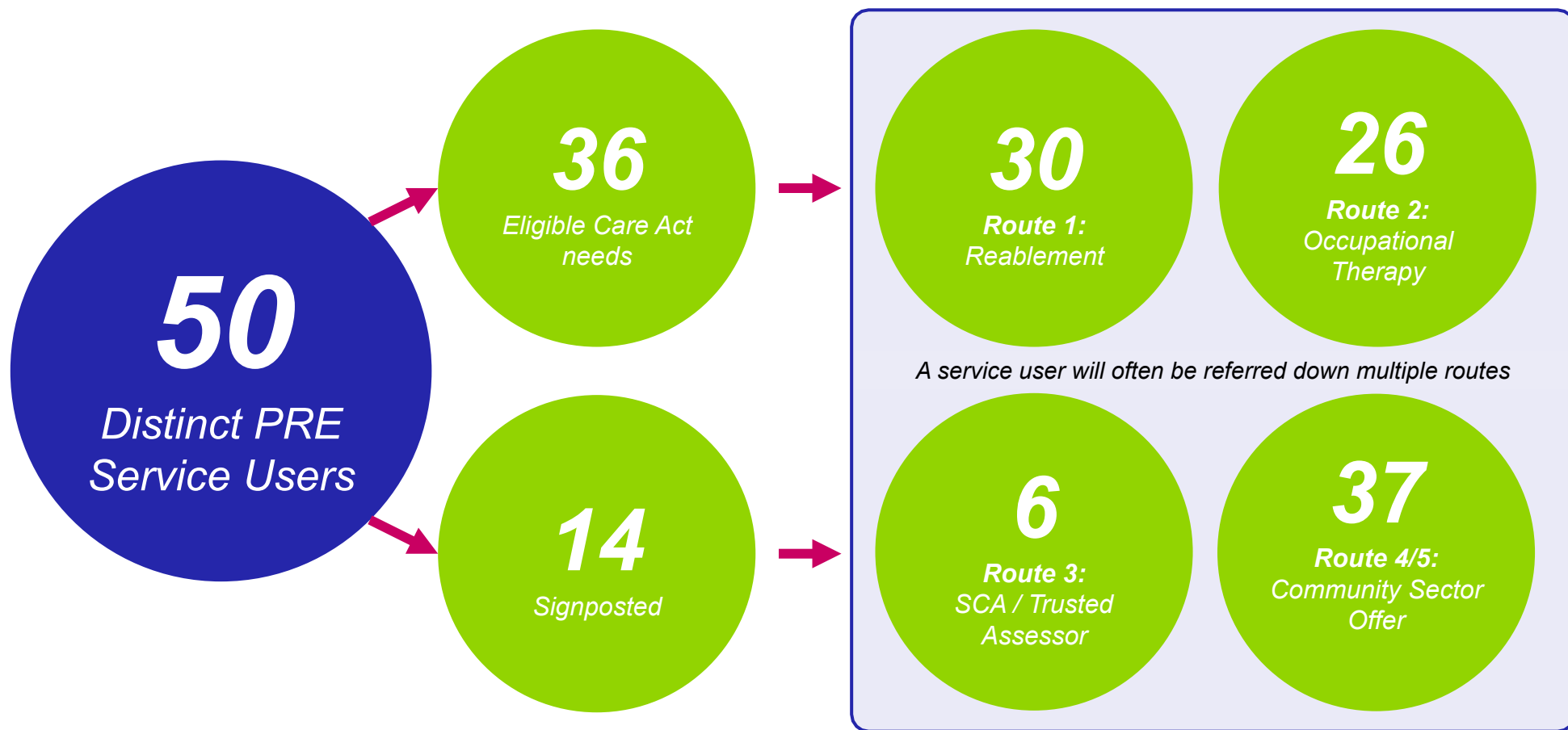
This is complimented by weekly meetings to review cases and identify emerging themes and trends. Common trends coming through include:

- Better support for carers
- Clarity on the Tech-Enabled Care (TEC) offer
- The benefits of a multidisciplinary team

These sessions have enabled rapid discussion on what needs to change or be enhanced, with actions taken to ensure interventions deliver maximum impact.

