Public Document Pack

Cheshire East Health and Wellbeing Board

Supplementary Agenda

Date:	**Tuesday, 19th November, 2024**
Time:	**2.00 pm**
Venue:	**Committee Suite 1,2 & 3, Westfields, Middlewich Road, Sandbach CW11 1HZ**

12. **Cheshire East Winter Plan** (Pages 3 - 60)

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Cheshire East Place System Winter Plan 2024/2025

Version 3: 11/11/2024

Slide Index

Review of Winter Plan 2023/24 – Reflection and Learning

Our Joint System Reflections

- Staff capacity to support change within identified timescales
- Workforce recruitment difficulties in recruiting alongside a growing and increasingly complex workload
- Non-Recurrent funding streams, not knowing how much funding will be available and when
- To work together on a joint systems Communication Plan
- The two Acute Trusts are working with ECIST to improve criteria led discharges and weekend discharge planning
- Continued development of virtual wards
- Cheshire East System focus is on all year-round operational resilience which is resource intensive

Winter Plan Risk Profile

Whilst mobilising the System Winter plan and enacting a number of additional Winter schemes that provided additional capacity, several wider system competing priorities and risks where managed at a system level during Winter as detailed below:

- Spikes of significant operational pressure across the system including challenges in discharging people to the most appropriate care settings such as specialist dementia nursing placements and domiciliary care in rural locations
- Winter Planning and ongoing assurance monitoring
- System recovery following Bank Holiday breaks and junior doctors' industrial action
- Raac Plank risks at Mid Cheshire Hospital Foundation Trust
- Responding to regional and national funding directives and producing capacity plans, monitoring spend and reporting on activity
- Maintaining quality and safety provision for the people of Cheshire East
- Workforce Challenges across the Health and Social Care system
- Junior Doctor Industrial Action

All of the above additional system challenges continued to be effectively managed and priorities across the system which should be recognised as exemplary joint system partner working in achieving across our Integrated Care System in Cheshire East Place

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Introduction - Forecast Winter 2024/25

Winter planning is a statutory annual requirement to ensure that the local system has sufficient plans in place to manage the increased activity during the Winter period and plans have been developed in partnership with Cheshire East system partners across the place.

The overall purpose of the Winter plan is to ensure that the system is able to effectively manage the capacity and demand pressures anticipated during the Winter period October 2024 to 31 March 2025.

Our system plans ensure that local systems are able to manage demand surge effectively and ensure people remain safe and well during the Winter months.

The planning process considers the impact and learning from last Winter, as well as continued learning to the ongoing UEC system priorities.

Plans have been developed on the basis of robust demand and capacity modelling and system mitigations to address system risk.

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

Forecast for Winter 2024/25

The following challenges have already been identified

- Cost of living rises
- System workforce challenges across the ICS.
- Care Home beds capacity challenges (dementia nursing beds)
- Seasonal flu vaccination remains a critically important public health intervention and a key priority for 2024 to 2025 to reduce morbidity, mortality and hospitalisation associated with flu at a time when the NHS and social care will be managing winter pressures whilst continuing to recover from the impact of the coronavirus (COVID-19) pandemic.
- This year's Autumn flu and Covid vaccine programmes will start later. Vaccinations began in October 24 for those most at risk
- Mental Health – ED & In patient mental Health delays
- Primary Care collective action
- Urgent care recovery
- Elective Recovery
- Additional NHS funding is not expected in Quarter 3 & 4
- Providers have identified additional high impact interventions. Prioritisation process subject to additional funding
- Clear message from the North West Winter Event 2023 – 'not to start anything new'

Delivering operational resilience across the NHS this winter

January 2024

Recovering Urgent & Emergency Care (UEC)

Primary Care Recovery Plan

Elective Recovery Plan

} Strong basis to prepare for winter

Key Ambitions 2024/25:

(1) 76% of patients being admitted, transferred, or discharged within 4 hours

(2) Ambulance response times for Category 2 incidents to 30 minutes on average

(3) The percentage of people (type 1 attendances) who are delayed over 12 hours from arrival to the ED. Target is <2%

(4) 14 day length of stay (LOS) – target is <25%

Key Focus

- UEC recovery plan – ensuring high-impact interventions are in place
- Operational surge planning
- Effective system working across all parts of the system
- Supporting our workforce
- Provider Market Sustainability & Oversight
- Good quality care and support for people

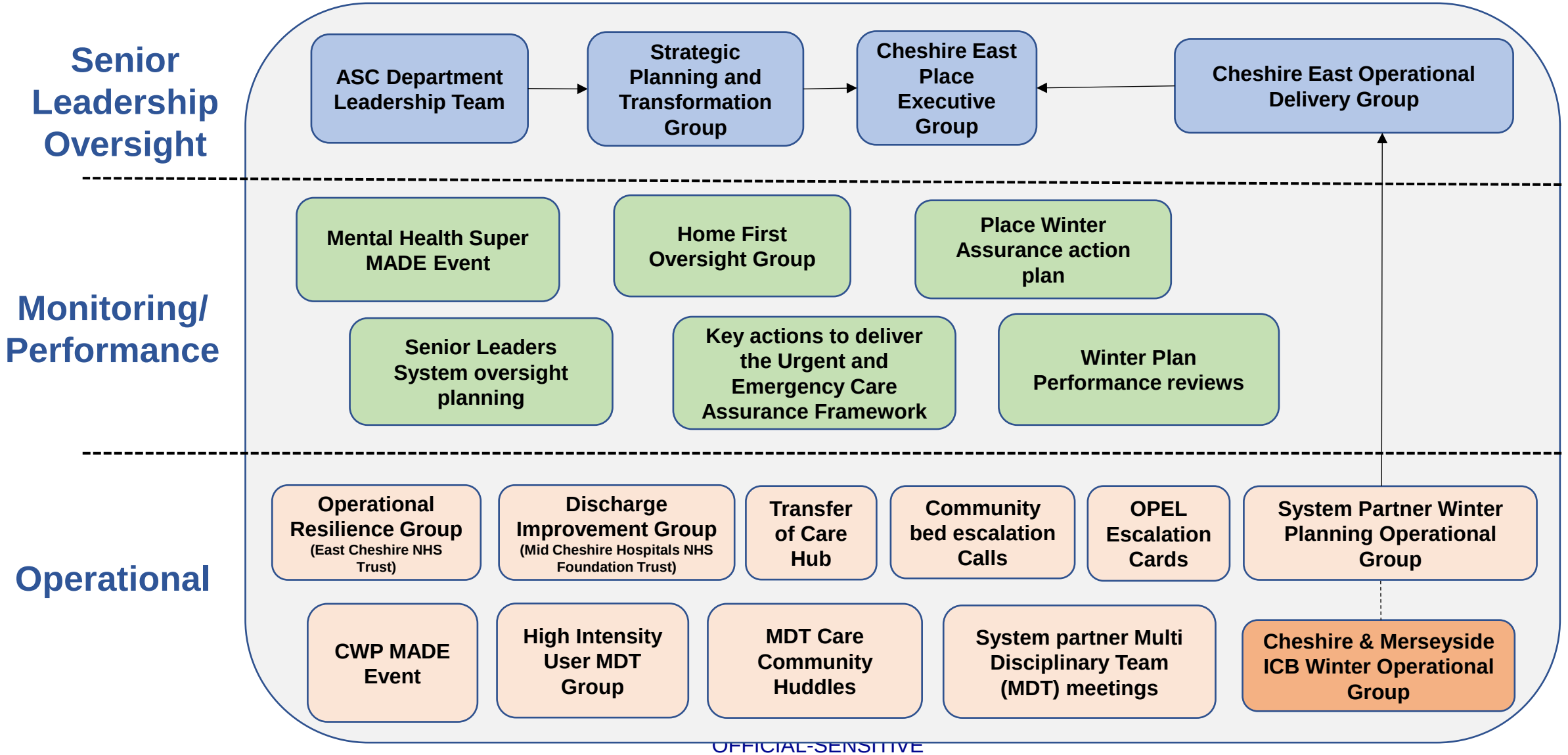
Ambition for Winter 2024/25

A&E 4-hour standard	• 76% of patients being admitted, transferred or discharged within 4 hours
Cat 2 ambulance mean response time <30 mins	• Category 2 ambulance calls are for condition such as stroke or chest pain that require rapid assessment
12-hour time in department	• The percentage of people (type 1 attendances) who are delayed over 12 hours from arrival to the ED. Target is <2%
14-day LOS	• target is <25%

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

Monitoring, Oversight and Governance Structure

NHS
Cheshire and Merseyside

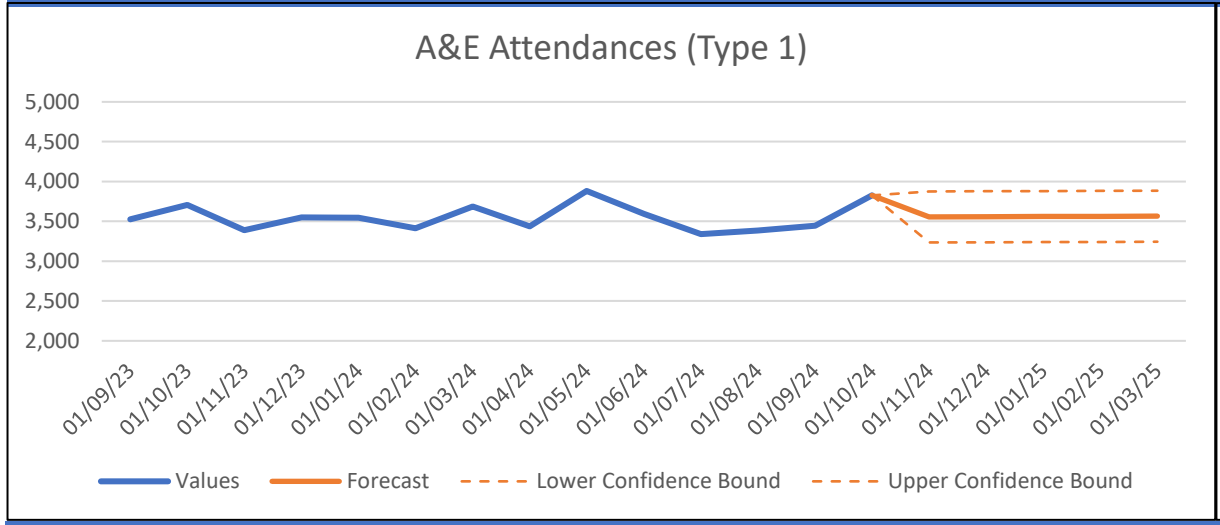


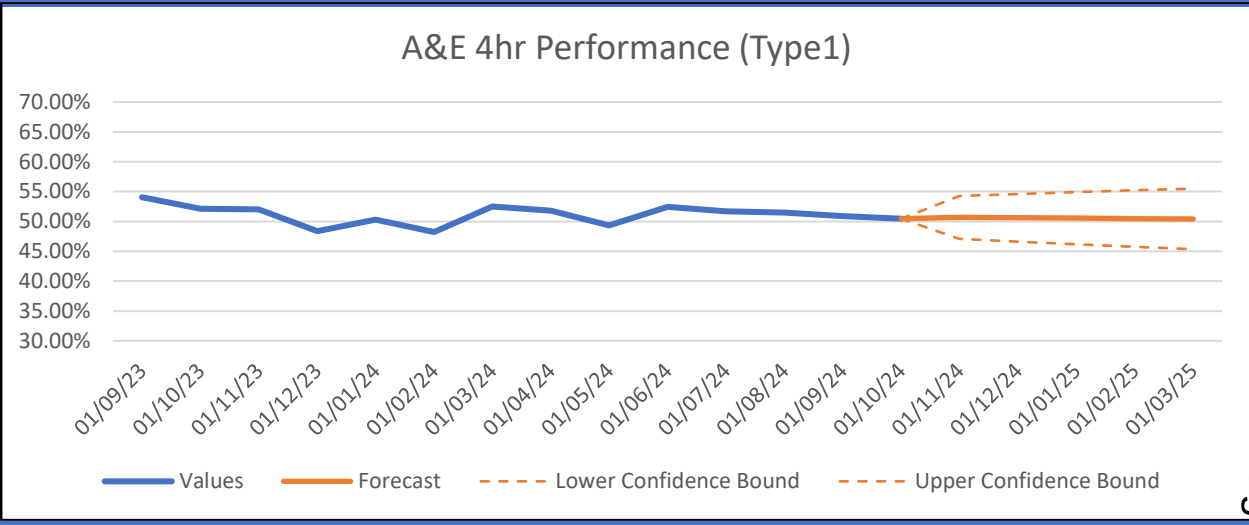
Demand Forecasting

Context:

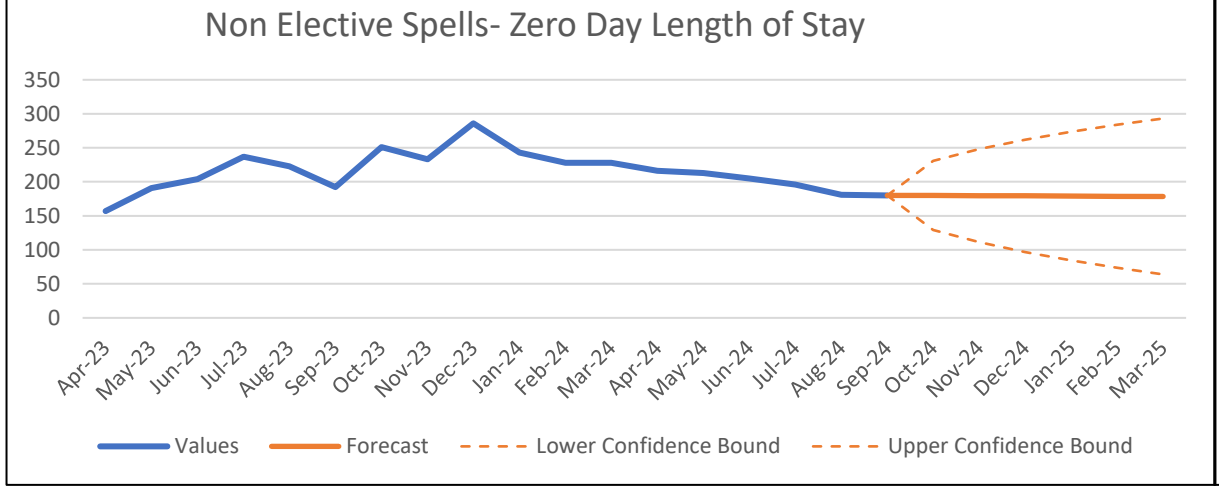
ECT Urgent & Emergency Care Activity Summary. This includes A&E activity and 4 hour performance and Emergency Admissions.

