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Cheshire East Health and Wellbeing Board

Agenda

Date:	**Tuesday, 18th March, 2025**
Time:	**2.00 pm**
Venue:	**Council Chamber, Municipal Buildings, Earle Street, Crewe CW1 2BJ**

The agenda is divided into 2 parts. Part 1 is taken in the presence of the public and press. Part 2 items will be considered in the absence of the public and press for the reasons indicated on the agenda and at the foot of each report.

It should be noted that Part 1 items of Cheshire East Council decision making meetings are audio recorded and the recordings will be uploaded to the Council's website

PART 1 – MATTERS TO BE CONSIDERED WITH THE PUBLIC AND PRESS PRESENT

1. **Apologies for Absence**

2. **Declarations of Interest**

   To provide an opportunity for Members and Officers to declare any disclosable pecuniary and non-pecuniary interests in any item on the agenda.

3. **Minutes of Previous meeting** (Pages 3 - 8)

   To approve the minutes of the meeting held on 21 January 2025

For requests for further information
Contact: Frances Handley
Tel: 01270 371378
E-Mail: frances.handley@cheshireeast.gov.uk with any apologies

4. **Public Speaking Time/Open Session**

In accordance with paragraph 2.24 of the Council's Committee Procedure Rules and Appendix on Public Speaking, set out in the Constitution, a total period of 15 minutes is allocated for members of the public to put questions to the committee on any matter relating to this agenda. Each member of the public will be allowed up to two minutes each to speak, and the Chair will have discretion to vary this where they consider it appropriate.

Members of the public wishing to speak are required to provide notice of this at least three clear working days' in advance of the meeting.

5. **Mental Health Partnership update on Plan and Priorities** (Pages 9 - 22)

To receive an update on the Cheshire East Place Mental Health Plan (2024-2029) by the Mental Health Partnership Board

6. **Self-Harm and Suicide Prevention Action Plan Update** (Pages 23 - 82)

To receive an update on the 2023-2025 Plan and to approve the 2025-2027 Plan

7. **Smoking Cessation Incentives Scheme** (Pages 83 - 88)

To receive an update on the progress of the local Smoking Cessation Incentives Scheme and the next steps for developing the project in the context of the introduction of a national scheme.

8. **Better Care Fund 2025-2026** (Pages 89 - 108)

To receive a report for consideration and approval so that the BCF plan for 2025/26 can be implemented.

9. **Local Transport Plan - consultation (Closing date Monday 21 April 2025)**

For information;

Local Transport Plan

Cheshire East's Vision for Transport

Local Transport Plan animation

Membership: L Barry, Dr P Bishop, A Blizard, D Bowman, Councillor C Bulman, H Charlesworth May, Councillor S Corcoran (Chair), P Cresswell, M Davis, T Leavy, Councillor J Rhodes, M Wilkinson, Councillor J Clowes, K Sullivan, I Wilson

CHESHIRE EAST COUNCIL

Minutes of a meeting of the **Cheshire East Health and Wellbeing Board** held on Tuesday, 21st January, 2025 in the Council Chamber, Municipal Buildings, Earle Street, Crewe CW1 2BJ

PRESENT

BOARD MEMBERS

Councillor Sam Corcoran (Chair), Cheshire East Council
Helen Charlesworth-May, Executive Director Adults, Health and Integration (Joined remotely via Microsoft Teams)
Councillor Janet Clowes, Cheshire East Council
Theresa Leavy Interim Executive Director Children and Families, Cheshire East Council.
Councillor Jill Rhodes, Chair of Adults and Health Committee, Cheshire East Council
Kathryn Sullivan, Chief Executive, CVS Cheshire East (joined remotely via Microsoft Teams)
Isla Wilson, Chair, Cheshire East Health and Care Place Partnership
Kate Little, Deputy CEO, CVS Cheshire East
Lucy Coates, Sector Development Officer and Social Action Lead, CVS Cheshire East
Louise Barry, Healthwatch Cheshire
Denise Bowman, Cheshire Fire and Rescue Service

OFFICERS IN ATTENDANCE

Guy Kilminster, Corporate Manager, Health Improvement
Prof Rod Thomson, Interim Public Health Consultant
Dr Susie Roberts, Public Health Consultant
Joel Hammond-Gant, Health Protection Officer
Lisa Davies, Interim Improvement Director, Children and Families, Cheshire East Council
Claire Williamson, Director, Education, Strong Start and Integration, Children and Families, Cheshire East Council
Frances Handley, Democratic Services Officer
Josie Lloyd, Democratic Services Officer

35 **APOLOGIES FOR ABSENCE**

Apologies were received from Councillor Carol Bulman, Chair of Children and Families Committee, Cheshire East Council, Dr Paul Bishop (NHS Cheshire and Merseyside Integrated Care Board), Superintendent Andrew Blizard (Cheshire Constabulary), Michelle Davies, Guinness Partnership, Mark Wilkinson, Place Director, NHS Cheshire and Merseyside Integrated Care Board, Phil Cresswell, Executive Director of Place

36 **DECLARATIONS OF INTEREST**

In the interests of openness, Professor Rod Thompson declared that he is a trustee of Everybody Health and Leisure

37 **MINUTES OF PREVIOUS MEETING**

That the minutes of the meeting held on 19 November 2024 be confirmed as a correct record.

38 **PUBLIC SPEAKING TIME/OPEN SESSION**

There were no public speakers.

39 **PAN CHESHIRE CHILD DEATH OVERVIEW PANEL ANNUAL REPORTS 2022/23 AND 2023/24**

The Board received two reports on the findings and recommendations from the Pan Cheshire Child Death Overview Panel Annual Reports 2022/23 and 2023/24.

A presentation was shared from Susie Roberts, Public Health Consultant that highlighted findings and learnings in an effort to ensure improvements in the future.

The Board raised concerns around maternal smoking and sudden infant death along with children in homes with smokers and how awareness can be improved. It was discussed that there would be more focus on campaigns to improve awareness.

Concerns were raised about tight funding environments and removing funding from the organisations that are depended on that have contact with children and families.

RESOLVED:

That the Board

1. Note the findings and recommendations within the Pan Cheshire Child Death Overview Panel Annual Reports.

2. To advocate for sustained focus on approaches to address the commonly associated modifiable and vulnerability factors amongst local children and families.

40 **HEALTHIER FUTURES UPDATE**

The Board received an update from Nicola Clemo Deputy Programme Director, Healthier Futures on the progress of the Healthier Futures Programme (to rebuild Leighton hospital).

The Board was asked whether a quarterly update was appropriate and was agreed that it was important to continue to receive regular updates about how that transformation process of service delivery is going, and be involved in the 'Big Conversation'. It was agreed that an update will be brought to the next meeting on 18th March 2025.

It was asked what consideration had been given to neurodiversity and learning disabilities in the design strategy. The board were informed that it was an inclusive design strategy and that targeted groups, staff and patients will be brought into the design process.

The Cheshire East Health and Care Place Partnership offered to share their network of expertise to support and assist the process.

The board raised questions around employment strategy and it was noted that a workforce strategy is being worked up in terms of the employment opportunities for local people within the trust itself and have started to establish a number of relationships with local schools and colleges.

It was noted that The Healthier Futures team are engaged with the head of highways, the head of planning and head of economic development, looking at the opportunities to link the hospital with the wider teams looking at Crewe's economic development, transport infrastructure improvements and active travel.

RESOLVED:

That the Health and Wellbeing Board note the update.

41 **DIRECTOR OF PUBLIC HEALTH ANNUAL REPORT 2024**

The Board received an update on the Director of Public Health Annual Report 2024. A presentation was shared from Joel Hammond-Gant which highlights the harmful health impacts of the commercial determinants of health (CDOH) and unhealthy commodity industries (UCIs).

The Board raised concerns around vaping, gambling and alcohol and discussed options as to how they can support in relation to these issues. It was suggested that these could be considered in the Local Plan

Helen Charlesworth May agreed to discuss with the Corporate Leadership Team at Cheshire East and agreed to raise at Place Partnership.
It was suggested that this is brought back alongside the public health plan in 12-18 months to review the progress.

An action was agreed for Councillor Sam Corcoran to discuss further with the Public Health team about the local plan and how more can be added into the local plan about spatial planning to promote exercise and healthy

lifestyles and to raise adding this report to the Corporate Policy Committee work programme.

RESOLVED: That the Health and Wellbeing Board

1. Receive and note the Director of Public Health Annual Report for 2024.

2. Consider how the Director of Public Health's recommendations and opportunities for change can be addressed, by whom, and by when.

42 **VCFSE SECTOR APPROACH TO PREVENTION / EARLY DETECTION**

The Board received a presentation on the VCFSE Sector Approach to prevention / early detection from Kathryn Sullivan, CEO, CVSCE and Lucy Coates, Sector Development Officer and Social Action Lead, CVSCE. The slides outline some of the successes of the programme and the positive feedback from community groups who have used funding from the cancer alliance to run projects for their beneficiaries.

The Board welcomed the approach and model and agreed that it needs to be backed by what is already commissioned.

The approach would be benefit from having other groups collaborate. The Care Communities are the networks where this could be adopted to ensure a broader approach.

RESOLVED (unanimously):

That the Health and Wellbeing Board adopt the template for other areas of work as appropriate in relation to future priorities.

43 **ALL TOGETHER FAIRER: THE CHESHIRE AND MERSEYSIDE HEALTH AND CARE PARTNERSHIP PLAN 2024-2029**

The Board received a report on All Together Fairer: the Cheshire and Merseyside Health and Care Partnership Plan 2024-2029

The Board suggested a further conversation about this and how they could be confident that the plan is on track and be measurable for Cheshire East specifically.

RESOLVED:

That the Health and Wellbeing Board;

1. Note the content of 'All Together Fairer: the Cheshire and Merseyside Health and Care Partnership Plan 2024-2029' and the alignment with the Cheshire East Health and Wellbeing Strategy and the 'Blueprint 2030'.

2. Work closely with the Cheshire and Merseyside Health and Care Partnership over the next four years to facilitate achieving our local objectives and contributing to the delivery of the Partnership's Plan.

3. Acknowledge that further work is to be undertaken to understand the implications of a 1% year on year increase in the Cheshire East Place budget going towards the social determinants of health and the promotion of good health (including clarity of definition and baseline).

The meeting commenced at 2.00 pm and concluded at 15.32 pm

Councillor S Corcoran (Chair)

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Cheshire East Place Mental Health Plan (2024-2029) update by the Mental Health Partnership Board

Adults and Health Committee – March 2025

#BecauseWeCare

Cheshire East Partnership

Cheshire East Mental Health Partnership Board

We will strive to ensure good mental health and well-being for people who live in the borough of Cheshire East

Reports to:
Cheshire East Health and Wellbeing Board

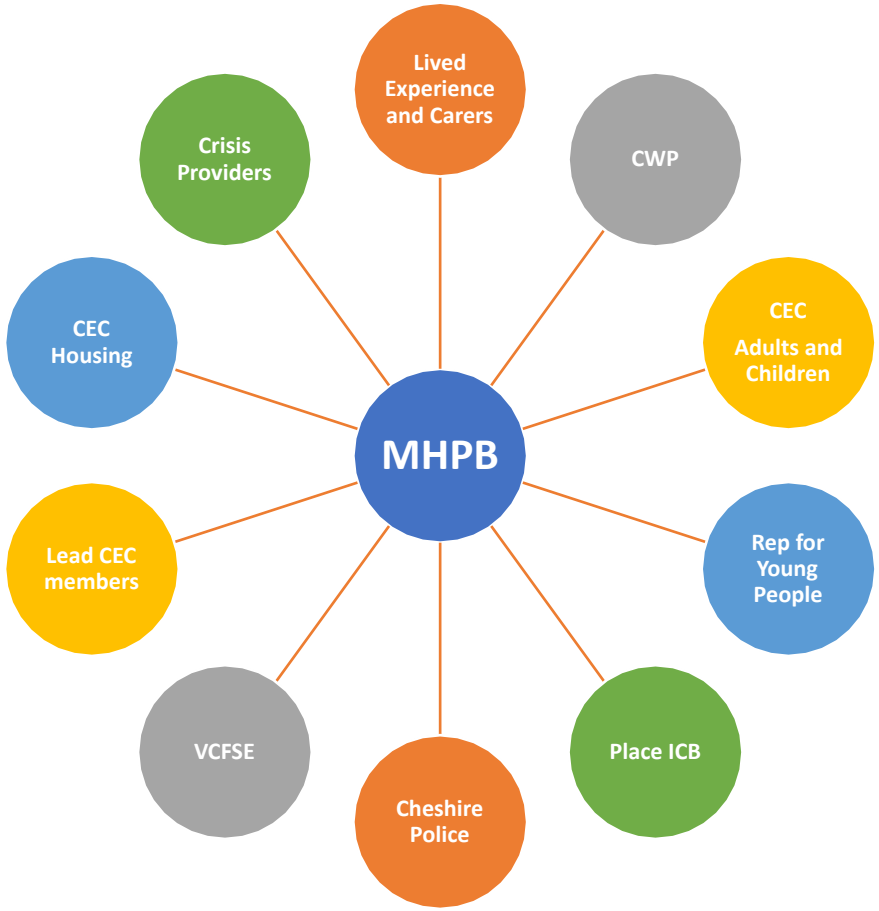
Provides updates on the implementation of the Cheshire East Place Mental Health Plan to:

- Adults and Health Committee
- Children's and Families Committee

Updates are provided on request

Mental Health Partnership Board Membership

- The Mental Health Partnership Board includes partners from a range of organisations across health, the local authority., police, VCFSE sector and people with lived experience.
- Many of the partners have their own plans/strategies and workstreams which have been aligned and are reflected in the development of the Cheshire East Place Mental Health Plan



Monitoring of the Cheshire East Place Mental Health Plan 2024-2029

- Monitoring of the plan is undertaken on a bi-monthly basis
- Partnership Board meetings focus on specific priorities from the plan on a rolling cycle
- Nominated Lead Officers submit a highlight report detailing progress updates and provide a verbal updates at meetings
- Officers can obtain feedback, collaboration opportunities and also escalate items which require further support.
- The board has a risk register in place, which contains identified actions to explore and mitigate their impact.