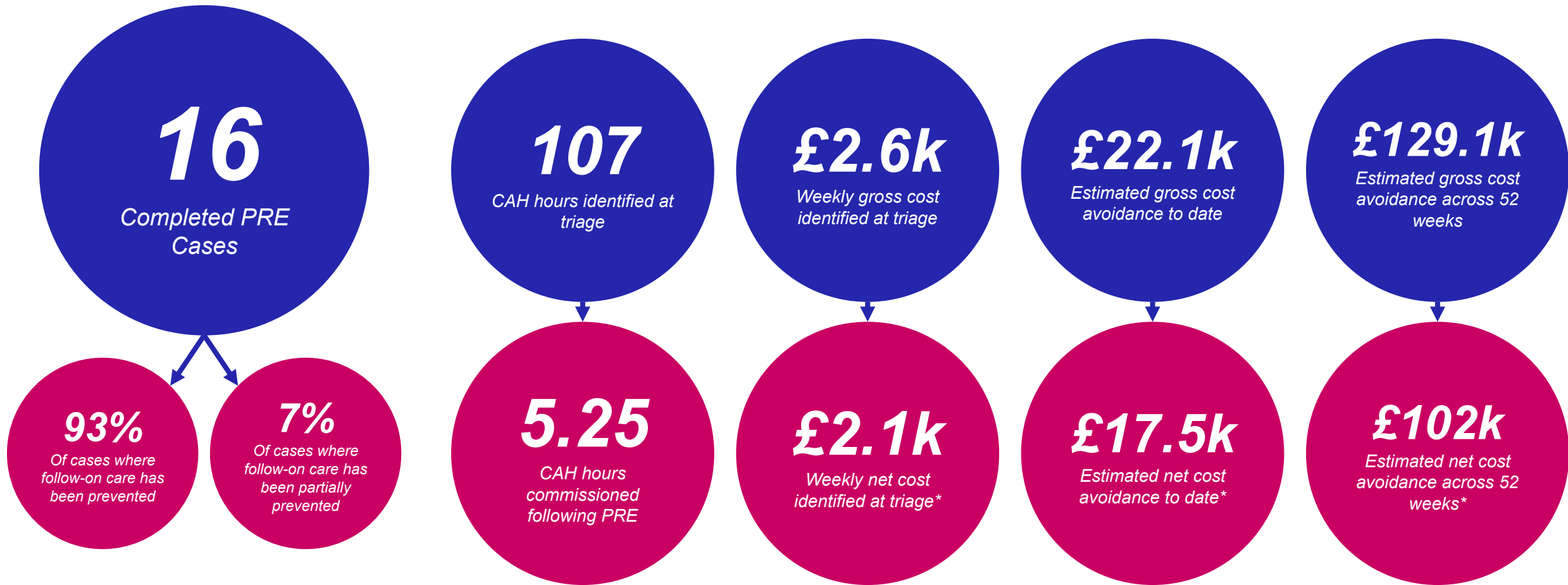


# PRE | Progress in Numbers





## PRE | Case Impact Data



# PRE | Case Impact Stories

## Case 1: Mrs M (67)

### Background

Limited post-discharge support left Mrs M unable to manage daily tasks and reliant on her daughter for care.

- Referred on 17<sup>th</sup> June by daughter following hospital discharge
- Returned home without support
- Experienced pain and mobility issues, limiting ability to manage daily tasks
- Relied on daughter, who travelled an hour daily to provide care

### Intervention

A coordinated response quickly put support in place to stabilise Mrs M at home.

- Package of care started on 18<sup>th</sup> June via Reablement: 3 x 30 min calls daily
- TEC installed: key safe and pendant alarm supplied
- OT support provided: bed lever, commode, toilet seat raiser

### Review & Progress

Support was gradually reduced as independence was regained.

- 7<sup>th</sup> July: Package of care reduced to 2 calls per day; microwave recommended to support independent meal prep
- 23<sup>rd</sup> July: All care calls ended as independence was regained

### Outcome

Early intervention supported recovery and prevented further escalation of needs:

- Prevented further deterioration in wellbeing
- Avoided hospital readmission
- Reduced risk of carer breakdown

## Case 2: Mr T (60)

### Background

A prison release referral highlighted significant health and mobility challenges impacting daily living

- Referred on 26<sup>th</sup> June by prison link worker ahead of release
- Returning to his flat in Macc, previously supported by daughter
- Mr. T was overweight, incontinent and had arthritis in both knees
- Low mood and very poor mobility
- Unable to wash, dress, prep meals, or maintain home.