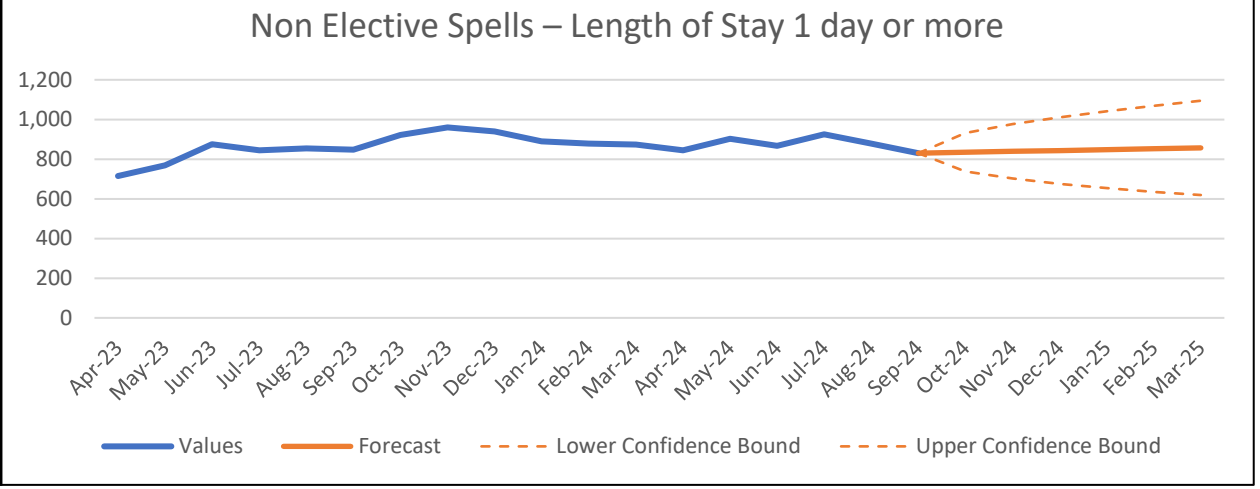
East Cheshire NHS Trust – A&E Attendances & Performance