Working with other lived experience forums

Representatives from lived experience groups/forums attend the MHPB

- East Cheshire Mental Health Forum (Macclesfield/Congleton, adults)
- Cheshire East Parent Carer Forum
- Cheshire East Carers Forum
- Representative from the Children and Young People's Co-Production Workstream

CEC Communities Team has been working with the Partnership Board to re-establish an adult user led forum in Crewe to ensure representation from this local area.

Priority 1: Children and Young People's Mental Health and Emotional Wellbeing

What have we achieved?

- An Early Help Partnership Board is now in place
- 6 Family Hubs have opened across Cheshire East, with a digital Family Hub offer available.
- MyHappyMind is supporting 61 schools and 13,469 pupils across Cheshire East with positive feedback from children, parents and teachers.
- Solihull approach evidenced based training to support mental health and wellbeing in parents and children, been made freely available to all parent carers across Cheshire East and all professionals within Cheshire East's children's workforce.
- The Healthy Young Minds service, launched in April 2024, is offering an accessible, inclusive service aimed at building resilience in children and young people (CYP) and their families, to address emotional wellbeing issues, at the earliest opportunity, to enable CYP to live their best lives in the future. A logo for the service was developed by one of our children and young people. Since its launch, 715 young people have been receiving bespoke package of support and 100% of young people (and families have reported satisfaction with the service received.
- The Healthy Young Minds Alliance was established October 2024, where providers are working together, towards a shared ambition of building resilience in CYP and their families, to achieve consistency and equality of delivery, address gaps in services as a collaborative and provide a mechanism for channelling funding, to enhance the impact of early intervention.
- Meetings between MH Hub and Healthy Young Minds Service providers- JDI and Visyon, to build relationships and reduce blocks in the system for CYP and families
- Demonstrable, positive co-production with children and young people across a range of activities/ topics. The Voice of the Child Partnership and Make your Mark programmes have been highly successful.

What does the data tell us?

Area	Date	Count / Wait time	Trend
Absenteeism in primary and secondary school	22/23	Primary: 3,320 children / 12.4% Secondary: 5,149 children / 23.4%	↓
1st contact MH appt	Jan 25	between 8 – 12 weeks	↑
Intervention MH appt	Jan 25	between 14-16 weeks	↔
Neurodevelopmental assessment	Jan 25	between 23-25 months	↓

What's next?

- Early Help Strategy Consultation
- Further development of Wave 11 of the Mental Health in Schools Team programme
- Further development of a shared outcomes framework across the Healthy Young Minds Service
- Further work in Healthy Young Minds Service priority areas population groups
- AAT , further drops in to support Parents / families waiting for assessment

Priority 2: Education, Employment and Training

What have we achieved?

- Senior Mental Health Lead role in in place at all college settings, 21/23 secondary schools and 113/124 primary schools. The Senior Mental Health Lead Network continues with high attendance, predominantly from schools, but including health and 3rd sector
- Engagement with rural isolated schools is underway
- IPS service in place via Standguide covering Cheshire East.
- Continued development and expansion of Supported Internships: 74% of young people with an EHCP and complex needs are achieving paid work within 12 months. On target for an increase in places from 40 to 60.
- Welfare to Work Partnership in place.

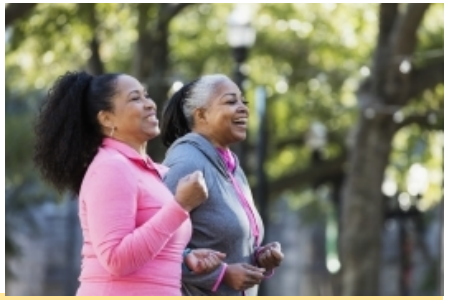
What does the data tell us?

Area	Date	Count	Trend
% of people in employment over the lifetime of the plan	23/24	183,400 (81.6%) in employment England average is 75.7%	↔
Working age claimant count	Jan 25	5,695 people / 2.4% North West average: 4.5%	↔
16-17 years old not in education, employment or training	22/23	205 people / 2.7% England average is 5.2%	↓
NEET as a % of pupils	22/23	2.6%	↔

What's next?

- Continue work with SMHL Network
- Agreement on use of Shared Prosperity Fund in 25/26
- Workshop to agree allocation of the Universal Support investment

Priority 3: Early Intervention and Prevention



What have we achieved?

- Cheshire East Self Harm and Suicide Prevention Action Plan 2023-2025 in place. Listed priorities and workstreams are discussed/updated at the Self Harm and Suicide Prevention Board each quarter.
- Domestic abuse and suicidality toolkit launched May 2024.
- 384 people have completed the Public Health Suicide Prevention training surveys, with between 500-600 completing the training.
- A wide range of public health work is in progress to promote good wellbeing in children and families, including the HENRY programme, the launch of the Eat Well and Move More Partnership, and the coproduction of the children and young people's lifestyle prescription.
- Active Cheshire have joined a national advisory group working to ensure that the benefits of physical activity in improving mental health outcomes are realised.
- Development of Active Futures: a project to deliver early interventions through sport and physical activity for young people at risk of crime.

What does the data tell us?

Area	Date	Count	Trend
stabilisation or reduction in % suicide rate for CE during lifetime of Plan	3 year rate	12.5/100,000 (previously 8.8/100,000) England 3-year rate: 10.7/100,000	↓
increase in % of physically active adults during lifetime of the plan	22/23	67.1% active (previously 63.2%) England average: 63.4%	↑

What's next?

- Evaluation of the 2-year CE Self Harm and Suicide Prevention Action Plan 2023-2025, with updated plan to be reviewed at the Health and Wellbeing Board.
- Work to strengthen the evidence base on clinical outcomes and cost effectiveness of physical activity to support integration into the Talking Therapies offer

Priority 4: Building Sustainable Communities

What have we achieved?

Housing

- The Cheshire East Specialist Housing Group meets on a bimonthly basis with representation from CWP. A key priority is establishing a pathway for those who are currently residing in inappropriate mental health accommodation.
- The Government has recently revised the National Planning Policy Framework which introduces changes to the way in which Local Plans are developed. Cheshire East's Strategic Planning Team are taking this forward.

Domestic Abuse

- The Custody suite intervention offer has been expanded to 7 days a week and supports front line officers to offer the right support to perpetrators before leaving custody.
- The Whole Housing Approach pilot for Cheshire East will conclude in March 25. University of Lancashire are conducting an evaluation of the pilot.

What does the data tell us?

Area	Date	Count	Trend
Homelessness: households owed a duty under the Homelessness Reduction Act	23/24	1,723 / 9.9% England average: 13.4%	↓
no of adults in contact with secondary mental health services who live in stable and appropriate accommodation	22/23	Adults with Learning Disability: 763 / 85.1% (22/23) Adults: 54% (20/21)	↔ Not known

What's next?

- Specialist Housing Group to engage with developing Registered Housing Providers.
- Revised Hospital Discharge Protocol to launch
- Whole Housing Approach pilot evaluation

Priority 5: Transformation of Mental Health Services

What have we achieved?

- Floating Mental Health Support Service commissioned through Making Space
- A low level mental health pathway has been extended following evaluation.
- ARRS workers in Primary Care (NB: not available across all 8 Care Communities yet)
- Implementation of 4 week waiting time standard for community MH access
- Work to strengthen the Community Alliance relationships and review contracts/ available funding for 3rd sector
- Personality Disorder Pathway work has agreed a strategic model with a clinical management pilot due to commence in East, Spring 25
- Autism outreach support workers recruited to support adults either waiting for autism assessment or following diagnosis.

What does the data tell us?

Area	Date	Count/ Wait	Trend
% of adult social care users who have as much social care contact as they would like	22/23	18+: 1,980 / 48.7% 65+: 1,165 / 45.4%	unknown
Excess under 75 mortality in adults with severe mental illness	21/23	508.7% England average: 383.7%	unknown
Access to adult secondary care mental health services	Jan 25	Referral to First Contact wait between 1-3 weeks (average)	↑
Neurodevelopmental assessment	Jan 25	ADHD: 21 months (ave) Autism: 23 months (ave)	↓

What's next?

- Implementation of MaST system at CWP to better support caseload oversight and clinical prioritisation
- PD pathway to work on CYP transitions and interface with Eating Disorder Services

Priority 6: Crisis Support

What have we achieved?

- CYP Urgent Support Team in place, in reaching to Cheshire East acute Trusts & EDs
- Ancora Care in place to support admission avoidance for young people and to facilitate earlier discharge from hospital
- Deep dive undertaken into CYP self-harm (ICB/ CWP)
- Review of Community Crisis beds completed
- Crisis Cafes remain in place in Crewe and Macclesfield, supported by information leaflets in a range of languages.
- NHS 111, option 2 offer now live for access to MH First Response, alongside CWP Crisis Line
- Mental Health Response vehicles now live. Crewed by a mental health nurse (employed through CWP) and a Emergency Technician (employed through NWAS). One vehicle is based in Northwich and one is based in Bebington.

What does the data tell us?

Area	Date	Count	Trend
Emergency hospital admissions for intentional self-harm	23/24	690 Value 180.9 England value 117.0	↑
hospital admissions for self-harm	22/23	10-14 years: 130 15-19 years: 150 20-24 years: 80	↓ ↔ ↔

What's next?

- Re-commissioning of the Crisis Cafes
- Community crisis beds: scoping for a new model with provider market and users
- Action plan to be developed following deep dive into CYP Self-Harm.

Risks

The MHPB holds a risk register which is reviewed at every meeting. 3 of the risks score 15 or above. These risks are around:

- Smaller rural schools finding it difficult to access the mental health support/ training available (score 16)
- Support for carers (all ages) is not being delivered as planned and according to statutory responsibilities (score 16)
- There are an increasing number of CYP presenting with self-harm at acute units in Cheshire East, with concerns being raised at the Parent/Carer forum about increases in self-harm behaviour in the community (score 15)

Discussions have been held at the MHPB about the actions partner organisations are taking to address these risks and updates are sought for the next meeting.

Overall Assessment

There is demonstrable progress across the Priorities with some commitments already completed. There is a high level of engagement from partners in this work.

Areas for focused attention include:

- Improving support for carers
- Supporting rural and isolated schools
- Addressing waiting times (CYP and adults)

Any Questions?

Agenda Item 6

Cheshire East Council

NHS
Cheshire and Merseyside

CHESHIRE EAST HEALTH AND WELLBEING BOARD
Reports Cover Sheet

Title of Report:	The Cheshire East Place Self-Harm and Suicide Prevention Plan
Report Reference Number	HWB75
Date of meeting:	18th March
Written by:	Lori Hawthorne
Contact details:	Lori.hawthorne@cheshireeast.gov.uk
Health & Wellbeing Board Lead:	Helen Charlesworth-May

Executive Summary

Is this report for:	Information ☐	Discussion ☐	Decision X
Why is the report being brought to the board?	For an update on the 2023-2025 Plan and to approve the 2025-2027 Plan		
Please detail which, if any, of the Health & Wellbeing Strategic Outcomes this report relates to?	1. Cheshire East is a place that supports good health and wellbeing for everyone ☐ 2. Our children and young people experience good physical and emotional health and wellbeing ☐ 3. The mental health and wellbeing of people living and working in Cheshire East is improved ☐ 4. That more people live and age well, remaining independent; and that their lives end with peace and dignity in their chosen place ☐ All of the above X		
Please detail which, if any, of the Health & Wellbeing Principles this report relates to?	Equality and Fairness ☐ Accessibility ☐ Integration ☐ Quality ☐ Sustainability ☐ Safeguarding X All of the above ☐		
Key Actions for the Health & Wellbeing Board to address. Please state recommendations for action.	To note the progress made in relation to the 2023-2025 Self Harm and Suicide Prevention Plan and to comment upon and agree the 2025-2027 Plan.		

Has the report been considered at any other committee meeting of the Council/meeting of the CCG board/stakeholders?	Yes, a stakeholder workshop was held on Teams on 4th March.
Has public, service user, patient feedback/consultation informed the recommendations of this report?	Yes, information from community and voluntary sector organisations working with families of people who have died from suicide and from those working to prevent self-harm and suicide has informed the Plan.
If recommendations are adopted, how will residents benefit? Detail benefits and reasons why they will benefit.	Levels of self-harm and suicide will stabilise and in due course reduce.

1 Report Summary

1.1 The 2023-2025 Cheshire East Place Self-Harm and Suicide Prevention Plan has run its course. A presentation will provide the Board with updates on progress made. The refreshed Plan for 2025-2027 is presented for the Board's consideration and approval.

2 Recommendations

2.1 That the Cheshire East Health and Wellbeing Board note the progress made in relation to the 2023-2025 Self Harm and Suicide Prevention Plan and to comment upon and agree the 2025-2027 Plan.

3 Reasons for Recommendations

3.1 To ensure that the collaborative work to reduce self-harm and suicide in Cheshire East is brought to the attention of the Board and that the Board supports ongoing work.

4 Impact on Health and Wellbeing Strategic Outcomes

4.1 Improving the mental health and wellbeing of people living and working in Cheshire East is a priority outcome within the Joint Local Health and Wellbeing Strategy with the reduction of hospital stays for self-harm and reducing the number of suicides indicators of success.

5 Background

5.1 The Cheshire East Place Self-Harm and Suicide Reduction Plan responds to the national Suicide prevention strategy for England: 2023 to 2028 and the Cheshire and Merseyside Suicide Prevention Strategy 2022-2027.

6 Access to Information

6.1 The background papers relating to this report can be inspected by contacting the report writer:

Name: Lori Hawthorn
Designation: Public Health Development Officer (Mental Health and Suicide Prevention)
Email: Lori.hawthorn@cheshireeast.gov.uk

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Self Harm and Suicide Prevention Action Plan

Online Workshop March 4th 2025.

- Evaluation of the 2023 – 2025 plan
- Priorities for 2025 – 2027

Cheshire East Integrated Care Partnership

Comments from Guy Kilminster and Dr Susie Roberts

Public Health Chairs of the Self-Harm Suicide Prevention Board:

We are really pleased with the continued level of interest and participation from members of the Partnership.

The 2-year action plan has achieved great work from a range of professionals from different organisations across the workforce.

It is evident the Partnership has a shared commitment to drive suicide prevention in Cheshire East.

