Delivering the Better Care Fund in Cheshire East 2017-19

‘Setting out the joint vision and approach for health and social care integration in Cheshire East, our next steps’

NHS
South Cheshire
Clinical Commissioning Group

Cheshire East Council

NHS
Eastern Cheshire
Clinical Commissioning Group

Contents

Section 1 - Summary

"Delivery of a fully integrated health and social care commissioning function by 2020 supporting the delivery of Accountable Care across Cheshire"

Cheshire East Better Care Fund Vision…

- Centre all care around the empowered individual, their goals, communities and carers
- Have shared decision-making and supported self-care, family and community care as integral components to all care
- Teams built around a person's needs and journeys, jointly accountable for outcomes and joint responsibility for continually improving care
- Focus its attention on health promotion, pro-active models of care and population level accountability and outcomes
- Continue to tackle health inequalities, the wider causes of ill-health and need for social care support e.g. poverty, isolation, housing problems and debt
- Have a strong clinically led primary care and community care system offering a comprehensive modern model of integrated care at scale
- Be delivering fully integrated and co-ordinated care, 7 days a week, close to home with a focus on the frail elderly and those with complex care needs

Supported by:

- System re-design of care – co-produced with our public and our workforce
- Strengthened and renewed primary care
- Shared information systems across health and social care so that people will only ever have to tell their 'story' once
- New contracting approaches that facilitate costs being moved from the acute sector to the community and that promote collaborations across multiple providers
- Joint commissioning utilising the Better Care Fund and other approaches
- A range of new roles to support models of care across traditional providers in the public, private and voluntary sector

To achieve:

- Accountability for all health and social treatment and care to the public
- High quality, safe care and a robust system of continuous improvement

Section 2 - Introduction

Today, people are living much longer, often with highly complex needs and multiple conditions. These needs require ongoing management or support from both health and care services, which combine both medical and social models of care. As our population ages and the financial pressures on the health and care system increase, we need to be better at providing proactive, preventative care in community settings, so that people can be supported to live at home for longer and avoid the need for commissioned health and care services *(2017-19 Integration and Better Care Fund Policy Framework).*

Health and Social Care leaders in Cheshire East are committed to improving our population's health and wellbeing outcomes, improving the experience of care and ensuring high value services are provided to our local populations within the resources available.

The Cheshire East health and social care economy have agreed to work together to be jointly accountable for the cost and quality of care for the whole population. It is our vision that clinical and financial accountability will be delivered through **Accountable Care** that deliver integrated care for the local population. To deliver this, a new model of care, centred around the individual and how they wish to live within their communities, will form the basis of health and social care integration by 2020. This will form part of our dedication to support our carers, clinicians, voluntary sector colleagues and other health and social care workers, putting the people it serves at the centre of everything that we do.

Accountable Care will be delivered in Cheshire East through our two Transformation Programmes, **'Caring Together'** in Eastern Cheshire and **'Connecting Care'** in South Cheshire. These programmes form our shared framework for integration, built upon the following principles:

Integrated Communities: residents will be supported within their communities by employing a mind-set that builds on the principle of community capabilities rather than deficits.
Integrated Case Management: residents will receive a more coordinated experience of care and support services through the use of a single point of access and our support of seven-day working.
Integrated Commissioning: services commissioned for local residents will be based upon strong evidence and proven effectiveness and commissioned as part of a whole system and integrated approach to commissioning.
Integrated Enablers: Working both within the Cheshire East Footprint and Cheshire-wide, infrastructure, technology and workforce planning supports integrated care.

The Cheshire East model of care will focus on:

- delivering financially sustainable services across the health and social care economy
- empowering people to live full and healthy lives, self-manage and where required supporting people and their families with improved information and technology
- strengthening primary care and its role in proactive long term condition management
- increasing the investment and portfolio of services in the community to support care closer to home where safe and effective to do so
- providing access to specialised services to optimise the safe care and clinical outcomes for patients
- people knowing where to get the right help at the right time
- people feeling safe in their communities

- people being active members of their communities and reducing social isolation
- carers supported to continue caring in partnership with other support services

Challenges in Cheshire East

Figure a

The main challenges to the delivery of BCF can be summarised as figure a. In addition the following points were raised in our annual review of the progress against delivery of the BCF in Cheshire East – the full report can be found in Appendix 2.

- Reporting – timing of information (NEL DTOC and finance) makes corrective decision making difficult given multi-layered governance structures and parallel workstreams looking at same issues (e.g. A&EDB and Better Care Fund)
- Reporting mechanisms and being able to understand how the Better Care Fund schemes have directly impacted on reductions in DTOC A&E attendance and 24hr care
- Care economy finances; deficit positions in NHS and savings challenges in council prevent service change which needs double running, whilst managing increased demand for health and care services, make service change more challenging.
- All partner challenges around the use of finances and successfully implementing new ideas and programmes into place mid-year
- Human Resources; workforce shortages in some areas have made finalising projects or keeping continuity or vision difficult.
- Implementing joined up approaches especially within delivery of services
- Adult social care is under significant financial pressures and has a statutory duty to meet the growing demand under the Care Act

Section 3 - The local vision and approach for health and social care integration

All partners within Cheshire East are committed to maximising the opportunities afforded via the Better Care Fund to further integrate health and social care, to promote health and wellbeing and improve the health outcomes of the local population. We are using the Better Care Fund and Improved Better Care Fund to target those areas identified as requiring immediate improvement to enable more people to remain independent and effectively cared for in the community, care in the community as an appropriate alternative to hospital admission and to support the timely discharge of anyone who is admitted to hospital with a focus on Home First. [1]

Our plans are aligned with our system-wide vision, objectives and principles related to the use of the Better Care Fund namely, to deliver fully integrated health and social care by April 2020

Our Better Care values:

- **Collaboration**
- **Empowerment**
- **Innovation**

Our Objectives:-

- Improve health outcomes and the wellbeing of local people.
- The recipients of care services and the staff providing them have a positive experience of care.
- Care is person centred and effectively coordinated.
- Services are commissioned and delivered in the most effective and efficient way.
- People are empowered to take responsibility for their own health and wellbeing.
- People spend the appropriate time in hospital with prompt and planned discharge into well organised community care when needed.
- Carers are valued and supported
- Staff working together, with the person at the centre, to proactively manage long term physical and mental health conditions.
- Expansion of 'out of hospital' offer
- Accountable care

[1] Our local plans are consistent with Integration and the Better Care Fund (Local Government Association 2015), the NHS Five Year Forward View (NHS 2015), Getting it Right First Time (The Kings Fund 2017), Making Every Contact Count (Public Health England 2016), General Practice Forward View (NHS 2016), Primary Care Home (National Association of Primary Care 2017) and the Five Year Forward View for Mental Health.

Section 4 - BCF and the delivery of a fully integrated health and social care commissioning function by April 2020

The key drivers for implementing the Five Year Forward View and the move towards a fully integrated health and social care service by 2020 in Cheshire East are via the pre-existing transformation programmes, Caring Together Eastern Cheshire and Connecting Care in South Cheshire.

These programmes work closely with health and social care providers to achieve the best outcomes for local people. This largely means shifting care from acute and reactive provision to home/community-level and proactive joined-up planned care and care that is rapidly responsive to escalating needs.

Our ambition is based on knowing how Cheshire East will change, looking ahead to the financial challenges we face and changes in national and local policy across adult's health and social care, whilst continuing to respond to the changing needs of Cheshire East population of residents.

Case for change – our 2016/17 plans continue

The case for change is still in line with that submitted for 2016/17, and as set out in our vision.

Key developments that add to the case are the emerging recent decreases in DTOC and falls in the over 65s – linked to transformation of service delivery during 2016/17. This will need to be built on further in order to meet the projected trajectory for 2017/18.

During 2017 partners are to look at redesigning the reablement services that are part of the Better Care Fund Scheme, this redesign will introduce an "all need" model of care and support that will include physical and mental health therefore reducing duplication and also silos within the current service. The redesign will take place from September 2017 and a new service to be in place by April 2018.

The second large scale change being undertaken in 2017/18 is a wholescale change to our carers' provision; Services Together, as part of a dedicated integrated carers hub, whereby all of our carers can access all of their requirements via dedicated provision. Business continuity will be maintained whilst the redesign work is co-produced with our carers, with the new service expected to be live in April 2018.

The third significant piece of work is the review and redesign of Older Peoples' Services with a view to delivering integrated and transformed services from 1st of April 2018.

Further additions to plans for 2017-19 are the schemes for Improved Better Care Fund, as detailed on pages 24 onwards. These schemes have been designed to have added increased value to our core provision and to add increased capacity and capability within our local social care market.

Section 5: Integrated Commissioning – to move to a unified health and care commissioning approach for the population of Cheshire

Across Cheshire East, and in partnership with Cheshire West and Chester Local Authority, significant work is underway to better align existing resources and programmes of work to help accelerate the development of integrated health and social care. Our local health organisations and local authorities have worked together to agree three key improvement priorities to jointly deliver in order to drive forward the necessary transformation and improvement of the health and care services across Cheshire. These three priorities are:-

1. The establishment of a Joint Commissioning Committee of the Cheshire Clinical Commissioning Groups (CCGs), with the involvement of the local authorities. The aim is to explore greater joint working and ultimately integration of health and social care by 2020.

2. Integrated provision – to work towards the creation of accountable care systems across Cheshire delivering integrated health and care services tailored to meeting the population health needs of each area. Fundamentally, this would involve moving towards an "Accountable Care System" with a single capitated budget, single leadership structure, distinctive new culture and way of working which makes it fully and openly accountable. This will also include a single operating model for the design and development of 'Neighbourhood Community Teams" that will be structured, operated and managed in a similar way across Cheshire including the integration of social care staff in a consistent way across Cheshire. This will provide a single resource pool for the whole of Cheshire that operates in the same way, with the same protocols, processes and even information management and technology solutions.

3. Sustainable hospital services across Cheshire – to ensure that we deliver hospital services that are sustainable both financially and clinically across Cheshire and that these services are more integrated with local health and social care services.

A joint strategic leadership group across health and social care has been established to provide oversight of this work and ensure regular communication to the Health and Well-Being Boards and the public. This group comprises all the Chief Officers from each CCG and the Local Authorities across Cheshire. This leadership group is supported by an Officer Working Group who have been tasked with the following responsibilities:-

- Support the work programme and implementation of the integrated commissioning approach across Cheshire;
- Oversight of the single operating model for Neighbourhood Community Teams including setting out the common specification for these teams across Cheshire;
- To oversee a programme of joint commissioning across Cheshire including health and social care functions;
- To co-ordinate the consultation and engagement plan for health and social care integration across Cheshire with a particular focus on resident and staff engagement and with regular reporting to the Health and Well-Being Board;
- To review the existing governance and strategic decision-making structures across Cheshire with a view to simplifying and streamlining these arrangements in the light of the emerging approach to health and social care integration across Cheshire.
- Terms of Reference will be revised and will be subject to the democratic approval process

Section 6 – What will be different as a result of the 2017/18 BCF plan?

By the end of 2017/18…

- Reablement services in Cheshire East will have become fully integrated to address both physical and emotional needs; the aim will be to provide more balanced provision including both proactive and responsive services for people with physical and/or mental health needs and thus an improved outcome for those in Cheshire East. This will be evidenced by an improved reablement score under National Metric 3.
- Carers' services will be integrated, providing a single solution for support, which supports wellbeing, de-escalates crisis and maintains quality of life for both the person caring and the person being cared for. This will be evidenced under an improved score under National Metric 3.
- Falls services will become streamlined across health and social care with a move towards joint commissioning arrangements and utilise assistive technology, in addition a Cheshire-wide project to widen use of assistive technology to support people in their own homes will be in progress. This will be evidenced by an improvement in National Metric 2.
- iBCF schemes provide increased capacity and capability in the community; this is evidenced by meeting the DTOC trajectory in a sustained way in addition to a reduction in those requiring residential and nursing home care particularly directly from acute care.
- Improved use of data and evaluation locally will mean that the Better Care Fund planning will respond to trends much faster than previous, providing a much faster and evidence-based planning process.

Table 1 is an overview of the current commissioning intentions covered by the Cheshire East Better Care Fund, NHS Easter Cheshire CCG, NHS South Cheshire CCG and Cheshire East Council – collectively. This table demonstrates how our programme contributes towards the outcomes required by each of the Better Care Fund National Metrics.

	National Metric 1 – Non-elective admissions (General and Acute)	**National Metric 2 - Admissions to residential and care homes**	**National Metric 3 - Effectiveness of reablement**	**National Metric 4 – Delayed transfers of care**	**Other**
Cheshire East Better Care Fund Priorities	Integrated Carers Hub Assistive Technology Disabled Facilities Grants Integrated Community Teams Multidisciplinary Approach to supporting Home First	Sustain the capacity, capability and quality within the social care market Care home assessments at the weekend Care home package retention for 7 days Increasing capacity in the care sourcing team over Bank Holidays Home First	Home First Integrated reablement services Integrated Carers Hub	Home First Hospital Discharge Services Care Home Assessments at the Weekend Care Package Retention of 7 Days Innovation and Transformation Fund Funding of additional social care staff to support 'Discharge to Assess' initiatives	The use of 'Live Well' online information and advice resource Programme Enablers

	National Metric 1 – Non-elective admissions (General and Acute)	National Metric 2 - Admissions to residential and care homes	National Metric 3 - Effectiveness of reablement	National Metric 4 – Delayed transfers of care	Other
				Increasing capacity in the Care Sourcing team and Social Work Team over Bank Holiday Weekends Sustain the capacity, capability and quality within the social care market place The use of 'Live Well' Online information and advice resource	
NHS Eastern Cheshire CCG Commissioning Priorities	Supporting the delivery of the Caring Together Ambitions and the CCG 5 year Strategy including the redesign and transformation of older people's services across health and social care	A clear Market position Statement	New approach to falls management which is jointly commissioned across health and social care Redesign of reablement services.	Improving A&E performance Reducing DTOCs	Implement a new Primary Care streaming model Delivery of Frailty Approach from emergency portals as part of the Home First model Expand the existing Single Point of Access Delivery of Frailty training across the health and social care economy Additional OT presence in Integrated Discharge Team Independent clinical review of DTOC leading to key actions (2017) 5 key actions to be implemented following the ECIP review (2017) Cancer treatment Redesigning musculoskeletal services

	National Metric 1 – Non-elective admissions (General and Acute)	National Metric 2 - Admissions to residential and care homes	National Metric 3 - Effectiveness of reablement	National Metric 4 – Delayed transfers of care	Other
					Implementing the Five Year Forward View Preventing ill health
NHS South Cheshire CCG Commissioning Priorities	Improve support for carers Implement a single point of access for rapid response	A clear Market Position Statement	Falls prevention and support. Develop integrated frailty pathway Discharge to Assess Model Implementation of a safe transfer of care model	Ambulatory Emergency Care Redesign of health and social care services that support rapid response to those in need of urgent care close to home Implementation of a health and social care integrated discharge team	Driving earlier diagnosis
Cheshire East Council Priorities	**Strategic Outcome 5 – People live well for longer** Develop a regional Assistive Technology Framework	**Strategic outcome 1 – Our local communities are strong and supportive** Review and redesign of councils Care4CE Review and redesign of domiciliary care (Care at Home) Review and redesign of care homes	**Strategic Outcome 3 – people have the life skills and education they need in order to thrive** New adult social care pathway Review and redesign of councils Care4CE Local integrated approach to reablement	**Strategic outcome 5– People live well for longer**	**Strategic outcome 5 – People live well for longer**

Table 1

Section 7 - Background and context to the plan

Cheshire East has an ageing population which means that there is a significant increase in the number of people in the older age groups, and a decrease in the number in the younger age groups.

By 2020, over a quarter of the Cheshire East population will be aged over 65, greater than the UK average.