East Cheshire NHS Trust – Non Elective Spells

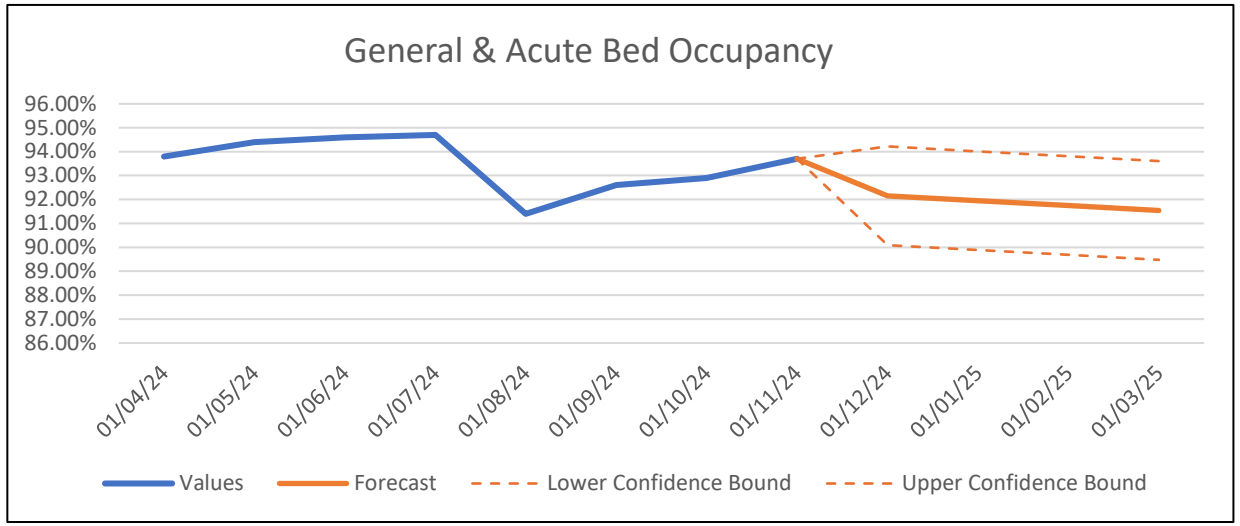


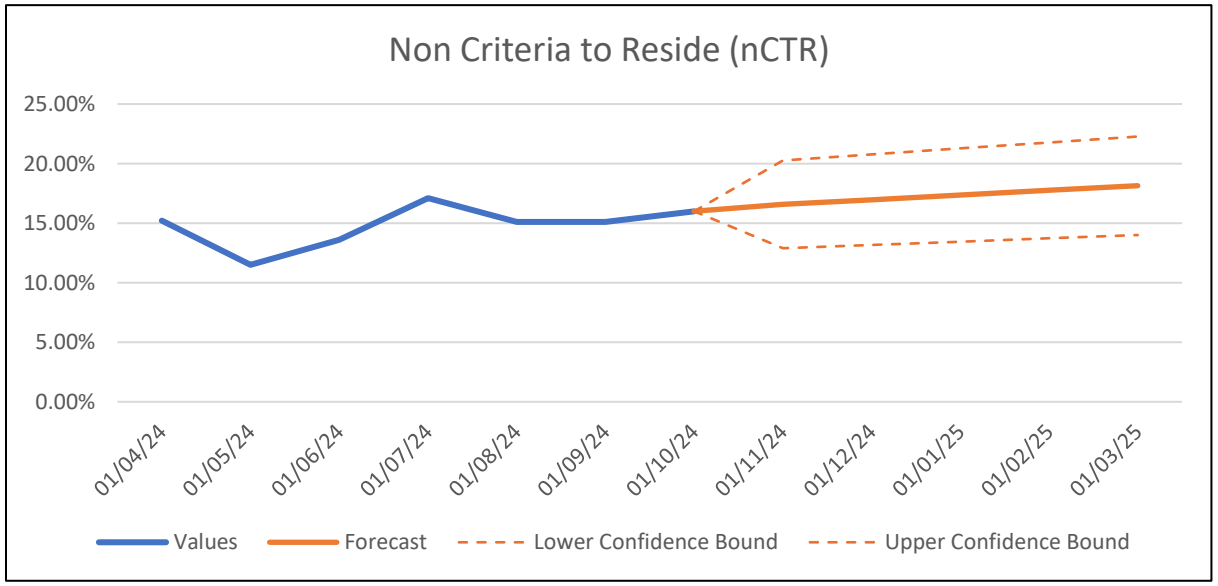


Data Source: ECDS & SUS inpatients

Demand Forecasting – Bed Occupancy & Non Criteria to Reside

East Cheshire NHS Trust

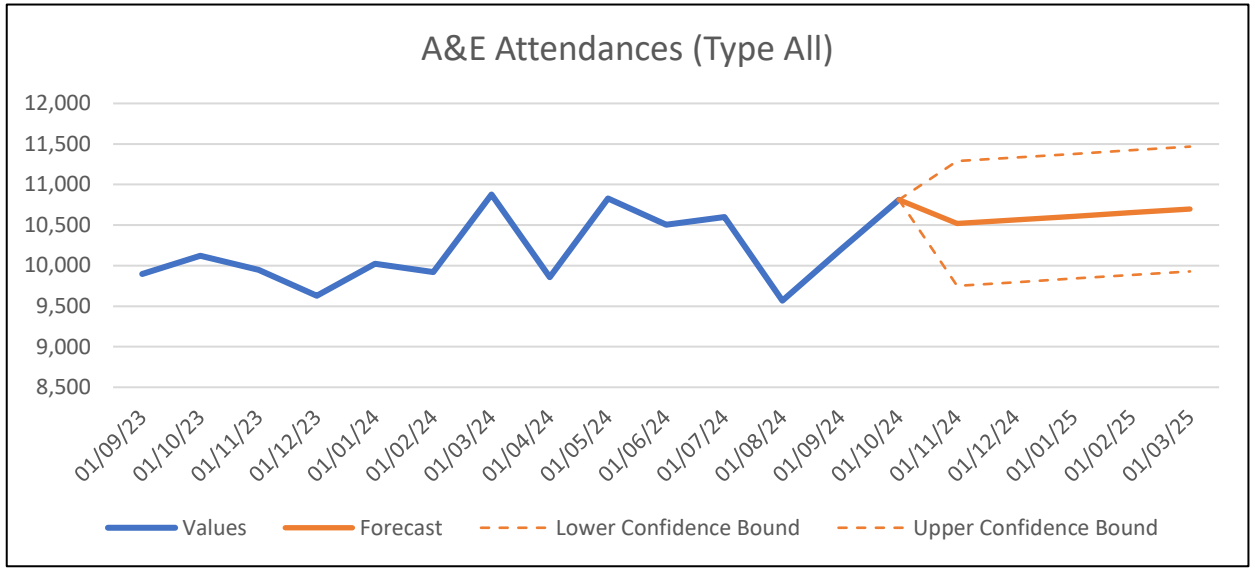


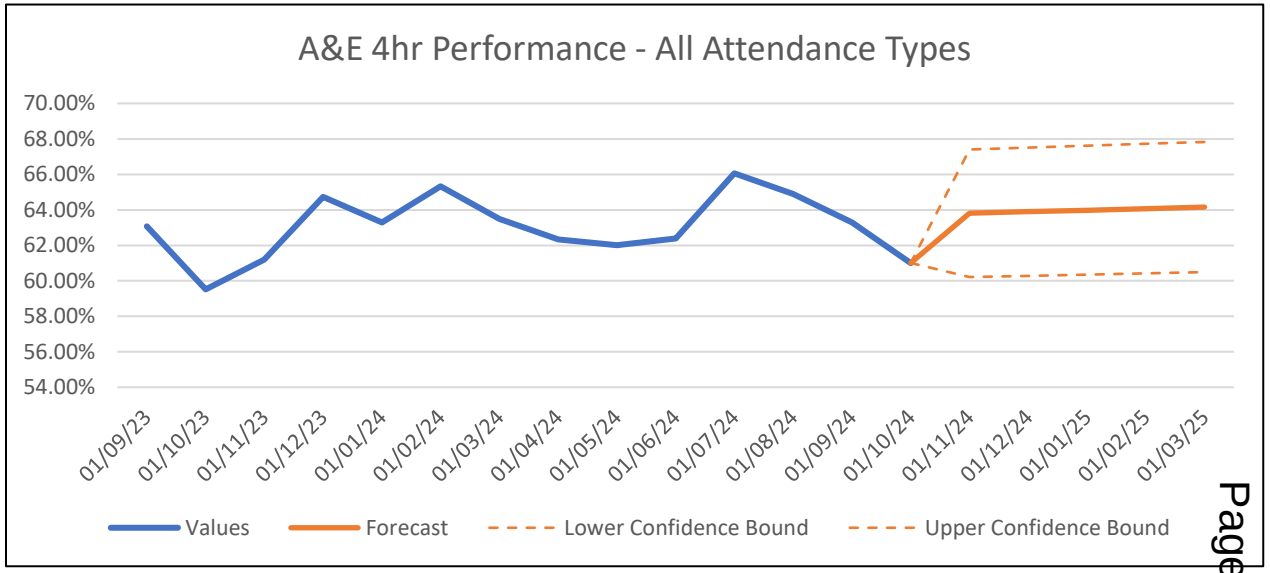


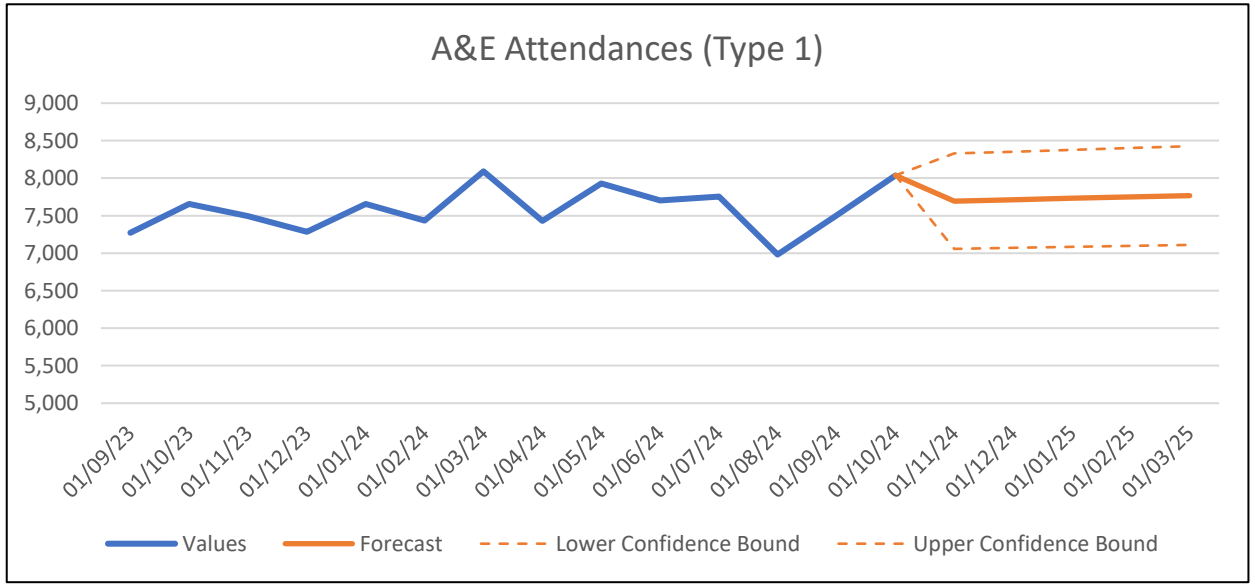
Data Source: ICB UEC Recovery Dashboard

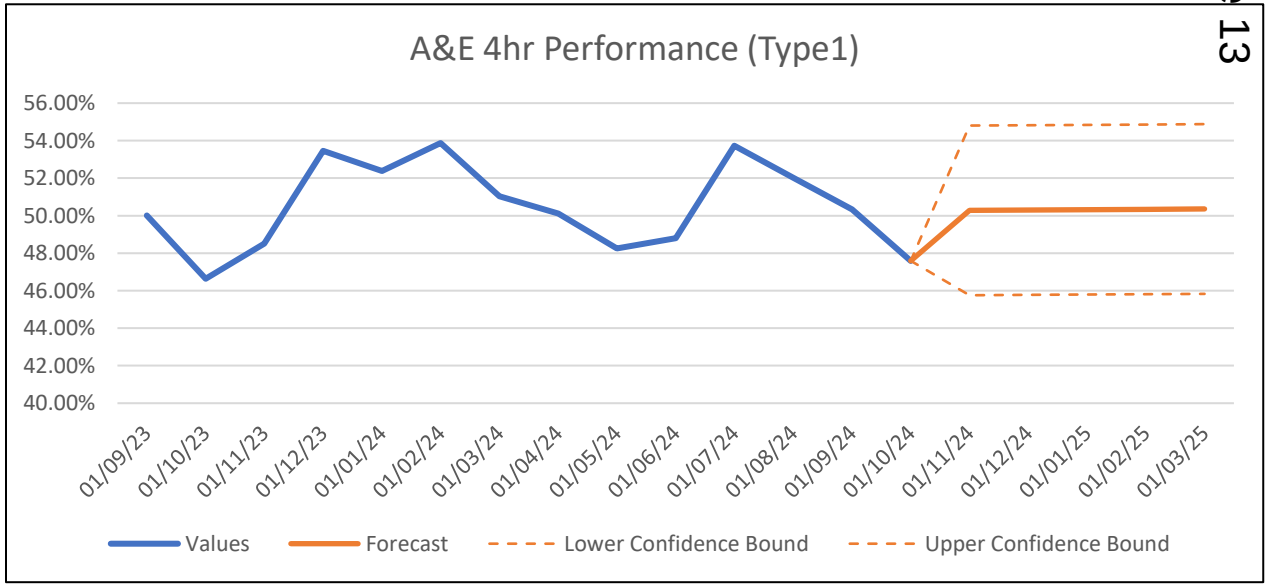
Demand Forecasting

Mid Cheshire Hospitals Foundation Trust - ED





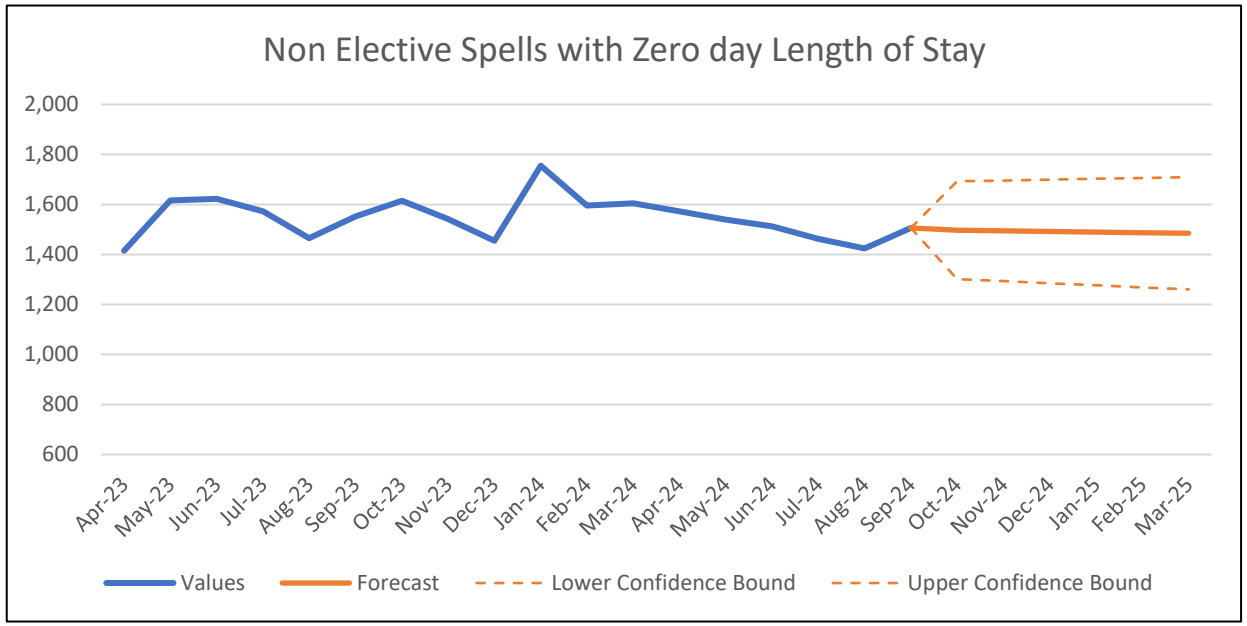


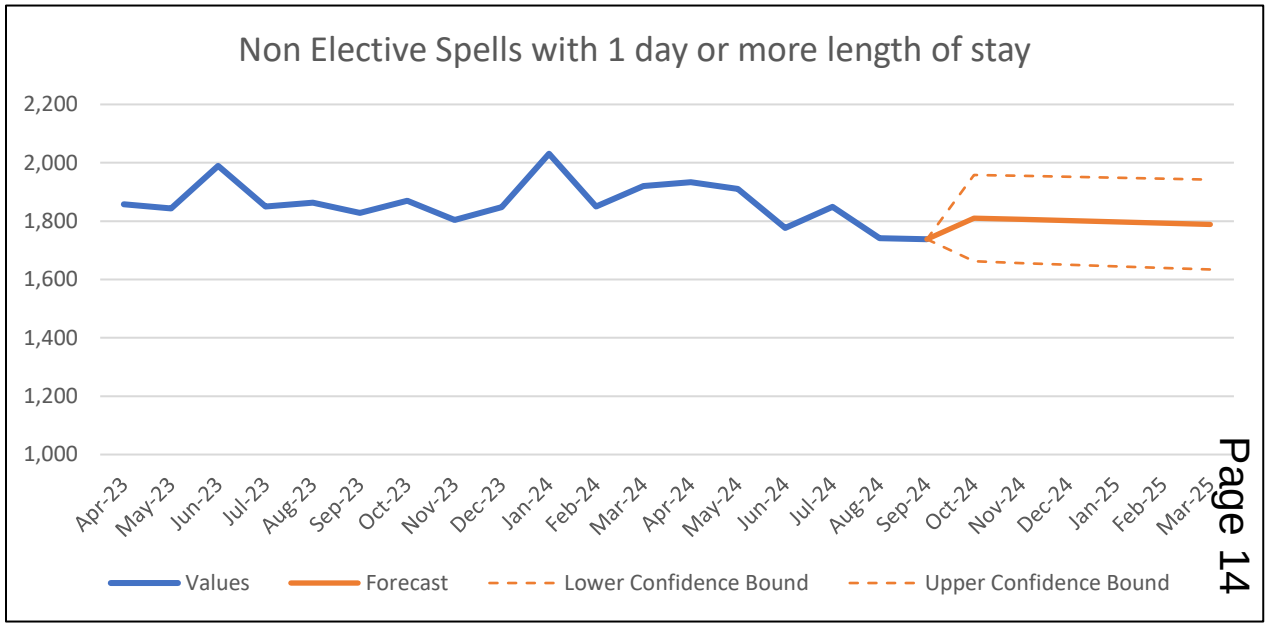


Data Source: ECDS & SUS inpatients

Demand Forecasting

Mid Cheshire Hospitals Foundation Trust - NEL

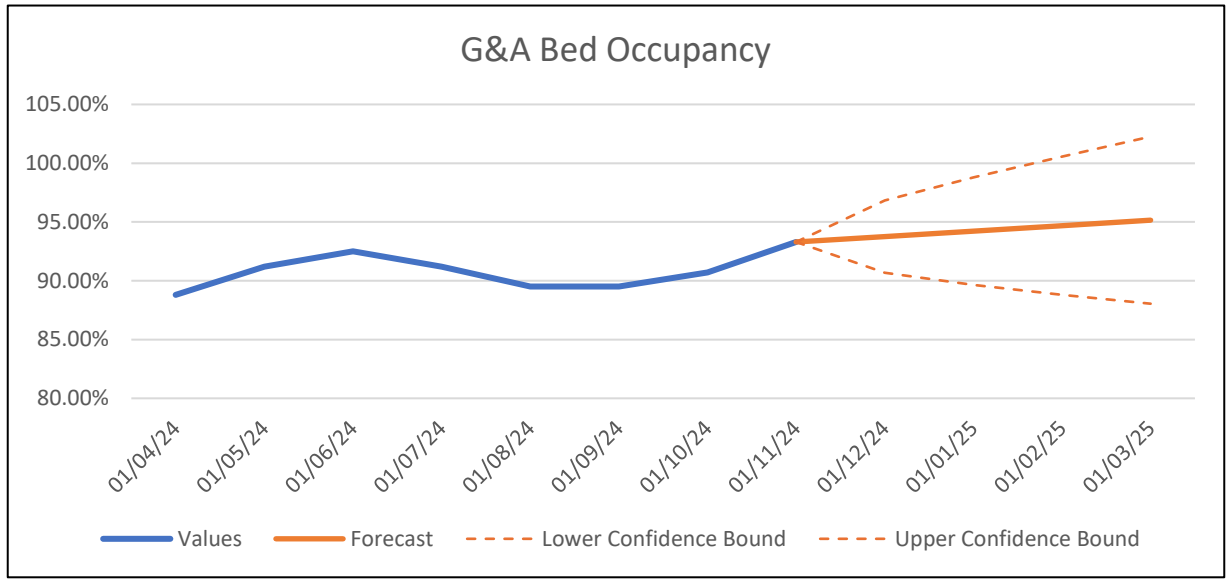


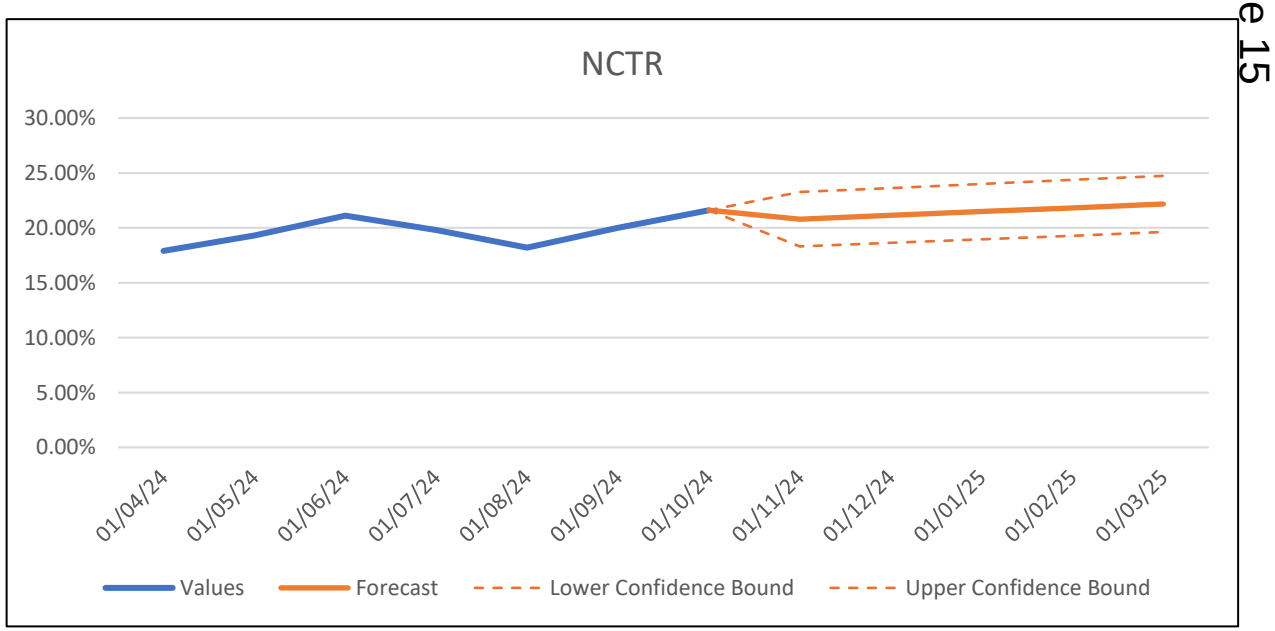


Data Source: ICB UEC Recovery Dashboard

Demand Forecasting

Mid Cheshire Hospitals Foundation Trust





Performance Management & Escalation

Cheshire East Assurance:

- ✓ Daily Multi Disciplinary Team meetings
- ✓ Weekly Capacity Dashboard – System understanding of current capacity issues and risks
- ✓ Patient harm reviews, reflective learning and measures and controls implemented to reduce harm – Quality & Safety Forum
- ✓ Monitoring of key improvement initiatives to demonstrate system impact and effectiveness
- ✓ Outcomes for individuals in D2A and Reablement Support
- ✓ Utilise data to target admission avoidance activities
- ✓ Review and utilise A&E forecasting tool
- ✓ Realtime system monitoring – NHS A&E wait times app includes East Cheshire NHS Trust and Mid Cheshire Hospitals NHS Foundation Trust
- ✓ Cheshire East Operational Delivery Group
- ✓ Winter System Oversight call
- ✓ System escalation calls to monitor capacity and flow
- ✓ Infection Prevention and Control Operational Group flexibility to step up and combined with daily MDTs
- ✓ Primary Care APEX System
- ✓ Implementation plan for the updated Operational Pressures Escalation (OPEL) framewok – Key actions Place/SCC
- ✓ System Coordination Centre System Calls – Oversight of a real time reporting tool for Cheshire & Merseyside - SHREWD (Single Health Resilience Early Warning Database)

Winter Planning Escalation

System Co-ordination Centres

- Revised operational standards issued for implementation by 01 November
- Central co-ordination service to providers of care across the ICB supporting patient access to safe, high quality care
- Responsible for the co-ordination of an integrated system response using OPEL Framework alongside provider and ICB policies.
- OPEL Framework contains specified and incremental core actions for the SCC at each stage of OPEL.
- Responsible for supporting interventions on systemic issues that influence patient flow.
- Concurrent focus on UEC and the system's wider capacity including, but not limited to, NHS111, Primary Care, Intermediate Care, Social Care, Urgent Community Response and Mental Health services.
- **3 Expected outcomes from SCC operations:**
- **Improved visibility of operational pressures:**
- **Real-time co-ordination of capacity and action:**
- **Improved clinical outcomes**

Operating Pressure Escalation Level (OPEL) Framework

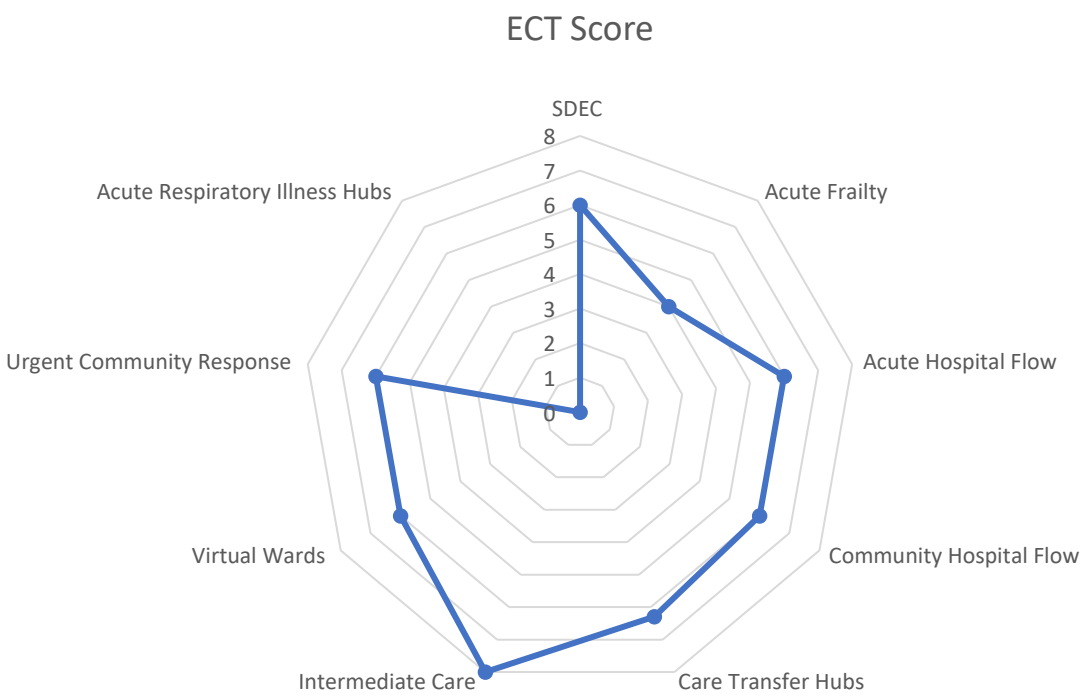
- New OPEL framework issued for Acute Trusts, to be implemented by 01 November 2023 using real time data.
- Real time data system in place - SHREWD
- OPEL score out of 50 across 10 parameters centred on ambulance handover, co-horting, ED attends and performance, majors and resus pressures, time to treatment, wider bed state including NCTR and corridor care
- ICB level OPEL will be determined automatically by the Trust declarations, with a proportion of the score for each acute site going towards the OPEL score for the ICS
- C&M SCC will operate daily calls through winter, likely minimum 2x OPEL declarations per day
- Action cards are defined nationally, ICBs need to define their triggers and action cards for system actions with local partners e.g. at Place level
- **Further work required to agree what the key actions are for Place at each OPEL stage, at ICB level and beyond, in particular escalation with local partners at OPEL 3 and 4**

High Impact Actions	Overarching principal of the winter plan Link to the High Impact Actions – Cheshire East Place
Same Day Emergency Care	Maximise the use of the Same Day Emergency Care triaging model for people, thus ensuring that people are fast-tracked to the right specialist at the start of their visit to hospital. SDEC will continue to reduce hospital admissions and in turn improve the person experience and help the hospital manage patient flow.
Frailty	Specialist nurses are deployed in the EDs across Cheshire East as part of the frailty response with the aim of avoiding hospital admissions. Falls – Steady on your Feet (SYOF) launch and roll out of MFAC training to Community Teams.
Inpatient Flow & LOS	
Community bed productivity and flow	Cheshire East's specific focus on Pathway 2 cluster model Length of Stay and P3 self-funding patients Length of Stay through Transfer of Care Hubs and multi-disciplinary team meetings, and transformation support to review community Length of stay pathways. A significant investment has been committed from the Adult Social Care Discharge Investment Fund to support the implementation of the Discharge to Assess model along with providing funding to purchase additional spot purchased bed base capacity when required, to meet the deficit indicated within the Demand and Capacity analysis. The funding has supported some initial double running costs, thus allowing the model to be fully implemented and support the reduction of a number of beds across the system.
Care transfer hubs	The Transfer of Care Hubs in ECT & MCHFT IS THE system-level place whereby (physically or virtually) all relevant services (for example, acute, community, primary care, social care, housing and voluntary) are linked to coordinate care and support for people who need it – during and following discharge and also to prevent acute hospital admissions. Daily Transfer of Care Hub escalation calls take place focus is to progress discharges (including community beds) in real time escalation.
Intermediate care demand and capacity	Cheshire East place are fully engaged in the 12 week programme to identify gaps in the system.
Virtual wards	Roll out of intravenous and sub cutaneous therapy provision to virtual wards has been completed with a number of areas increasing their intravenous at home offer. Continue to promote Virtual Wards and pathways and increase bed occupancy targets. A heart failure VW specialty will also be added.
Urgent Community Response	Monitoring Performance impact and effectiveness against a bespoke set of UCR metrics.
Single Point of Access	To support patients to access care more easily, Care Community Services have Single Points of Access for patients and referrers to access support and care. The single point of access aligns to the care community (neighbourhood) footprint.
Acute Respiratory Infection Hubs	We don't have any acute respiratory hubs in Primary Care in Cheshire East. The two locations that were mobilised last year ceased at the end of the funding.