If you or anyone you know is affected by suicide, then please find support and information in the following link:

Suicide Prevention, Support, and Information

Governance

SUICIDE PREVENTION STRATEGY | Cheshire & Merseyside 2022-2027

GOV.UK Menu

Home > Health and social care > Public health > Health protection > Suicide prevention strategy for England: 2023 to 2028

Department of Health & Social Care

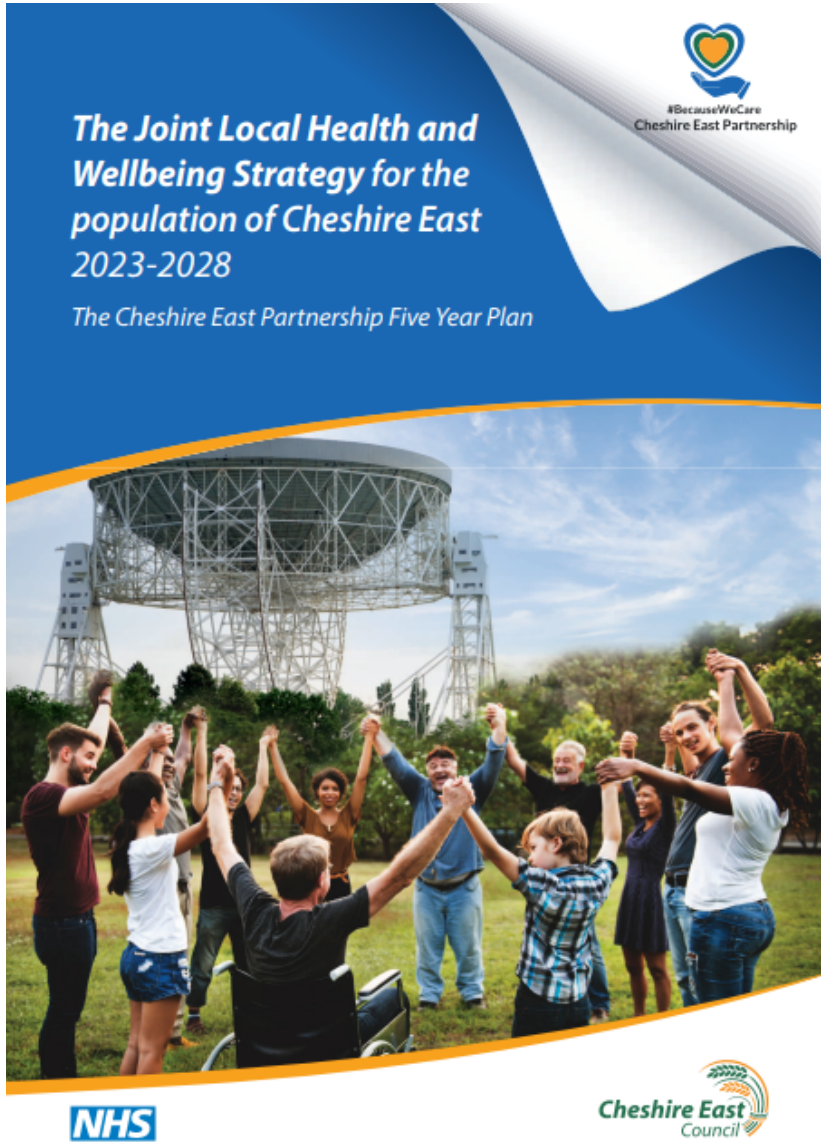
Policy paper

Suicide prevention in England: 5-year cross-sector strategy

Published 11 September 2023

[Suicide prevention in England: 5-year cross-sector strategy - GOV.UK]

[Suicide-Prevention-Strategy-2022-2027-compressed.pdf]



[Health and Wellbeing Board]

Contents

Introduction & Interaction https://www.menti.com/alvwxsguoc2d

The Cheshire East Self Harm and Suicide Prevention Partnership Action plan was developed with over 60 professionals who attended 3 online workshops in 2023.

This plan has been endorsed by the Health and Wellbeing Board.

Key Priority groups include:
1. Men **2. Children and Young people** **3. Self Harm**

The action plan is a public facing document and updated ever 3 months on the Live Well Site

What does your organisation do that includes suicide prevention?

Cheshire East (CE) Self Harm and Suicide Prevention Action Plan 2023 - 2025	
Long Term Outcomes	
Reduced Suicides	Reduced Self Harm

Priorities	*What are we doing?*	*Who inputs into this work?*	*Frequency*	*Short term outcomes*

Partnership

The Self Harm and Suicide Prevention Partnership board includes professionals from:

NHS, Social Care, Education, Lived Experience, Police, Voluntary, Community and Faith sectors.

Board meetings are every 3 months chaired by senior public health suicide prevention leads.

Members have an opportunity to review the action plans and the agenda items include presentations and evaluations of completed and ongoing actions.

Collaboration

Cheshire East Mental Health Plan (2023-2028)

The Self Harm and Suicide Prevention Partnership action plan is part of our all-age Mental Health Plan; priority 3, early intervention and prevention.

Regular updates are provided to achieve the best outcomes for Cheshire East.

[Cheshire East Place Mental Health Plan]

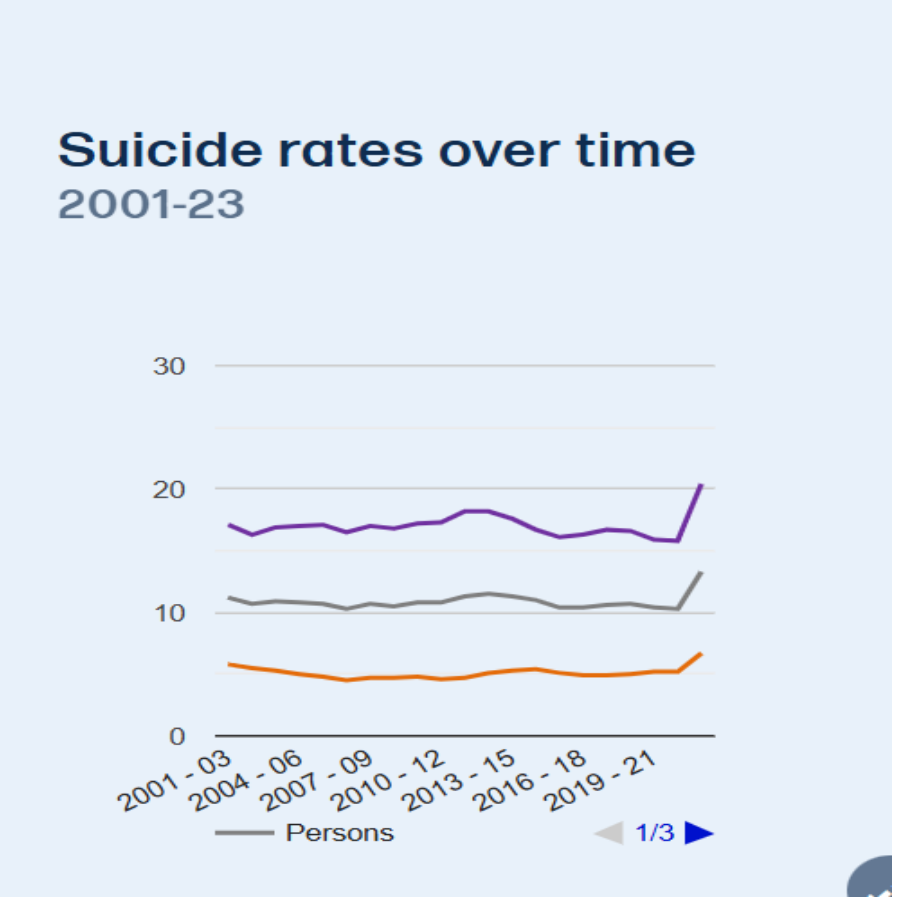
Six key priorities that have been developed to deliver the plan vision:

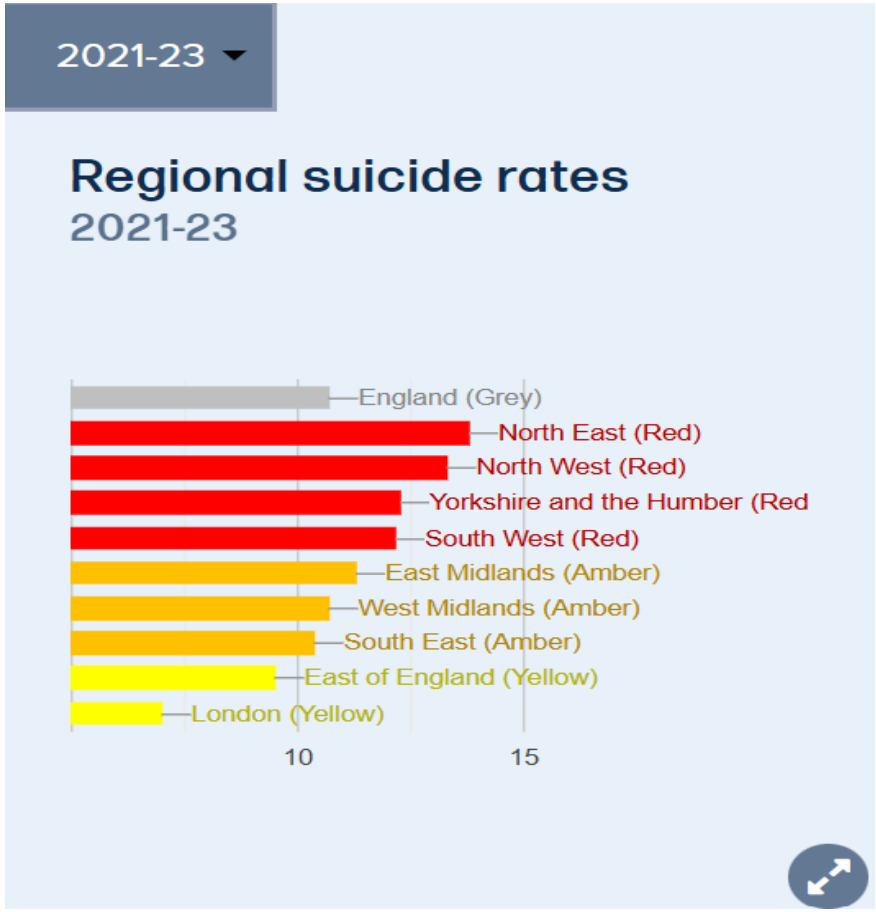
Regional Data

Zero Suicide Alliance have regional dashboards with key information on suicide rates and related risk factors for each region within England.

Lori to share the webpage and is discuss:

[North West region dashboard]

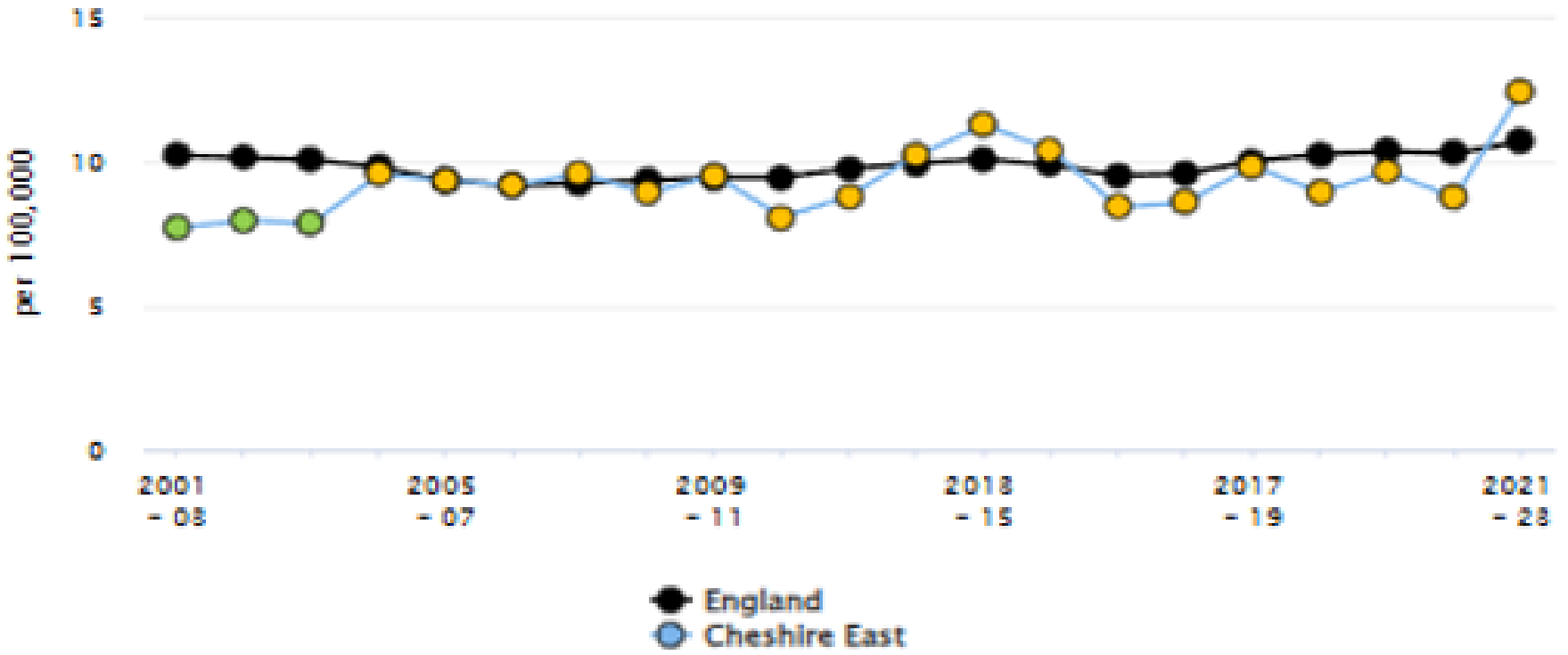




Local Data

Cheshire East has increased (12.5 /100,000 compared to 8.8/100,000 for 2020-2022).

The rate is also higher than the England rate of 10.7/100,000.



Office for Health Improvement & Disparities. Public Health Profiles. [27 February 2025] https://fingertips.phe.org.uk © Crown copyright [2025]

Self Harm Data & Interaction https://www.menti.com/alvwxsguoc2d

The Office of National Statistics (ONS) data indicates that both self-harm and suicidality admissions from children are higher than England's average in Cheshire East.