### Intervention

A multi-agency support package was put in place to aid Mr T's transition and recovery

- Package of care: 2x 45 min calls (morning and bed-time)
- OT support provided: aids and minor adaptations provided
- Community Connector / LACs: social activities, voluntary services, shopping support
- Food support: parcel provided by local food bank

### Review & Progress

Support was stepped down as Mr T regained confidence and independence

- 18<sup>th</sup> July: Package of care reviewed
- Mr. T had regained confidence and independence in most daily activities
- The decision was made to end future care calls

### Outcome

Early support prompted recovery and successful reintegration into the community

- Prevented deterioration in physical and emotional wellbeing
- Enabled Mr. T to regain confidence and independence
- Supported successful reintegration into the community

# PRE | *Self-Funder Pilot Progress*

81

*Clients contacted*

52

*Clients willing to engage*

## Case 1: Mrs D (81)

### Background

**A family referral raised questions about need for residential care placement**

- Lived in a care home for 5 months
- Family contacted ASC to review need for ongoing care and requested a Mental Capacity Assessment
- She expressed a clear wish to return home.
- Assessment confirmed Mrs. D has capacity to make decisions about her care and living arrangements

### Intervention

**Targeted support was introduced to help Mrs D return home and regain independence**

- Package of Care: 2 calls per week to assist with shopping and showering
- Rehab support: short-term rehab identified to help Mrs. D return to baseline level of independence.

### Outcome

**Independence was restored quickly, leading to reduced care needs and costs**

- After 3 weeks, Mrs. D had returned to her baseline level of independence and was able to move home
- Mrs. D's care costs reduced from £1,000/week to £100/week

# LD Programme

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# LD Programme | Plan

	2024				2025								2026						
Month	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
<b>Phase 2</b>																			
Phase mobilisation																			
Project governance mobilisation																			
LD Transformation data analysis and discovery activity																			
Data cleansing and provider audit for Supported Living																			
TEC engagements and workshop																			
Strategic analysis to set provider-level investigations and action plan																			
Shared Lives business case development and approval																			
<b>Phase 3</b>																			
Shared Lives business case mobilisation																			
Supported Living business case																			
Care4CE outline business case draft																			
Handover of Care4CE business case to HoS																			
Shared Lives recruitment post appointed																			
Commissioned Care Review Team Manager appointed																			
Mobilisation and delivery phase Commissioned Care Review Team																			
Implementation of shared Lives delivery plan																			

# LD Programme | Overview of Progress

The LD Programme is shaping a new way of delivering support in the community. The focus of the work is on ensuring services are right for residents while supporting the market to become more sustainable.

## Supported Living

- The 'Commissioned Care Review Team' as outlined in the business case is being recruited to and will be in place to start reviews of Supported Living placements in **September 2025**
- The team will undertake **387** reviews across ten providers by **March 26**
- Work will be undertaken **in collaboration with providers**, ensuring provision meets residents' needs and aligns with a sustainable market model

## Care4CE

- A **review of the service** is being undertaken by the new Head of Service to ensure the service meets the needs of residents
- A **new Supported Living referral pathway** has been introduced across all networks to better understand where Care4CE can't meet needs and aims to reduce voids across the service

## Shared Lives

- To enable rapid mobilisation, **internal resource has been identified** to oversee recruitment of new Shared Lives carers
- A targeted **comms and recruitment plan** has been developed and aims to reach a wider range of potential carers

Each of these programmes of work has established KPIs for both activity and spend which will be tracked as they move into delivery