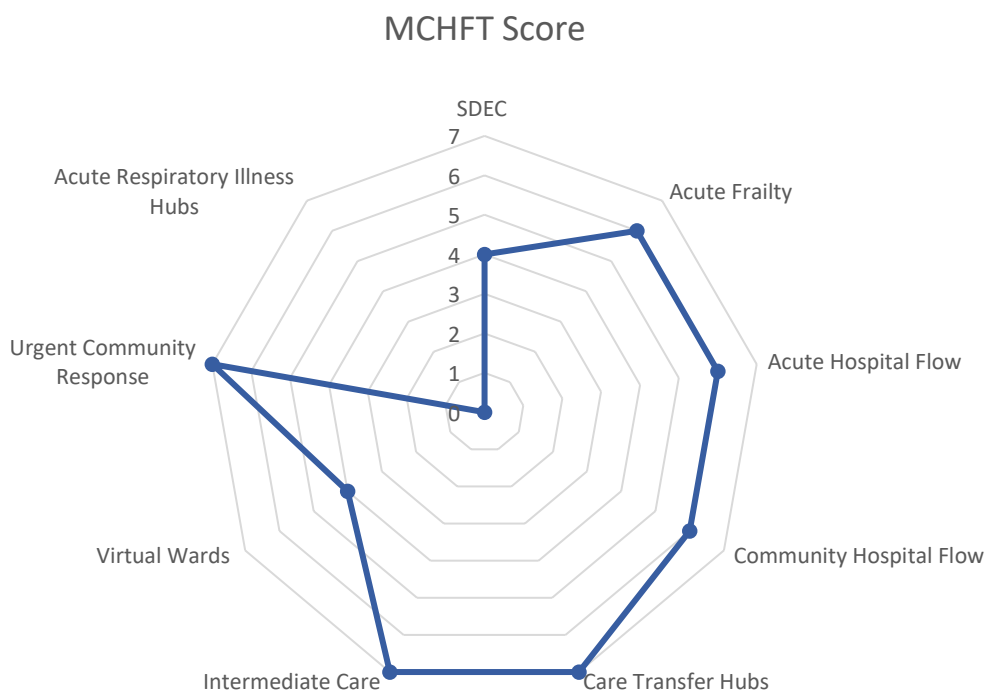
	High Impact Interventions – Actions . Requirement to focus on 4 areas, national visit & maturity assessments	System Roles & Responsibility
1	❖ **Same Day Emergency Care**: reducing variation in SDEC provision by providing guidance about operating a variety of SDEC services for at least 12 hours per day, 7 days per week.	East Cheshire NHS Trust Mid Cheshire Hospitals FT
2	❖ **Frailty**: reducing variation in acute frailty service provision. Improving recognition of cases that could benefit from specific frailty services and ensuring referrals to avoid admission.	East Cheshire NHS Trust Mid Cheshire Hospitals FT
3	❖ **Inpatient flow and length of stay (acute)**: reducing variation in inpatient care (including mental health) and length of stay for key iUEC pathways/conditions/cohorts by implementing in-hospital efficiencies and bringing forward discharge processes for pathway 0 patients	Cheshire & Wirral Partnership FT East Cheshire NHS Trust Mid Cheshire Hospitals FT
4	**Community bed productivity and flow**: reducing variation in inpatient care and length of stay, including mental health, by implementing in-hospital efficiencies and bringing forward discharge processes.	Cheshire & Wirral Partnership FT East Cheshire NHS Trust, Central Cheshire Integrated Care Partnership
5	❖ **Care transfer hubs**: implementing a standard operating procedure and minimum standards for care transfer hubs to reduce variation and maximise access to community rehabilitation and prevent re-admission to a hospital bed.	Transfer of Care Hubs System Partners
6	**Intermediate care demand and capacity**: supporting the operationalisation of ongoing demand and capacity planning, including through improved use of data to improve access to and quality of intermediate care including community rehab	ICB & System Partners
7	**Virtual wards**: standardising and improving care across all virtual ward services to improve the level of care to prevent admission to hospital and help with discharge and increasing the specialities supported. Maintain % utilisation of 60 beds, Extending scope to include Heart Failure offer and Palliative	East Cheshire NHS Trust, Central Cheshire Integrated Care Partnership
8	**Urgent Community Response**: increasing volume and consistency of referrals to improve patient care and ease pressure on ambulance services and avoid admission. Maintain 2hr 70% compliance and ensure full utilisation inc. NWAS referrals & Care Homes	East Cheshire NHS Trust, Central Cheshire Integrated Care Partnership
9	**Single point of access**: driving standardisation of urgent integrated care co-ordination which will facilitate whole system management of patients into the right care setting, with the right clinician or team, at the right time. This should include mental health crisis pathways and alternatives to admission, eg home treatment	Cheshire & Wirral Partnership FT Central Cheshire Integrated Care Partnership
10	**Acute Respiratory Infection Hubs**: support consistent roll out of services, prioritising acute respiratory infection, to provide same day urgent assessment with the benefit of releasing capacity in ED and general practice to support system pressures.	Primary Care East Cheshire NHS Trust, Central Cheshire Integrated Care Partnership

Maturity Self Assessments September 2024

East Cheshire NHS Trust



Mid Cheshire Hospitals Foundation Trust



Maturity signifies the right components to deliver a better experience for people in line with national ambitions

***Respiratory illness is an identified area for improvement across both ECT and MCHFT and is being addressed by the system.**

Score out of 8	Maturity Level
0-2	Early Maturity
3-5	Progressing Maturity
6-7	Mature
8	Benchmarkable Maturity

Maturity assessments help ensure that national improvement is tailored to the areas of greatest need and highlights areas of best practice nationally.

Mental Health & Community Collaborative Priorities

Cheshire East Place

Mental health support communications toolkit to find the right support

https://webstore.cwp.nhs.uk/smh/toolkits/cheshireeastmay23.pdf

Key headlines for Winter 2024/25

- ✓ First Response services continue to develop the First Response ethos.
- ✓ The Crisis Line receives around 4,000 calls per month.
- ✓ Implemented the Rapid Response Service to convey people away from Emergency Departments once mental health beds have been identified
- ✓ Observational support into the Emergency Departments (ED's).
- ✓ In addition to this the British Red Cross are working with CWP services to support high intensity users of Liaison and Crisis Line services and a new MH side by side triage process has been implemented plan in place to roll out to all Eds
- ✓ Development of the Discharge Facilitation Team to support flow both within CWP beds but also to support flow across out of area beds.
- ✓ Working with both Cheshire and Merseyside Police to complete a deep dive around people being detained on Section 136 in line with a wider action plan led by Cheshire and Mersey.
- ✓ 2 Mental health response vehicles (Bebington and Northwich) mobilised to support community response and divert ambulances called by MH patients as clinically indicated.

Cheshire & Wirral Partnership Mental Health Winter Plans

Actions taken and plan to increase capacity in acute/ community service.

The established bed base across Cheshire and Wirral Partnership NHS Foundation Trust is 320 beds for 2024/25.

Number of beds available:

CONTRACTED	Commissioned beds
NWBB - Crewe	12
Priory Notts - Coppice	6
ELYSIUM Bluebell - Huyton	9
ELYSIUM Leo - Warrington	2
CHESTER/ Bowmere Hospital	
BEECH	22
JUNIPER	24
WILLOW	7
CHERRY	11
WIRRAL/ Springview Unit Clatterbridge	
LAKEFIELD	20
BRAKENDALE	20
RIVERWOOD	13
BROOKLANDS	10
MEADOWBANK	13

CONTRACTED	Commissioned beds
EAST/ Macclesfield	
MULBERY	26
SILK	15
SADDLEBRIDGE	15
OAKTREES	0
ALDERLEY UNIT	10
MAPLE	18
EASTWAY	8
GREENWAYS- LD Inpatient Unit / Macclesfield	12
INDIGO- CAMHS INPATIENTS / CHESTER (TIER 4)	16
CORAL- CAMHS INPATIENTS / CHESTER (TIER 4)	14

Richmond Fellowship and	14
ECHC Crisis Beds	3

Mental Health

	Mental Health Operational Services Supporting People and the System
1.	Mental Health Floating Support delivered by Making Space, providing 75 hours of support in both the North and South of Cheshire East. This service is has been recommissioned and will build on the successful model which is in place as part of a low-level mental health pathway.
2.	Complex Needs DPS – A framework containing over 160 providers, which contains providers who can support people with MH Support Needs. Services commissioned under the framework include supported living (including step down provision) and outreach provision. This is currently being reviewed with a new framework to be developed called the Complex Needs Care Provider Collaborative. This has a timeline of September 2025 for go live.
3.	Mental Health Rapid Response Reablement funded via the ASC discharge funding supporting facilitated discharge provided by ISL has been extended until 31/03/25. This along with the Mental Health Floating Support Service and Reablement Service forms part of the low-level mental health pathway. This service is consistently at full capacity (46 hrs per week) and is playing a vital role in providing short term interventions
4.	3 Mental Health Crisis beds which are located in Crewe, Macclesfield and Congleton delivered by East Cheshire Housing Consortium. These crisis beds support step up/down referrals and are in place until 31 March 2025. A review of crisis beds is underway covering Cheshire West, Cheshire East and Wirral to look at future delivery models.
5.	ISL in reach support to each ED. This is highly effective and provides 1to1 support to people supporting with de-escalation support and 1to1 bespoke support for people. It also offers additional staffing support within each ED. A further £250k has been approved via the BCF for a bespoke model for each hospital ED (Macclesfield and Leighton) from 1 April 2024 to 31 March 2025 proving 8am till 8pm cover 7 days a week.
6.	Additional £15k ring fenced to support carers and facilitated discharge and hospital avoidance.
7.	Crisis Cafes Crewe and Macclesfield and a pathway has been developed between the domestic abuse service directly to crisis cafes and trained the staff in DA awareness. These contracts are currently in place until March 2025 and CWP (as the contract holder) are looking at conducting a procurement exercise in the near future.
8.	CWP Community Mental Health Transformation is now phasing its engagement work down and mobilising new models of care. At the core of this is having practitioners operating at PCN level as part of a multi-disciplinary team with GP Practices. MH services will operate on a person-centred needs basis rather than referral criteria. This should address some of the volume incidence of community crisis and re-admission of people previously discharged back into the community.
9.	CAMHS - Additional investment has gone in to improving access and reducing waiting times however workforce shortage remain challenging to recruit to. A gap we need to address is working with Education Teams. A system planning session is required to explore how we address the gap moving forward.
10.	Talking Therapies (IAPT) Additional investment made to improve access and reduce waiting times in the North of the patch.
11.	Acute Beds Demand and capacity review underway for completion September (Cheshire & Wirral). A CWP worker is to lead on this work, with a view to create flow, reduce out of area placements. There is a need to understand the investment from West and Wirral into Winter planning to improve flow.
12.	Weekly MAADE meetings which is a new format to include admissions and discharges in one meeting
13.	Weekly oversight and Governance around the system VOIDS to support discharge flow – weekly SITREPS are now stood up and shared amongst the system.
14.	Underutilized hours in commissioned service Routes – being repurposed to support MH Discharge
15.	Home For Christmas weekly meetings to be stood up including providers, both Trusts and CWP for additional oversight and support to get people home for Christmas

Primary Care

- ✓ Primary Care Network led Extended Hours for evening and Saturdays
- ✓ Primary Care Access Recovery Programme including transition to a new model of modern General Practice.
- ✓ Robust and resilient General Practice Out of Hours service including Acute Visiting Service.
- ✓ Care Communities Business cases to extend Primary Care Assessment – Respiratory, Frailty, High Intensity Users, Falls – Subject to additional funding
- ✓ The nationally commissioned Community pharmacy consultation service (CPCS) as this will have a potentially bigger and synergistic impact with the Pharmacy First minor ailments service on lower acuity conditions. CPCS takes referrals from general practice and NHS111, while Pharmacy First provision also takes walk ins
- ✓ Primary Care resilience and activity data
- ✓ Exploring initiatives to enhance the falls prevention programme, including access to falls exercise classes and care homework (System)
- ✓ Health & Wellbeing services for Asylum seekers and Refugee communities
- ✓ Full implementation of the Primary / secondary care interface recommendations
- ✓ Roll out of the General Practice OPEL system to support system pressures reporting
- ✓ Care home & house bound vaccinations – CCICP Supporting Primary Care in delivery of COVID & Flu
- ✓ SDF Proposal Funding – This will be used across the Care Communities:
  - **Congleton & Holmes Chapel (CHAW)** - Additional sessions to help during Winter pressures and reduce A&E Admissions.
  - **Congleton & Holmes Chapel (CHOC)** - To fund PCN Clinical Educational Lead role for 7.25 months. This will provide clinical mentorship for a number of PCN ARRs team members. At Scale funding will be used to increase clinical capacity.
  - **Crewe Eaglebridge** - Additional GP sessions across the reporting period. Plus funding to support ARRS clinical leadership.
  - **Crewe GHR** - Additional GP sessions across the reporting period. Plus funding to support ARRS clinical leadership.
  - **Nantwich & Rural** - ARRS role supervision, training and education. At Scale funding enables PCN to increase capacity to deal with the expected increase in requests for urgent assessment and treatment of winter related illness
  - **Middlewood** - Continued clinical supervision for ARRS Roles. Funding will support 2.5 additional GP sessions per week for a 4 month period (including on-costs)

Care Community Investment 2024-2025:

NHS Cheshire and Merseyside

- **Eastern Cheshire Care Communities** (CHAW, CHOC, Knutsford, Macclesfield, BDP)Scope: Proactive management of frailty within HIUs and Pts registered with a GP Practice with a frailty syndrome and within a RUB of 4 or 5 Aim: Reduce number of unplanned or crisis contacts, proactive case management through risk stratification. Reduce LOS and emergency hospital admissions Improved Pt experience and quality of Care.