Data published in the JSNA shows increased presentations for self-harm in younger children of 12 – 15 years old.

Published data is in our Joint Strategic Needs Assessment (JSNA)

What is your understanding on self harm behaviour?

Cheshire East Integrated Care Partnership

Workstream Progress & Evaluations

Men’s mental health

Cheshire East Integrated Care Partnership

Both Mentell and Lightwood Green Methodist Chapel deliver support services in farming/rural communities.

The project evaluations were shared with the Partnership (2023/2024) achieving successful community engagement, uptake of support groups and increased awareness of support services specifically for men.

Mentell has weekly support groups in Wilmslow, Congleton, Macclesfield and Crewe.

Lightworks Project is based in Audlem and reaches out to the local community, schools and Reaseheath College.

Lightwood Green Church Information

Mentell – Men, is it time to talk?

Children and Young People

Early intervention and prevention

Pilot project: Keep Safe Cope Well plans

An early intervention framework delivered in Primary schools to prevent poor mental health in teenage/ adulthood.

Key outcomes are for children to have understanding and awareness:

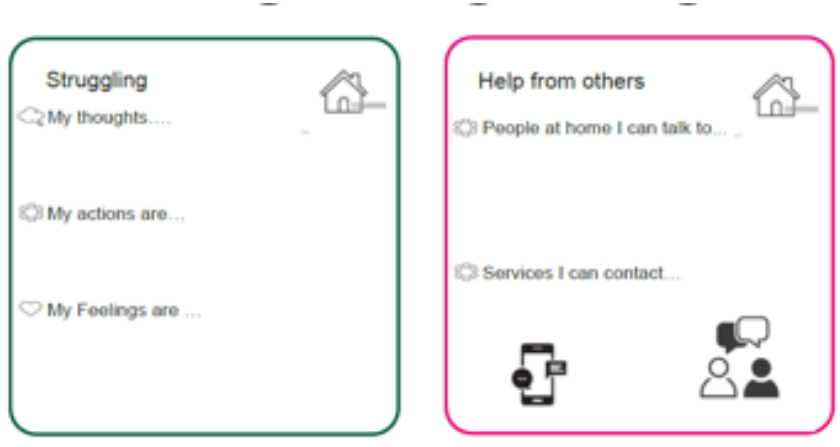
1. **Coping well**
2. **Keeping safe**

Short term outcomes – increased PSHE on social, emotional and mental health learning in primary schools.

Long-term outcomes are a reduction in mental health related admissions in A&E.

The project has been shared at the Royal College of Psychiatrists – Public Mental Health conference.

The Plans are being evaluated in 8 Primary schools in 2024- 2025.



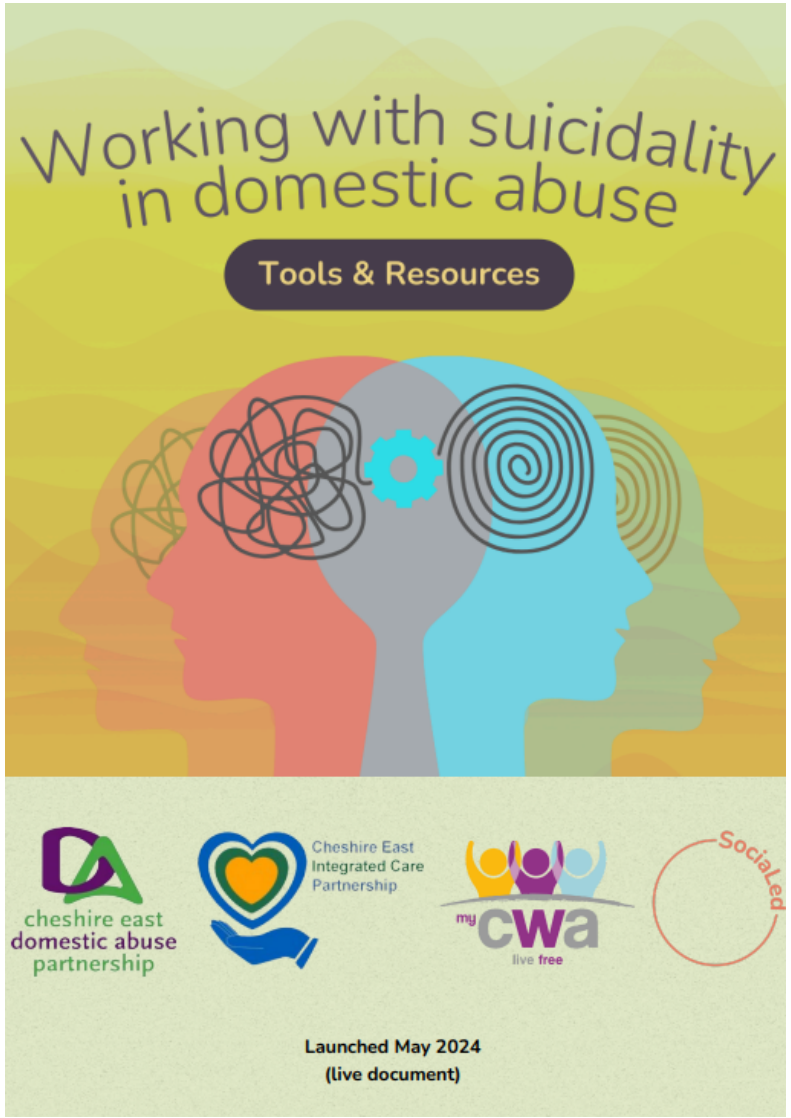
Domestic Abuse

The Suicidality and Domestic Abuse toolkit was developed by a small multiagency group and launched in May 2024 with attendance of professionals from the UK.

The toolkit has been shared with other Local Authority's we have opportunity to share at Lincolnshire conference in March 2025

In 2024 bespoke suicide and domestic abuse training was delivered to our frontline domestic abuse practitioners and Cheshire police.

LINCOLNSHIRE DOMESTIC ABUSE PARTNERSHIP



Self Harm Awareness / Training

Cheshire East Integrated Care Partnership

Collaboration with the Healthy Young Minds Alliance

- **Raise Awareness**: Increase Healthy Young Minds member's understanding of CYP self-harm at an early intervention and prevention stage.
- **Review Resources**: Collaborate on evaluating existing self-harm resources.
- **Deliver Training**: Provide training sessions on self-harm awareness and intervention
- **Support Professionals**: signposting to latest resources available.

30 YEARS VISYON

Cheshire East Council

Suicide Prevention Training

January 2022 – January 2025 over 500 attendees have completed the half day training.

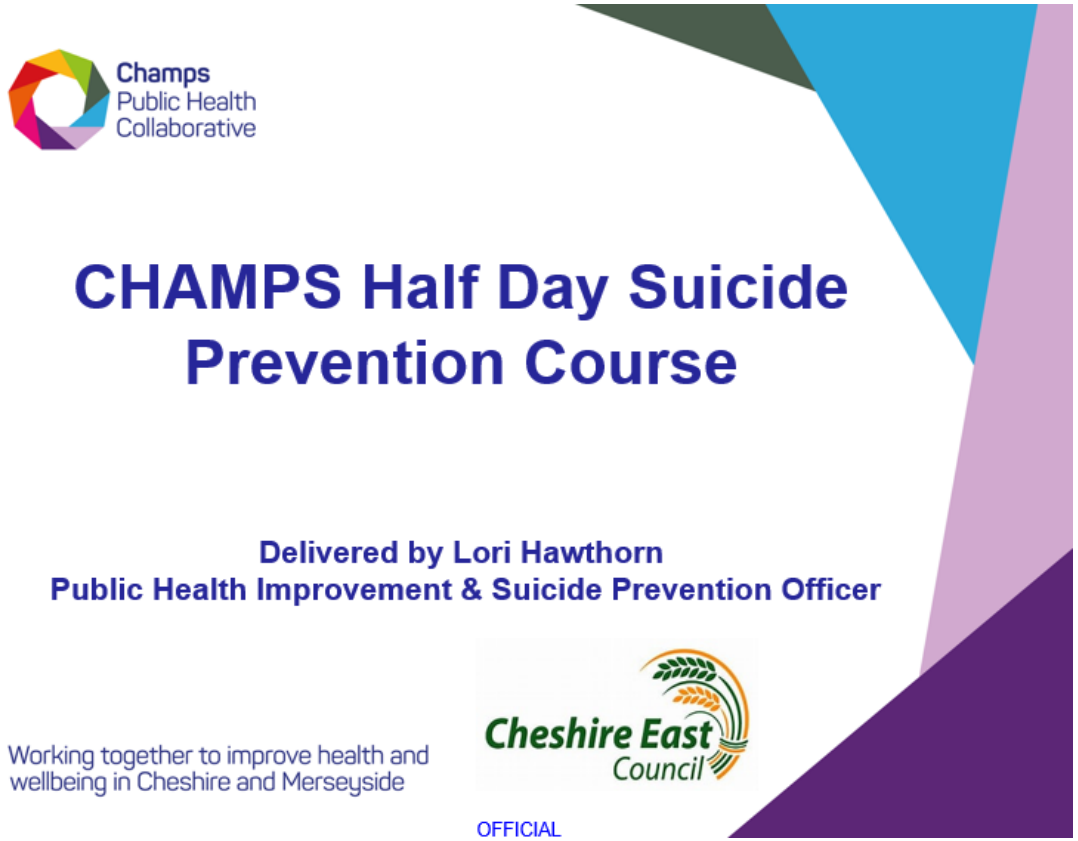
Based on 384 attendees scale 0 -10 (min to max)

Knowledge and awareness before training 5.3 and after completing course 7.9

Confidence to respond before training 5.0 and after completing course 7.7

ZSA offer eLearning modules on Live Well page for public and professionals FREE Suicide Prevention Training ZSA listed online courses

Training resources and signposting also on Live Well page self-harm and suicide prevention and support



Cheshire East Integrated Care Partnership

Suicide Prevention Online Conference

For World Suicide Prevention day
September 2024

Further information: lori.hawthorn@cheshireeast.gov.uk

Menti – meter results from attendees here:
https://www.mentimeter.com/app/presentation/n/alpc7c9qovvnxtotd2hctmsfai7q9w3i/present

New Services / Initiatives
2023 -2025

- Martin Gallier offer intervention support to those who are feeling suicidal. They are based in Crewe and Macclesfield.
- 2 wish offer support for those who have experienced a sudden death of a child or young person.
- i-Thrive is a system wide approach to navigate children and young people's mental health support.
- Further information and websites – here: Cheshire East Suicide Prevention Conference 2024

Support after a Suicide - Postvention

Cheshire East Integrated Care Partnership

Amparo is our immediate support service shared when there has been a death by suicide.

- 75 people received support between April 2023 – December 2024

We have a lived experienced peer led support service called SoBS based in Crewe and a new group opened in 2024 in Macclesfield.

AMPARO
support following suicide

[Cheshire & Merseyside - Amparo]

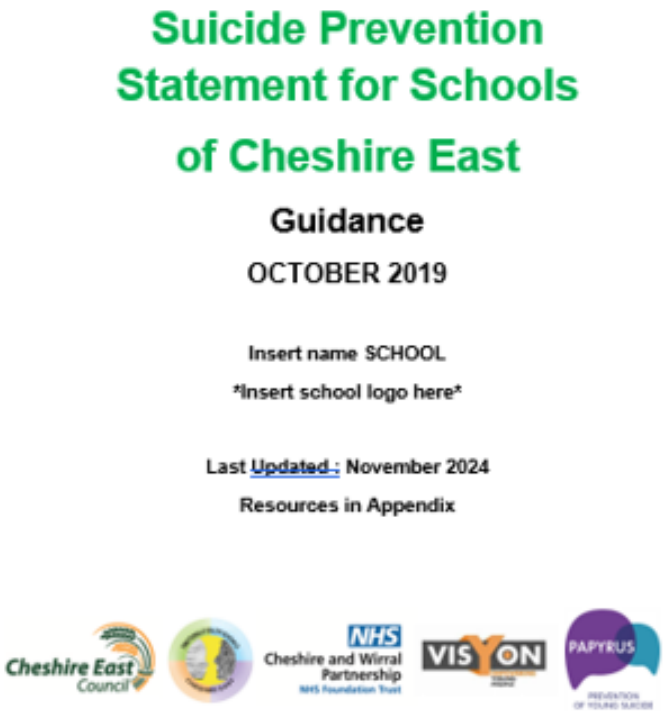
Support in Schools

Cheshire East Integrated Care Partnership

The Guidance document has been updated with resources and signposting. This is shared in the half day suicide prevention training.

Over 80 professionals from primary, secondary schools and colleges have attended the training in the last 2 years.

Step by Step is a Samaritans service that provides practical support to help schools prepare for and recover from a suspected or attempted suicide.


Suicide Prevention Statement for Schools of Cheshire East

Guidance

OCTOBER 2019

Insert name SCHOOL

Insert school logo here

Last Updated : November 2024

Resources in Appendix

Cheshire East Council

NHS Cheshire and Wirral Partnership

VISION

PAPYRUS

[Step by Step | Samaritans]

Community Engagement

Samaritans are a fundamental service for suicide prevention.

Their volunteers in Cheshire East have attended wellbeing, employment and domestic abuse awareness events in the past 2 years.