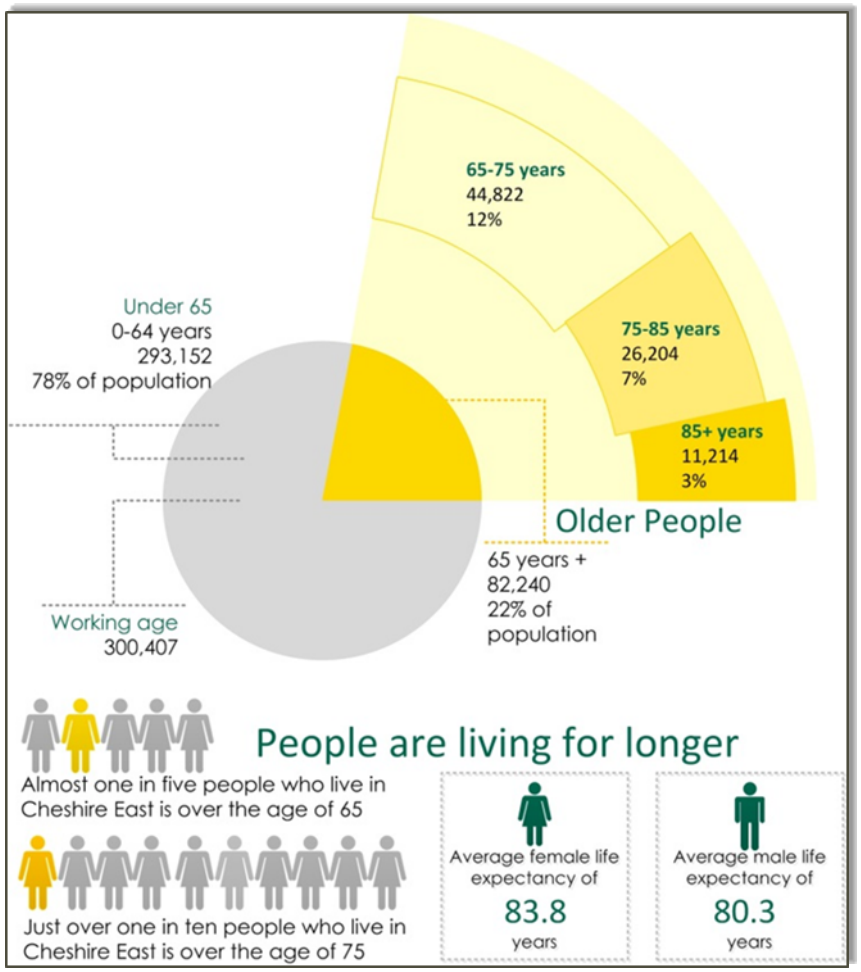
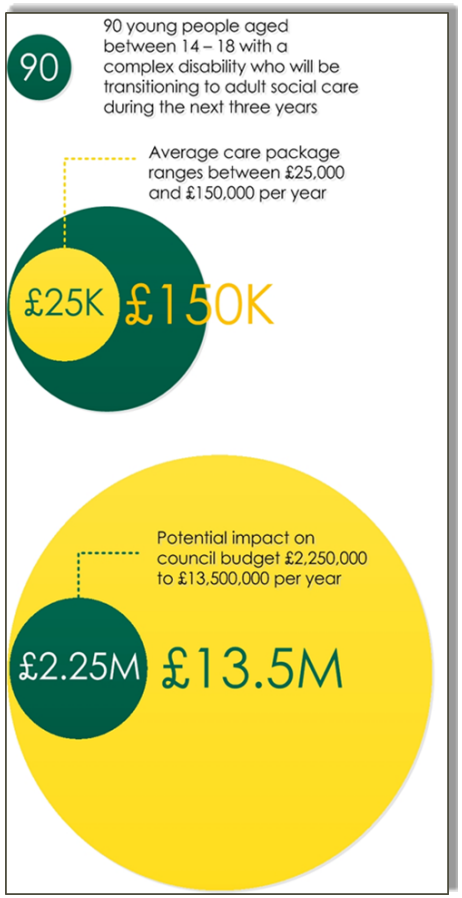


Figure b



In terms of the impacts on the Better Care Fund in Cheshire East, having a significantly older population means that people living locally are more likely to be living with long term health conditions that will require support from health and social care services.

Life expectancy in Cheshire East is higher than for the region (North West) and nationally (England). For females it is 83.8 years, compared to 81.9 years in the North West and 83.2 years nationally.

As we move towards 2020, Cheshire East will see a significant shift from numbers in the working age population to numbers in the older age/dependants population. The dependency ratio is considerably higher than the England average 68.9% for Cheshire East, compared to 60.7% for England.

Of the 65+ population in Cheshire East, approx., 33.154 (40%) are living with a limiting long term illness. This too has significant implications for Better Care Fund planning, as this cohort of people are more likely to require medical and social care support to maintain their health and wellbeing and maintain their independence.

In Cheshire East there are estimated to be 5,730 people over the age of 65 living with dementia.

- 65% are likely to be women
- one in five people over 80 has a form of dementia
- one in 20 people over 65 has a form of dementia

22% of the Cheshire East population is over the age of 66. We have the highest percentage in England compared to 16% nationally.
In terms of Better Care Fund planning, considering the needs of those with dementia and their carers in paramount, both now and as we head towards 2020. Early intervention and prevention services is key in ensuring that those with dementia and their carers feel supported and able to cope in a crisis, without having to resort to calling in emergency care.

Within Cheshire East that has been an increase in the number of people that have been admitted following a fall, from July 2017 there is a new requirement within the GP contractual requirements to identify people with moderate and severe frailty using the (Electronic frailty Index) eFI and put a plan in place, although outside BCF this will assist in supporting non-elective admissions and ultimately delayed transfers of care. South Cheshire have a lower rates of patients admitted following a fall, in June South Cheshire introduced an integrated clinical falls model this is delivered through NWAS as well as Central Cheshire Integrated Care partnership (CCICP) this approach has reduced ambulance conveyances of patients who have had a fall at home and within a care home significantly and has contributed in the reduction of non-elective admissions into Acute Medical Unit (AMU).

As part of the core Better Care Fund schemes, the Assistive Technology workstream is currently reviewing its provision to align technology to support more patients at home through tele health and tele care solutions.

Right Care

NHS South Cheshire CCG (together with NHS Vale Royal CCG) are part of Wave 2 of Right Care implementation. NHS Right Care have produced a number of Right Care packs that local, regional and national variations within a number of health conditions. The aim of this programme is to ensure the standardisation of clinical pathways so all areas embrace good practice and introduce a standardised approach to supporting patients adhering to NICE guidelines. CCG areas that have been part of wave 1

have found that through this approach patients receive the right clinical intervention at the right time and this has resulted in a reduction in unnecessary procedures, hospital admissions as well as a positive patient outcome.

Through our analysis of the Right Care packs Vale Royal and South Cheshire highlighted the following areas where we had high variation amongst our regional CCG partners and this resulted in unnecessary attendances and admissions as well as an increase in first and follow up outpatient's appointments, the 7 areas are:

1. Lower GI
2. Upper GI
3. Cataracts
4. Hip & Knee
5. Neurology
6. Emergency Gastro Pathway
7. Alcohol Related Liver disease
8. Respiratory

NHS South Cheshire CCG are working closely with primary care and secondary care partners to reduce variation and support patients in a number of alternative ways rather than acute solutions. Intermediate care teams as well Care Community Teams are involved to support patients at home to reduce A/E attendance, Non Elective admissions and reduced premature into 24 hour care. Presently the top 4 areas in the list above are now in place and work has commenced have agreed pathways in place for neurology, emergency gastroenteritis, alcohol liver disease, and a self-care respiratory pathway. The progress of the Right Care approach will be monitored the NHS right care data returns, as well as activity monitoring through the CCG.

In NHS Eastern Cheshire CCG the Right Care priorities identified are:

- CVD (Cardiovascular including Circulation)
- Neurological (Care of people with Epilepsy and Back Pain)
- Gastrointestinal (Alcohol Harm and Endoscopy)
- MSK (Elective care pathways and Falls and Injury Prevention)

The CCG plans focus on prevention, self-care and reducing unnecessary hospital activity. This focus both looks to ensure that best practice care is consistently applied across care pathways.

The progress of the Right Care approach will be monitored the NHS right care data returns, as well as activity monitoring through the CCGs.

Section 8 - Current state of health and adult social care delivery in Cheshire East

For an overview of the current Market Position Statement in Cheshire East, please see Appendix 1, page 59

Current state

- Ageing population
- Financially challenged
- Social care market facing pressures
- Managing demand but not yet improving against nationally mandated targets

How will the Better Care Fund support local challenges?

At present, a key risk is to social care in maintaining the quality, capacity and sustainability of the local care market. Any market failure or disruption will have a huge impact not only on delayed transfers of care but the critical care provided in the community to vulnerable individuals.

The ageing population in Cheshire East and the pressures that this brings to the local health and social care market is central to the planning behind the iBCF schemes and core Better Care Fund schemes which have been developed for Cheshire East Better Care Fund.

A significant proportion of the iBCF is dedicated to sustaining the capacity, capability and quality within the social care market place. Included in this is the requirement for investment into community resources and increases in care packages, in order to sustain and stabilise both the domiciliary care markets and care home markets. This means transforming the care and support offer to ensure Cheshire East has greater capacity and an improved range of services. It is intended that the CCGs together with Cheshire East Council jointly commission the new offer and for it to include: discharge to assess beds, step up/step down beds, more specialist provision for complex needs and care at home services that promote quality of care. The joining up of commissioning and contracting with provide partners with an opportunity to promote and champion a single and shared view of high-quality care and support. With our partners we need to ensure that health and social care services provide people with safe, effective, compassionate, high quality care and that as partners we encourage care services to improve, this may include quality payment premiums to providers.

A recent development to support those who already have a care package funded via iBCF is 'Care Package Retention for 7 days.' Cheshire East Council have an agreement with domiciliary care providers to pay a retainer to the care provider in order to keep the care provision open whilst the individual is absent for a period of time, for example in hospital. The retainer ensures that the individual's existing care provider is kept available for a period of up to 7 days to resume the existing care package when the person is fit or ready to return home. If the person is in hospital this should facilitate a timelier and appropriate discharge.

The Better Care Fund will support local challenges by supporting seven day working. With NHS services moving into seven day serves, it requires social care to match the provision to allow for efficient flow. As part of the iBCF scheme, 'Care Home assessments at the weekend,' work has been undertaken with the care home sector to ensure that any individual who is fit for discharge over the weekend period can be assessed and returned to their care home. This will form part of our contracts with

care homes as the new service is developed and procured in April 2018. In addition to this, the iBCF scheme, increased capacity in the 'Care Sourcing Team and Social Work Team over Bank Holiday weekends,' will ensure patient flow and assist in reducing the pressure on the NHS during times when it can be difficult to maintain seven day services.

Reducing Delayed Transfers of Care is vital is working with our local trusts in reaching their agreed Delayed Transfers of Care improvement target. The iBCF scheme, 'Funding of additional social care staff to support 'Discharge to Assess initiatives' is funding of additional staff to support the local transformation programmes Caring Together and Connecting Care in implementing a 'Discharge to Assess' model. Work is currently undertaken in the eastern part of our locality to design at D2A model, so the additional funding will ensure that equitable provision is provided across Cheshire East.

Reducing the demand for health and care services, by enabling people to enjoy a healthy and active life within their communities, is a key priority for our local NHS and social care system. As part of the iBCF schemes the use of 'Live Well' Online information and advice resource, has been included as a key part of the provision in the Cheshire East plan. Cheshire East Council has embarked on a programme to deliver a new online resource to the public 'Live Well Cheshire East'. It is designed to give citizens greater choice and control by providing information and advice about care and support services in the region and beyond. This new digital channel went live in June 2017, initially offering information and advice and a directory of local services in one place covering Adult, Children, Community and Public Health services. Both Clinical Commissioning Groups have expressed a desire to utilise this platform and expand the offer to create a community infrastructure that maps all existing assets for use of professional staff alongside members of the public. This channel is well placed to link into all of our carers' resources and social care act links, to provide low level support to those who are new to caring roles, as well as those who are firmly established.

Part of the Cheshire East local approach to the Better Care Fund is remaining flexible to respond to emerging needs, in order to do this a there has been the creation of an 'Innovation and Transformation Fund' as part of the iBCF schemes. The purpose of this Fund is to support the 'Caring Together' and 'Connecting Care' (health and social care) transformation plans. Cheshire East Council will create a fund that the NHS and partners can access to support initiatives that promote the move towards integrated working (community teams) to achieve better outcomes for the residents of Cheshire East. The funding bids will run in October 2017 and will need to clearly demonstrate that their intended outcomes will directly impact the Better Care Fund National Metrics.

Core Better Care Fund schemes have been developed since 2015 with our ageing population and their needs in mind. The table below summarises how schemes are categorised, under three strands, **PREVENT**: the need for long term support and services; **REDUCE**: targeted intervention for those at risk or with established illnesses; and **REABLEMENT**: promoting continued wellbeing.

Overarching theme	What is it that we are trying to achieve	What BCF scheme is going to deliver this? (WHAT DO WE COMMISSION?)	What National metric will this contribute towards?
PREVENT the need for long term support and services	**Early intervention/out of hospital commissioned services** • Improved systematic targeting, access and co-ordination of services	Assistive Technology (& falls service) Social Care Act Carers Assessments	NC: Effectiveness of reablement NC: Admissions to residential and care homes

	• Integrated rapid response • Working together to avoid unnecessary hospital admission, supporting people at home wherever possible	Carers Breaks Disabled Facilities Grants Red Cross early supportive discharge service	
REDUCE targeted intervention for those at risk or with established illnesses	**Integrated urgent response** • Integrated, proactive case management from multidisciplinary teams. • Integrated data sharing, risk stratification, care planning and care co-ordination.	Single Point of referral Acute Visiting Service, Psychiatric Liaison, Falls Responder, as part of the responsive Home First model. Redesign of reablement service to become an all needs model.	NC: Non-elective admissions (General and Acute) NC: Delayed transfers of care
REABLEMENT promoting continued wellbeing	**Hospital discharge and reablement** • Safe, timely and effective discharge via consistent pathways reducing the length of stay.	Home First model of care. Phase 1 in place through the introduction of community matrons Introduction of Discharge to Assess model and streamlined discharge process Early support and intervention through Red Cross 7 day care package retainer Integrated mental and physical health and reablement services Hospital Discharge Scheme (Cheshire East wide)	NC: Effectiveness of reablement NC: Admissions to residential and care homes NC: Delayed transfers of care

Table 2

Section 9 - Progress to date

The existing approach to integration and the main points of the current BCF plan

The current approach to integration from the 2016/17 Better Care Fund submissions are:

- Self-care and self-management
- Integrated Community Services (MDT, care coordination, care plans)
- Community Based urgent care and rapid response services

This approach, and the schemes that support it continues as a thread into 2017/18/19 – however, refreshed terminology of **Prevent**, **Reduce**, **Reablement** has been to add a thematic to the Cheshire East schemes as we progress on our journey to health and social care integration.

Review progress to date through the BCF

The process used to evaluate the 2016/17 Better Care Fund schemes presents a somewhat fragmented picture, however, all evaluated schemes were reviewed to aid decision making for 2017/18 (for full details, please see Appendix 2, page 60)

A robust evaluation was carried out, however this revealed that more detailed work was needed to understand overlaps between schemes both within and outside the BCF and work is on-going through a structured review programme to ensure all BCF schemes provide benefit in terms of the national metrics to partners and represent responsible investment in current challenging climate

Current performance on national metrics

During 2016/17 progress was made towards each of the National Metrics and towards the locally agreed metric (reducing falls in those 65+), despite the increase in demand and the financially challenged position of our local health and social care economy. Whilst progress was made locally, this has not been reflect in the targets set at national level, and therefore the RAG rating has resulted in either amber/red ranking according to national performance.