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

- **Crewe Care Community** The service will be delivered in the leg club model of multi-disciplinary team working. All High Intensity Users will be registered with a Nantwich/SMASH GP. Focus will be on high intensity users. Aim: Reduction in acute presentation or Emergency admission with Care Plan in place, Reduction in presentation in crisis to out of hours teams, Reduction in the number of falls which could have been prevented. Increasing Patient and Carer satisfaction rates, Continuity of care measures – District Nurse team and in Primary Care
- Health Neighbourhood Voluntary Infrastructure and Model of Support, see attached paper for further reference of the invested schemes and funding allocation: Projects were categorised based on service provision under the following themed areas.
    - Universal Community led social prescribing.
    - Provide targeted advice, guidance, and support.
    - Mental Health Targeted Health and Wellbeing Cafes
    - Physical Health Targeted Community Clinics

Care Communities

Cheshire East Care Communities will all have a joint focus on supporting high intensity users, including falls prevention this winter. Winter Schemes are being developed to support this cohort of people. **Note Subject to additional funding**

The operational delivery of each scheme has been determined by local need and service delivery, to ensure that it makes the most impact and is the most outcome focused for the people receiving services

These schemes will be linked and support the Cheshire East Winter Plan for 2023/24, by lowering admission to hospital and enabling people to live safe and well at home and in their communities.

The schemes will support the priorities and responsibilities of the Integrated Care Board. They will support the responsibilities of working together to deliver a resilient winter, as well as supporting mental health provider pathways, social care priorities and supporting the acute trusts.

Overview of Schemes

Knutsford Home First - High Intensity User Ward - Caring for high intensity users in hospital and within their own home, in keeping with the Home First initiative. The aim is to reduce the number of unplanned or crisis contacts by proactively case managing this cohort of patients using an MDT model of care/virtual community wards.

Bollington, Disley, Poynton (BDP) - Access to services (Provision of transport to access services) - To reduce DNAs, home visits and access inequity by supporting residents with transport issues (due to economic, geographical, winter weather difficulties or individual patient needs) to attend essential appointments for their health and well-being.

Bollington, Disley, Poynton (BDP) - High Intensity User - Rapid Short-Term Clinical and Social Care - To provide high quality, rapid short-term clinical and social care, to avoid admissions to hospital or aid early discharge of high-intensity service users.

Macclesfield - High Intensity User Virtual Ward - Macclesfield Care Community are focusing on high intensity users of services, to reduce the number of unplanned or crisis contacts by proactively case managing a cohort of patients using an MDT model of care.

Congleton & Holmes Chapel (CHOC) - High Intensity User Urgent Care - To provide proactive care to high intensity primary care respiratory patients (including those that are likely to require hospital attendance/admission).

Chelford, Handforth, Alderley and Wilmslow (CHAW) - Responsive Integrated Care - Help CHAW patients with respiratory conditions to be managed appropriately in the community reducing unnecessary admissions to secondary care.

Crewe - High Intensity User Mitigation and Education (Paediatric Focussed) - Trial a model of care pilot at Eaglebridge PCN which would address both HIU needs but also serve as a model for other patients who may otherwise be directed straight to ED.

Care Communities continued

Crewe - The Crewe Leg Club - Relaunching the Community Leg club in Crewe. The approach has been adapted to contribute towards reducing winter and on-going pressures for primary care, secondary care, and community services.

Sandbach, Middlewich, Alsager, Scholar Green, Haslington, Brereton (SMASH) - High Intensity User - Falls Prevention - SMASH are looking to expand out to an app which will be used for patients over the age of 65. Our first port of call would be to send a message to our patients through Accurx to gain data on falls prevention.

Nantwich - High Intensity User - Falls Prevention - Nantwich and Rural are looking to expand out to an app which will be used for patients over the age of 65. Our first port of call would be to send a message to our patients through Accurx to gain data on falls prevention.

Aims

All main aim of all the schemes is to prevent admission or readmission to hospital, by identifying risks, health need and providing the right support and access to services to people in their own homes and/or local communities. It is vital to identify the High Intensity Users in the system so that we can assist in preventing them from hospital attendance in the future

System Impact, benefits

By identifying and targeting High Intensity Users is expected to reduce attendances at Primary and Secondary Care, as the patients will be supported earlier in the journey before requiring urgent care. Examples of system impact could be: possible prevention of need for urgent appointments (including A&E attendance), reduce requests for emergency GP appointments, maintain or reduce A&E attends, which would have a positive impact on department overcrowding and patient flow, increased co-ordination of care for patients by proactive planning, increased collaboration across the system.

Anticipated Quality Outcomes

There are many anticipated quality outcomes of the schemes for people, these include:

- Reduction in inequalities (enabling all access to appointments) particularly for those who live in areas with limited public transport, have economic difficulties or require additional support to access services.
- Reduce deterioration in health.
- Patients feel supported in maintaining their health and wellbeing.
- Reduce isolation of patients.
- Holistic, joined up, proactive care for High Intensity Users
- Improved experience of care and outcomes for patients that are high intensity users of services.

Cheshire East Discharge to Assess Model of Care (by Hospital Footprint) for 2024/25

The current Discharge to Assess bed model for ECT and MCHFT for 2024/2025

Key areas of focus:

Pathway 2 – There is a Project in place to focus on maximising people's outcomes and improving length of stay, to support flow through MDTs

Multi Agency Discharge Event (MADE) - Events have been stepped up for Winter

The Home for Christmas Campaign

	Provider	No beds	Bed Type
East Cheshire Trust	Wilmslow Manor	10	Nursing
	Eden Mansions	5	Nursing Dementia
	Henning Hall	4	Nursing
		2	Nursing Dementia
	The Rowans	4	Nursing
	Tabley House	3	Nursing
	Leycester House	6	Residential
	The Willows	4	Nursing
	Prestbury House	6	Nursing/Residential/Dementia
	Aston Ward	27	Rehab
	Subtotal	71	
Mid Cheshire Trust	Clarendon Court	8	Nursing/Residential/Dementia
	Telford Court	8	Nursing Dementia
	Twyford House	5	Residential/Residential Dementia
	Station House	10	Nursing D2A
		2	CIB
	Alexandra Mill	5	Nursing/Nursing Dementia
	The Elms	3	Residential SRB
	Turnpike Court	2	Residential Dementia SRB
	Elmhurst	30	Nursing/Nursing Dementia
	Subtotal	73	
	Total Beds	144	

Mid Cheshire Hospital Foundation Trust Winter Plan

1. The Winter Plan 2024/25 is based on ensuring two key principles:
    i. To create a winter ward for escalation due to demand (30 Bed) as soon as RAAC works allow. This will now be in mid December 2024.
    ii. To invest in a number of non-bed based schemes that have either been proven to work over previous winters or as part of rapid tests of change undertaken during summer-autumn 2024. These are all aimed at creating additional weekend or evening capacity or enabling delivery of workstreams which are part of the wider UEC and Flow Transformation Programmes.
2. The Winter Plan 2024/25 includes provision for the additional capacity needed to support delivery of our My Next Patient Programme (additional transfer teams) and flow improvement (length of stay team).

Bed Based Services	
Scheme	Plan
Winter ward (30 beds)	30 beds to be opened from December 24 to end March 25. Current plan is that Ward 19 will be the Winter Ward.
Elective service resilience	
Ward 9 – Inpatient Elective Orthopaedics	Ward 9 to remained as an Orthopedic inpatient elective service.

This plan represents the best possible targeted investment in bed capacity, enhancements to weekend and evening capacity and two key elements of the UEC and Flow Transformation Programme. Rationale for including schemes is based upon schemes having worked previously, been tested in the last six months and/or being necessary to deliver the transformation programme.

Hospital Services (Non-Bed-Based Services)		
Scheme	Duration (Months)	Plan
CAU Paediatric Nursing	4	To support increased acuity.
CAU Paediatric Medical Support	4	Additional consultant ward time to support earlier discharges during the evening.
ED Paediatric Support	3	To support increased activity during the winter.
Additional Transport Discharge Vehicles	6	To avoid failed discharges 'on the day' and support a higher level of discharges resulting from additional beds being open.
Pharmacist support for ED	12	Permanent funding to support the ED teams and reduce LOS in ED.
Pharmacist support for Wards	4	Reduce LOS due to increased support for discharge arrangements and care planning.
Therapy Support	4	Reduce LOS due to increased support to deliver care / treatment plans.
Transfer Team	4	More timely movement of patients from ED to the wards.
GP Out of Hours	5	ED attendance avoidance. GPOOH/UTC – Additional capacity for winter – weekend & BH to stream away from ED.
Prescribing Pharmacist	3	Pharmacy cover between 17:00 and 20:00 to support TTOs and avoid failed discharges.
4th Consultant @ the weekend	3	Additional 9 hrs (Sat and Sun) of Acute Consultant time to facilitate discharges.
ST1/2 General Surgery to support ED	3	Additional surgical doctor between 08:00 – 20:00 (Sat and Sun) to support ED and facilitate earlier discharges.
IV at home	4	expansion to include BD service. Launching Cellulitis Pathway & Frusemide & additional winter capacity.
My Next Patient transfer team capacity	5.5	Transport team in place for MNP moves pre 10 am and accelerated transfer at 4.30pm
LoS /Flow team	5.5	LoS reduction team –digital management of all P0,P1 patients on gateway, discharge management early facilitated discharge
SDEC Weekend Opening	4	Opening of the SDEC assessment area on Saturdays and Sundays to avoid admissions to the core bed base.
Discharge Lounge – Weekend Opening	4	Opening of the Discharge Lounge on Saturdays and Sundays to create core bed availability earlier in the day.
Pharmacy – weekend support	4	Extended opening times for dispensary.
ED – 2nd Registrar (Nights	4	To support senior decision making and discharges from ED overnight.

East Cheshire Trust Schemes

East Cheshire NHS Trust

UEC Programme	Workstream	Description	Benefits
Hospital @ Home	UCR / VW Responders	To support the increase in VW utilisation and UCR referrals	Increased utilisation and response times supports the AVS / VW / UCR Home 1st principles
	ED Nursing / Navigation	Dedicated navigation team and support for surges in extremis. HCA for nursing care provision	Redirection and streaming away from ED Safety – corridor care
	Acute Medicine Registrar	To provide dedicated timely senior reviews within the Emergency Department and promote H@H principles / admission avoidance	Senior clinical decision preventing unnecessary admissions
Inpatient Flow	30-day Challenge - nurse co-ordinators Ward 2 & 4	To improve the ward and board principles and support inpatient flow and discharge	Senior Ward Leadership timely discharge planning.
	Length of Stay	Acute therapy deconditioning prevention – additional resources to provide therapy to all ward areas daily	Reduction in LOS
	Discharge	Registered Nurse to support the discharge lounge to facilitate early flow	Early flow from wards / discharge Ability to finish off treatments in the DL
	Discharge	Pharmacy discharge team expanded to support rapid medication reviews and discharge processing	Timely discharge
	Outliers	Surgical / Orthopaedic and Medical junior drs to ensure clinical reviews of outliers	Safe management of Surgical / Orthopaedic / Medical Outliers

East Cheshire Hospice Contribution to Cheshire East Winter Plan 2024-25

Overview

East Cheshire Hospice (ECH) provides services for the population living in the northern locality of Cheshire East. It offers a specialist 15-bed in-patient unit staffed by a Multi-Disciplinary Team (MDT) for both palliative and end of life care patients, four community teams delivering care @Home 24/7/365, living well services for all disease groups and a range of family support services such as Carer Wellbeing programmes and all age bereavement support. It is fully integrated with the Specialist Palliative Care Team in North Cheshire East.

All of the above resource will be deployed to support the System through Winter 2024-25.

Referral criteria and forms for ECH services are available here: How to refer - East Cheshire Hospice

What is different from Winter 2023-24 that will improve performance in 2024-25

- Daily MDT huddles for Palliative and End of Life Care (P&EoLC) patients are now well-established improving performance in patient flow and crisis avoidance
- Knutsford Home First (KHF) team is operating to its capacity keeping people at home for longer or getting them out of hospital sooner
- Additional Hospice @Home capacity has, together with KHF, increased resource by 100% from Winter 2023-24
- 0.8WTE Community Palliative Care Consultant now in post and fully inducted and supported by ECH MDT

East Cheshire Hospice Contribution to Cheshire East Winter Plan 2024-25

Action Plan for winter 2024-25

- Continue to use the MDT Daily Huddles to identify early patients who are deteriorating and who would benefit from admission to ECH or receive care at home to avoid hospital admissions
- Offer the System one (possibly two depending on availability) winter pressure step down beds for people who meet the criteria
- Ensure all referrers are aware of and practiced in the referral process for ECH
- Subject to availability there will be ad hoc facilitation of late afternoon rapid discharges from hospital to home outside of normal Specialist Palliative Care Team's hours of operation
- Specialist assessment of long-stay hospital patients who do not reach the threshold for Specialist Palliative Care Team (SPCT) invention but who could benefit from optimisation during an ECH in-patient stay
- Use ECH resource to ensure the SPCT is fully staffed throughout the winter
- Support Care Homes through ECH 24-hour Advice line 01625 666 999
- Subject to availability, offer rapid response Clinical Nurse Specialist support to P&EoLC patients at Home in and out of business hours
- From January 2025, Palliative Advice Centre East (PACE) will be working with acute, virtual wards and primary care services to wrap additional support and care
  co-ordination around P&EoLC patients earlier in their disease/co-morbidities/frailty journey to avoid crisis admissions to hospital

Infection Prevention Control provided by Cheshire & Wirral Partnership Foundation Trust

Infection Prevention & Control measures are as follows:

- ✓ Single Point of Contact for all telephone requests for advice & support from the IPC Team – Tel: 01244 397700 (Mon – Friday between 9am & 5pm, except BHs)
- ✓ Single point of contact for all e-mail communications – cwp.ipct.admin@nhs.net
- ✓ IPC link Meetings – held quarterly, with emphasis on outbreak management from September onwards.
- ✓ Ongoing support via IPC audit and review.
- ✓ Ongoing Training offer regarding all aspects of IPC, including outbreak management, chain of infection, PPE and Antimicrobial Stewardship.
- ✓ Review and communication of IPC related guidance, including Covid-19 guidance.
- ✓ Outbreak visits and support, with bespoke advice.
- ✓ Support to the Multidisciplinary approach regarding the Risk Assessment for possible early bed opening during outbreaks in care settings.

North West Ambulance Service

Every Second Counts - Help us save more lives this winter. Every year, we face increasing demand for our service during the colder months. It's important to us that when you need us the most, we are there for you. It's no secret that our 999 service is there to bring you emergency care when in a life-threatening situation, but our 111 online service is equally there to support you with your urgent medical needs.

This year, we launch our winter campaign **Every Second Counts** to continue to support and inform our public on which service best suits your medical needs. We want to ensure you understand what our services are for and when to use them. We ask you the public to stop and think:

- Is this a life-threatening illness or injury? **Think 999**
- Is this an urgent injury or illness? **Think 111 online**
- Do you feel unwell or is an injury causing you pain? **Think walk-in centre or GP**
- Can you treat your symptoms at home? **Think self-care, first-aid kit and well-stocked medicine cabinets**

Our Hero Next Door campaign aims to recruit community first responders (CFRs) all across the North West. CFRs are ordinary people who do extraordinary things as volunteers for the ambulance service. They find the time to save the lives of their neighbours whilst going about their normal routines. The idea of the campaign is to show people that volunteers can go about their everyday lives and have no other healthcare connection but still find time to be a hero!