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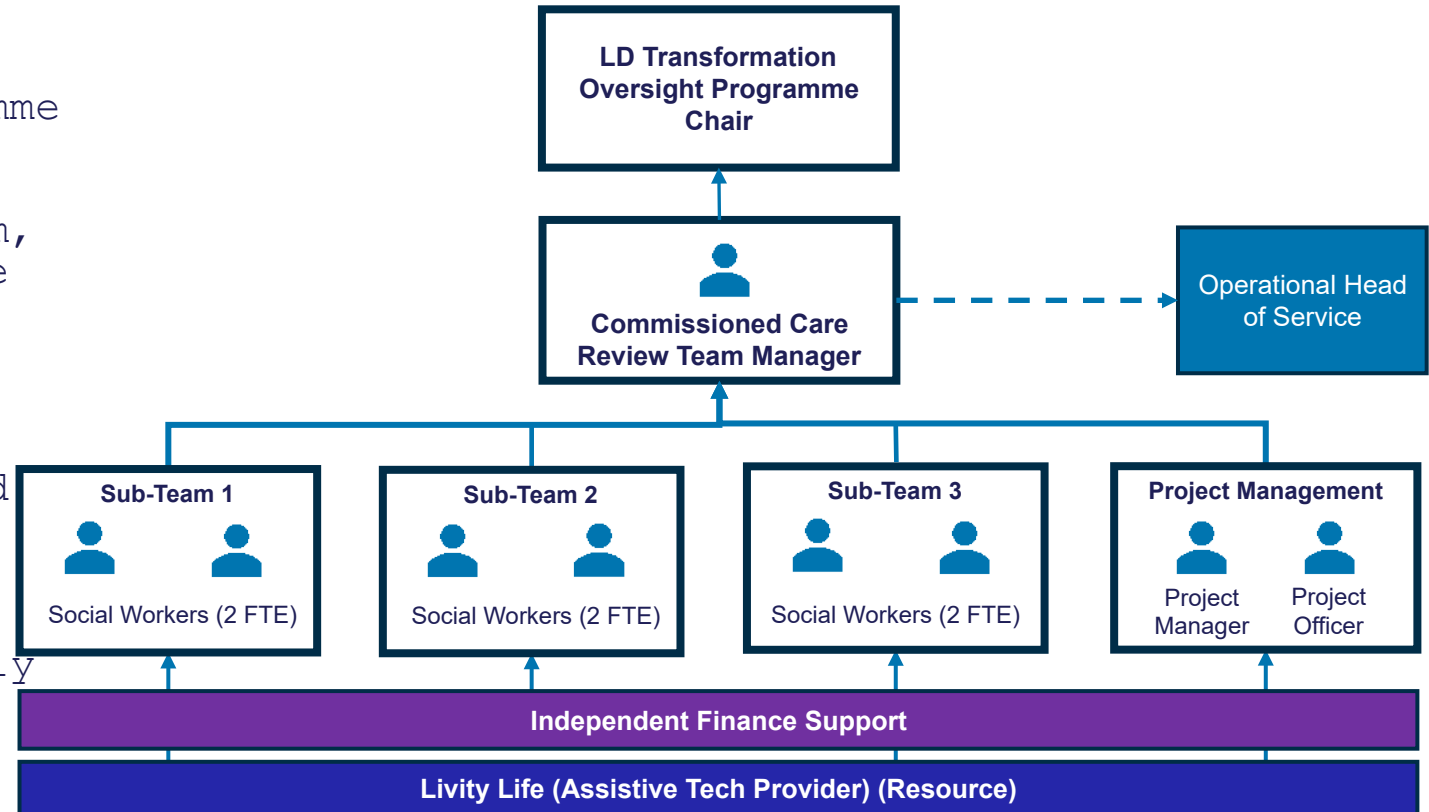
# LD Programme | Commissioned Care Review Team

The team chart below reflects the agreed Commissioned Care Review Team Structure as detailed in the Outline Business Case.

Alongside mobilisation, the programme is developing Standard Operating Procedures to ensure a clear and consistent approach across the team, and a fair and equitable experience for providers.

These will set out agreed ways of working for how reviews are planned and delivered.

This will help ensure a consistently high standard of review, with provider engagement that is constructive, transparent and solution-focused.



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# LD Programme | Outcomes & Impact

- The LD Programme is forecast to achieve savings of £1.0m in 25/26 following implementation dates of the Supported Living and Shared Lives activity initiating in September 2026.
- Through partnership working with our TEC provider (Livity Life) and Cheshire East's Learning Disability Teams, **20** items of equipment have already been identified and deployed to enable residents in Supported Living to live more independently.
- The Shared Lives **carer allowance is being increased in line** with other regional **Shared Lives services** to recognise the positive work of current carers, support retention and to make recruitment more appealing.