Table 3 shows the end of year position for the 2016/17 BCF National Metrics. The end of year RAG rating is how Cheshire East performed in line with the targets set at the beginning of 2016.

National Metric	Summary of end of year position	End of year rating
Non-Elective Admissions (NELs)	The combined end of year position shows that despite a challenging position, overall the rate of Non-Elective Admissions has been maintained during 2016/17. This has been largely supported by the streaming of less complex activity, however those presenting at A&E are often more complex. However despite an amber rating this has maintained a local level trajectory against a backdrop of increased demand.	
Delayed Transfers of Care (DTOCs)	The combined end of year position shows a continuing challenging position for delayed transfers of care in Cheshire East. Within Eastern Cheshire the 8 High Impact Changes are solely focused on DTOC. NHS South Cheshire CCG have introduced a Primary care streaming model that is resulting in reduced non elective admissions , as well as the introduction of the D2A model on all high delay wards supported by the integrated discharge team.	
People who Feel Supported to Manage Long-Term Conditions	The end of year position for Cheshire East represents a 0.5% decrease from the starting position in March 2016, 64.5% compared to 65%. There is variation within this figure, with Eastern Cheshire residents reporting 67% feeling supported to manage their long term conditions. 61.9% of people in South Cheshire reporting that feel supported to manage their long term conditions	
Admissions to Residential Care	The year end position demonstrates that despite a decrease in admissions in Q4 there is an increase on the outturn for 2015/16. There is a higher rate of permanent admission to residential care in South Cheshire than there is in Eastern Cheshire. South Cheshire has seen an increase in the number of patients being admitted into 24 hour care, mainly requiring nursing care or dementia beds. There is not at present a clear alternative for patients in the 24hr care offer such as Extra Care or enhanced care at home.	
Reablement	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services, the final score for Q4, and thus year end is 82.3%. This figure is a decrease from the 2015/16 outturn of 85.4%, and means that the target of 88% of people remaining out of hospital for 91 days has been missed in 2016/17. The work to redesign and target reablement services more effectively will address this area of performance.	
Locally Agreed Metric Injuries Due to Falls in People Aged 65+	The number of people aged 65+ who have been injured by falls has risen by a small amount since 2015/16. There are more injuries due to falls in the Eastern part of Cheshire East than in South Cheshire, which is reflective of the older population and complexity of patients.	

Table 3

Successes and areas that require more work

Successes

- ✓ Delivered within planned resources
- ✓ Introduction of a primary care mental health hub
- ✓ Establishment of a new dementia reablement service that manages demand on system and has excellent outcomes.
- ✓ Community teams operational across the care communities
- ✓ Implementation of community teams MDT approaches within primary care
- ✓ Continued expansion of the use of Assistive Technology to prevent demand and enable independence and safe discharge home from hospital
- ✓ Continued expansion of the Cheshire Care Record. This has moved from 'project' status to being delivered as part of business as usual.

Further to this South Cheshire CCG achievements following 16/17 BCF:

- Development of a Home First model to support both admission avoidance and early discharge. Phase 1 is in place through the introductions of Community Matrons and First Contact Practitioners. Through this service there has been a noticeable reduction in A&E attendances for older people.
- Introduction of the Discharge to Assess model. This model has enable the introduction of a streamlined assessment on discharge, EDFD coverage through social care, health and red cross as well as the introduction of a new triage this has reduced duplication of assessment early decision making through a multi-disciplinary approach and we are starting to see a reduction in DTOC.
- A frailty pathway and ward has been in place now for 6 months and this has supported the reduction in Non-elective admissions. The pathway enables direct contact for primary care as well as a direct admission from A/E as appropriate. This early transfer and the multi-disciplinary approach has supported patients to be discharged home 72hrs after acute input.
- Introduction of a community Non-Obstetric Ultrasound (NOUS) as well as a DVT services has support the reduction in attendances and further NELs
- Trusted Assessor model being tested through the streamlining of assessments within an acute setting
- Community bed review will provide an increase in the number of assessments beds by 22.

Where the Better Care Fund work continues in 2017/18 and onwards – continuing to integrate data systems

During 2017/18 the CCGs will continue with expansion of the Cheshire Care Record project through additional data sharing agreements and technical changes. This system that currently enables seamless sharing of patients' data across health and social care providers in Cheshire will be extended to allow other organisations to both submit and have access to digital patient records. It is anticipated that the Cheshire Care Record will be expanded to include:

- Electronic Palliative Care Co-ordination System (EPaCCS) template for End of Life Diagnosis
- Integrated access for the current Out of Hours Clinical system
- Provision of access to the three Hospices in Cheshire and integrate their relevant clinical data
- Continue to work with other Health and Social care agencies, NWAS, Continued health Care, Fire service to expand the data available
- Inclusion Community Services data

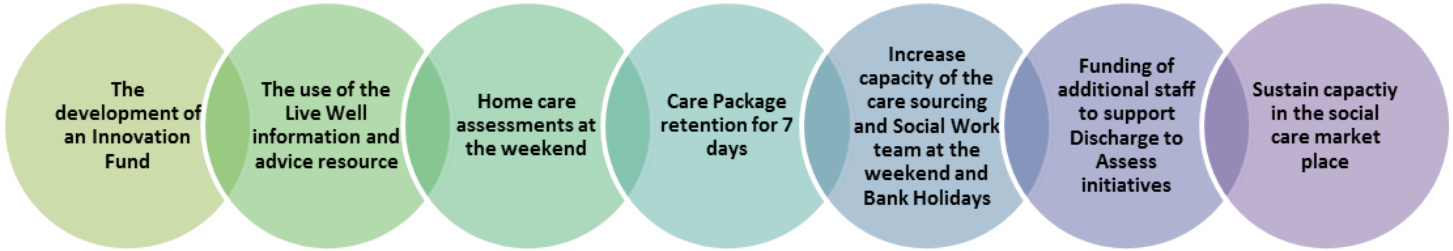
- Expand acute datasets to include electronic information for Radiology Reporting, Electronic Clinical Letters, Pathology results etc.
- Implement real time updates from GP Clinical System of Choice (EMIS)
- Continue to promote to patients through expanded communication and media routes

Section 10 - Better Care Fund Plan

Agreed approach to use of the Improved Better Care Fund to increase capacity and stability in the care market

Cheshire East Council is committed to co-production with its partners and is open and transparent on the iBCF, and how monies are to be spent. Therefore all partners have worked together to develop schemes that will contribute towards avoiding unnecessary admission to hospital and care homes, reducing Delayed Transfers of Care to meet nationally and locally agreed targets. Locally agreed targets are 3.5% by November for South Cheshire CCG and 5.2% for Eastern Cheshire CCG by March 31 2018 and to support the implementation of the High Impact Change Model. These schemes are subject to sign off for all partners through the regular organisational governance structures. The key risk is to Social Care is maintaining the quality, capacity and sustainability of the care market. Any market failure or disruption will have a huge impact not only on delayed transfers of care but the critical care provided in the community to thousands of vulnerable individuals. iBCF is non-recurrent money and will put pressure on the system after the 3 years. There is also a potential risk associated with the new reviews announced that areas failing to be seen to be delivering against the iBCF monies, which may result in their funding being reduced.

The Improved Better Care Fund Schemes in Cheshire East for 2017/18



This diagram illustrates the connections between the iBCF spend, and how together they will support and enable the development of both health and social care outcomes in Cheshire East.

Whilst social care in focus, meeting adult social care needs the iBCF schemes will also reducing pressures on the NHS, including supporting more people to be discharged from hospital when they are ready

Scheme Name: Care Home Assessments at the Weekend (iBCF)

Sept	Oct	Nov	Dec	Jan	Feb	March	April	May	June	July	August
Pre-planning work, linked to re-commissioning of Care at Home. Liaison with current providers to establish interest for pilot. To provide an update during October for Q2 iBCF reporting			Pilot provision to test methodology and to develop outcomes metrics for full service delivery which will become operational in April 2018. To provide an update during January as part of Q3 iBCF reporting				Full new service becomes operational. To set operational baseline as part of Q4 iBCF Q4 reporting.	First month reporting against baseline	Continued monthly reporting as part of business as usual reporting, linked to reducing delayed transfers of care at the weekend.		

Scheme type: 9. High Impact Change Model for Managing Transfers of Care
Subtype: 16. Other
BCF Scheme Description:

Work has been undertaken with the care home sector to ensure that any individual who is fit for discharge over the weekend period can be assessed and returned to their care home. This will form part of our contracts with care homes. This meets the requirements of the 'High Impact Change Model' for managing Transfers of Care in particular seven day working and reducing the pressure on the NHS.

National Metric outcome criteria:

4. Delayed Transfers of Care

This work links to the wider recommissioning of our Care at Home provision. In advance of the new contracts becoming live in April 2018, a pilot will precede this, to develop operations with providers and to integrate into discharge processes.

Links to existing BCF schemes:

- Home First

Financial Year 2017/18:

Scheme	Total
Care Sourcing team	**£159,000**

Scheme Name: Care Package Retention of 7 Days (iBCF)

Sept	Oct	Nov	Dec	Jan	Feb	March	April	May	June	July	Aug
Development of baseline	First review of impact on DTOC. To provide an update during October for Q2 iBCF reporting			Second review of impact on DTOC. To provide an update during January as part of Q3 iBCF reporting			Third review of impact on DTOC. To provide an update during January as part of Q4 iBCF reporting				

Scheme type: 10. Integrated Care Planning
Subtype: 1. Care Planning
BCF Scheme Description:

Cheshire East Council have an agreement with extra care housing schemes and Care at Home providers to pay a retainer to the care provider in order to keep the care provision open whilst the individual is absent for a period of time, e.g., in hospital. The retainer ensures that individual's existing care provider is kept available for a period of up to 7 days to resume the existing care package when the person is fit or ready to return home. If the person is in hospital this should facilitate a timelier/appropriate discharge

National Metric outcome criteria:

4. Delayed Transfers of Care

Retainer has on DTOC as care package is able to continue without need for further assessment
Development of baseline on which to determine impact on DTOC
Review of impact on 7 days or extension to 14 days

Links to existing BCF schemes:

- Home First
- Frailty Approach

Financial Year 2017/18:

Scheme	Total
Care package retention	**£550,000**

Scheme Name: Creation of an Innovation and Transformation Fund (iBCF)

Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug
Bids to be placed to the Innovation Fund. To provide an update during October for Q2 iBCF reporting		Successful bidders notified and plans to be developed with measureable outcomes against National Metrics.		First monthly reporting expected from successful bids. To provide an update during January as part of Q3 iBCF reporting	Continued monthly monitoring to demonstrate impact to the local health and social care system		To provide an update during January as part of Q4 iBCF reporting		Continued monthly monitoring to demonstrate impact to the local health and social care system		

Scheme Type: 16. Other
BCF Scheme Description:

In order to support the 'Caring Together' and 'Connecting Care' transformation plans. Cheshire East Council will create a fund that the NHS and partners can access to support initiatives that promote the move towards integrated working (community teams) to achieve better outcomes for the residents of Cheshire East

National Metric outcome criteria:

1. Non-elective admissions (General and Acute)
2. Admissions to residential and care homes
3. Effectiveness of reablement
4. Delayed Transfers of Care

Business Cases to Better Care Fund Governance Group, October 2017

Links to existing BCF schemes:

New provision, but has the opportunity to link to all schemes

Financial Year 2017/18:

Scheme	Total
Innovation Fund	**£500,000**

Scheme Name: Funding of additional social care staff to support 'Discharge to Assess' initiatives (iBCF)

Sept	Oct	Nov	Dec	Jan	Feb	March	April	May	June	July	Aug
Transfer of additional funding to teams to facilitate additional team members	Recruitment of additional team members within mid-Cheshire team. To provide an update during October for Q2 iBCF reporting		New team members to be in post and DTA model to be implemented within mid-Cheshire	Baseline measurements captured to measure impact of introduction of DTA model. To provide an update during January as part of Q3 iBCF reporting	Capture impact against baseline, to determine progress against reducing DTOC		To provide an update during January as part of Q4 iBCF reporting	Continued monthly monitoring to demonstrate impact to the local health and social care system			

Scheme Type: 10, Integrated Care Planning
Subtype: 2. Integrated Care Packages
BCF Scheme Description:

Funding of additional staff to support the local transformation programmes Caring Together and Connecting Care in implementing a 'Discharge to Assess' model. This builds on the existing initiative with Eastern Cheshire where funding is being targeted at continuing to provide a team manager, social worker and occupational therapist, plus the roll out across mid-Cheshire.

National Metric outcome criteria:

4. Delayed Transfers of Care

Ongoing, review in 6 months' time

Links to existing BCF schemes:

- Home First

Financial Year 2017/18:

Scheme	Total
Discharge to Assess	**£145,000**

Scheme Name: Increasing capacity in the Care Sourcing team and Social Work Team over Bank Holiday Weekends (iBCF)

Sept	Oct	Nov	Dec	Jan	Feb	March	April	May	June	July	Aug
Ensure additional capacity is sourced to cover Bank Holidays.	To provide an update during October for Q2 iBCF reporting			Baseline measurements captured. To provide an update during January as part of Q3 iBCF reporting	Capture impact against baseline, to determine progress against reducing DTOC	To provide an update during January as part of Q4 iBCF reporting	Continued monthly monitoring to demonstrate impact to the local health and social care system				

Scheme Type: 9. High Impact Change Model for Managing Transfers of Care **Subtype: 5. Seven Day Services** **BCF Scheme Description:** This is to ensure patient flow and assisting in reducing the pressure on the NHS can be maintained over a seven day period	**National metric outcome criteria:** 2. Admissions to residential and care homes 3. Effectiveness of reablement 4. Delayed Transfers of Care Ongoing, review in 6 months time (March 2018)
Links to existing BCF schemes: • Home First • Reablement Services	**Financial Year 2017/18:** **Scheme** — **Total** **Care sourcing Bank Holidays/Weekends** — **£17,000**

Scheme Name: Sustain the capacity, capability and quality within the social care market place (iBCF)

Sept	Oct	Nov	Dec	Jan	Feb	March	Apr	May	June	July	Aug
A year long rolling process will be undertaken to ensure that we are responding to emerging demand as required.											

Scheme Type: 8. Healthcare Services to Care Homes
Subtype: 2. Other – Physical Health
BCF Scheme Description:

In order to sustain and stabilise both the Care at Home markets and Accommodation with Care markets. This means transforming the care and support offer to ensure Cheshire East has greater capacity and an improved range of services. Local partners will jointly commission the new offer and include: discharge to assess model, step up/step down beds, more specialist provision for complex needs and care at home services that promote quality of care under the system beds programme.

National Metric outcome criteria:

2. Admissions to residential and care homes
3. Effectiveness of reablement
4. Delayed Transfers of Care

Ongoing, outcomes delivery within 12 months (sept 2018)

Links to existing BCF schemes:

- Home First

Financial Year 2017/18:

Scheme	Total
Sustaining capacity	**£3.218m**

Scheme Name: The use of 'Live Well' Online information and advice resource (iBCF)

Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug
The Live Well online officially launches in September 2017 and will begin to roll out across Cheshire East. The resource will link into CCG services and operations in order to provide a joined up and consist approach to signposting and providing early help.											

Scheme Type: 15. Wellbeing Centres
BCF Scheme Description:

Cheshire East Council has embarked on a programme to deliver a new online resource to the public: Live Well Cheshire East. Both Clinical Commissioning Groups have expressed a desire to utilise this platform and expand the offer to create a community infrastructure that maps all existing assets for use of professional staff alongside members of the public.