We will continue to encourage resources and digital signage in public spaces:

- ✓ Doctors' surgery
- ✓ Pharmacy
- ✓ Hospitals
- ✓ Train Stations
- ✓ Shops

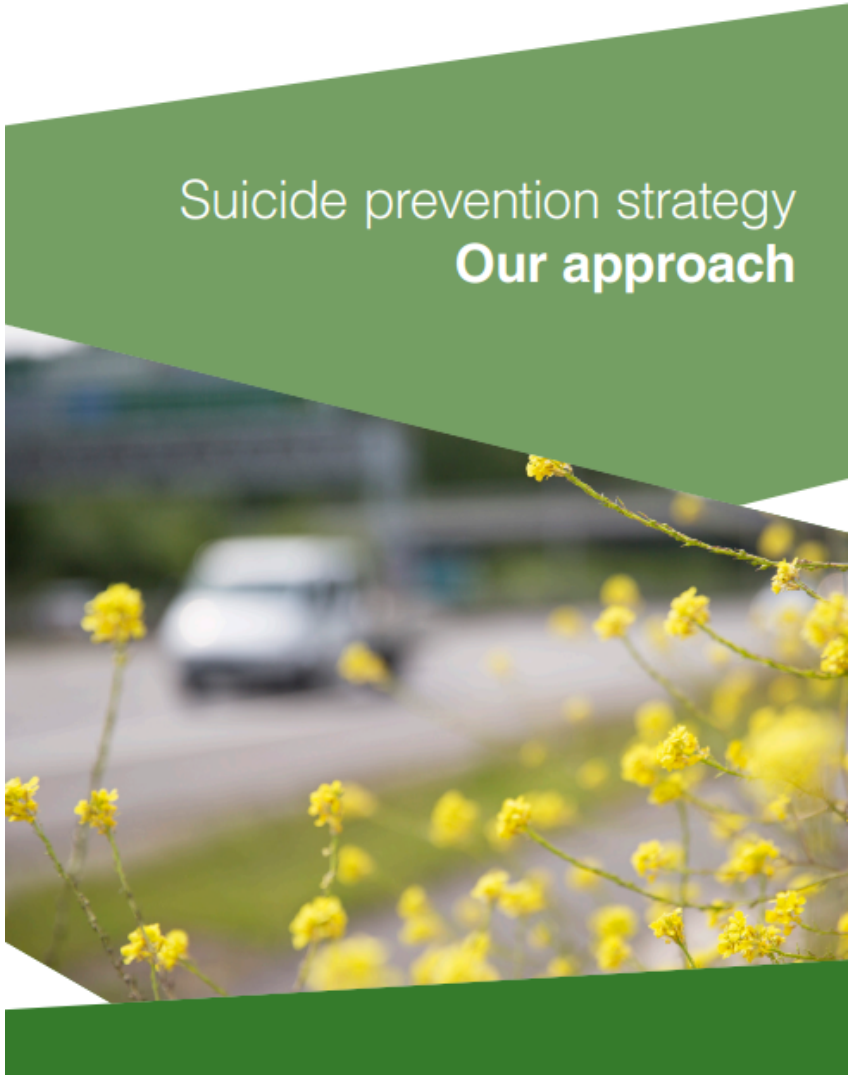
Network Rail & Highways

Samaritans works with Network Rail and the wider rail industry to reduce suicide on the railways and to support everyone affected by them.

Their work in Cheshire East has included supporting the station staff, training and awareness and assessment of safety at the stations.

Rail Industry Suicide Prevention Programme

Risk assessments on a new bridge has been completed , following the guidance of the 2022 national highways strategy and the Suicide prevention: suicides in public places - GOV.UK



Continued Actions 2025 -2027

& Interaction https://www.menti.com/alvwxsguoc2d

This new Plan will include existing and new actions for 2025 -2027 and presented at the Health and Wellbeing Board in March 2025.

Key Priority groups include:

- **1. Men** **2. Children and Young people** **3. Self Harm**

Is there any work that you are involved in or aware of that hasn't been captured in the plan?

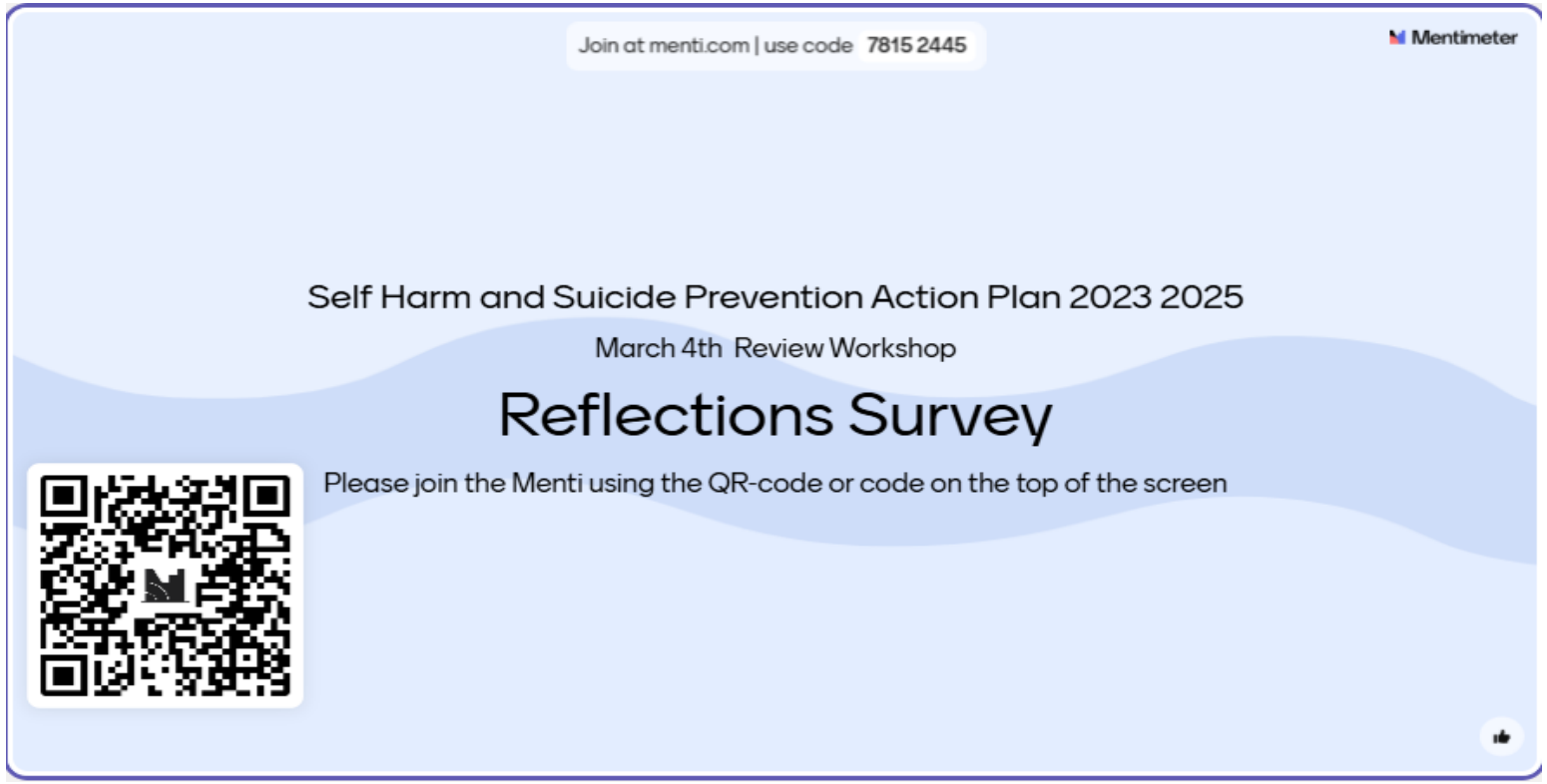
Cheshire East (CE) Self Harm and Suicide Prevention Action Plan 2023 - 2025	
Long Term Outcomes	
Reduced Suicides	**Reduced Self Harm**

Priorities	*What are we doing?*	*Who inputs into this work?*	*Frequency*	*Short term outcomes*

Digital Survey

& Interaction https://www.menti.com/alvwxsguoc2d

Any questions / comments / suggestions ?



If you or anyone you know is affected by suicide, then please find support and information in the following link:

Suicide Prevention, Support, and Information

Cheshire East Self Harm and Suicide Prevention Action Plan 2025 – 2027

Introduction

It is estimated that for every one suicide there can be up to 135 people affected.

This means that in Cheshire East between 2019 to 2021 there were approximately 13,500 people that experienced loss by suicide [1].

Suicide prevention is everyone's business and therefore it's important that we work together across Cheshire East to reflect this message.

This local action plan has been developed following the publication of the Cheshire and Merseyside Suicide Prevention Strategy in November 2022. It aligns closely with other local plans, including the Cheshire East Joint Local Health and Wellbeing Strategy, and the Cheshire East Place Mental Health Plan (All Age Strategy).

In 2023 we delivered three online workshops to gather consultation and feedback to inform the development of this plan. Each workshop covered a separate component of the priorities in our regional strategy. The first session looked at prevention, followed by intervention and lastly postvention (support after a suicide). There were over 50 attendees at each workshop, these included representatives from the voluntary sector, health colleagues, town councillors, and representatives of those with lived experience ***(see Appendix 1 for full list).*** The input from these workshops and further engagement was used to influence the local priorities.

In March 2025, we held a workshop to review the 2023 -2025 plan and look at the ongoing priorities for this 2-year action plan. There were 40 attendees from different organisations that attended. ***(see Appendix 1b for full list).***

[1] Office for Health Improvement and Disparities. (2022). Public Health Profiles. https://fingertips.phe.org.uk/ © Crown copyright 2023

Comments from both Dr Susie Roberts Consultant in Public Health and Guy Kilminster Head of Public Health, Chairs of the Self-Harm Suicide Prevention Board (March 2025)

We are really pleased with the continued level of interest and participation from members of the Partnership.

The 2-year action plan has achieved great work from a range of professionals from different organisations across the workforce.

It is evident the Partnership has a shared commitment to drive suicide prevention in Cheshire East

If you or anyone you know is affected by suicide, then please find support and information in the following link: Suicide Prevention, Support, and Information

This is a live document that will be monitored and updated throughout the 2-year period.

The listed projects in the *action plan under 'tailer approaches to improve mental health in specific groups',* are ongoing for this period. We acknowledge that this action plan will be developed and reflect contributions that support people with other protected characteristics.

Cheshire East (CE) Self Harm and Suicide Prevention Action Plan 2025 - 2027

Long Term Outcomes	
Reduced Suicides	**Reduced Self Harm**

Priorities	*What are we doing?*	*Who inputs into this work?*	*Frequency*	*Short term outcomes*
Governance, leadership, and partnership working.	Effective and regular meetings with suicide prevention leads and frontline professionals both on a local and regional footprint. Cheshire and Merseyside Suicide Prevention Partnership Board Cheshire and Merseyside Suicide Prevention Group (LASP) Cheshire East (CE) Mental Health Partnership Board CE Self-harm and Suicide Prevention Board (SHSP board)	- Cheshire and Merseyside Public Health (CHAMPS) - Cheshire East Council - Health and Social care - Integrated Care Board (ICB) - Voluntary, Community, Faith, and Social Enterprise organisations (VCFSE) - Cheshire and Wirral Partnership (CWP) - North West Ambulance Service (NWAS) - Criminal Justice System - All Age Carers Reps (CEPCF) - Lived Experienced Networks	Monthly meetings with LASP Quarterly Board Meetings (CE)	Regional strategy renewed every 5 years. Local action plan reviewed at quarterly board meetings.
Data analysis and monitoring (RTS)	Receive and sensitively store real time surveillance (RTS) data notifications. Attend the Cheshire and Merseyside Data Learning panel.	- Cheshire Coroner - CHAMPS Suicide Prevention - Public Health Intelligence - Public Health Improvement	RTS monitoring and receiving data.	Review and manage (RTS) data to inform response.

Priorities	*What are we doing?*	*Who inputs into this work?*	*Frequency*	*Short term outcomes*
	Review and update Memorandum of Understanding (MOU) in collaboration with CHAMPS and Cheshire Coroner Have Public Health Data Learning groups. Identify high risk groups using regional and local data. Trends and risk factors. Receive monthly self-harm analysis (CYP) from local hospitals. Laison with NWAS data analyst Identify clusters and if required complete a CHAMPS Community Response Plan (CRP) following the procedures in the CRP document.	- CE Hospital Data Analysts - CWP designated Suicide Prevention Lead - NWAS data analysts - Community Response Plan (CRP) listed professionals	Bi-monthly meetings	Establish enhanced data sharing with Cheshire Coroner and Police Re-establish a date to complete suicide audits – progressed April 2025 Community Response Planning Group (if required)
Reduce access to means. Network Rail ⟶	Continue to support the work with Network Rail/Samaritans in our train stations – *Rail Industry Suicide Prevention Programme* Support community response circulate Samaritans campaigns and share digital and cards signage in Primary Care / Pharmacy / Hospitals	- Network Rail/Samaritans - British Transport Police - Public Health Suicide Prevention leads.	Ongoing	Partnership approach to placing signage in identified risk areas Increased visibility of Samaritans signage at train stations.

Priorities	*What are we doing?*	*Who inputs into this work?*	*Frequency*	*Short term outcomes*
Reduce risk of suicide in high-risk groups	Using the key groups from the national and regional strategy to prioritise locally. The JSNA will provide local information to influence action to recognise groups with multiple ***risk factors to suicide (Appendix 2)***	- Public Health Intelligence - Public Health Improvement - Joint Strategic Needs Assessment (JSNA) steering group. - JSNA multi-agency subgroups	2025 -2027	Develop and produce a Local Self-Harm and Suicide Needs Assessment progressed 2025 - 2027 Recognise high risk groups locally. Input into all JSNA's For example, CYP Emotional, Health and Wellbeing, Loneliness and Social Isolation, Special Education Needs and Disability (SEND)
Intervention support Martin Gallier Project →	A non-clinical Intervention service for people who are suicidal, based in Macclesfield and Crewe. The Martin Gallier Project	- Martin Gallier Project - CWP - CE Hospital Trusts		Increased specialist support for people who have suicidality

Priorities	*What are we doing?*	*Who inputs into this work?*	*Frequency*	*Short term outcomes*
Tailor approaches to improve mental health in specific groups. Men's Mental Health ⟶	Identify areas of Cheshire East to support development of specific mens groups. Paint your bar/gym/coffee shop blue campaign in local businesses	Service Providers: - Mentell - Lightworks Project - Andy's Man Club		Increased engagement, awareness of support services specifically for men.
Children and Young People ⟶	Education, social, health care and VCFSE services to have awareness of self-harm and suicide prevention resources and have access to the free training. Continue to share ***Suicide Prevention Guidance in schools (Appendix 3)*** with colleagues and schools. Continue to work with CWP partners with [The gateway programme] uses specific assessment tools to identify unmet need	- Healthy Yong Minds Alliance (HYM) - Integrated Care Board (ICB) - Primary care/NHS - Secondary care/NHS - Cheshire and Wirral Partnership (CWP) - Cheshire East Council Public Health - Education settings CE - Safeguarding Children in Education Settings (SCiES) - Children's Safeguarding (CEC) - Youth Service and Participation Team	2025 -2027	Increased uptake of Suicide prevention self-harm awareness training from professionals via digital booking platforms. All schools using ***Suicide Prevention Guidance in schools (Appendix 3)*** and embedding into their whole school approach. Increased awareness of unmet needs (health and social determinants in children and young people.