£1.0m

Forecast savings for 25/26

59

TEC Reviews undertaken by Livity Life of care packages

12

New Shared Lives carers in application pipeline (10 sessional, 1 respite, 1 long-term)

5

New sessional support Shared Lives carers onboarded

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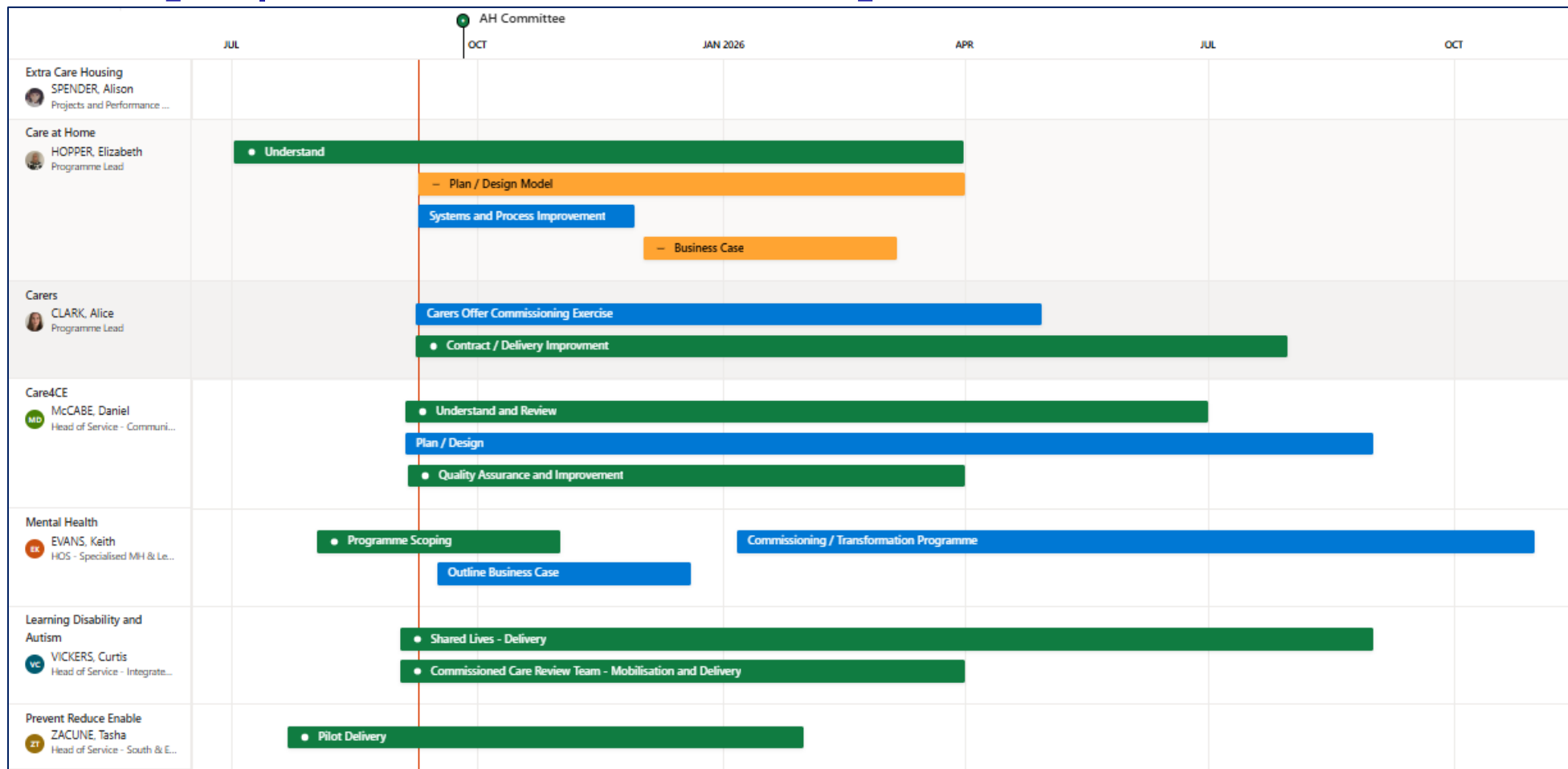


# Next Steps

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# Next Steps | Transformation Pipeline



# Next Steps | Overall Progress

- We provide good Adult Social Care services, and this transformation programme will enable us to further improve services
- We want to ensure we can deliver better outcomes, which often comes with reduced costs
- Some timing challenges between budget setting for the MTFS and refinement and implementation of the transformation programme means that some delay to savings will need to be mitigated
- However, we are working in the right areas and are on track against our plan to deliver the impact we want for the residents of Cheshire East