National Metric outcome criteria:

1. Non-elective admissions (General and Acute)
2. Admissions to residential and care homes

Ongoing, 12 months for benefits realisation (March 2018)

Links to existing BCF schemes:

- Carers Assessments
- Carers Breaks
- Reablement Services
- Hospital Discharge

Financial Year 2017/18:

Scheme	Total
Live Well	**£103,000**

Section 11- Approach to the use of the Disabled Facilities Grants

The Disabled Facilities Grant (DFG) contributes to preventing non-elective admissions and DTOC in Cheshire East through the provision of adaptations that enable independence at home, and reduce falls and the risk of injury to disabled people and their carers. It is anticipated that 800 people will benefit from adaptations to their home over the period of the BCF plan.

In 2016/17 Cheshire East Council awarded 369 grants at an average of £4,336 per grant. 24% of the programme was spent on early intervention, preventing people's health and social care needs escalating, and 76% on supporting people with high health and social care needs, enabling them to live independently or to receive care at home. 20% of expenditure was on adaptations for children and young people, and 43% for older people - the proportion of expenditure for over 85s was 29%.
More than half of the adaptations provided resulted in a reduction in reliance on informal carers, and 78% would prevent falls that result in injury.

The flexibility of the DFG funding afforded to us through the BCF is being used innovatively through a number of initiatives in Cheshire East:

- An early intervention pathway has been developed, providing early support that prevents people's health and social care needs escalating unnecessarily as a result of non-elective admissions. In 2016/17 this pathway supported 120 people to adapt their homes, increasing their personal dignity, emotional wellbeing, physical wellbeing, reduced reliance on informal carers and preventing non-elective admissions. Local research has shown that two years after bathroom adaptations were provided, 91% of grant recipients were still living with full independence after two years.
- A local adaptation policy has been created which increases the maximum disabled facilities grant from £30,000 up to £50,000, so that large or complex adaptations can proceed quickly without delays being caused by a shortfall in funding.
- The adaptations policy provides for homeowner loans that can be used by family members to adapt their homes so they can provide respite care for disabled people, giving disabled people the same opportunities for family life as able bodied people and allowing them to receive care from other family members.
- Whilst the statutory test of resources is applied, it is recognised that sometimes people are disproportionately affected by the outcome so Cheshire East offer a loan to help with paying contributions
- Cheshire East support people to move to a more suitable home by helping with relocation costs
- Cheshire East maximise choice and control for disabled people, including allowing people to use the grant towards bigger home improvement schemes so that adaptations can be integrated into the home environment more effectively

A comprehensive housing advice service is in place for disabled people through the Home Improvement Agency and the Homechoice team. The Home Improvement Agency provides tailored support to organise home adaptations and apply for funding, provide information and advice about maintaining the home including affordable warmth, home repairs and privately funded adaptations, and provide specialist support for people who are hoarding, an increasing problem which can result in DTOC. The Homechoice team provide help to register and apply for social housing, identifying suitable alternative housing and provide advice on housing options including access to different forms of supported housing and tenancy support.

Section 12 - Assessment and management of risks

Main risks to the delivery of the Better Care Fund in Cheshire East

- Not meeting and achieving the planned DTOC reduction trajectory as outlined and agreed by all partners and NHSE in the planning returns (A&E Delivery Board returns)
- Not completing the redesign of reablement services as per schedule, leading to inefficient reablement and consequent readmissions to hospital
- Failure to support the social care market effectively in order to ensure capacity and capability to provide an effective, efficient and robust workforce is not realised
- Continued financial constraints within the local health and social care system
- Workforce, sustaining the current workforce and growing and diversifying workforce to meet a growing demand
- The ability to mobilise new schemes and interventions that have a measureable impact on the BCF metrics within the existing financial year
- Creating cultural change

At present a comprehensive risk log is maintained and discussed at monthly Better Care Fund Governance Group meetings with all partners. This contains mitigating actions to manage risks and responsible senior leads. An example of this shown below, the log separates risk into Executive owned risks, programme owned risks and, scheme owned risks.

The risk sharing arrangements for over and underspends is directly linked to each scheme specification and the lead commissioning organisation will be responsible for the budget management of the pooled fund allocated to the each individual scheme. The risks of overspends for the schemes included in the BCF plan are currently limited to the funding contribution. A variation schedule has been included in the partnership agreement to provide the lead commissioner with the escalation process to raise issues and concerns.

Current Executive owned Better Care Fund Risks

Risk Ref	Risk Description	DATE IDENTIFIED	DATE LAST REVIEWED	BCF Scheme Ref	Agreed Risk Owner	Current Score			Direction of Travel for Risk Score	Planned Actions	Planned Action Lead	Planned Action Due Date	Residual Score		
						Likelihood	Impact	Total Score					Likelihood	Impact	Total Score
						L	I	Lx I					L	I	Lx I
E1	Failure of BCF schemes to contribute towards reduction in acute activity will lead to MCHFT and ECHT being unable to remove capacity and costs in line with plans, thus reducing the available resource to invest in upstream and/or community-based interventions.	01/09/2014	28/07/2017	All	Fleur Blakeman, Tracy Parker-Priest and Ann Riley	4	4	16	⇆	Agreed that this risk needs to be managed by A&E Delivery Boards but that BCFGG needs to be cognisant of its contribution to mitigating this risk via the contribution of the schemes. Mitigating action includes robust evaluation of all schemes and decommissioning of ineffective or inefficient schemes during	CCGs	Apr-18	4	4	16
E2	Failure of BCF schemes to deliver 7 day services where required and appropriate (e.g. due to lack of available resource and/or breakdown in partner working relationships), will impact on wider 7-day working associated targets and reduce the potential service and system improvements in care.	01/09/2014	28/07/2017	All	Fleur Blakeman, Tracy Parker-Priest and Ann Riley	4	4	16	⇆	Agreed that this risk needs to be managed by A&E Delivery Boards but that BCFGG needs to be cognisant of its contribution to mitigating this risk via the contribution of the schemes. Mitigating action includes robust evaluation of all schemes and agreement amongst partners regarding where 7-day services are required.	CCGs	Apr-18	2	3	6
E15	Failure to support cultural change to promote self-care, and the resulting impact on NELs/DTOC. Should the BCF plans not sufficiently support the culture to promote self-care as well as reablement after ill health, the health and social care system will expend all resources.	31/07/2017	31/07/2017	All	Fleur Blakeman, Tracy Parker-Priest and Nichola Glover-Edge	3	3	12	⇆	This risks cross-cuts across many areas, including Public Health. However, central to creating a balnce to reducing NEL/DTOC our population needs to become empowered to self-care where possible as a first course of action. This is being syupported via activity within the iBCF, its impact with be measured.	CCGs	Oct-17	2	3	6
E16	The CCGs Capped Expenditure Programme places constraints upon the planning processes for health and social care integration during the next 12 months.	31/07/2017	31/07/2017	All	Fleur Blakeman, Tracy Parker-Priest	4	4	16	⇆	Risk is managed by CCGs, however the limitations are managed and supported by ensuring that opportunities to investigate maximum ROI for BCF schemes are being undertaken. Further opportunities to co-deliver services to be explored.	CCGs	Oct-17	3	3	9
E17	The capability and capcity of the health and social care provider market is both in need of development in order to respond to the needs of a changing economy and requires support around staff rention/development.	31/07/2017	31/07/2017	All	Fleur Blakeman, Tracy Parker-Priest and Nichola Glover-Edge	3	4	12	⇆	Plans for iBCF firmly support the development of the capability and capacity of the workforce to deliver the health and social care integration plans in Cheshire East. Cheshire East Council is working with social care providers to deliver new care contracts from April 2018. The VCFS sector is supporting the develiry of a new framework to provide services also from April 2018.	CEC	Apr-18	2	3	6
E18	The ambitious plans for the Accountable Care in Cheshire East are subject to a range of both internal and external influences, of which the BCF is one key stepping stone.	31/07/2017	31/07/2017	All	Fleur Blakeman, Tracy Parker-Priest and Nichola Glover-Edge	3	4	12	⇆	Regular review of planning is essential to ensure that work towards health and social care integration is taking place. New reporting processes have been developed for 2017/18 to capture process, which ensures that evidence-based decisions can be made about developing such ambitious plans.	CCGs	Oct-17	2	3	6
E19	Redesign of reablement services is highlighted a required improvement project reflecting on last years performance (82.4% achievement against an 88% target), also from a service delivery point of view to integrate phyiscal and mental health services into a holistic service. The new service must become operational in April 2018.	31/07/2017	31/07/2017	All	Nichola Glover-Edge	3	3	12	⇆	Dedicated personnal for all partners will follow a project plan whilst business continuity is maintained. Monthly progress will be reported, with risks and any mitigating actions, to ensure plans are on track for new service commencement in April 2018.	CEC	Oct-17	2	3	6

Table 4

(Risks correct as of 17th August 2017)

NB: Risks are reviewed on a quarterly basis as part of good governance arrangements

Financial level risk

The ambition of all partners is to operate a balanced pooled budget, whereby the carry forward of funding is on an exceptional basis and individual partners are not overexposed to financial risk from the schemes included in the BCF this ambition is contained within the S75 agreement between partners and specifies how over/underspends are to managed. At the end of 2016/17 a small underspend of £441,000 was carried forward by Cheshire East Council and partners are in the process of agreeing the deployment of these funds following the S75 agreement to the benefit of the wider BCF and to the overall health and social care system.

Risk sharing contingency arrangements

At present the Cheshire East Better Care Fund group does not have the opportunity to share risks at a system level.

However, the way 'risk' is managed is detailed as below:

- Where BCF schemes are operationally co-managed (via a pooled budget), such as via discharge services that involve health and social care services – risk is managed at an operational level via the teams delivering the services.
- Where there is no formally pooled budget, there is no risk share, each individual organisation retains its own ownership
- The management of over/underspend is managed via an agreement via the S75 policy.

Governance Structure

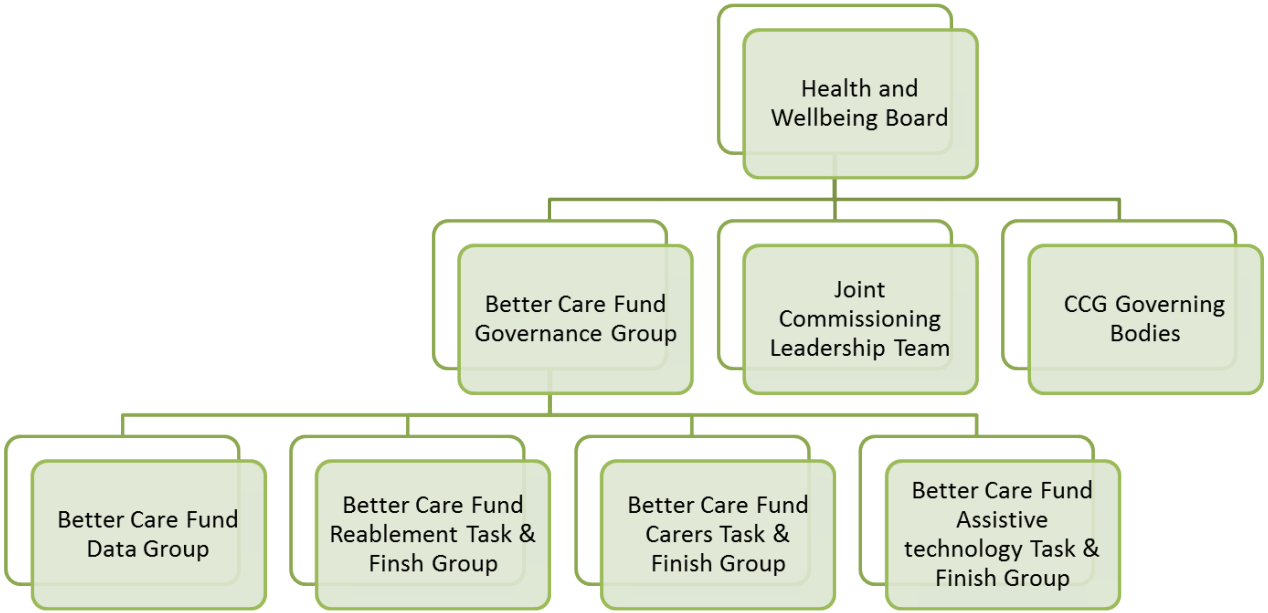


Figure c

Figure d provides an overview of the current structure of the Cheshire East Better Care Fund Governance Structure.

Main management of all risks associated with the Better Care Fund in Cheshire East are undertaken via the **Better Care Fund Governance Group**, which is attended by Directors from all three partner organisations, together with the Better Care Fund Manager, and relevant commissioning and finance colleagues. Manages risks as a standing agenda item and reports risks to the Health and Wellbeing Board as appropriate.

The **Better Care Fund Task and Finish Groups** are time-limited groups, who focus on developing specific areas of work and responding to emerging need. Risks from these groups are reported upwards to the Better Care Fund Governance Group.

Any key decisions will require a cabinet and full council approval before entering any formal agreements

Section 13 – Meeting National Conditions

National condition 1 – a jointly agreed plan

Cheshire East Council, NHS Eastern Cheshire CCG and NHS South Cheshire CCG have jointly agreed the contents of this plan, and will work together collaboratively in order to deliver the National Metrics as set out in the *Integration and Better Care Fund planning requirements for 2017-19*. As local delivery partners we have produced clearly articulated plan for meeting each national condition in their BCF narrative, as set out in the policy framework and operationalised by the guidance contained in this document, as well as in the scheme details entered in the planning template.
Contained in this plan are the clear links to other relevant programmes or streams of work in place locally to deliver these priorities. Our plan demonstrates how we manage risk, from programme level, operational level to financial level. In Appendix 4 there is a section on how as a local health and social care economy we address health inequalities in the area in line with duties in the Health and Social Care Act 2012 and reduce inequalities between people from protected groups in line with the Equality Act 2010.

National condition 2 – social care maintenance

The Cheshire East plan meets the national condition that the NHS contribution to adult social care is maintained in line with inflation. This condition gives effect to the commitment in the Spending Review to continue to maintain the NHS minimum mandated contribution to adult social care to 2020. Further detail is demonstrated in the Financial Plan which compliments this Narrative plan. Costings for each scheme are demonstrated on each individual scheme plan page within this document.

National condition 3 – NHS commissioned out of hospital services

The Cheshire East plan provides details of the schemes that have a clear evidence base and are expected to lead to sustained reductions in acute activity and unplanned admissions. This includes a wide range of services including services targeted to the most vulnerable/ 'at risk' groups via community nursing, therapeutic and adult social care, and have been determined locally to meet the needs of our local population as set out in Section 7 on page 13.

National Condition 4 – Managing Transfers of Care

The Cheshire East plan sets out the agreed joint approach to funding and implementing the joint approach for implement the High Impact Change Model for Managing Transfers of Care. This builds on existing successful local practice and tailored to local demographics. Table 2 provides an overview of the plans for Cheshire East, then the individual schemes plans from pages 24 to 30, then 45 to 56 provides the timescales and costs for individual schemes.

Managing transfers of care in Cheshire East

The Cheshire East BCF schemes are closely aligned to the work undertaken by the A&E Delivery Boards in both areas of Cheshire East, which are part of the North Region. Unless indicated by **RED TEXT** activity is already operational, commence dates are indicated by the dates in brackets.