Priorities	***What are we doing?***	***Who inputs into this work?***	***Frequency***	***Short term outcomes***
	and reduce likelihood of hospital admissions using a multiagency approach.	- Voluntary, Community, Faith, and Social Enterprise organisations (VCFSE)		Decreased multiple hospital admissions for self-harm and suicidality.
'Keep Safe and Cope Well Plans' →	Piloting the Keep Safe and Cope Well plans and initiative over the academic year 2024/2025 Keep safe and cope well plan Evaluation 2025/2026 Develop PSHE lesson plan on 'coping well' and 'keeping safe' to be delivered to primary age school children.	-Public Health CEC -Youth Participation CEC -Youth Council -SEND Team -0-19 Nursing service provider -NHS ICB	2025- 2027	Increased engagement using the plans with children in primary schools. Children completing PSHE learning on coping skills and keeping safe in school
Serious Mental Illness (SMI) →	Steering group working together to increase annual health checks for people with a diagnosed serious mental illness. Project plan to deliver SMI health checks with funding to commission a service provider.	- Public Health Team CEC - Voluntary, Community, Faith, and Social Enterprise organisations (VCFSE) - Integrated Care Board (ICB) - Cheshire East Council Public Health - Primary Care (NHS	2025 - 2027	Increased uptake of annual health checks in primary care, Evaluation of Health Junction engagement model in Crewe Develop/enhance pathways of support into health and

Priorities	*What are we doing?*	*Who inputs into this work?*	*Frequency*	*Short term outcomes*
	Health Junction provider for 2024/25 in 2 PCN areas of Cheshire East. Reports to Steering group.	- Community Mental Health Team (CWP) - Lived Experience and Carers - Commissioned health and wellbeing services		wellbeing services (social prescribing / One You Cheshire East
Inclusion Health Groups →	Raise awareness and share information with colleagues, partners. Developed Health inclusion training and resources.	- Primary care/NHS - ICB - Community Team - Care Communities - VCSF	2023-2025	Increased access to health in primary care. Improved understanding and awareness of different culture/ nationalities to provide inclusion.
Domestic Abuse →	Suicide prevention will be added to the strategy and training prioritised for all frontline professionals. Raise awareness on Domestic abuse and Suicidality Guidance Toolkit and review its used by Multi-Agency Risk Assessment Conference (MARAC) representatives. Contribute to data and monitoring. DASH data on suicidality	- Cheshire East Domestic Abuse Board members - Domestic Homicide Review Panel - NHS - VCFSE - MyCWA - Domestic Abuse Lead Advisor (CEC)	2025-2027	Increased awareness of suicide prevention and domestic abuse. Increased support to service users and suicide safety planning.

Priorities	***What are we doing?***	***Who inputs into this work?***	***Frequency***	***Short term outcomes***
Substance Misuse ⟶	Contribute towards the place substance misuse strategy and delivery plan.	- CE Combating Drugs Partnership	2025 -2027	Increased awareness of suicide prevention and substance misuse.
All Age Carers ⟶	Contribute towards the place all age carers strategy.	- CE All Age Carers Strategic group	2021 -2025	Increased awareness of suicide prevention with professionals supporting carers.
Cost of Living Information and Support ⟶ Crewe Wellbeing Event 2025	A range of information, support and a Crisis phone line is offered to all residents. More is on the website: Cost of living (cheshireeast.gov.uk) Multi agency service event to help engage with employment, wellbeing and support	- Frontline professionals - CE Cost of Living Strategic group - Youth Task Force (led by DWP) - Welfare to Work group	Ongoing 2025	Increased awareness of information and support offered to all residents living in CE. Residents confident accessing support initiatives Professionals cascading relevant information and offering support/signposting.
Internet safety ⟶	We are raising awareness and encouraging all organisational settings and parent/carers to download a suicide safety software called R;pple. https://www.ripplesuicideprevention.com/	- CE Suicide Prevention Board - Education settings - Health settings - Cheshire East Council - VCFSE CE residents	Ongoing	For all education, voluntary settings to download the software (free cost) For parent/carers to feel confident to install Businesses and organisations using the software and raising awareness.

Priorities	*What are we doing?*	*Who inputs into this work?*	*Frequency*	*Short term outcomes*
Awareness in the community and tackling stigma. Community Engagement ⟶	Support national wellbeing campaigns and awareness days/months. Offer awareness and information at community events, including mental health and wellbeing services and services listed on our Live Well page. self-harm and suicide prevention and support Engage with lived experienced networks/groups to break down stigma.	- Mental Health Groups Wellbeing Networks - Care Communities - Communications Team - Communities Team - CE Communication Team - VCFSE	2025- 2027	A multi-agency approach to recognise national awareness days. Community approach to deliver campaigns and raise awareness on local and national support services. Increased engagement with Lived Experienced Networks (LEN)
Suicide prevention and self-harm awareness training	Continue to deliver FREE suicide prevention training to frontline professionals (health, social care, VCFSE, education and criminal justice system) Developed learning, using case studies to reflect how to support people with inequalities and/or protected characteristics: For example, supporting and caring for elderly people, people exposed or experiencing domestic abuse or substance abuse. Those who are from a minority ethnicity and people with a severe mental health illness residing in supported living housing. Please see ***risk factors to suicide (Appendix 2)***	- Self-Harm and Suicide Prevention Board members - Commissioned providers - VCFSE - MHST Cheshire and Wirral Partnership (CWP) - Visyon - Healthy Young Minds Alliance	2023-2025	Increased numbers of professionals trained in suicide prevention, meet learning outcomes of the course. Received feedback from digital survey:

Priorities	*What are we doing?*	*Who inputs into this work?*	*Frequency*	*Short term outcomes*
Self-harm Awareness Training 2025	Develop a booklet resource for frontline staff supporting Adults. **(Appendix 5)** Source train the trainer suicide prevention training and secure funding. Source train the trainer with self-harm awareness and secure funding. Self Harm Awareness course reviewed and delivered to 3 cohorts (20 delegates) in 2025 Public Health and Healthy Young Minds Alliance review and contribute towards an evaluation.	- Healthy Young Minds Alliance - Public Health - Visyon		Develop and deliver a self-harm training offer for CYP professionals. Increase capacity of trainers delivering free courses to frontline staff.
Supporting those bereaved by suicide and monitoring the media.	A postvention service is in place to provide specialist bereavement support to those who are exposed to or affected by suicide. Community response framework to respond to any suicide clusters. Continue to share information on the specialist bereavement services. A specialist support group (SoBS) offered in Crewe and opened in Macclesfield 2024. Explore postvention guidance documents for organisations and schools.	- Amparo - 2Wish - Survivors of Bereavement by Suicide (SoBS) - Samaritans (Step by Step for Education settings) - Self-Harm and Suicide Prevention Board members - Martin Gallier Project - Samaritans Media support service - Cheshire East Council (CEC) Communications Team	Ongoing	Increased awareness and uptake of the specialist postvention support offer. Increased numbers of professionals attending Amparo training. Raised awareness of 2Wish bereavement support of a child (0-25 years) Increase awareness of guidance for schools document and step by step offer

Priorities	*What are we doing?*	*Who inputs into this work?*	*Frequency*	*Short term outcomes*
	Step by Step Samaritans support offer – introduce training 2025.			Data monitoring on engagement of support services. Continued monitoring of the media and training offer to communication professionals.

Strategies/Guidelines/Information

National	Regional/local
National suicide Prevention 5-year cross sector strategy (2023 Suicide prevention in England: 5-year cross-sector strategy - GOV.UK (www.gov.uk) National Confidential Enquiry (2022) NCISH | Annual report 2022: UK patient and general population data 2009-2019, and real-time surveillance data - NCISH (manchester.ac.uk) NICE Guidelines 2018 Recommendations | Preventing suicide in community and custodial settings | Guidance | NICE	Cheshire and Merseyside Suicide Prevention Strategy Suicide-Prevention-Strategy-2022-2027-compressed.pdf (champspublichealth.com) Cheshire East Joint Local Health and Wellbeing Strategy and Five-Year Plan Layout 1 (cheshireeast.gov.uk) Cheshire East Place Mental Health Plan (All Age Strategy). Cheshire East Place Mental Health Plan Cheshire East Livewell Information page Suicide Prevention, Support, and Information (cheshireeast.gov.uk)

Appendix 1 – List of organisations who have contributed.

We wish to thank all organisations who have contributed to the development of this action plan and look forward to working together to address suicide prevention.

Organisations are listed A-Z.

Organisations

- Active Cheshire
- CE Parent Carer Forum (CEPCF)
- AMPARO
- Beacon Counselling Trust – Gambling Harms
- Big Life Group
- The Bridgend Centre
- Care community representatives
- Change Grow Live (CGL)
- Central Cheshire integrated Care Partnership – Mental Health and Social Prescribing
- Cheshire East Council – Communications
- Cheshire East Council – Communities
- Cheshire East Council – Education Welfare Service
- Cheshire East Council – Youth Work and Participation
- Cheshire East Council – Social Care
- Cheshire East Council – Swab Squad
- Cheshire East Council – Public Health
- Cheshire and Merseyside Integrated Care Board (ICB)– Mental Health
- Cheshire and Merseyside Local Authority Suicide Prevention Group (Chair)
- Cheshire Police
- Cheshire without Abuse (myCWA)
- Cheshire and Wirral Partnership (CWP) - Children Services
- Cheshire and Wirral Partnership (CWP) – Community Mental Health
- Citizens Advice Bureau
- Councillors

- Department of Work and Pensions (DWP)
- Healthwatch
- Holy Trinity Hurdsfield
- Lived Experience Network (LEN) Cheshire and Merseyside Coordinator
- Mid Cheshire Hospital Foundation Trust
- Survivors of Bereavement by suicide (SoBS)
- Social Prescribers (PCN)
- The Samaritans
- Visyon

Appendix 1b – List of organisations who have contributed March 2025 Review

- Active Cheshire
- CE Parent Carer Forum (CEPCF)
- Cheshire East Council – Communities
- Cheshire East Council – Education Welfare Service
- Cheshire East Council – Domestic Abuse
- Cheshire East Council – Youth Work and Participation
- Cheshire East Council – Mental Health
- Cheshire East Council – Public Health
- Cheshire East Council – Public Health Commissioning
- Cheshire East Council - Highways
- Cheshire East Council – Safeguarding Adults
- Cheshire and Merseyside Integrated Care Board (ICB)– Mental Health
- Cheshire Police
- Cheshire and Wirral Partnership (CWP) - Children Services
- Cheshire and Wirral Partnership (CWP) – Community Mental Health
- CVS Cheshire East
- Department of Health and Social Care (OHID)
- Department of Work and Pensions (DWP)
- East Cheshire Hospital Trust

- Lived Experience Parent Carer Forum
- Martin Gallier Project
- Mentell
- Mid Cheshire Hospital Foundation Trust
- Survivors of Bereavement by suicide (SoBS)
- Social Prescribers (PCN)
- The Samaritans
- Visyon
- Vesta
- Wirral Community Care 0-19 Cheshire East

Appendix 2 – Risk factors to suicide

The following risk factors were highlighted during an online workshop with professionals and people with lived experience that took place on the 20th of January 2023. Responses were collected through Mentimeter (an online tool to collect feedback from attendees). These have subsequently been grouped into the following themes:

Risk factors are sorted A-Z.

Individual and family risk factors

- All forms of addiction (e.g., substance misuse, gambling)
- All forms of abuse (e.g., domestic abuse, sexual abuse)
- Bereavement
- Bullying
- Carers
- Criminal justice system
- Employment problems (e.g., poor quality and conflict)
- Ethnicity and culture
- Gender
- Homelessness
- Individuals with debt and money issues
- Lack of physical exercise

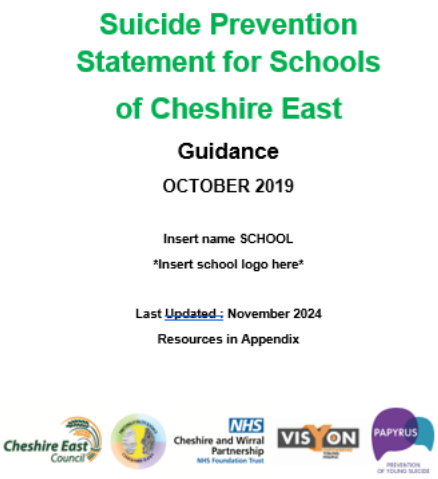
- Living on your own
- Loneliness and social isolation
- Mental health conditions
- Nationality
- Neurodevelopment conditions
- Older people
- Perinatal mental health
- Poor physical health
- Refugee and asylum seekers
- Relationship breakdowns
- Self-harm
- Sexuality
- Side effects of prescription drugs
- Social care involvement with family
- Stigma
- Stress and poor mental health
- Unemployment
- Young people

Environmental risk factors

- Access to means (e.g., readily available access to paracetamol in shops)
- Access to services and the reduction of services (such as libraries closing)
- Arriving in the country as a Refugee, Asylum seeker, Migrant
- Cost of living
- Housing (quality and affordability)
- Impact of the Covid-19 pandemic
- Natural disasters and climate change
- Neighbourhoods and where people live
- Transition from child to adult services

Appendix 3 – Schools Guidance Document reviewed 2024

Suicide Prevention Statement for Schools can be downloaded using the link below:



Appendix 4 – Mentell Evaluation 2024

Mentell Evaluation- Farming Rural Community 23_24

Lightworks_rural_community_evaluation_Cheshire East_2024.pptx

Appendix 5 – Responding to Suicide Risk A5 booklet

Public Health - Cheshire East Council

Cheshire East Council

Professionals and **Self-care…**

It is essential for all staff to practice self-care, this **avoids burn out, stress and poor mental health.**

If you need to talk – the Samaritans offer confidential emotional support at any time of the day or night to anyone in distress, including people who may feel suicidal. They also have a Self-help app that can be accessed via their website. Self-Help | Samaritans

Helpline 116 123 (free)

Email jo@samaritans.org / www.samaritans.org

"Lifestyle change can lead to better health. By making changes, however small, you can make a big difference to your health and wellbeing."