CFRs can be called upon to attend incidents such as cardiac arrest as well as other emergency situations, so that they can start lifesaving treatment as quickly as possible before the ambulance gets there.

Only required to commit a few hours per week, a CFR could be anyone over the age of 18 and doesn't require any previous training. For more information visit our **volunteer** section.

West Midlands Non Emergency Patient Transport

In Hours

- Non means tested, eligibility criteria dependent on medical requirement
- **Winter Plan due October**
- prioritise patient discharges
- Increased support around bank holidays

Out of Hours – Details of transport Services organised by

East Cheshire Trust

Mid Cheshire Hospital NHS Foundation Trust

Mental Health

- Cheshire and Wirral Partnership NHS Foundation Trust commissioned Independent Support Living (ISL) contract in place in reach support to mental health patients in A&E
- ICB funded secure transport - utilise Response 365 to ensure quality & value

Cheshire Police

- **Safer Streets** - Working together for even safer streets in Cheshire. Safer Streets is an extensive initiative that sees Cheshire Police ramping up its determination to make Cheshire's streets even safer. It aims to benefit everyone who visits, lives or works in Cheshire.

Safer Streets
Working together for even safer streets in Cheshire

- **Safety Buses** - 'Safe space' safety vehicles, branded as Safety Buses, patrol city and town centres where there are high levels of night life. They are clearly visible and provide a safe space for vulnerable people. The vehicles have on-board safety equipment such as defibrillators, first aid kits, phone chargers and bottles of water. They are staffed by police officers and community safety specialists from partner agencies who are on hand to ensure that anyone in need of help is cared for until they are able to get home safely.

- **Personal safety app** - The Hollie Guard personal safety app helps the user to discreetly alert their chosen emergency contacts, pinpoints their location, and sends video and audio evidence directly to their mobile phones. An alert is automatically generated if the user doesn't arrive safely at their destination. The app is free to download here Hollie Guard Personal Safety APP

Hollie Guard

- **GoodSAM** - GoodSAM technology has revolutionised emergency call handling, providing enhanced capabilities and additional reassurance to callers. It has enabled vulnerable people to receive immediate face to face video communication, instant location tracking for those who are lost and the ability to upload attachments that can be used as future evidence.

Cheshire Constabulary

Cheshire Fire & Rescue Service

- ✓ Promotion of ways to keep well and warm during winter via our comms channels and community engagement **Cheshire Fire & Rescue Service - Keeping Warm**
- ✓ Safe and Well visits
- ✓ Reminder of flu vaccine offer to over 65's during Safe and Well visits
- ✓ "Keep warm" packs with a number of other agencies, given out during a Safe and Well visit
- ✓ Working with partners Cheshire East Council and the NHS to look at ways to prevent some of the consequences of Winter Pressures, particularly with the added pressure of the energy price increases.
- ✓ Safe and Well offer for residents who may use unsafe fire practices to heat themselves/homes
- ✓ Candles in the home – how to use them safely
- ✓ Chimney fire safety
- ✓ Carbon monoxide/gas safety
- ✓ Christmas safety tips - **Cheshire Fire & Rescue Service - Christmas**

Cheshire
Fire & Rescue Service

Communications

Strategic Approach for UEC Communications 24/25

Cheshire and Merseyside System Recovery Plan
In order to respond to the System Recovery Plan, UEC has moved into a structured multi partner approach with overall strategic governance being led by the ICB and within five multi partner UEC recovery footprints. This allows for overall strategic and assurance at system (Cheshire and Merseyside) level which includes specific 'at scale' workstreams with local recovery footprints focussing on local pathways and improvement across partners.

Cheshire and Merseyside UEC Communications Group
From October 2024, the existing System Pressures Cell will be repurposed into the UEC Communications Group in line with this strategic approach and in response to the UEC Recovery Plan.

The repurposing element will make clear the alignment between partners across the Cheshire and Merseyside system and have at its core a partnership approach which includes clearly reflecting the specific responsibilities for NHS C & M (ICB) and each of its system partners by sector and locality.

Cheshire East Assurance:
Our system winter campaigns will be based around the following 'key pillars'

1. Prevention: Reducing avoidable hospital admissions by helping people stay well – with a focus on people with respiratory illnesses, frailty, falls awareness & prevention, mental health awareness and suicide prevention. This includes the flu and Covid vaccination programmes.

2. Signposting: Reducing inappropriate attendances by helping people choose the right service, linking to the national Help Us Help You campaign, Pharmacy First, GP access, emergency dental care, NHS 111, Urgent Treatment Centre's and other urgent care services.

3. Self-care: Messages in relation to the promotion of pharmacies to get expert advice, gastrointestinal illnesses, with hand washing/hygiene advice, alcohol awareness, respiratory illness and common childhood illnesses.

Cheshire East Council
Adult Social Care Winter Plan 2024/2025

Introduction

Winter planning is a statutory annual requirement to ensure that the local system has sufficient plans in place to manage the increased activity during the Winter period and plans have been developed in partnership with Cheshire East system partners across the place.

The overall purpose of the Winter plan is to ensure that the system is able to effectively manage the capacity and demand pressures anticipated during the Winter period which this year runs from November 2024 to 31 March 2025.

Our system plans ensure that local systems are able to manage demand surge effectively and ensure people remain safe and well during the Winter months.

The planning process considers the impact and learning from Winter 2023/24. Plans have been developed on the basis of robust demand and capacity modelling and system mitigations to address system risk.

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

Adult Social Care Winter Priorities and Responsibilities

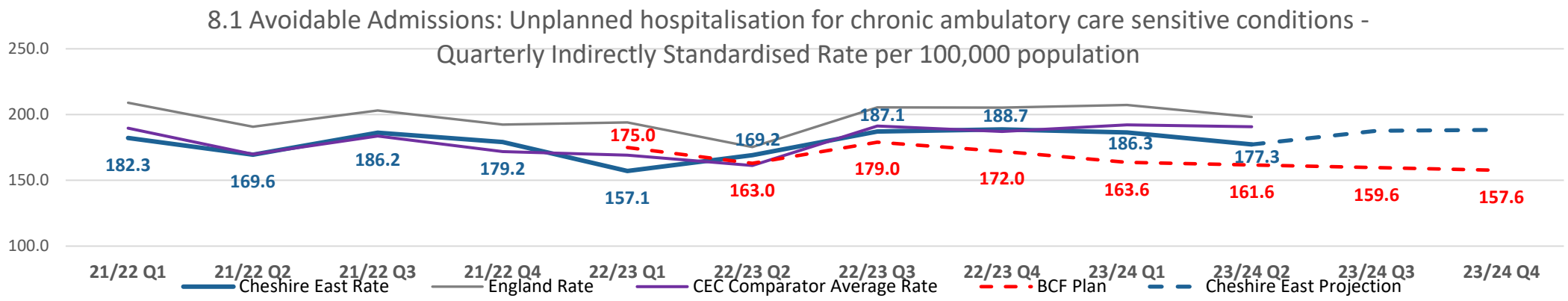
Local Adult Social Care Priorities 2024/25
1. Workforce Capacity, Market Sustainability and Improvement
2. Intermediate Care and Discharge from Hospital – including Transfer of Care Hubs (TOCH)
3. Better Care Fund Capacity and Demand
4. Unpaid Carers
5. Public Health and Infection Prevention and Control (IPC)
6. Energy and Adverse Weather
7. Reablement and Shared Lives
8. Mental Health
9. Governance and Oversight
10. Communities

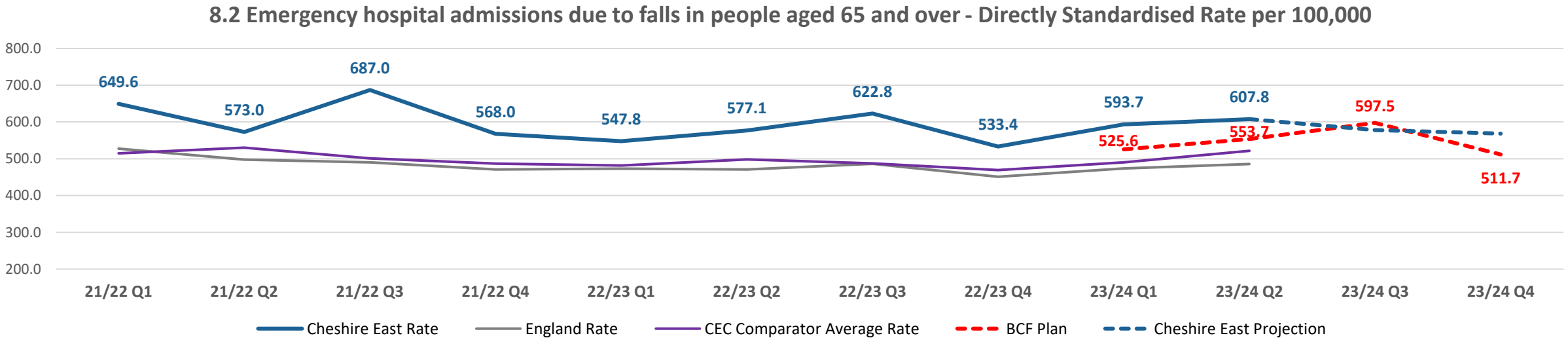
Adult Social Care Winter Ambitions
To meet a fluctuating demand and maintain flow with safe, responsive and outcome focused Health & Social Care services
Ability to access community provision unhampered by covid or other viral infections & Infection Prevention
To protect, expand and retain a healthy and resilient workforce
To support and improve access to Primary Care
To promote Self-Care and help our population to 'Choose Well' when contacting Adult Social Care Services
To maximise the transformation momentum and current resources to construct a sustainable model of Home First delivery
Increased use of Voluntary Community Faith Sector
To attain performance recovery as agreed with NHSE/I and achieve favourably amongst Cheshire & Merseyside peers A&E attendances reduced and no ambulance delays
High uptake in the Flu and COVID-19 vaccination boosters
People deemed to no longer meet the criteria to reside in hospital have clear exit and support routes out
Robust governance and system oversight

Demand Forecasting

Better Care Fund 2024-25

Metrics Report - Charts

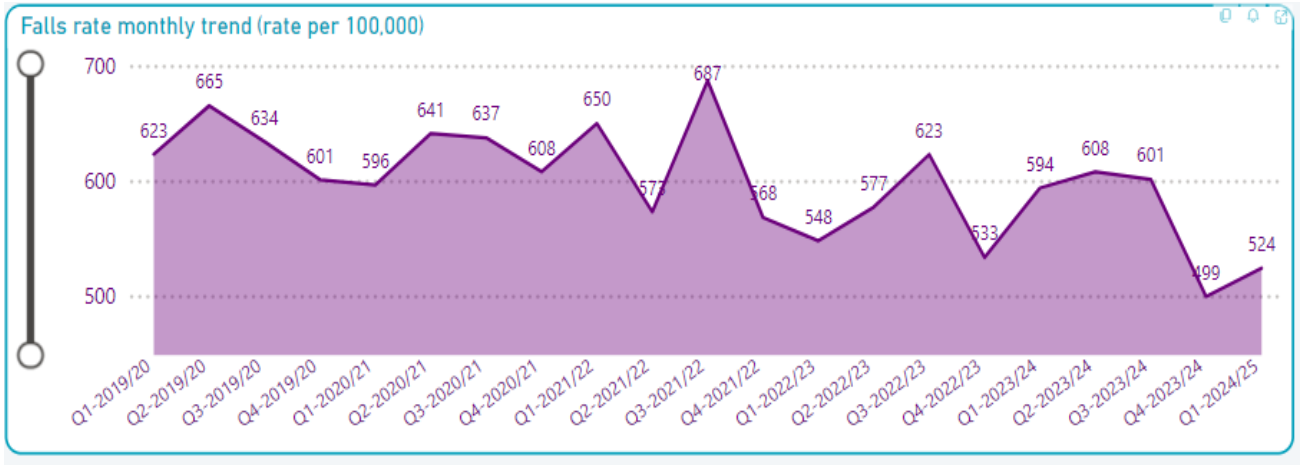


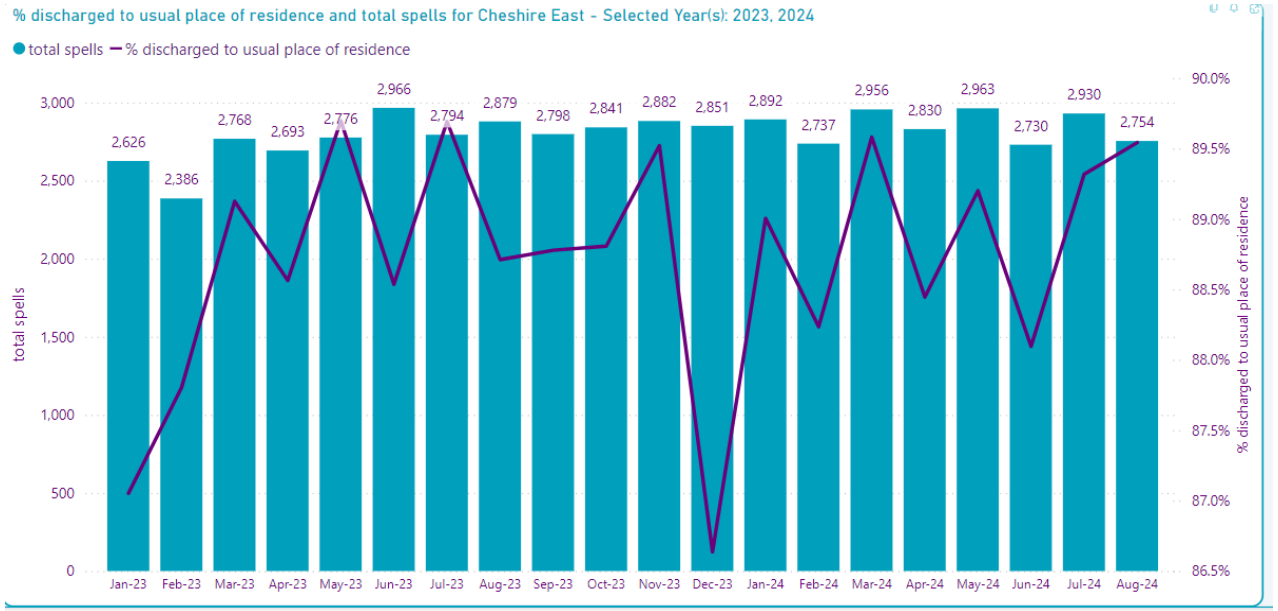


Demand Forecasting

Better Care Fund 2024-25

Metrics Report - Charts





Market Capacity, Sustainability and Improvement

To ensure provider market risk management oversight, the Council, ICB and Hospital Trusts have established a number of tools to appropriately manage the care home and domiciliary care market. These include the use of a quality dashboard, capacity tracker and bed vacancy management. Tangible results from this work to-date have included us targeting low quality homes for intervention by deploying district nurses.

There are strong relationships between partners to highlight and share system risk information and then deploy appropriate resources. A narrative care market strategic overview is produced on a regular basis, strategic data is produced and shared and a live strategic risk register is maintained.

We ensure data sharing arrangements are in place to enable rehabilitation/recovery plans to be shared by partners providing services to people, to streamline pathways and reduce duplication.