	High Impact change	NHS Eastern Cheshire CCG	NHS South Cheshire CCG	Better Care Fund
1	Early discharge planning	SAFER bundle Frailty approach – comprehensive geriatric assessment within emergency portals, on wards and in community. Frailty training for health and social care staff then Expected Discharge Date within 6 hours Pre-assessment clinics Integrated Health and Social Care Discharge team Daily Ward Rounds 2 x weekly stranded patient reviews Primary Care Streaming	Establish REACT team in Emergency Dept. to enable to be discharged home rather than being admitted with follow up support if required Early Discharge Facilitator development Development of daily MDTs on the wards. Development of early discharge facilitators on the wards to coordinate timely discharges. Joint discharge policy under review Establish ambulatory care unit Testing direct access for GPS and community matrons to Geriatrician to enhance clinical decision making and if admission is required, supported discharge planning is agreed. Early identification of frailty on presentation to ED, development of Comprehensive geriatric assessment to expedite early discharge planning End of life partnership initiative to work with acute trust and CHC to support coordination of end of life Acute oncology and orthopaedic schemes in place to support pre op education to support planned surgery to improve patient outcomes Psychiatric Liaison support in ED PJ paralysis initiative in acute care	**Supporting Discharge to Assess is part of the iBCF funding (October 2017)**
2	Systems to monitor patient flow	SAFER flow bundle e.g. stranded patient review Action focused bed management meetings Prioritisation & proactive management of DTOC	System requirements currently being defined and comparing best practice to determine future need locally Development of shared care records, funding approved to establish EMIS link in ED and with community teams and primary care. EPACS for cancer services	
3	Multidisciplinary/multi-agency discharge teams	Integrated Discharge Team, multi-disciplinary staff from across health and social care Daily meetings/Board rounds – commissioners involved	Single assessment developed with health and social care to support triage processes for complex discharges and discharge to assess. Development of morning MDT integrated discharge team to allocate patient discharges and support development of discharge to assess model. MDT approach for palliative care developed involving acute and community	A significant element of the iBCF fund in Cheshire East has been allocated towards supporting the development of Connecting Care and Caring

	High Impact change	NHS Eastern Cheshire CCG	NHS South Cheshire CCG	Better Care Fund
		Proactive management approach to delays WTE nurse working on out of area delays to improve repatriation and discharge	service providers including third sector Continue British Red Cross contract to support timely safe discharges using designated BCF funding	Together in Cheshire East. The additional funding is to be utilised over the next 6-12 months to further develop the local health and social care economy **(Feb-Aug 2018)**
4	Home First / Discharge to Access	Single Point of Access Continuing healthcare scheme in place Frailty approach working on a 'Support to Assess' model which avoids admissions **(October 2017)** Spot purchase arrangements in place for discharge to assess	Referrals from wards using single assessment forms into integrated discharge team. Testing discharge of patients to identified community bed bases. Testing discharge of patients using forms to reablement starting 14/8/17 Continuing Health care testing Audit completed on bed based services across acute and community beds to understand current need to inform future modelling as per bed reconfiguration paper Integrated discharge team have developed dashboard to identify key worker to support discharge Workforce review of community services to support management of complex needs in the community and discharge to assess Development of revised role of the community matron to support assessment at home for urgent need Need to develop single point of access to support discharge to assess. Discussions taken place with community providers. Reablement rapid response resource ringfenced to support timely discharge	By the end of March 2018, 75% of hospitals nationally is expected to have this in place. Within Cheshire East this is already in operation within Macclesfield District General Hospital, and through the iBCF funding stream, the same provision will be supported within Mid-Cheshire Hospitals Foundation Trust **(October 2017)**
5	Seven Day Service	Frailty work across 7 days, including single point of access. Recruitment underway Social care weekend working **(October 2017)**	"Community services review of capacity and demand and modelling to support home first model. Current services provided over 7 days include community nursing, intermediate care, community rehab to support falls, hospital at home, GP out of hours. People with existing reablement packages that are admitted to the acute care, have the packages held for 7 days Acute care action plan to support 7 day services. Social care business case being considered to support social care support over the weekend and extended over the week, following pilot and evaluation. Psychiatric Liaison access 7 days per week to support appropriate discharge	Two schemes, 'increased delivery of weekend and Bank Holiday working, and increasing capacity of the care sourcing team over the weekend', are being funded via iBCF monies to further support seven day services in Cheshire East, thus delivering social care support with a health outcome.

	High Impact change	NHS Eastern Cheshire CCG	NHS South Cheshire CCG	Better Care Fund
			plan	
6	Trusted Assessors	Testing Trusted Assessor model Streamlined assessment process in place	Development of Home first care clusters based around geographical footprint with a number of GP clusters based on population of 35k. Single assessment developed with health and social care to support triage processes for complex discharges and discharge to assess to test Review of reablement services across East Cheshire to identify opportunities to widen access to meet demand.	Supporting the delivery of the Trusted Assessor model is part of the iBCF funding plan. **(October 2017)**
7	Focus on choice	*Supporting Patient Choice to Avoid Long Hospital Stays* – policy implemented April 2017	Patients and relatives planning for discharge from point of admission All staff understand choice and can discuss discharge proactively Voluntary sector fully integrated as part of health and social care team in acute and community	Promoting choice and self-care for patients – the 'Live Well' online resource which is one of the additional iBCF schemes will contribute to promoting choice and self-care for patients. Whilst the resource is currently in its infancy it is intended that CCGs and partner organisations add their information to this portal to allow citizens to access to their health and social care information from one place **(September 2017 onwards)**
8	Enhancing health in Care Homes	Nursing Homes – enhanced primary care medical services, proactive Low standardised rates of admission from Nursing Homes Work to be developed in residential homes **(September 2017 onwards)**	Care homes integrated into health and social care systems No variation in the flow of people from care homes into hospital Care homes CQC rates reflect high quality care	

Table 5

Section 14 - Overview of funding contributions

The confirmed spend for the Cheshire East Better Care Fund for the following areas is:

2017/18 Better Care Fund	Amount £
Assistive technology	743,000
Early Discharge	242,000
Combined Reablement	3,961,000
Social Care Act	390,000
Programme Enablers / Residual headroom	1,167,000
Carers Assessment / Support	319,000
Carers breaks	376,000
Frailty /Community Care	8,378,000
Home First (Intermediate Care	7,427,000
Disabled Facilities Grant	1,775,000
TOTAL	**24,778,000**

Improved Better Care Fund

Scheme No.	Name of scheme	Amount £
Scheme 1	Care Home assessments at the weekend	17,000
Scheme 2	Care Package Retention for 7 days	550,000
Scheme 3	Increased capacity in the Care Sourcing Team and Social Work Team over Bank Holiday weekends	159,000
Scheme 4	Funding of additional social care staff to support 'Discharge to Assess initiatives	145,000
Scheme 5	Sustain the capacity and capability within the social care market place	3,218,000
Scheme 6	Creation of an Innovation and Transformation Fund	500,000
Scheme 7	The use of 'Live Well' Online information and advice resource	103,000

All BCF partners within Cheshire East confirm that all spends are being used for their intended purposes and have been agreed with relevant stakeholders

Section 15 - National Metrics

National Metric	Forecast	Level of Ambition	Rationale
Non-elective admissions (General and Acute)	Q1 9,496 Q2 9,631 Q3 10,569 Q4 10,072 2018 Q1 9,622 Q2 9,487 Q3 10,559 Q4 10,063	The level of ambition for Cheshire East is balanced between reducing NELs are part of the delivery plans to keep people out of hospital and supported in the community where possible.	Effective prevention and risk management of vulnerable people through effective, integrated Out-of-Hospital services will improve outcomes for people with care needs and reduce costs by avoiding preventable acute interventions and keeping people in non-acute settings. Within Cheshire East our better care Funds schemes are aligned to the 'prevent' thematic in order to do this using: Assistive technology, Carers assessments, Carers breaks (NB: to become part of the Integrated carers Hub by April 2018), Dementia reablement services (NB: to become part of the Integrated reablement service by April 2018), Disabled facilities grants, Frailty approach, Home First, Reablement services, Social Care Act, iBCF: The use of 'Live Well' online information and advice resource.
Admissions to residential and care homes	616	Please note that the 16/17 figure was the plan figure. The actual totals were: numerator 616; rate 730.5 (using population projection for 16/17). As this target was not achieved in 16/17 it is prudent to use this target again in 17/18	*How will you reduce admissions into residential homes?* Reducing admissions to residential homes in Cheshire East is a challenge given our ageing population. However ensuring that our social care economy is suitably developed to provide additional care and capacity is a key component of the iBCF for 2017/18. In addition, ensuring that those who leave hospital care are enabled and supported is a key feature of our planning, to ensure that people are able to return home instead of being placed into intermediate care. Our other schemes are complimentary to supporting the reduction to residential homes, Frailty approach, Home First, iBCF: Increasing the capacity in the care sourcing team and Social Work team over the Bank Holiday Weekends, iBCF: Sustain the capacity, capability and quality within the social care market place, iBCF: The use of 'Live Well' online information and advice resource.
Effectiveness of reablement	In 2016/17 the target set was 88.4%. The outturn was 82.2%. Therefore the proposal for Cheshire East is that we should continue to work towards 88.4%	The level of ambition of **88.4%** represents a challenge in Cheshire East; given that our population and demographics provide a population who are ageing, with often multiple and complex conditions that require support from multiple providers.	*How will you increase the effectiveness of reablement?* In Cheshire East all BCF partners have agreed to an ambitious plan to bring together our current 'reablement; services to develop a newly designed integrated reablement service that will provide a holistic service, supporting a person physical and mental wellbeing needs. At the same time, and aligned to this, our carers provision is also being redesigned to provide an integrated service – together these two services will become complimentary and thus increase the effectiveness of the wider reablement offer to people living in Cheshire East, and to their carers. In addition, the wider provision of Assistive technology, Disabled facilities grants, Frailty approach, Home First, Hospital Discharge, iBCF: Increasing the capacity in the care sourcing team and Social Work team over the Bank Holiday Weekends, iBCF: Sustain the capacity, capability and quality within the social care market place will provide

			additional efficiencies that will assist us in realising our ambition.
Delayed transfers of care	2017 Q1 1,462.7 Q2 1,217.3 Q3 1,252.2 Q4 1,257.4	The level of ambition is set out in the figures as submitted to NHSE and as part of the CCG returns as part of the A&E Delivery Board Plans. For Cheshire East cumulatively, these are described in table 5 (and also demonstrated separately for both CCG) The data has been calculated using 33.3%, which is the most recent performance data for our locality.	In Cheshire East work is continuing in a dual focussed manner that the local health and social care economy reduces the need for people to go into hospital in the first place via preventative approaches, self care, and early intervention. Where this is not possible, through the complexities of a person's condition, the following schemes form part of the 'reduce and reable' offer. Frailty approach, Home First, Hospital Discharge, Reablement Services, iBCF: High Impact Change Model for Managing transfer of Care, iBCF: Care home assessments at the weekend, iBCF: Care package retention of 7 days iBCF: Funding for additional social care staff to support 'Discharge to Assess' initiatives iBCF: Increasing the capacity in the care sourcing team and Social Work team over the Bank Holiday Weekends, iBCF: Sustain the capacity, capability and quality within the social care market place.

Table 6

An agreement on patient flow

Managing patient flow is linked to the 8 national best practice standards.

Contributions that BCF schemes will make to meeting DTOC targets and meeting the ambition in the A&E Improvement plan

The BCF schemes in Cheshire East make a significant contribution to meeting the ambition in the A&E Improvement plan. Please see pages 45 to 56 for the details of the schemes which contribute directly to this target, together with their timelines and spend.

Developing the Discharge to Assess Model or Trusted Assessor Model in Cheshire East

Cheshire East has a Discharge to Assess pathway in place which involves spot purchasing for Continuing Health Care. There is a draft pathway and model, developed in partnership with East Cheshire Trust, Cheshire East Council and NHS South Cheshire CCG, which will be signed off in September 2017.

The final model is likely to include spot and block purchasing to ensure we retain flexibility to meet differing complex needs e.g. resolving delirium. Targeting the 'right' patients is critical to make this financially sustainable and to prevent additional transitions of care if there is no clinical benefit

The data in table 5 shows the return that was sent to NHS England on the 21st of July 2017, which is coterminous with the A&E Delivery Board Plans to reduce Delayed Transfers of Care.

The data in table 5 is presented as the number of bed days, per day – which need to be reduced in order to meet the projected targets. The Cheshire East Better Care Fund Data Group has developed this accessible data in order to assist operational colleagues in planning.This data forms part of the local data pack which will be routinely collected as part of our monthly data tracker dashboard from October 2017, which will allow close monitoring of outcome and performance in order to react swiftly to emerging trends.

Plans based on 33.3% being attributable to adult social care

Delayed Transfers of Care

Delayed Days per 100,000 population

	17-18 plans												18-19 plans											
	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
NHS attributed delayed days	1082	912	898	1019	1085	951	893	724	727	707	601	645	651	651	651	651	651	651	651	651	651	651	651	651
NHS Eastern Cheshire CCG				444	557	440	414	400	393	372	299	310	327	327	327	327	327	327	327	327	327	327	327	327
NHS South Cheshire CCG				575	528	511	480	324	334	334	302	334	324	324	324	324	324	324	324	324	324	324	324	324
Social Care attributed delayed days	553	487	498	496	528	462	433	350	351	341	289	310	313	313	313	313	313	313	313	313	313	313	313	313
Jointly attributed delayed days	1	0	4	9	10	9	10	10	10	10	9	10	10	10	10	10	10	10	10	10	10	10	10	10
Total Delayed Days	1636	1399	1400	1524	1622	1422	1336	1083	1088	1057	899	964	974	974	974	974	974	974	974	974	974	974	974	974
			Q1 17/18			Q2 17/18			Q3 17/18			Q4 17/18			Q1 18/19			Q2 18/19			Q3 18/19			Q4 18/19
BCF Submission Quarterly Profile			4435			4568			3507			2920			2921			2921			2921			2921
Population Projection (SNPP 2014)	303,216	303,216	303,216	303,216	303,216	303,216	303,216	303,216	303,216	304,505	304,505	304,505	304,505	304,505	304,505	304,505	304,505	304,505	304,505	304,505	304,505	305,640	305,640	305,640
TOTAL Delayed Transfers of Care (delayed days) from hospital per 100,000 population (aged 18+)	540	461	462	502.5	535.1	469.0	440.6	357.2	358.9	347.2	295.2	316.6	319.8	319.8	319.8	319.8	319.8	319.8	319.8	319.8	319.8	318.6	318.6	318.6
NHS attributable Delayed Transfers of Care (delayed days) from hospital per 100,000 population (aged 18+)	357	301	296	336.0	357.7	313.6	294.6	238.7	239.8	232.0	197.3	211.7	213.8	213.8	213.8	213.8	213.8	213.8	213.8	213.8	213.8	213.0	213.0	213.0
Social Care attributable Delayed Transfers of Care (delayed days) from hospital per 100,000 population (aged 18+)	182	161	164	163.5	174.1	152.4	142.7	115.3	115.7	111.8	94.9	101.7	102.8	102.8	102.8	102.8	102.8	102.8	102.8	102.8	102.8	102.4	102.4	102.4

Delayed Days per Day per 100,000 population

	17-18 plans												18-19 plans											
	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
NHS attributed delayed days per day	36	29	30	33	35	32	29	24	23	23	21	21	22	21	22	21	21	22	21	22	21	21	23	21
NHS Eastern Cheshire CCG				14	18	15	13	13	13	12	11	10	11	11	11	11	11	11	11	11	11	11	12	11
NHS South Cheshire CCG				19	17	17	15	11	11	11	11	11	11	10	11	10	10	11	10	11	10	10	12	10
Social Care attributed delayed days per day	18	16	17	16	17	15	14	12	11	11	10	10	10	10	10	10	10	10	10	10	10	10	11	10
Jointly attributed delayed days per day	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total Delayed Days per day	55	45	47	49	52	47	43	36	35	34	32	31	32	31	32	31	31	32	31	32	31	31	35	31
Population Projection (SNPP 2014)	303,216	303,216	303,216	303,216	303,216	303,216	303,216	303,216	303,216	304,505	304,505	304,505	304,505	304,505	304,505	304,505	304,505	304,505	304,505	304,505	304,505	305,640	305,640	305,640
TOTAL Delayed Transfers of Care (delayed days) per day from hospital per 100,000 population (aged 18+)	18.0	14.9	15.4	16.2	17.3	15.6	14.2	11.9	11.6	11.2	10.5	10.2	10.7	10.3	10.7	10.3	10.3	10.7	10.3	10.7	10.3	10.3	11.4	10.3
NHS attributable Delayed Transfers of Care (delayed days) per day from hospital per 100,000 population (aged 18+)	11.9	9.7	9.9	10.8	11.5	10.5	9.5	8.0	7.7	7.5	7.0	6.8	7.1	6.9	7.1	6.9	6.9	7.1	6.9	7.1	6.9	6.9	7.6	6.9
Social Care attributable Delayed Transfers of Care (delayed days) per day from hospital per 100,000 population (aged 18+)	6.1	5.2	5.5	5.3	5.6	5.1	4.6	3.8	3.7	3.6	3.4	3.3	3.4	3.3	3.4	3.3	3.3	3.4	3.3	3.4	3.3	3.3	3.7	3.3

Table 7

Non Elective Admissions

Through the schemes listed above NHS South Cheshire CCG have already seen a reduction in both A&E attendances and NELs compared to 15/16 data. NEL Type 1 attendances to admissions are also down nearly 4% compared to 2016 data. The A&E 4 hour performance was 92.63% which is still above the STF trajectory of 91.34%. NEL length of stay has further decreased resulting in lower numbers of medical outliers.