Resources and support are available from Lifestyle on prescription (cheshireeast.gov.uk)

Responding to Suicide Risk

Guidance supporting residents or colleagues

This booklet offers guidance and information to help recognise and support someone who is feeling suicidal.

Reaching out can save a life!

"Evidence shows, by asking someone if they're suicidal can protect them. They feel listened to, and hopefully less trapped. Their feelings are validated, and they know that somebody cares about them."

Ref: Myths about suicide (samaritans.org)

This resource has been developed based on the CHAMPS Suicide Prevention Training. If you would like to attend this FREE training.
Please use the booking system: How to apply for a training course (cescp.org.uk)

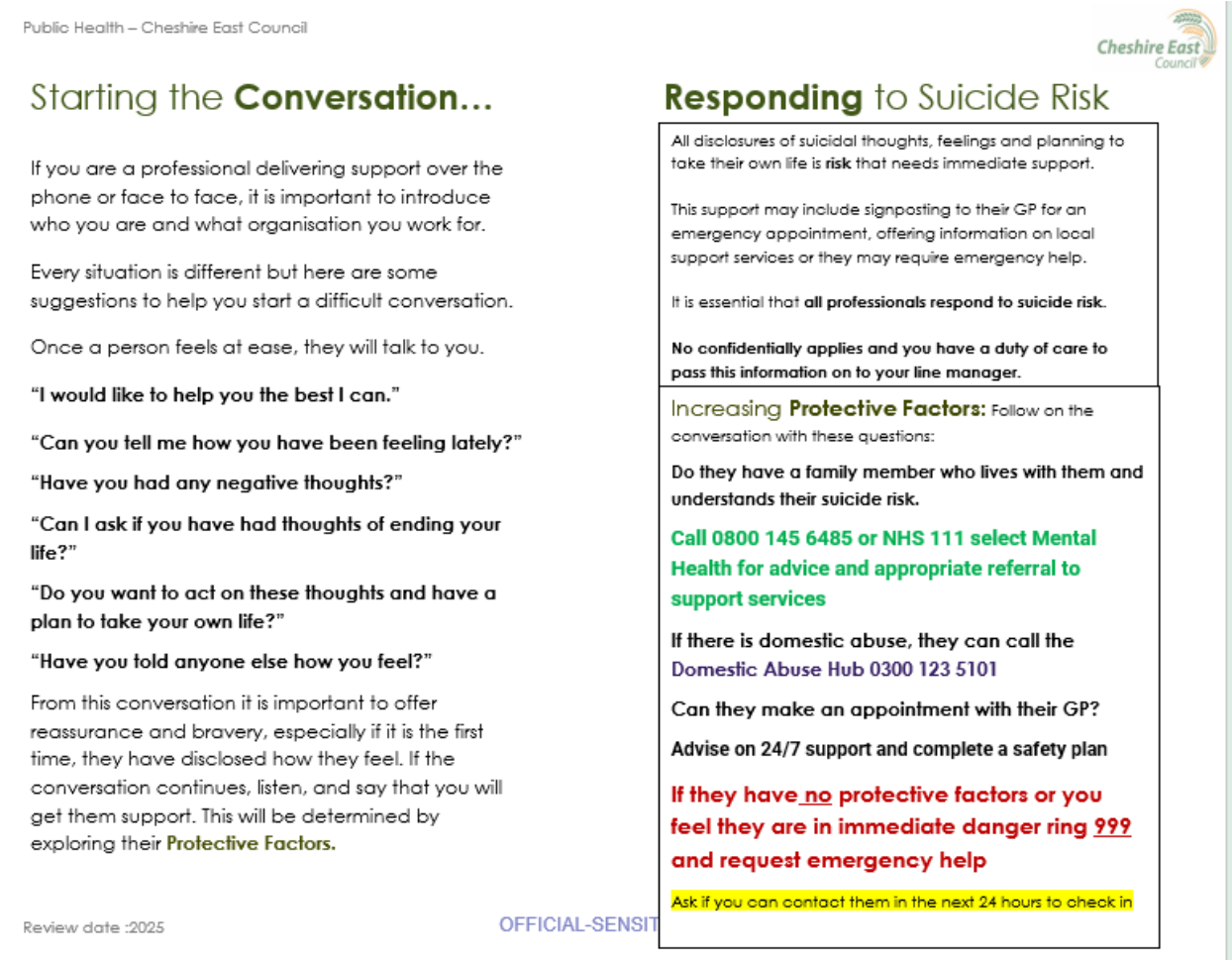
More information / local services visit the Livewell website:
self-harm and suicide prevention and support (cheshireeast.gov.uk)

Review date - 2025

OFFICIAL-SENSITIVE

Suicide Risk Guidance for Professionals_CEC_24 FINAL_pdf

Appendix 5 – Inside page of A5 booklet



Public Health – Cheshire East Council

Cheshire East Council

Starting the **Conversation…**

If you are a professional delivering support over the phone or face to face, it is important to introduce who you are and what organisation you work for.

Every situation is different but here are some suggestions to help you start a difficult conversation.

Once a person feels at ease, they will talk to you.

"I would like to help you the best I can."

"Can you tell me how you have been feeling lately?"

"Have you had any negative thoughts?"

"Can I ask if you have had thoughts of ending your life?"

"Do you want to act on these thoughts and have a plan to take your own life?"

"Have you told anyone else how you feel?"

From this conversation it is important to offer reassurance and bravery, especially if it is the first time, they have disclosed how they feel. If the conversation continues, listen, and say that you will get them support. This will be determined by exploring their **Protective Factors.**

Review date :2025

OFFICIAL-SENSIT

Responding to Suicide Risk

All disclosures of suicidal thoughts, feelings and planning to take their own life is **risk** that needs immediate support.

This support may include signposting to their GP for an emergency appointment, offering information on local support services or they may require emergency help.

It is essential that **all professionals respond to suicide risk.**

No confidentially applies and you have a duty of care to pass this information on to your line manager.

Increasing **Protective Factors:** Follow on the conversation with these questions:

Do they have a family member who lives with them and understands their suicide risk.

Call 0800 145 6485 or NHS 111 select Mental Health for advice and appropriate referral to support services

If there is domestic abuse, they can call the Domestic Abuse Hub 0300 123 5101

Can they make an appointment with their GP?

Advise on 24/7 support and complete a safety plan

If they have no protective factors or you feel they are in immediate danger ring 999 and request emergency help

Ask if you can contact them in the next 24 hours to check in

[Suicide Risk Guidance for Professionals_CEC_24 FINAL_pdf]

Appendix 6 – Responding to Self-Harm and Suicide Risk in Children A5 booklet

Public Health - Cheshire East Council

Cheshire East Council

Professionals and **Self-care…**

It is essential for all staff to practice self-care, this **avoids burn out, stress and poor mental health.**

If you need to talk – the Samaritans offer confidential emotional support at any time of the day or night to anyone in distress, including people who may feel suicidal. They also have a Self-help app that can be accessed via their website. Self-Help | Samaritans

Helpline 116 123 (free)

Email jo@samaritans.org / www.samaritans.org

"Lifestyle change can lead to better health. By making changes, however small, you can make a big difference to your health and wellbeing."

Resources and support are available from Lifestyle on prescription (cheshireeast.gov.uk)

Responding to Self-Harm Suicide Risk in Children

Guidance for professionals

"People self-harm for many different reasons. Some people find it hard to explain why they do it, but often it's a way for people to let out feelings that are hard to explain or control."
Lucas 19
Young Minds website

Hyper-links embedded to documents below:

Review date - 2025

OFFICIAL-SENSITIVE

Appendix 6 – Inside page of A5 booklet

Public Health – Cheshire East Council

Cheshire East Council

Starting the **Conversation.**

Asking about ***self-harm and suicide*** helps to get children the right support at the right time.

Self-harm is common in children and young people and often in secret.

"I would like to help you the best I can."

"Can you tell me how you have been feeling lately?"

"Have you had thoughts of or have harmed yourself?"

"Can I ask if you have had thoughts of ending your life?"

"Do you want to act on these thoughts and have a plan to take your own life?"

"Have you told anyone else how you feel?"

Do they have a family member who lives with them and can support them? And can you offer information/guidance:

Young Minds – The TIPP technique on distraction/managing self-harm

Charlie Waller – guidance and advice

Childline – 121 support, advice and coping technique

Review date :2025

OFFICIAL-SENSIT

Responding to Self-Harm

All disclosures of self-harm suicidal thoughts, feelings and planning to take their own life is **risk** that needs immediate support.

This support may include signposting to their GP for an emergency appointment, offering information on local support services or they may require emergency help.

It is essential that **all professionals respond to suicide risk. No confidentiality applies and you have a duty of care to pass this information on to your line manager.**

Increasing **Protective Factors:** Follow on the conversation with these questions:

Do they have a family member who lives with them and understands their self-harm / suicide risk.

Call 0800 145 6485 or NHS 111 select Mental Health for advice and appropriate referral to support services NHS My Mind – urgent support information

If there is domestic abuse, they can call the Domestic Abuse Hub 0300 123 5101

Can they make an appointment with their GP?

Advise on 24/7 support and complete a Safety Plan

If they have no protective factors or you feel they are in immediate danger ring 999 and request emergency help

Ask if you can contact them in the next 24 hours to check in

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Mentimeter

Self Harm and Suicide Prevention Action Plan 2023 2025

March 4th Review Workshop

Reflections Survey

Please join the Menti using the QR-code or code on the top of the screen

2

What does your organisation do that includes suicide prevention?

Peer support

Signposting

Crisis line

Talking therapies

Signposting to services, mental health awareness sessions

Crisis cafes

Raising awareness at a strategic level within the Council and wider health and care system

We are a Suicide Bereavement charity and we know that postvention support is also prevention

1

24

What does your organisation do that includes suicide prevention?

Wellness and recovery plans

We promote schools to use the suicide prevention guidance and complete training.

Support those within mental health services who may be suicidal or affected by suicide. This is encompassed in our organisations Suicide Prevention Strategy

Ongoing work with residents and carers AMHP/ Mental health service Workforce trained in conversations about suicial thoughts

Harm reduction advice

The Martin Gallier Project is a suicide prevention, intervention & postvention charity that offers immediate acess to non-clinical support to anyone impacted by suicide over the age of 16

We integrate CNEST into our triage with CYP.

Cheshire Polcie - We deliver suicide first aid training to anyone in force. We now have 2 x trainers We also deliver MHFA training.

What does your organisation do that includes suicide prevention?

Raising awareness, signposting

Beacon Counselling Trust provide early intervention, education and treatment for gambling related harms across the North West.

Supporting regional implementation of national policy (and feeding information back to inform policy priorities), and sharing learning and best practice across North West

We are not commissioned to do any direct work with clients. We raise awareness of the needs of our community

Multi- agency iHV Perinatal and infant mental health training, Fathers and Perinatal Mental Health Training and LGBTQI+ and Perinatal Mental health training delivery as iHV Champions

Welfare officer Works with NGBs to ensure sport coaches are informed on signposting and safeguarding officers are equipped to support

Monitor RTS, suicide audit both to highlight areas of concern in terms of clusters methods ages, occupations etc. JSNA,

Early intervention and prevention work through counselling, mentoring, group work. Safety planning in our one to one work

What does your organisation do that includes suicide prevention?

Speak to families who are suffering bereavement and offer counselling and signpost others agencies such as papyrus.

We promote and empower schools to become trauma informed and mentally healthy places for all CYP

Policy, signposting, working closely with partner organisations, clear pathways, safeguarding oversight if required

Mentell contributes to suicide prevention through several key initiatives. Facilitating Peer Support Groups and Community Awareness raising the main two.

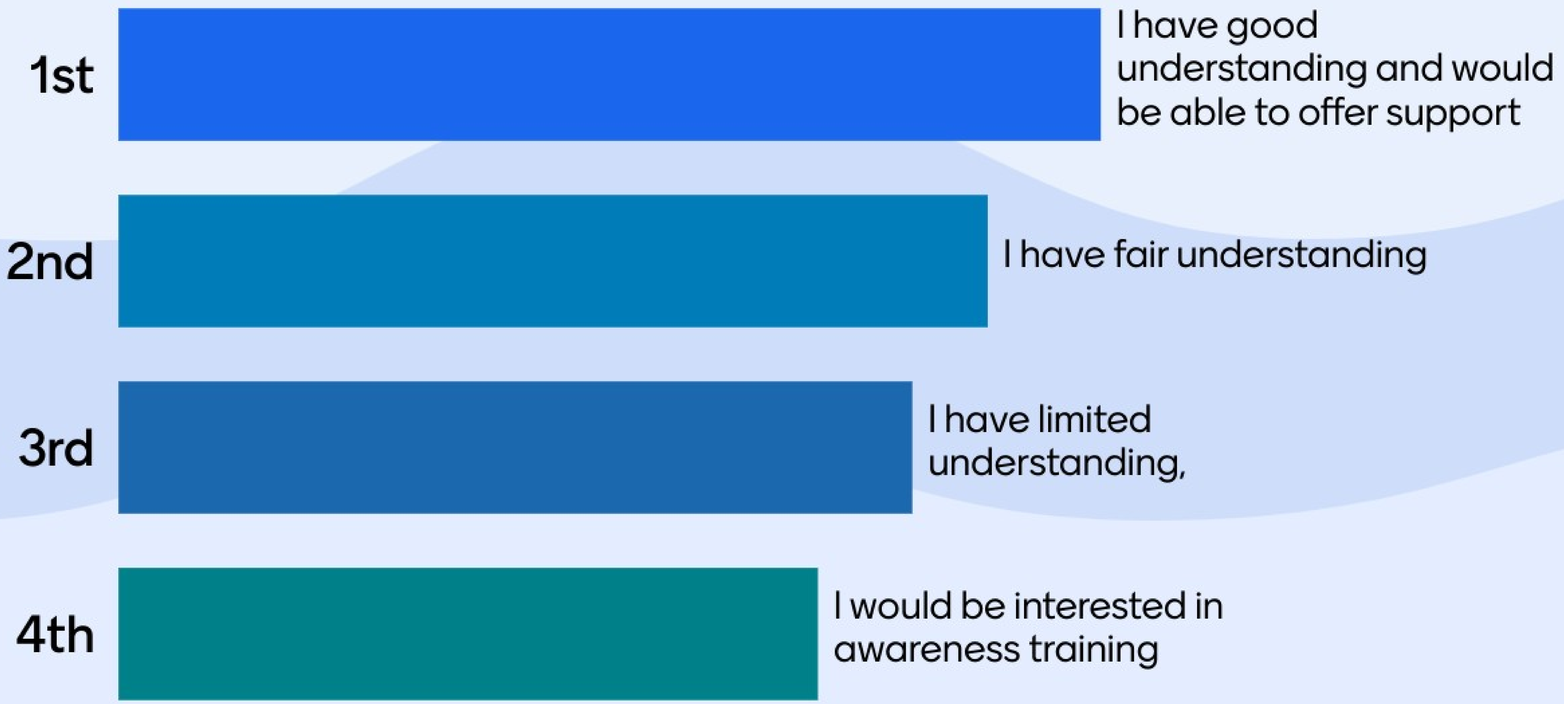
Embed healthy lifestyle coaches in CWP SMI MDT in the community

We haven't really considered within landscape and urban design, we tend to focus on safety

The Healthy Young Minds services support children and young people at an early intervention and prevention stage to help them to develop awareness/coping strategies to help prevent suicide .