We will also hold:

- Regular and effective contract management meetings with our Adult Social Care providers (ensuring winter plans and contingency plans are in place)
- IPC risk management calls
- Provider Forums

Two integrated falls prevention specialist therapists have been recruited. They will operate across Cheshire East to provide falls prevention specialist care in the community, including in clinic and care home settings.

Intermediate Care and Discharge from Hospital

D2A Cluster Model
A significant investment has been committed from the Adult Social Care Discharge Investment Fund to support the implementation of the Discharge to Assess model, along with providing funding to purchase additional spot purchased bed base capacity when required, to meet the deficit indicated within the Demand and Capacity analysis.

System Resilience blocked booked beds (formerly referred to as Winter Pressure beds) are in place to aid pressures - 5 blocked booked system resilience beds are available until 31st March 2025,

Home First Community Prevention Reablement:
To support the identified capacity gap, an investment proposal is being taken forward to enhance the delivery for Community Reablement which would operate on a hybrid multi-disciplinary model of service delivery.

The aim of this investment and additional workforce infrastructure is to design a model of support that effectively responds within the first 72 hours of a person experiencing an escalation of their health and social care needs. The service will provide short-term social care rehabilitation, to support people to become or remain independent at home achieving the right outcome and work closely with the Care Communities.

Approved Mental Health Professionals Cover
To provide cover evenings & weekends for ECT and MCHFT, to support the increased number of Mental Health Act Assessments.

Adult Social Care Discharge Investment Fund
15 additional discharge funding schemes have been commissioned to the value of £2.3m. These include additional staffing, equipment, beds and payments, to coordinate, support and deliver home first models of care and timely discharges from hospital. Reablement is recognised as being a key partner in preventing avoidable hospital admissions and ED attendance.

The Transfer of Care Hub
The system-level place whereby (physically or virtually) all relevant services (for example, acute, community, primary care, social care, housing and voluntary) are linked to coordinate care and support for people who need it – during and following discharge and also to prevent acute hospital admissions.

There is a pre-existing mechanism for the Ready for Discharge Date to be identified for pathway 1-3 people, which is recorded on the Gateway System (Mid-Cheshire), and EMIS (Egton Medical Information Systems) East Cheshire, which in turn are fully accessible by health and social care colleagues. Pathway 0 people are discharged as soon as they are identified as having a Ready for Discharge date.

Business as usual system escalation calls are in place daily (Mon-Fri) where individual case escalations can be progressed.

Through the Transfer of Care Hubs, multi-disciplinary team meetings and transformation support , we review community length of stay pathways. Criteria to Reside data is collated daily within the acute trusts, identifying discharge ready date and community bed capacity.

Implementation of specific pathways for delirium and step-up capacity have been completed.

Roll out of intravenous and sub cutaneous therapy provision to virtual wards has been completed with a number of areas increasing their intravenous at home offer.

Cheshire East Council – Additional Discharge Fund 2024/25

Number	Scheme	Summary
1	Approved Mental Health Professional Cover, evenings & weekends for ECT and MCHFT	Approved Mental Health Professional Cover, including evenings & weekends for East Cheshire Trust and Mid Cheshire Hospital Foundation Trust
2	Assistive Technology & Gantry Hoists to reduce double handling care packages	To purchase additional gantry hoists to facilitate more rapid discharge from hospital. This provides an alternative to the provision of ceiling track hoists which are time consuming to deploy.
3	CAH Investment Increase 2023/24 Non-Recurrent	To ring fence the whole £1.2 million allocation of the Adult Social Care Discharge Fund to provide a fee increase to Cheshire East Care at Home providers to ensure ongoing sustainability, growth and ongoing investment across the sector.
4	Home First Occupational Therapist	The role of the Occupational Therapist (OT) is a project which is part of the implementation of the Home First model across Cheshire East place and will have a primary focus on specific tasks to ensure that we continue to keep people at home following an escalation in their needs and/or to support people to return home as quickly as possible, with support.
5	Community Support Volunteers	Hospital facilitated discharge and home support service includes: • Home welfare and health & safety checks • Follow up where necessary. • Settling in and linking up • Deliver 7-day support package. • Bespoke or social support to ensure maximum benefit is realised in each case. • Additional support to reduce hospital admission.
6	Increased General Nursing Assistant Capacity care at home via CCICP	Expand GNA service to continue to support bridging people awaiting domiciliary care at home in the East locations of Cheshire East.
7	Mental Health Rapid Response Outreach	Timely Mental Health Act assessments which will impact upon person, family/ carers, psychiatrists, CWP, ED departments, police, and other partnership agencies.
8	St Pauls Extra Miles	Cheshire East Council and its partners will collectively deliver integrated support to patients in hospitals in Cheshire East and service users of its Adult Social Care teams. The services will have a view to supporting their admission avoidance, discharge from hospital and preventing their readmission. In addition, they will support people known to Cheshire East Councils Adult Social Care teams to remain independent in their own home.
9	Transfer of Care Hub, Nurses and additional Social Workers to support discharges out of ED and out of hospital	Increase workforce to improve assessments and onward form completion for people who are ready for discharge. Review all patients over 14 days to reduce the length of stay.

Cheshire East Council – Additional Discharge Fund for 2024/25

Number	Scheme	Summary
10	Spot Purchase Beds and Cluster Model	Spot purchase beds and cluster model • Centralised cluster of D2A facilities strategically positioned across Cheshire East Place have ensured that people are discharged to a D2A bed as near to their local community as possible. • 158 beds have been added to the system to ensure people are discharged from hospital for a period of further treatment, assessment, and rehabilitation. • Seamless discharge and transition to D2A beds has been achieved with the removal of unnecessary authorisation processes. • A reduction in Length of Stay has been achieved. • Transformation towards a financially sustainable model for step up and step-down beds. • A reduction in the risk associated with people remaining in a hospital environment and deconditioning. • A reduction in the number of people who have No Criteria to Reside in Hospitals • Increased discharge rates on the wards, creating acute bed base capacity. • Increased patient flow through the hospital. • Supporting people out of hospital, to streamline discharge to enable recovery. • Centralise the wraparound support: Nursing, Therapy, Social Work, and GP clinical resource into key locations, reducing staff travel time and creating staffing capacity to reinvest back into the system. • A significant reduction in the spot purchasing of bed base placements. • Improved Health & Wellbeing outcomes for people. • People require lower levels of formal care on return home due to successful period of rehabilitation. • Optimisation prior to return home increases the success rate of discharges and reduces the risk of re-admission.
11	Care Community Joint Bid	This funding is on a bid basis from each of the 8 Care Communities to rapidly mobilise local initiatives that support Place strategic Priorities. Conditions of the funding are as follows: • Applications for Funding will align to the Frailty Agenda. This can be tailored to local population health need within each Care Community but must support improvements in care and wellbeing for residents living with frailty and aligned to one or more of the Priority Target areas below • Applications will be submitted on the attached template • Contribute to local systems in managing demand effectively and ensure people remain safe and well. Especially over Winter months

Cheshire East Council – Additional Discharge Fund 2024/25

Number	Scheme	Summary
		• Projects must have an evidence base and have a clear set of metrics that can demonstrate any improvements or impact. • Projects must also be deliverable within 2024/25 • And where possible support the system to get up stream ahead of winter. • Plans should not duplicate existing Commissioned services but provide additionality to what is already in place or support new ways of working to improve health outcomes. • Priority Targets: admission avoidance, falls, social isolation, dementia • Development of integrated holistic models of care within existing resources • Enhanced Care in Care Homes, Virtual Wards, 2 Hour Urgent Crisis Response
12	AED In Reach	The service will provide 168 hours per week of support:12 hours of support daily in each A&E site over 7 days per week, between the hours of 8am and 8pm (this could be flexed after 3-month review depending on what is required once the service commences and agreed with commissioners)
13	Residential Care Home Competence Nurse	In January 2023 Central Cheshire Integrated Care Partnership (CCICP) launched a 12-month secondment project for a Competency Nurse Role which was funded by the Cheshire East Better Care Fund. The project was for a whole-time band 6 registered clinician. The objective of the role was to reduce preventable skin damage and improve patient care to avoid unnecessary hospital admissions for elderly residents. Over the last 11 months the Competency Nurse has worked alongside care home managers and care staff to develop and deliver bespoke face-to-face training sessions providing clinical expertise and demonstrating evidenced based clinical skills and best practices to achieve this.
14	Practice Development Nurse	The opportunity for an experienced nurse to work with the Quality matron for community beds in supporting external providers to deliver safe outstanding care to our patients either in their own homes or in care homes. This role will focus on staff competency development and the delivery of training and education to a wide range of staff with varying experiences.
15	Community Support Connectors In TOCH	To provide recurrent funding for the following Communities staff, from BCF monies, in the continuance of their discharge work at Mid and East Cheshire Hospitals and support in avoidance of Adult Social Care services: 1x Senior Community Development Officer G10, 4x Community Connectors G7. The team have established themselves in each setting in September 2022, as a critical part of the Transfer of Care Hub (TOCH). With the support of the BCF funded Integrated Community Support Commission, and an array of VCSFE groups, the Community and Discharge Support Team enable discharge of patients from each location, leading to improved through put in the hospital. In addition, the wrap around support is provided in the Community leading to avoidance of readmission to hospital and increased care packages in the Community.

Support for Unpaid Carers

Identifying Carers

Carers need to be identified as early as possible to ensure that appropriate support, advice, and information are offered to them. Often carers only seek or are offered support once they reach a crisis point. Early identification can support the carer with the tools, knowledge, and confidence to enable them to manage their caring role, while still having a life of their own and maintaining their own health and wellbeing. Through Accelerating Reform Funding, a provider, Mobilise, has been commissioned to deliver a digital platform for carers across the Cheshire and Merseyside footprint (including Cheshire East), providing free online support and a peer-to-peer community for unpaid carers, enabling carers to access support at any time in a way that works for them. The Carers Hub are refreshing their communications and engagement plan to further develop and strengthen partnerships and referral pathways with local community health, educational services/settings and social prescribers, to ensure ongoing promotion of the Carers Hub offer, to increase the identification of unpaid carers and the number of carers supported over the winter period and onwards.

Carer Respite

Joint work across Cheshire and Merseyside to implement Accelerating Form Funding includes a proposal to invest in innovative ways to enhance the carer breaks offer in Cheshire East which provides unpaid carers more choice and control in the support they receive and has positive impacts on the carer's health and wellbeing. This includes planned carer breaks as well as a Community Reablement Service offering crisis intervention for carer respite, provided by our in-house Care4CE Team to prevent carer breakdown/ escalating need. This would include personal care for the cared for (if required). It is planned the pilot will commence during the winter period.

Support to Carers this Winter

It is vital that we support our unpaid carers to stay well this winter. We will be continuing to support our carers to:

- Receive the flu vaccination
- Register as a carer with their GP
- Register with the Cheshire East Carers Hub

Carers Strategy 2021-2025

The Cheshire East Council All Age Carers Strategy 2021-2025 was coproduced with carers, health and VCS partners with the aim of developing an effective partnership to support all carers in Cheshire East, ensuring unpaid carers receive the support they need, when they need it. A key priority of the strategy is health and wellbeing and we will continue to work across the borough, with key partners to ensure a diverse offer is available for our carers of all ages to stay healthy, well active and to have fun this winter. Plans are currently being developed to re-fresh the strategy beyond 2025, in partnership with key stakeholders, including carers.

Support for Unpaid Carers

Pilot Carer Respite Scheme

Joint work across Cheshire and Merseyside to implement Accelerating Form Funding includes a proposal to invest in innovative ways to enhance the carer breaks offer in Cheshire East which provides unpaid carers more choice and control in the support they receive and has positive impacts on the carer's health and wellbeing. This includes planned carer breaks as well as a Community Reablement Service offering crisis intervention for carer respite, provided by our in-house Care4CE Team to prevent carer breakdown/ escalating need. This would include personal care for the cared for (if required). It is planned the pilot will commence during the winter period.

Commissioned Adult Carer Respite

An assessed number of allocated nights are awarded and can be used when a carer is unable to support the person that they care for, for a period of time. Typical examples of this are when a carer would like to plan a holiday, break or perhaps has a hospital stay scheduled.

Heliosa – Nursing Respite
Heliosa is a nursing home in Congleton. It is very welcoming, with staff, residents and relative's having fun and laughter and being very pleased with the wonderful care feeling part of a big family.
CQC – Care Quality Commission Rating - Good
Latest inspection: April 2021

- X3 Beds – Heliosa – Nursing/ Dementia
- X1 Heliosa – Emergency Bed

Bucklow Manor – Residential Respite

Home in Knutsford has a carer's respite bed, and some people choose to just spend some time with us during the day but if they chose to stay with us residents will have their own room which can be personalised with familiar objects and family photographs. Of course friends and family are always welcome to drop in anytime to visit.

CQC – Care Quality Commission Rating - Good
Latest inspection: January 2023

X2 Beds – Bucklow Manor – Residential/ Dementia

Commissioned Learning Disability Carer Respite
Accommodation based respite support for individuals with learning disabilities in Cheshire East is one part of respite support service. The focus is on providing modern and flexible support which aims to enable the cared for person to retain and develop skills and independence.
The service enables Carers to have a break from their caring role, knowing the cared for person is being appropriately supported.

- 3 beds at Warwick Mews (Macclesfield)
- 1 emergency bed Warwick Mews (Macclesfield)
- 1 bed at Hani Grange (Handforth)
- 2 beds at Valleybrook (Crewe)

Public Health & Infection Prevention Control

Public Health priorities over the winter period will be as follows:

- Promote and support the seasonal flu vaccination programme (led by the NHS). The campaign started on the 3rd October 2024 and will end on 31st March 2025.

- Cheshire East Council staff flu vaccination programme - free flu vaccines will be available for all staff who wish to have it. This will be via community pharmacies as well as clinics held across corporate buildings (Crewe Municipal, Delamere House, Westfields and Macclesfield Town Hall). We have worked with CWaC colleagues to include CWaC pharmacies in a bid to increase accessibility.

- Supporting the Cheshire Wirral Partnership (CWP) Living Well team to deploy the 'Living Well Bus' to venues/geographies across the borough, providing seasonal booster vaccinations (including COVID-19, flu, pneumococcal and a range of primary immunisations) as well as broader physical and mental wellbeing assessments, to ensure our most vulnerable people are best protected.

- Winter messaging will include:
  - Washing hands (including respiratory hygiene – 'catch it, bin it, kill it'
  - Sanitising surfaces
  - Getting seasonal flu and COVID-19 vaccinations
  - A healthy diet - good nutrition **and** hydration
  - Antimicrobial Resistance (AMR) – Champs will be launching a campaign aimed at parents and young people
  - Mental health promotion. These will range from suicide prevention to general mental health promotion.

- We will support CWP IPC colleagues with outbreak management, as appropriate – Making sure settings/providers report outbreaks of infectious disease to UK Health Security Agency (UKHSA)

- Health Improvement colleagues will be supporting 'Keep Warm this Winter' messaging and dependent on the national budget outcome (Wednesday 30th) this may reach a new group of people who become eligible for pension credit.

- A series of Hydration webinars have been delivered to Cheshire East care providers (including Care Homes, Supported Living and Domiciliary Care). More will be scheduled and delivered over the coming weeks - It is essential that vulnerable people stay hydrated over winter.

- Keep Warm Kits will be distributed, as per need and vulnerability. Distribution is via the Local Area Co-Ordinators, Social Workers, Library Staff and Community Development Team. They either respond to need identified through a home visit, or in the case of libraries can assist if someone comes in and asks for help (assuming there is some genuine evidence of need).