DTOC

There has been a general decrease in the number of DTOC, however in July we saw an increase in the number of DTOC mainly due to the higher dependency of patients requiring ongoing care. The introduction of the Discharge to Assess process has resulted in a significant reduction in DTOCs and the trajectory of 5.5% has been achieved. However this needs to be further reduced over the following months both through the schemes within the BCF and ongoing transformation of services to reach the nationally and locally agreed targets A target of 3.5% by November 2017 has been agreed for South Cheshire CCG and a target of 5.2% by March 31 2018 for Eastern Cheshire CCG. Some of the schemes especially within the iBCF are going to be in place realistically in Q4 and this may affect the both DTOCs and NELs as the winter period will have commenced.

Further work is commencing locally regarding the out of area patients' impact on our DTOC trajectory position. Due to the geographical position of Cheshire East, a significant number of patients are from out of the area (350 in July 2017 for Eastern Cheshire CCG), which further impacts on our ability to achieve challenging targets.

Scheme Name: Assistive Technology

Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug
Review of existing contract with CCG partners to identify opportunities for efficiencies. Provide update for Q2 iBCF reporting.			Plan implementation of any changes proposed including impact assessments. Provide update for Q3 iBCF reporting				Implement changes, setting measureable impact against BCF National Metrics.	Initial impact report for Q4 iBCF reporting.			First report on impact of changes.

Scheme Type: 1. Assistive Technology
Subtype: 1. Telecare & 2. Wellness Services
BCF Scheme Description:

The use of Assistive Technology (AT) is increasing and new initiatives are being developed. Assistive technologies will be considered as part of the assessment for all adults who are eligible for social care under the Care Act. The provision of assistive technology will be personalised to each individual and will be integrated within the overall support plan.
Assistive technology has generally been focused on maintaining the independence of older people in a community setting and Cheshire East generally supports over 1,925 customers a month with telecare support.
The scheme aims to continue to support the existing assistive technology services and piloting assistive technology support for adults with a learning disability living in supported tenancies and living in their own homes.

National Metric outcome criteria:

1) Non-elective admissions (General and Acute)
3) Effectiveness of reablement

<u>Adult Social Care Outcome Framework</u>
1B: Proportion of people who use services who have control over their daily life
3A: Overall satisfaction of people who use services with their care and support
3B: Overall satisfaction of carers with social services
3D: The proportion of people who use services and their carers who find it easy to find information out about services
4B: The proportion of people who use services who say that services have made them feel safe and secure

Links to other BCF schemes:

- Reablement

Financial Year 2017/18:

Scheme	Total
Assistive Technology	**£743,000**

Scheme Name: Carers Assessments/ from April 2018 – Integrated Carers Hub

Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug
Carers Assessments will be delivered as part of business as usual between September 2017 and March 2018. During this period, service redesign will take place to develop an integrated Carers Hub, to bring together all services and resources for carers to commence from April 2018. During the period of redesign routine outcome data will be collected on a quarterly basis to inform BCF quarterly monitoring returns.							First month of service provision for the new Carers Hub	First data returns to be received from new service. Collation of data for Q4 BCF reporting.	Continued data collection as part of business as usual.		

Scheme Type: 2. Carers Services
Subtype: 2. Implementation of Care Act
BCF Scheme Description:

Increase the number of carers assessments performed and to develop a clearer understanding of residents who rely on carer support
To provide effective crisis support for carers to reduce unnecessary emergency admissions to hospital and reduce admissions to residential care, to maintain the independence of the person being cared for
Establish what works for carers and what produces sustainable savings locally by understanding the impact of carer support on delayed discharges, the need for social care and emergency hospital admissions, and by evaluating the range of carer support packages.
Reduce the need for health and social care services and improve wellbeing of carers by providing short-term preventative packages of support.

National Metric outcome criteria:

1) Non-elective admissions (General and Acute)
3) Effectiveness of reablement

<u>Adult Social Care Framework</u>
1I: The proportion of people who use services, and their carers, who reported that they had as much social contact as they would like.
1D: Carer reported quality of life.
3B: Overall satisfaction of carers with social services.
3c: Proportion of carers who report that they have been included or consulted in discussion about the person they care for
3D: The proportion of people who use services and their carers who find it easy to find information out about services.

Links to other BCF schemes:

- Carers breaks
- Making Space also provide Trusted Assessor Mental Health assessments

Financial Year 2017/18:

Scheme	Total
Carers Assessments	**£319,000**

Scheme Name: Carers Breaks – from April 2018 Integrated Carers Hub

Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug
A Carers wellbeing Fund will be initiated as part of business as usual between September 2017 and March 2018. During this period, service redesign will take place to develop an integrated Carers Hub, to bring together all services and resources for carers to commence from April 2018. During the period of redesign routine outcome data will be collected on a monthly basis to inform BCF quarterly monitoring returns.							First month of service provision for the new Carers Hub	First data returns to be received from new service.			

Scheme Type: 3. Carers Services
Subtype: 2. Implementation of the Care Act
BCF Scheme Description:

Partners across Health and Social Care recognise that by aligning our resources to support carers we enable to delivery of more consistent outcomes, whilst also reducing the waste and duplication between historic arrangements. This scheme combines the former CCG funded carer breaks with the social care act carer assessment duties.

To effectively commission carers' breaks across Cheshire East across the health and social care boundary
To ensure Cheshire East Council meets its duties under the Social Care Act
To provide effective Carers' Breaks to reduce unnecessary admissions to hospital and reduce admissions to residential care, to maintain the independence of the person being cared for
Generate evidence to inform future commissioning intentions

National Metric outcome criteria:

1) Non-elective admissions (General and Acute)
3) Effectiveness of reablement

Adult Social Care Outcomes Framework

1D: Carer reported quality of life

Links to other BCF schemes:

- Carers Assessments
- Social Care Act
- Reablement

Financial Year 2017/18:

Scheme	Total
Carers breaks	**£376,000**

Scheme Name: Disabled Facilities Grants

Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug
The provision of Disabled Facilities Grants is a year round programme. However, additional reporting is due to be undertaken in 2017/18 in order to further triangulate the data about the recipients of the grants to determine the impact it has in reducing or social care needs (i.e. reduced social care packages) or if it helps a person to return home from hospital sooner. Additional narrative reporting will be undertaken for BCF reporting in November 2017 for Q2, March 2018 for Q3 and May for Q4.											

Scheme Type: DFG Adaptations
BCF Scheme Description:

The Disabled Facilities Grant scheme is to provide 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.

What outcomes will be delivered:

1) Non-elective admissions (General and Acute)
3) Effectiveness of reablement

Links to other BCF schemes:

- Reablement
- Social Care Act

Financial Year 2017/18:

Scheme	Total
Disabled Facilities Grants	**£1,775,000**

Scheme Name: Home First (NHS Eastern Cheshire CCG)

Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug
Home First in Eastern Cheshire continues as part of business as usual, however this work is subject to the review and ongoing work carried out by Fusion48, so may be subject to some changes as the outcome of these reviews is known.											

Scheme Type: 10. Integrated Care Planning
Subtype: 1. Care Planning
BCF Scheme Description:

Providers will empower people with more complex needs with support from a fully integrated community team. So that:
Risk stratification of the population will enable services to be targeted to the people who need them. It will identify the top 20% of the population who are most at risk of experiencing poor health and empower them to live more independently
These people will receive a single assessment focused on their lifestyle, goals and care needs using a joint assessment across health and social care
For those most at risk, a care co-ordinator will be identified from within an integrated community team
A care plan will be created jointly with the person to include goals, required interventions, provider details, and information on who to contact in case of change or crisis. For less complex needs, this may simply be a crisis plan
Services will then be put in place to empower the person and their carers and meet their needs. The integrated community team and care co-ordinator (if appointed) will then undertake case management to empower the person to follow the care plan and make sure that care takes place

National Metric outcome criteria:

1) Non-elective admissions (General and Acute)
2) Admissions to residential and care homes
3) Effectiveness of reablement
4) Delayed Transfers of Care

<u>Adults Social Care Outcomes Framework</u>
Domain 1- Enhancing quality of life for people with care and support needs

Domain 2 - Delaying and reducing the needs for care and support

Domain 3 - Ensuring that people have a positive experience of care and support

Domain 4 - Safeguarding people whose circumstances make them vulnerable and protecting them from harm

Links to other BCF schemes:

- Reablement

Financial Year 2017/18:

Scheme	Eastern Cheshire	Total
Frailty Approach	**£8,378,000**	**£8,378,000**

Scheme Name: Home First (NHS South Cheshire CCG)

Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug
Home First is continuing service delivery, however is subject to local review and is part of wider developments such as the GP Integrated Care.											

Scheme Type: 9.High Impact Change Model for Managing Transfer of Care
Subtype: 4. Home First / Discharge to Assess
BCF Scheme Description:

Explore and identify opportunities to work in collaboration with the wider health and social care economy, such as voluntary sector, pharmacy services and primary care to create more of an emphasis on enablement and self-empowerment to meet health and social care needs.
Scope the potential financial impact on reducing emergency admissions as part of the redesign, with greater emphasis on medical responsibility being maintained in primary care, with support from specialist services.
Streamline the assessment process of patients that supports safe transfer of care and improves patient experience, utilising a comprehensive geriatric assessment to outline future management plans and reduce the risk of readmission or long term care placement. There is a need to quantify potential impact on readmission rates and CHC reduction costs based on national data if possible
Target a reduction in delays in transfers of health and social care with the development of the trusted assessor framework.
Develop a discharge to assess model that improves timely discharge from acute care of frail older people to their normal place of residence as soon as the acute treatment is complete with an assessment that have agreed personalised goals agreed in conjunction with the person and carers.
Improve utilisation of commissioned community bed stock to meet patient need rather than service need.

National Metric outcome criteria:

1) Non-elective admissions (General and Acute)
2) Admissions to residential and care homes
3) Effectiveness of reablement
4) Delayed Transfers of Care

Links to other BCF schemes:

- Reablement

Financial Year 2017/18:

Scheme	South Cheshire	Total
Home First	**£7,627,000**	**£7,427,000**

Scheme Name: Hospital Discharge

Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug
Business as usual, however monthly data collection to commence in order to provide more robust reporting and increased intelligence of how service is used.						Collation of relevant narrative to demonstrate impact on National Metrics for Q3 BCF reporting.		Collation of relevant narrative to demonstrate impact on National Metrics for Q4 BCF reporting.			

Scheme Type: 16. Other
BCF Scheme Description:

The service will support people who are at risk of hospital admission or who have been admitted to hospital.
The service will accompany patients' home following discharge from hospital following an inpatient stay, discharge from A&E or where an individual has been identified by a health or social care professional as being at risk of admission to hospital. Assistance will be provided to the individual in settling back home and followed up to ensure that the individual is managing well.
The service will provide a Safe and Well risk assessment upon arrival at the individual's home, and will trigger appropriate Safeguarding and Welfare processes where concerns are raised - for example, serious concerns about living conditions.
The service will provide assistance to transport the patient home from hospital where appropriate and based on need, may refer the individual for additional support from the Support to Return Home service to meet the needs of the individual for up to four weeks.

National Metric outcome criteria:

3) Effectiveness of reablement
4) Delayed Transfers of Care

<u>NHS Outcomes Framework</u>

Domain 2: Enhancing quality of life for people with long-term conditions
Domain 3: Helping people to recover from episodes of ill health or following injury.

<u>Adult Social Care Outcomes Framework</u>

Domain 1: Enhancing quality of life for people with care and support needs
Domain 2: Delaying and reducing the need for care and support.

<u>Cheshire East Council's Corporate Outcomes</u>

1. Our local communities are strong and supportive
5. People live well and for longer

Links to other BCF schemes:

- Frailty Service

Financial Year 2017/18:

Scheme	Total

• Home First • Reablement	**Hospital Discharge**	**£242,000**

Scheme Name: Programme Enablers

Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug
Development of the 2 year BCF Plan	Q2 iBCF reporting	Q2 BCF reporting		Q3 iBCF Reporting		Q3 BCF Reporting	Q4 iBCF Reporting	Q4 BCF reporting			

Scheme Type: 7. Enablers for integration
Subtype; 3. Programme Management
BCF Scheme Description:

The delivery of the Better Care Fund will relies on joint commissioning plans already developed across the Cheshire East Health and Social Care economy.

The role covers the following skill set:

- 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.

National Metric outcome criteria:

1) Non-elective admissions (General and Acute)
2) Admissions to residential and care homes
3) Effectiveness of reablement
4) Delayed Transfers of Care

Links to other BCF schemes:

- Assistive Technology (& falls service)
- Carers Assessments
- Carers Breaks
- Dementia Reablement services
- Disabled Facilities Grants
- Frailty Approach (East)
- Home First / Intermediate Care (South)
- Hospital Discharge Scheme (Cheshire East wide)
- Reablement services
- Social Care Act

Financial Year 2017/18:

Scheme	Total
Programme Enablers	**£139,000**

Scheme Name: Reablement Services

Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug
Reablement services are to be redesigned and developed into an integrated service that will support both physical and mental health needs. It is anticipated that the new service provision will become operational in April 2018.											

Scheme Type: 11. Intermediate Care Services
Subtype 4. Reablement Services
BCF Scheme Description:

Rapid response to assess people at home within 2 hours of referral which enables packages of care to be arranged in the person's home until they return to full health and function.
Short term intervention at a person's place of residence to enable the patient to recover safely and achieve baseline functional skills with a review of future health and social care needs.
Step up bed based services that prevent inappropriate admission to acute care by taking referrals from community.
Step down bed based services that facilitate a stepped pathway out of hospital and enables facilitation to support return to a patient's normal place of residence.
Strengthen interface with primary and community care to improve continuity in care and case management approach.

National Metric outcome criteria:

1) Non-elective admissions (General and Acute)
3) Effectiveness of reablement
4) Delayed Transfers of Care (reducing Delayed Transfers of Care (DToC) nationally to 3.5% of occupied bed days by September 2017)

Links to other BCF schemes:

- Dementia reablement service
- Carers Assessments
- Carers breaks
- Social Care Act

Financial Year 2017/18:

Scheme	Total
Reablement Services	**£3,961,000**

Scheme Name: Social Care Act

Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug
The provision of Social Care Act is a year round programme. However, additional reporting is due to be undertaken in 2017/18 in order to further triangulate the data about the recipients of Social Care Act to determine the impact it has in reducing or social care needs (i.e. reduced social care packages) or if it helps a person to return home from hospital sooner. Additional narrative reporting will be undertaken for BCF reporting in November 2017 for Q2, March 2018 for Q3 and May for Q4.											

Scheme Type: 3. Carers Services
Subtype; 2. Implementation of Care Act
BCF Scheme Description:

This scheme strengthens the implementation of the Care Act 2014 responsibilities that are funded from the Better Care Fund. The Care Act 2014 introduced and revised some of the statutory responsibilities of local authorities. This scheme will ensure sustainable appropriate embedded solutions are in place to meet these responsibilities.

This scheme also includes a number of Social Care Act services which were identified as being funded from the Better Care Fund.

National Metric outcome criteria:

1) Non-elective admissions (General and Acute)
3) Effectiveness of reablement

Adult Social Care Framework
3A: Overall satisfaction of people who use services with their care and support
3B: Overall satisfaction of carers with social services
3D: The proportion of people who use services and their carers who find it easy to find information out about services
4B: The proportion of people who use services who say that services have made them feel safe and secure

Links to other BCF schemes:

- Carers assessments
- Reablement
- Carers breaks

Financial Year 2017/18:

Scheme	Total
Social Care Act	**£390,000**

Scheme Name: Innovation and Transformation Fund (Core BCF)

Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug
Bids to be placed to the Innovation Fund.		Successful bidders notified and plans to be developed with measureable outcomes against National Metrics. To provide an update during November for Q2 BCF reporting		First monthly reporting expected from successful bids.	Continued monthly monitoring to demonstrate impact to the local health and social care system. To provide an update during February as part of Q3 BCF reporting		To provide an update during May as part of Q4 BCF reporting		Continued monthly monitoring to demonstrate impact to the local health and social care system		

Scheme Type: 16. Other
BCF Scheme Description:

In order to support the 'Caring Together' and 'Connecting Care' transformation plans. Cheshire East Council will create a fund that the NHS and partners can access to support initiatives that promote the move towards integrated working (community teams) to achieve better outcomes for the residents of Cheshire East

National Metric outcome criteria:

1. Non-elective admissions (General and Acute)
2. Admissions to residential and care homes
3. Effectiveness of reablement
4. Delayed Transfers of Care

Business Cases to Better Care Fund Governance Group, October 2017

Links to existing BCF schemes:

New provision, but has the opportunity to link to all schemes

Financial Year 2017/18:

Scheme	Total
Innovation Fund	**£1,028,000**

Section 16 - Approval and sign-off

Signed on behalf of the Cheshire East Health and Wellbeing Board	
By	Cllr. Rachel Bailey
Position	Leader of the Council, Chair of the Health and Wellbeing Board
Date	11th September 2017

Signed on behalf of NHS Eastern Cheshire Clinical Commissioning Group	
By	Jerry Hawker
Position	Chief Officer
Date	11th September 2017

Signed on behalf of NHS South Cheshire Clinical Commissioning Group	
By	Tracy Parker-Priest
Position	Executive Director of Transformation and Commissioning
Date	11th September 2017

The following documents are appended into this document:	**Embedded document**
People live well, for longer. Cheshire East Council Commissioning Plan 2017-20	 PEOPLE LIVE WELL FOR LONGER - V4 -5
Adult Social care, Market Position Statement, Cheshire East Council 2017 to 2020	 ADULT SOCIAL CARE MPS - V4 5.5.17.pdf
Central Cheshire Operational Plan, 2017-2019	 FINALCentral_Cheshi re_(NHS_South_Ches
NHS Eastern Cheshire CCG Plan on a Page, 2017-19	 ECCCG Plan on a Page 2017-19.pdf

Appendix 1 – The Cheshire East Council Market Position Statement 2017-20

Excerpt from the Cheshire East market Position Statement 2017-20

(Adapted from Adult Social Care Market Position Statement, The way to excellent care and support in Cheshire East, 2017 to 2020)

Cheshire East Council is currently working with a wide range of care home providers, mostly private sector organisations, covering Cheshire East. At present a re-commissioning exercise is being undertaken to re-procure the domiciliary care (to be renamed ***Care at Home***) market in Cheshire East. Providers are working closely with the council as part of this exercise which is expected to be completed in April 2018.

There are 95 care homes (48 residential and 47 nursing homes) in Cheshire East, which represents 3838 beds (1242 residential beds and 2596 nursing beds).
The council commission on average 33% of the available care home beds within the council footprint.
There is an average of 5% vacancies across care homes within the council footprint. Annual cost for care home placements (including respite/short stay) for 2015/16 was £46,517,556.
The primary need group is older people and frail and about 20% people under 65 with more complex care needs.
The current purchasing arrangement is a 100% post purchase bases.

Domiciliary Care (Care at Home)

Cheshire East Council is currently working with a wide range of domiciliary care (Care at Home) providers, mostly private sector organisations, covering Cheshire East with some smaller third sectors providers.
The Council commission with 61 Domiciliary Care (Care at Home) agencies (42 within Cheshire East Council area and 19 outside of the area)
This represents 1279 people in receipt of a domiciliary care service, each week.
At an annual cost of £9,942,605.

Domiciliary Care (Care at Home) in Supported Living with a local landlord

Cheshire East Council contract with 29 providers (8 within the council area and 21 outside of the area)
This represents 258 residents (152 within the Council area 106 outside the area)
At an annual cost for personal support of £13,535,807.
The main needs group being people under 65 presenting with more complex care needs – such as learning disabilities/ Autism and Mental health.

Carer Respite (Residential)

Cheshire East Council currently commission 16 beds (14 pre bookable and 2 emergency. Beds are spread across 11 homes throughout the Council area – this provision is currently being reviewed.
This represents 234 residents having access to the pre booked respite beds since Dec 2015, equating to over 2,400 nights stay.

Extra Care Housing PFI (Private Finance Initiative)

Cheshire East Council commission five extra care schemes, 3 in Cheshire East which has (256 apartments) and 2 in Cheshire West which has (177 apartments), at an annual cost for PFI of £4,800,000, the majority of which is funded through Grant (PFI credits) from central government.
Cheshire East Council also commissions non – PFI Extra Care, 2 schemes where the Council contracts for the care in 136 apartments.
Whilst some people are working age under 65 with various disabilities – most people are older people and frail.

Appendix 2 – Summary of evaluation of schemes in 2016/17

Scheme **New name in red**	**Outcome from evaluation meeting**	**Next steps**
STAIRRs Programmes (Reablement programmes)	Not evaluated in 2016/17 due to ongoing redesign work through the Home First approach.	Transformational plans in place implement a community focused Home First model. Links to DTOC trajectory
Dementia Reablement Service	Service evaluated however, dementia reablement should form part of a core 'reablement offer'	
Assistive Technology	Following evaluation the continuation of assistive technology is subject to redesign in order to continue to be funded under BCF.	Prepare to redesign jointly across CCGs/CEC and including the current falls services. Improved identification of target audiences Target: work to be completed by 01/12/2017 Efficiency saving of 25% against full year spend NB: CEC currently re-let AT contract and are committed for 3 years
Carers Assessments	Not evaluated as part of Mandatory provision	No further action at this point
Carers Breaks	Following evaluation Carers Breaks will continue, however it was decided that there should be increased support in order to achieve improved outcomes for this area	Prepare to meet in 8 weeks' time to share all best practice relating to carers breaks Cross-cuts other service lines Improved identification of target audiences
Cheshire Care Record	Evaluated within its own governance arrangements	Decision taken to discontinue.

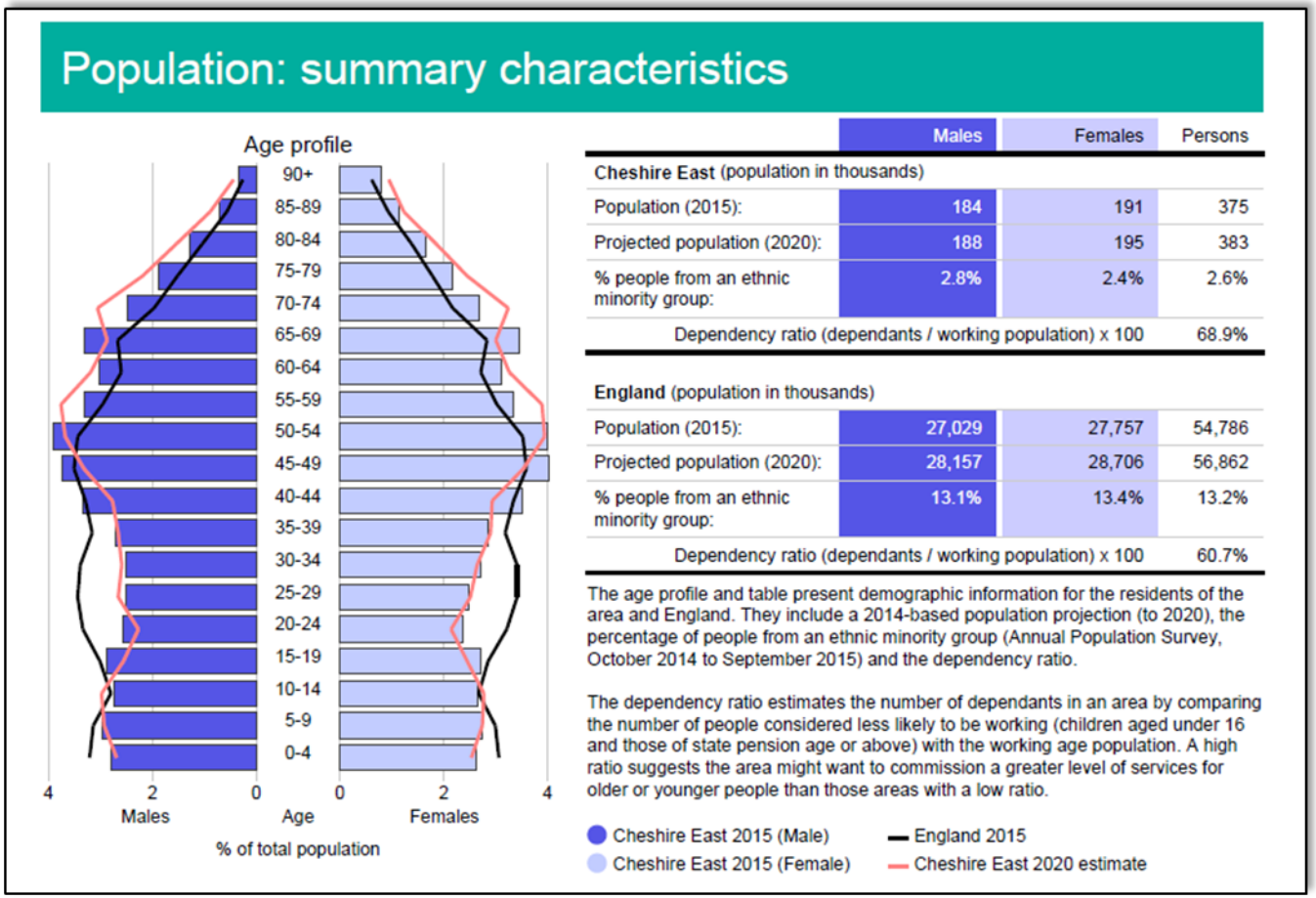
Scheme New name in red	Outcome from evaluation meeting	Next steps
Community Equipment Store - additional contribution **Community Equipment**	Service evaluated outside BCF.	No further action required.
Disabled facilities Grants	Not evaluated during 2016/17 within BCF.	Cheshire East Council is required to pool this funding within BCF
Early Discharge Schemes **Hospital Discharge Scheme**	Evaluation was carried out which led to the development of a new service specification Being re-procured with new service spec	New enhanced specification now completed to support the reduction in admissions and support the reduction in DTOC through admission avoidance
East Community Based Co-ordinated Care (Frailty) **Home First (East)**	Caring Together awaiting outcome of NHS regulator review of service proposals/options (also link to Capped Expenditure Programme outputs). Services within BCF support admission avoidance/patient flow. Internal evaluation on-going and will be shared when complete. in progress	No further action required at this point
Life Links	Following evaluation in December 2016, it was decided to discontinue the service.	Learning is taking place from this pilot. Ann Riley is lead.

Scheme New name in red	Outcome from evaluation meeting	Next steps
Program Enablers	Not evaluated as part of Mandatory provision (Further breakdown of spend requested)	2016/17 Budget was £295,000 Actual was £185,157 Underspend was £109,843 The main items of expenditure incurred were as follows :- Programme Management £78k Financial Support Communications Support £58k Training £21k Other £5k As a result of the position for 2016/17 BCF Governance Group have agreed to reduce the Enablers budget for 2017/18 to £139,175 – a reduction of £155,825 The £139k is made up of :- Programme Management £93k Financial Support £36k Other (conference, training etc.) £10k
Social Care Act	Not evaluated as part of Mandatory provision	No further action at this point
South Integrated Community Teams	Service not evaluated during 2016/17. Redesign of the service ongoing to ensure care communities are developed	No further action required
Supporting Empowerment	Previously agreed that this should be discontinued.	No further action required

Table 8

Appendix 3 -Background and context – demographics

Figure d Age demographics



	Males	Females	Persons
Cheshire East (population in thousands)			
Population (2015):	184	191	375
Projected population (2020):	188	195	383
% people from an ethnic minority group:	2.8%	2.4%	2.6%
Dependency ratio (dependants / working population) x 100			68.9%
England (population in thousands)			
Population (2015):	27,029	27,757	54,786
Projected population (2020):	28,157	28,706	56,862
% people from an ethnic minority group:	13.1%	13.4%	13.2%
Dependency ratio (dependants / working population) x 100			60.7%

The age profile and table present demographic information for the residents of the area and England. They include a 2014-based population projection (to 2020), the percentage of people from an ethnic minority group (Annual Population Survey, October 2014 to September 2015) and the dependency ratio.

The dependency ratio estimates the number of dependants in an area by comparing the number of people considered less likely to be working (children aged under 16 and those of state pension age or above) with the working age population. A high ratio suggests the area might want to commission a greater level of services for older or younger people than those areas with a low ratio.