Infection Prevention Control

- CWP are commissioned to provide an Infection Prevention and Control (IPC) service to all care homes in the CEC footprint. Our contact details and operational hours are below.
- Winter preparedness has included : promoting seasonal influenza and Covid-19 vaccinations to staff and residents, reinforcement of IPC practices specifically decontamination, personal protective equipment (PPE) usage, distribution of the UK Health Security Agency (UKHSA) flu pack when it is published and guidance on how to recognise and report a potential outbreak at the earliest opportunity.
- In the event of a provider having an outbreak of communicable disease such as acute respiratory illness or diarrhoea and vomiting the IPC service will support the provider with co-ordination of the outbreak response, IPC advice and guidance, site visits where deemed clinically necessary, signposting to other stake holders for support.
- CWP will issue a weekly Situation Report (SITREP) to key partners across the health economy. This SITREP outlines which providers are closed due to an outbreak, the reason for the outbreak and the latest update on the situation. The frequency of this communication can be increased if required. If any partners are not receiving this SITREP and would like to be included on the circulation list please contact us using the details below.
- The IPC service will work with partners including but not limited to secondary care discharge planning teams to support patient flow, UKHSA and local authority public health.

Monday – Friday (09:00-17:00hrs excluding bank holidays)
Tel: 01244 397700
Email: cwp.ipct.admin@nhs.net

For urgent advice and outbreak reporting outside of normal working hours contact UKHSA on 0344 225 0562

Energy and Adverse Weather

Adult Social Care Teams and Providers will be helping people stay safe this winter. Support available includes:

- Prompting all providers to update their business continuity plans to prepare for any disruptions this winter. This includes having access to all data should disruption occur and identifying people most at risk (via RAG rating).
- Communicate regularly with providers, including sharing key points from the government's Adverse Weather and Health Plan, to help support their planning and response to adverse weather in winter. Communicate any national and local issues that may affect them and the people of Cheshire East and signpost them to support.
- Health Improvement colleagues will be investing in 'keep warm' kits that will be distributed through libraries, communities team etc. There will be a Winter Wellbeing Comms Plan, with regular media responses.
- Encourage people who depend on electricity to power medical equipment to speak to their healthcare provider about what to do in the event of a power cut and to ensure equipment and backup systems have been recently serviced and tested.
- Urgent Community Response: The Urgent Community Response services provided by Central Cheshire Integrated Care Partnership and East Cheshire Hospitals NHS Trust operate 12 hours a day, 7 days a week, is a multidisciplinary service which responds to falls within 2 hours of referrals.

Cheshire East Council Reablement

Community Reablement – Short-term intervention

. Continue to support hospital discharges Mid & East Cheshire NHS Trusts working as part of the TOCH teams and offer home visits prior to discharge where environmental or equipment issues are identified to avoid a readmission to hospital.

. Continue to support system partners in bridging care packages with IPOCH (Mid Cheshire Trust).

. Work towards an increase in referrals into Reablement for all discharges where no care needs were previously required to maximize a return to full independence for people.

. Continue to signpost to third sector and universal services including Community Connectors and volunteers, Carers Hub

. Continue to develop hospital avoidance by supporting Urgent Community Response and Virtual Wards.

. Support therapy rehabilitation for people at home or on Pathway 2 and support functional assessments.

. Deploy staff in times of system pressures into ED.

. Currently supporting Aston Ward Pilot in Congleton with daily individual and group therapy sessions aiming to increase mobility and independence and reduce care packages prior to discharge.

. Continue as the Service of Last Resort for Provider Failure.

. Supporting the Prevent/Reduce Enable Programme.

Mental Health Reablement – Short-term intervention (6 weeks)

. Respond to urgent referrals from Liaison Psychiatry and the mental health wards to reduce hospital admission and to support safe discharge home.

. Continue to take referrals from a wide range of referrers including the Community Mental Health Team, Home Treatment, Liaison Psychiatry, First Point of Contact, CWP Crisis Line, Housing, Children's Services, GPs, Talking Therapies, Substance Misuse Services, Complex Care Nurse, Probation.

. Continue to provide support for adults with social care issues such as housing , debts , also improving mental health with coping techniques and a self-help approach, promoting social inclusion, building self-esteem and goal setting.

Dementia Reablement – Short-term intervention (12 weeks)

. To provide outreach, information and Reablement support to adults newly diagnosed with Dementia in the early to moderate stages.

. Provide time limited interventions of up to 12 weeks to support individuals to achieve outcomes that support them in maximizing their independence through social interaction within the community.

. Reduce the need for care provision by offering strategies and information on equipment to support in the home, such as assisted technology and memory aids.

. Work closely with other Health & Social Care professionals to provide a fluid support experience to those diagnosed with Dementia.

Cheshire East Council Shared Lives

- To continue to provide intermediate support, respite support or community support to any vulnerable adult over 18 years old who meets Cheshire East Council's eligibility criteria.
- To continue to work in partnership with health and social care colleagues to provide practical support to address the social care issues that impact on customers physical and mental health.
- To continue to take referrals from a wide range of referrers including the Community Mental Health Team and First Point of Contact.
- To respond to urgent referrals for emergency respite or placement offers we can support to reduce the risk of a person going into a care bed or hospital.
- To offer emergency sessional support throughout the day to give a family member a break from their caring role.
- To continue to signpost to third sector services including the Carer's Hub and Dementia Cafes & voluntary groups.
- To work closely with other Health & Social Care professionals to provide a holistic person-centered service.
- To continue to support people with complex physical or mental health needs to remain as independent as possible in the community.
- Support people to increase their self-confidence, develop daily living skills, engage in employment/education or voluntary work.
- Provide support to people with daily living skills to enable them to live as independently as possible.
- To promote the flu vaccination and covid boosters, for both people who receive support, and our carers and staff team.

Mental Health

	Mental Health Operational Services Supporting People and the System
1.	Mental Health Floating Support delivered by Making Space, providing 75 hours of support in both the North and South of Cheshire East. This service is has been recommissioned and will build on the successful model which is in place as part of a low-level mental health pathway.
2.	Complex Needs DPS – A framework containing over 160 providers, which contains providers who can support people with MH Support Needs. Services commissioned under the framework include supported living (including step down provision) and outreach provision. This is currently being reviewed with a new framework to be developed called the Complex Needs Care Provider Collaborative. This has a timeline of September 2025 for go live.
3.	Mental Health Rapid Response Reablement funded via the ASC discharge funding supporting facilitated discharge provided by ISL has been extended until 31/03/25. This along with the Mental Health Floating Support Service and Reablement Service forms part of the low-level mental health pathway. This service is consistently at full capacity (46 hrs per week) and is playing a vital role in providing short term interventions
4.	3 Mental Health Crisis beds which are located in Crewe, Macclesfield and Congleton delivered by East Cheshire Housing Consortium. These crisis beds support step up/down referrals and are in place until 31 March 2025. A review of crisis beds is underway covering Cheshire West, Cheshire East and Wirral to look at future delivery models.
5.	ISL in reach support to each ED. This is highly effective and provides 1to1 support to people supporting with de-escalation support and 1to1 bespoke support for people. It also offers additional staffing support within each ED. A further £250k has been approved via the BCF for a bespoke model for each hospital ED (Macclesfield and Leighton) from 1 April 2024 to 31 March 2025 proving 8am till 8pm cover 7 days a week.
6.	Additional £15k ring fenced to support carers and facilitated discharge and hospital avoidance.
7.	Crisis Cafes Crewe and Macclesfield and a pathway has been developed between the domestic abuse service directly to crisis cafes and trained the staff in DA awareness. These contracts are currently in place until March 2025 and CWP (as the contract holder) are looking at conducting a procurement exercise in the near future.
8.	CWP Community Mental Health Transformation is now phasing its engagement work down and mobilising new models of care. At the core of this is having practitioners operating at PCN level as part of a multi-disciplinary team with GP Practices. MH services will operate on a person-centred needs basis rather than referral criteria. This should address some of the volume incidence of community crisis and re-admission of people previously discharged back into the community.
9.	CAMHS - Additional investment has gone in to improving access and reducing waiting times however workforce shortage remain challenging to recruit to. A gap we need to address is working with Education Teams. A system planning session is required to explore how we address the gap moving forward.
10.	Talking Therapies (IAPT) Additional investment made to improve access and reduce waiting times in the North of the patch.
11.	Acute Beds Demand and capacity review underway for completion September (Cheshire & Wirral). A CWP worker is to lead on this work, with a view to create flow, reduce out of area placements. There is a need to understand the investment from West and Wirral into Winter planning to improve flow.
12.	Weekly MAADE meetings which is a new format to include admissions and discharges in one meeting
13.	Weekly oversight and Governance around the system VOIDS to support discharge flow – weekly SITREPS are now stood up and shared amongst the system.
14.	Underutilized hours in commissioned service Routes – being repurposed to support MH Discharge
15.	Home For Christmas weekly meetings to be stood up including providers, both Trusts and CWP for additional oversight and support to get people home for Christmas

Communities

- **Winter Wellbeing Goods** - Purchasing items to keep people safe and warm at home due to the impact of fuel poverty. This in turn should drive down unnecessary cold home related hospital admissions/winter related deaths.
- **Community Support Connectors** - Dedicated Communities staff based at Macclesfield Hospital and Leighton Hospital. They have a focus on **reducing care packages** and **Increasing hospital discharge** by providing constructive challenge and alternative provision through **Community Support Packages.** Packages include but not limited to:-
  - **Practical support** referrals will be actioned by the Community Support Connectors and carried out by the VCFSE sector. Support will include Pre-discharge home inspection – removal of trip and fall hazards, clutter removal, deep cleans, personal shopping, utilities top up, medication collection, advocacy, winter wellbeing items (slow cookers, blankets, hot water bottles), handyman service, minor adaptations and community equipment.
  - **Advice, guidance and advocacy** referrals will be actioned by the Community Support Connectors for support such as: emergency food and fuels, mental wellbeing, befriending, hot food delivery, transport to appointments, benefits advice/ form completion and dementia support.
  - **Assisted tech** key safe, lifeline installation, medication carousels, OT identified equipment, toilet frames, walkers, perching stool, mobile hoists etc.
- **St Pauls Commission** - Integrated Community for the Community and Discharge Support Team. The service will relieve some of the current system pressures around hospital discharge and care at home for Pathway 0, 1 and 2 patients and prevent, delay or reduce the need for ASC intervention. St Paul's will provide: Removal or replacement of home items such as a bed to make way for hospital equipment or to position the patient in a safer environment such as the ground floor, transport patients from hospital to their place of residence, will undertake a home needs assessment to establish the needs of the person, including: Emergency food parcels, hot meal delivery, medication collection and drop off, shopping, wellbeing checks, heating, lighting, initial light cleaning, signposting to other relevant services for example food banks or befriending for on-going support, obvious home safety issues which require attention prior to returning home, transport to medical appointments, advocacy.
- **Cost of Living Information Sharing** - E-mail, Web Page and Telephone Line as well as online communications campaign and offline marketing (COL Posters, leaflets at GP surgeries)
- **Food Poverty Coordination** - We have employed a staff member via CVSCE who is providing infrastructure support for the VCFSE sector to ensure sustained activity to support food poverty.
- **Household Support Fund (HSF)** - the HSF grant provides crisis support to financially vulnerable households most in need. The fund is also available to support those adults and families struggling to afford household basics including food, energy, and wider essentials. The HSF is available to trusted professionals to refer financially vulnerable adults and families that they work with for support.

Cheshire East Winter Plan Stress Testing	
Operational Scenario	**System Mitigation**
Lack of Capacity within General Practice to meet winter demand	Primary Care Access Recovery Programme
	Repurpose in hours and extended hours capacity to support urgent / on the day demand
	OPEL: Demand management reporting over winter
	Maximising the use of ARRs - Additional Roles Reimbursement Scheme
	Primary Care Network Acute Respiratory Hubs / urgent on the day Hubs - No funding identified
	Revert to Generics for prescribing in the event of ongoing medicines supply shortage
	Primary Care Network Workforce Planning
	Expanding Community Pharmacy Consultation Service in community Pharmacy
	Population segmentation using John Hopkins model adopted across all GP Practices
	Limited amount of SDF funding has been allocated to support additional GP Capacity between Nov – Feb
Lack of Acute Hospital beds leading to Overcrowding in Emergency Departments	Cancellation of lowest risk Elective procedures to release bed capacity for Urgent Care.
	Enact spot purchasing of Discharge to Assess (D2A) bed capacity across existing D2A cluster model.
	Opening of acute sector G&A beds escalation / winter ward beds (Unfunded)
No Criteria to Reside & Length of Stay (LOS)	Frequent Length of Stay reviews and identified nurses working closely with system partners for all patients who have a prolonged LOS. Staff to expedite discharges to reduce the level of deconditioning.
	Daily MDT calls with system partners to monitor system capacity and flow.
	Senior Leaders system calls
	Care Community Huddle
	Community D2A community meetings to monitor capacity and flow.
	UCR system performance metrics
	Multi Agency Discharge Events (MADE) scheduled every month throughout Winter commencing in September.
	Oversight of people delayed in community beds MADE will take place for those individuals

Cheshire East Winter Plan Stress Testing	
Mental Health Pressures in ED and bed based place	Effective Mental Health escalation procedures in place that ensures all MDT partners are actively supporting discharge plans for any patient within ED
	Bed management 4 x daily calls via Cheshire & Wirral Partnership Foundation Trust
	ISL In reach model of support in place
	Increased ISL Mental Health Outreach capacity aligned to each ED
	High Intensity User support model being worked up by each Care Community
	Weekly MADE events and Super MADEs
Infection Control (IPC) Outbreak within care homes	Vaccination Programmes Adopt the IPC Risk Assessments protocol that supports early admissions into Care Homes on a risk-based approach
Workforce Challenges	Mutual Aid via system partners and providers
	Agency staff for key roles to support the system and a robust staff induction in place
	Organisational repurposing of staff to support system pressure and emerging risk areas
	Joint working between General Nursing Assistants and Reablement to increase workforce and staff capacity
	Heath and Wellbeing programmes to support staff wellbeing
Winter Schemes Opportunities	Expediate any agreed funded scheme to support with any additional capacity that supports the system
System Communication Strategy	Place comms cell in place with key organisational comms reps
	Tactical coordination of the system comms plan. Trigger points and comms messages procedure in development
	Development of a Cheshire East Resident Winter Wellbeing Booklet to be dispatched promoting self-care options
	Cheshire East Council Communities Team Winter Communications offer
Lack of available Domiciliary Care	Undertake urgent social work reviews to release capacity
	Home First Occupational Therapy and reablement assessments via the Trusted assessor role
	Repurposes any available block purchased capacity through Routes Health Care, General Nursing assistants and Reablement to support people who require discharging or to prevent an admission.
	Maximise the use of the commissioned Third sector offer.
	Carers payment to support rapid discharge.
	Maximise the use of Assistive Technology and remote monitoring options.
	Deploy Senior Clinical Leads to ensure we maximise Virtual Ward and Urgent Crisis Response capacity.
	Increase community reablement provision.
	Enact system risk management approach.

Cheshire East System Partner Winter Plans

System Partner	Link To Winter Plans
• Cheshire East Council – Adult Social Care Winter Plan 2024-25	• CEC ASC Winter Plan 24/25 (Glasscubes link)
• North West Ambulance Service – Winter Strategic Plan 2023-24	• NWAS Strategic Plan 2024 link to be added once published
• NHS Cheshire & Merseyside Communications Winter Plan	• NHS Cheshire & Merseyside Communications Winter Plan link to be added once published