Figure e Life Expectancy in Cheshire East

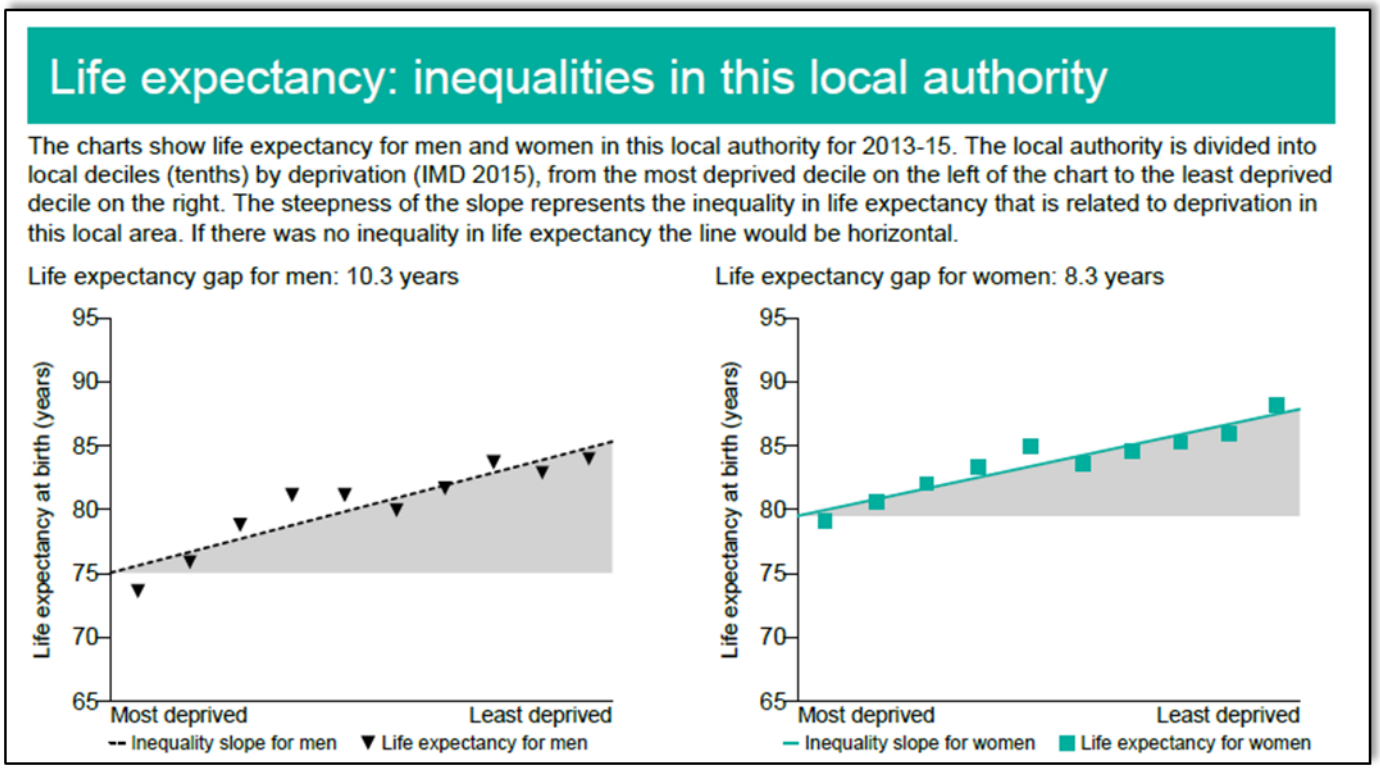
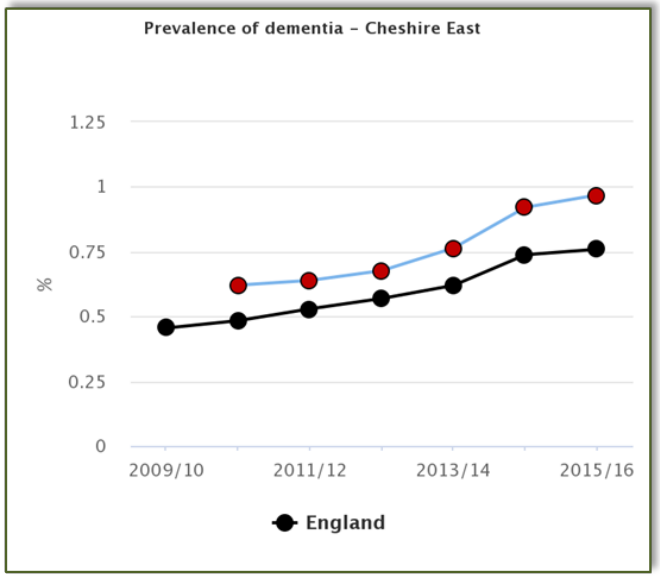


Figure f Prevalence of Dementia

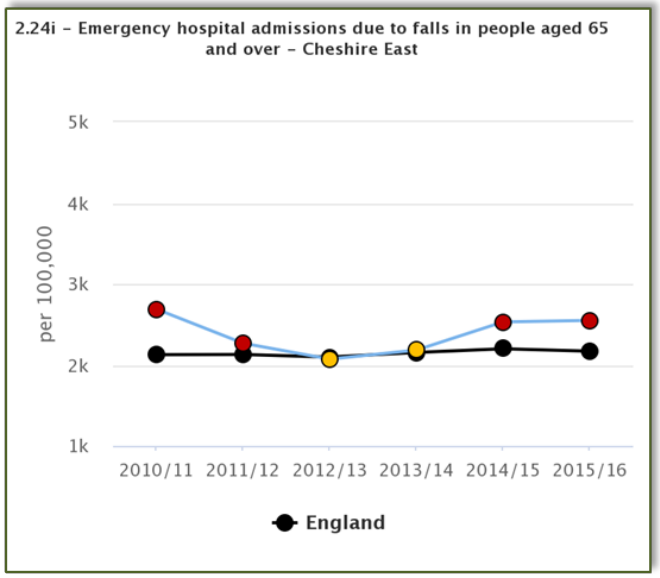


Recent trend:

Period		Count	Value	Lower CI	Upper CI	North West	England
2011/12		2,434	0.6	0.6	0.7	0.6	0.5
2012/13		2,594	0.7	0.7	0.7	0.6	0.6
2013/14		2,950	0.8	0.7	0.8	0.7	0.6
2014/15		3,578	0.9	0.9	1.0	0.8	0.7
2015/16		3,797	1.0	0.9	1.0	0.8	0.8

Source: QOF

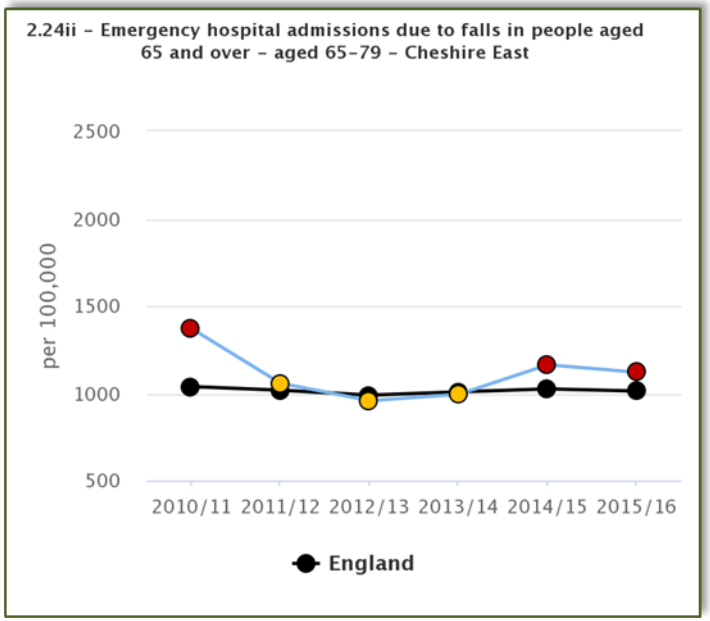
Figure g Emergency hospital admissions in Cheshire East



Recent trend: –

Period		Count	Value	Lower CI	Upper CI	North West	England
2010/11	●	1,917	2,690	2,570	2,814	2,516	2,126
2011/12	●	1,679	2,268	2,160	2,379	2,453	2,128
2012/13	●	1,575	2,072	1,970	2,177	2,376	2,097
2013/14	●	1,720	2,183	2,080	2,289	2,393	2,154
2014/15	●	2,063	2,531	2,422	2,643	2,547	2,199
2015/16	●	2,130	2,549	2,442	2,660	2,452	2,169

Source: Hospital Episode Statistics (HES), NHS Digital for the respective financial year, England. Hospital Episode Statistics (HES) Copyright © 2016, Re-used with the permission of NHS Digital. All rights reserved. Local Authority estimates of resident population, Office for National Statistics (ONS) Unrounded mid-year population estimates produced by ONS and supplied to the Public Health England

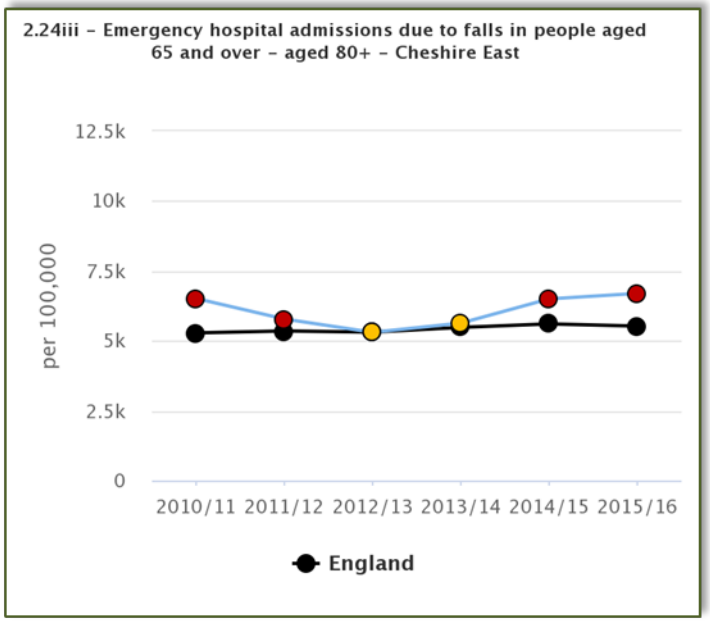


Recent trend: –

Period		Count	Value	Lower CI	Upper CI	North West	England
2010/11	●	682	1,371	1,270	1,478	1,307	1,038
2011/12	●	536	1,057	969	1,151	1,236	1,017
2012/13	●	504	957	875	1,045	1,174	989
2013/14	●	550	993	912	1,080	1,164	1,007
2014/15	●	657	1,162	1,075	1,255	1,234	1,024
2015/16	●	652	1,120	1,035	1,209	1,206	1,012

Source: Hospital Episode Statistics (HES), NHS Digital for the respective financial year, England. Hospital Episode Statistics (HES) Copyright © 2016, Re-used with the permission of NHS Digital. All rights reserved. Local Authority estimates of resident population, Office for National Statistics (ONS) Unrounded mid-year population estimates produced by ONS and supplied to the Public Health England

Figure h Continued, Emergency hospital admissions in Cheshire East



Recent trend: –

Period		Count	Value	Lower CI	Upper CI	North West	England
2010/11	●	1,235	6,513	6,152	6,890	6,022	5,282
2011/12	●	1,143	5,779	5,447	6,125	5,981	5,352
2012/13	●	1,071	5,303	4,990	5,631	5,859	5,310
2013/14	●	1,170	5,632	5,313	5,965	5,956	5,479
2014/15	●	1,406	6,499	6,164	6,848	6,357	5,604
2015/16	●	1,478	6,695	6,358	7,046	6,066	5,526

Source: Hospital Episode Statistics (HES), NHS Digital for the respective financial year, England. Hospital Episode Statistics (HES) Copyright © 2016, Re-used with the permission of NHS Digital. All rights reserved. Local Authority estimates of resident population, Office for National Statistics (ONS) Unrounded mid-year population estimates produced by ONS and supplied to the Public Health England

Appendix 4 - Commissioning for Value - Where to Look pack - Right Care Data packs (January 2017)

Spend and outcomes

1. Trauma & injuries
2. Mental health – NHS Eastern Cheshire CCG
3. Gastro-intestinal – NHS South Cheshire CCG
4. Respiratory – NHS South Cheshire CCG
5. Musculoskeletal - NHS South Cheshire CCG

Outcomes

1. Gastro-intestinal – NHS South Cheshire CCG & NHS Eastern Cheshire CCG
2. Trauma & injuries – NHS Eastern Cheshire CCG
3. Mental health – NHS Eastern Cheshire CCG

Spend

1. Gastro-intestinal – NHS South Cheshire CCG & NHS Eastern Cheshire CCG
2. Neurological –NHS South Cheshire CCG NHS Eastern Cheshire CCG
3. Respiratory – NHS South Cheshire CCG
4. Circulation – NHS Eastern Cheshire CCG
5. Musculoskeletal – NHS South Cheshire CCG & NHS Eastern Cheshire CCG

Bed days

Big users of bed days (elective and non-elective combined):

1. Gastro intestinal
2. Respiratory
3. Circulation
4. Genito-urinary
5. Neurological
6. Trauma and injuries

Elective bed days

1. Gastro-intestinal
2. Genito-urinary
3. Cancer
4. Circulation
5. Musculoskeletal

Non-elective bed days

1. Neurological
2. Respiratory
3. Circulation
4. Gastro-intestinal
5. Trauma & injuries

Appendix 5 – How Cheshire East assess risk

How Cheshire East RAG rates risk:

SCORING CHART FOR IMPACT				SCORING CHART FOR LIKELIHOOD				
	Factor	Score	Effect on Project		Factor	Score	Description	Indicator
Threats	Critical	4	Complete failure or extreme delay of project (3 months or more). Critical impact on project objectives and performance and could seriously affect project reputation. Long term damage that may be difficult to restore with high costs - £1m.	Threats	Very likely	4	>75% chance of occurrence	Regular occurrence Frequently encountered - daily/weekly/monthly
	Major	3	Major impact on project objectives and performance, could be expensive to recover from (between £500k - £1m). Failure to achieve expected benefits and/or major delay to project (2-3 months)		Likely	3	40% - 75% chance of occurrence	Within next 1-2 yrs Occasionally encountered (few times a year)
	Significant	2	Significant impact on project objectives, performance and quality, could have medium term effect and be potentially expensive to recover from (between £100k - £500K). Significant slippage (3 weeks–2 months).		Unlikely	2	10% - 40% chance of occurrence	Only likely to happen 3 or more years
	Minor	1	Minor impact on project objectives and performance, could cause slight delays in achievements (less than 2 weeks). However if action is not taken, then such risks may have a more significant cumulative effect. (Costs less than £100k)		Very unlikely	1	<10% chance of occurrence	Rarely/never before
	Factor	Score	Effect on Project		Factor	Score	Description	Indicator
Opportunities	Exceptional	4	Result in major increase in ability to achieve project objectives.	Opportunities	Very likely	4	>75% chance of occurrence or achieved in one year.	Clear opportunity, can be relied on with reasonable certainty to be achieved in the short term.
	Significant	3	Impact on some aspects of the achievement of one or more strategic objectives		Likely	3	40% to 75% chance of occurrence. Reasonable prospects of favourable results in one year.	May be achievable but requires careful management. Opportunities that arise over and above the plan.
					Unlikely	2	<40% chance of occurrence or some chance of favourable outcome in the medium	Possible opportunity which has yet to be fully investigated by management.
					Very unlikely	1	<10% chance of occurrence	Has happened rarely/never before

Table 9

Risk can be considered at different levels – from a project level, to organisation level, and system level.

Appendix 6 – Meeting our duty under the Equality Act 2010

As the leaders for our local health and social care economy, all BCF partners in Cheshire East are conversant and complaint with the Equality Act 2010.

In addition full Equality & Human Rights Impact Assessment (EHRIA) will be carried out in due course, as significant changes occur within service delivery.

NHS Eastern Cheshire CCG:

As a commissioner (buyer) of services: The CCG is committed to making sure equality and diversity is a priority when we plan and commission local healthcare services. To do this we work closely with our communities to understand their needs and how best to commission the most appropriate services to meet those needs.

As an employer: We are committed to ensuring we have a diverse workforce by providing fair and equal access to all job opportunities, including access to career development and training opportunities for existing and future staff. To do this we aim to recruit the best talent that we can and remove any barriers to ensure that we have the widest possible pool of talent to draw from.

NHS South Cheshire CCG:

NHS South Cheshire Clinical Commissioning Group signed up to the NHS wide Equality Objectives and works with our providers to improve performance in relation to equality and diversity.

Our commitment to the equality and diversity agenda and our evidence of compliance with the Public Sector Equality Duty is supported by the NHS Equality Delivery System and the NHS Workforce Race Equality Standard.

We are committed to ensuring our organisation pays due regard to the aims of the public sector equality duty. One of the ways of doing this is to carry out systematic equality analysis of the impact of our actions and decisions on our diverse communities.

Cheshire East Council:

The Council recognises that promoting equality and diversity will improve public services for everyone. We want Cheshire East to be an area of equal opportunity, where everyone has a fair chance and people from all backgrounds take part in community life. Our aim is to make equality an integral part of the way the Council works by putting it at the centre of everything we do. We are committed to celebrating diversity and promoting equality – as an employer, in the services we provide, in partnerships, and in the decisions we make.