0-19 Practitioners utilise NICE guideline screening questions at mandated contacts within Healthy Child Programme. Practitioners assess risk and screen for GAD and Depression at 0-12 month contacts.

What is your understanding on self harm behaviour?



The 2023 -2025 Action Plan

Is there any work that you are involved in or aware of that hasn't been captured in the plan?

Nothing.

Does this involve private schools as well as state schools?

Not involved in any particular project Carers is an area which I think would benefit from focus

Launch of the CWP Suicide Prevention Strategy and Implementation Plan and their continued involvement/representation in the CE Suicide Prevention Group and suicide prevention as a whole within CE

Yes, could you capture work around Perinatal and Infant Mental Health within Governance, Men and Children. iHV Perinatal and Infant Mental Health Training is delivered multi-agency across CE.

High levels of suicidal ideation in parent carers of CYP and Adults

Not at this time

Partnership between The Martin Gallier Project & CWP urgent reaponse teams to supprt those impacted by suicide

The 2023 -2025 Action Plan

Is there any work that you are involved in or aware of that hasn't been captured in the plan?

Women in complex households have the highest rate of presentation in A&E for self harm/ suicidal behaviour

All looks good, and given the stats, continuing to have men as one of the areas of focus seems sensible.

Nothing more to add

Parental MH being key in prioritising children. Children of parents with mental health problems are at significantly higher risk of engaging in self-harm and suicide behaviours.

It would be good to see further focus on gambling related harms, whilst it is mentioned as a risk factor under addictions. We deliver a number of prevention programmes for professionals and YP

The main minority groups are not currently included in the action plan. Their needs must be considered across all elements of the plan

Although suicide rates are higher in men suicide attempts during a lifetime is higher in women

CYP Screen time and sleep and using physical health for an improved emotional wellbeing and mental health

The 2023 -2025 Action Plan

Is there any work that you are involved in or aware of that hasn't been captured in the plan?

Possibly to link up with the Cheshire Agricultural Chaplaincy https://www.agchap.com/ which is a Cheshire & Wirral offering 24:7 support to the farming community including mental health support

Could Wirral Community Health and Care NHS Foundation Trust 0-19 Service be added as inputting within Governance and Leadership.

Suicide remains leading cause of maternal death between 6 weeks and 1 year postnatally (MBRRACE Sumary 2024) Training and work undertaken around this will be important to add.

NSPS identified that many men who attempt suicide are in contact with their GP prior to their death, is there work to strengthen awareness and support pathways between 1st care and VCSFE providers?

Care leavers

What happens next?

Any questions / comments / suggestions ?

No, thank you for sharing the information and links.

What happens next?

great update on achievements and plans - Healthy Young Minds looks forward to working with the Partnership via the Alliance's thematic self harm group, to support the future plan 25/27

3

Agenda Item 7

Cheshire East Council

NHS Cheshire and Merseyside

CHESHIRE EAST HEALTH AND WELLBEING BOARD
Reports Cover Sheet

Title of Report:	Smoking Cessation Incentives Scheme – Update
Report Reference Number	HWB76
Date of meeting:	18th March 2025
Written by:	Nik Darwin, Programme Lead for Thriving and Prevention Dr Matthew Atkinson, Consultant in Public Health
Contact details:	Matthew.atkinson@CheshireEast.Gov.uk
Health & Wellbeing Board Lead:	Helen Charlesworth-May

Executive Summary

Is this report for:	Information ☒	Discussion ☐	Decision ☐
Why is the report being brought to the board?	To update the Board on the progress of the local Smoking Cessation Incentives Scheme and the next steps for developing the project in the context of the introduction of a national scheme.		
Please detail which, if any, of the Health & Wellbeing Strategic Outcomes this report relates to?	1. Cheshire East is a place that supports good health and wellbeing for everyone ☐ 2. Our children and young people experience good physical and emotional health and wellbeing ☒ 3. The mental health and wellbeing of people living and working in Cheshire East is improved ☐ 4. That more people live and age well, remaining independent; and that their lives end with peace and dignity in their chosen place ☒ All of the above ☐		
Please detail which, if any, of the Health & Wellbeing Principles this report relates to?	Equality and Fairness ☒ Accessibility ☐ Integration ☐ Quality ☒ Sustainability ☐ Safeguarding ☐ All of the above ☐		
Key Actions for the Health & Wellbeing Board to address. Please state recommendations for action.	Members are asked to note the report and to support the continuous improvement of the scheme as it evolves and progresses.		

Has the report been considered at any other committee meeting of the Council/meeting of the CCG board/stakeholders?	The Adults and Health Committee received this report in January 2025 and approved the continuation of the incentive scheme for household members.
Has public, service user, patient feedback/consultation informed the recommendations of this report?	Engagement took place with maternity units as part of the introduction of the scheme. Ongoing meetings have also taken place to progress this further. Service users will be contacted to provide feedback as part of the evaluation of the project to date. The findings will inform quality improvement work for the next phase of the scheme.
If recommendations are adopted, how will residents benefit? Detail benefits and reasons why they will benefit.	Keeping the household member element of the scheme alongside the new national scheme for pregnant women means that parents and household members can have improved chances of quitting smoking, which will benefit them and their children. The measures sit alongside and complement other local smoking cessation interventions.

1 Report Summary

1.1 Smoking is the leading cause of premature, preventable death worldwide, and the leading cause of health inequality in the UK. Smoking in pregnant women is a significant risk factor for stillbirth, miscarriage and pre-term birth, and household smoking contributes to childhood illnesses and deaths.

1.2 In 2023, the Council introduced a pilot incentive scheme in partnership with local maternity services and the commissioned provider, which was aimed at pregnant women and people living within their household. Its chief purpose was to reduce the impact of tobacco on the health of the mother and the unborn child, by encouraging people to quit smoking.

1.3 This report summarises the initial activity in the scheme and suggests only continuing the household element, given that a national stop smoking in pregnancy scheme is launching.

1.4 The focus on household members will allow us to increase the activity in this element of the scheme.

2 Recommendations

2.1 Members are asked to note the report and that their organisations support the continuous improvement of the scheme as it progresses.

3 Reasons for Recommendations

3.1 The maternity units intend to join the Department of Health's national incentive scheme for pregnant women so that they are aligned with other areas in England. This will bring an end to the local smoking cessation incentives scheme for pregnant women.

3.2 The decision has been taken to continue the incentive scheme for household members, which costs a relatively small amount and can be a useful tool to encourage quitting.

3.3 There are clear consequences from second-hand smoke exposure for the unborn child as a result of someone smoking within the same household. It is estimated that second-hand smoke exposure makes sudden infant death 45% more likely. It is also estimated that birth weight will be reduced by 30-40g on average. To get the maximum benefit to child health, all household members need to be supported to quit.

3.4 By facilitating whole household quit attempts, we hope to increase the chances of parents successfully quitting. Focusing on the household member element of the scheme will allow us to increase the number of household members who are likely to stop smoking.

3.5 Since the report was seen at the Council's Adults and Health Committee in January 2025, we have identified a lead officer who will evaluate the scheme to date and conduct quality improvement work to increase the uptake and effectiveness of the household member scheme going forward. This will be a collaboration between local authority public health and commissioning colleagues, and the maternity services in Mid Cheshire Hospitals NHS Foundation Trust and East Cheshire NHS Trust.

3.6 A report on the evaluation of the service to date will be taken back to Adults and Health Committee in autumn 2025 and an update on the progress of the household member scheme will be taken in early 2026.

4 Impact on Health and Wellbeing Strategic Outcomes

4.1 The intervention aims to improve the health of unborn children, infants and other children in the household where one or both parents smoke.

4.2 Improving rates of smoking cessation for pregnant women or their household members will increase the number of adults who are smoke free as they age, helping them to live and age well.

5 Background and Options

5.1 Cheshire East Council's Adults and Health Committee approved the introduction of a financial incentive scheme to help pregnant women to quit smoking as well as people within their household at Committee in July 2022.

5.2 The scheme involved vouchers of increasing value being provided to pregnant women and/or their household members for successfully reaching specific quit milestones, as validated through carbon monoxide testing. Implementation has involved the Council, both local acute trusts and One You Cheshire East.

5.3 The maximum voucher a pregnant women could receive was £400, with household members (due to the impacts of passive smoking on the unborn child) receiving up to £200. This compares with an average cost of over fifteen pounds for twenty cigarettes.

5.4 A key reason for implementing the scheme was the evidence base for its effectiveness. For instance, a comprehensive review of studies previously carried out concluded that there was 'moderate certainty evidence' that such schemes improve smoking cessation rates. The majority of schemes covered were from the USA, however, with only a single study from the UK.

5.5 The pilot scheme has operated in two phases:

February 2023 – March 2024

- Smoking cessation support was delivered solely by the One You Cheshire East service (for pregnant women and household members);

May 2024 – onwards

- Smoking cessation support for pregnant women was delivered by smoking cessation practitioners based within acute trust maternity units (with implementation being phased in due to hospital staff capacity).

Note - the change in smoking cessation model took place due to a release of stop smoking funding from the Department of Health for maternity units and a decision by the Local Authority in conjunction with the acute trusts that this in-house approach was likely to be more effective. This shift reduced the risk of loss of contact with pregnant women, by eliminating the need for external referrals.

5.6 Data for phase 1:

-238 pregnant women were referred to the scheme
-54 set a quit date
-21 quit at 4 weeks, 39% quit rate
-19 confirmed to have quit at 12-14 weeks after the quit date
-10 confirmed to have quit at 34-38 weeks after the quit date

5.7 Data for phase 2:

-92 women were referred to the scheme
-49 set a quit date
-17 4-week quits were achieved, 35% quit rate
-12 confirmed to have quit at 12-14 weeks after the quit date
-2 confirmed to have quit at 34-38 weeks after the quit date

5.8 Household Members:
-8 household members were referred
-8 set a quit date
-4 quit at 4 weeks
-4 confirmed to have quit at stage 3 (12-14 weeks after the quit date)
-3 confirmed to have quit at stage 4 (24-28 weeks after the quit date)

5.8 The primary aim of the scheme was to incentivise people to start and then continue their quit journey. Quit rates under phase 1 (39%) and phase 2 (35%) are above the current national average which is 25% for England (both the national and local figures required carbon monoxide validation). Locally, the proportion of women setting a quit date is 52% in phase 2 of the project (it was 22% in phase 1). This compares with 44% in England.

5.9 Similar comparison for household members is unfeasible as the national quit rate is not measured for this cohort. However, the quit rate in England for smokers in general is 12%.

5.10 Comparison with a similar incentive scheme in Glasgow and Clyde shows that the validated quit rate for pregnant women achieved in Cheshire East is higher at 4 weeks (35% compared to 31%) but slightly lower at 12 weeks (24% compared to 26%). Data on non-validated quits (requiring self-reporting) has not been routinely collected.

5.11 Therefore, the project appears to have had some success. Ideally, comparison would also have taken place with local rates prior to the start of the incentive scheme. However, this is not possible, due to issues with data recording by the previous provider (prior to 2023).

5.12 The cost of a four-week quit under the Cheshire East incentive scheme in vouchers is £378. ASH (an independent public health charity) produce a ready reckoner tool, which allows the impact of smoking on a local area to be estimated. This states that the social care cost of smoking is £74.6M, with the healthcare cost being £8.91M in Cheshire East.

5.13 The Government has now started a national financial incentives scheme for pregnant women. Cheshire East has provided input into this work. This scheme uses the same total of £400 shopping vouchers as the current local scheme, but vouchers are provided at different intervals. The learning that has taken place provides good grounding for implementation of this new scheme and will increase its chances of success.

5.14 The Council has provisionally agreed with maternity units that the local incentive scheme for pregnant women will stop once the national scheme commences locally. The timescale is unclear around this. However, it is likely to be introduced at Mid-Cheshire Hospital Trust early in 2025, with practicalities still being discussed with East Cheshire Trust.

5.15 Under this initiative, future voucher costs would be funded by the Department of Health. However, household members who smoke (who are included in the local scheme) are not covered. Therefore, it is proposed that the local scheme continues for household members given the low expenditure required and the impact of passive smoking on the unborn child. Voucher spend to date on this element has been circa £800.

5.16 A report will be produced which evaluates the pilot in further detail. This will be shared regionally and nationally and will serve as useful intelligence for future incentive led projects.

5.17 Following a decision by Adults and Health Committee in March 2024, the One You Cheshire East service was recommissioned using a competitive procurement process, with the new contract commencing in November 2024 under Everybody Health and Leisure. Smoking cessation capacity has been expanded under this new contract due to a new stop smoking grant from the Office for Health Improvement and Disparities. This includes more locations for access, greater ability to target groups of smokers e.g. from areas of deprivation, routine and manual workers, and improved ability to provide tailored support. The contract also encompasses supporting the local incentive scheme.

5.18 Of additional note, is that the proportion of women who smoke at time of delivery has decreased in Cheshire East in recent years. This is 7.2% for 2023/24 in comparison to 7.4% England which is encouraging. However, as more smokers quit, it is likely that those remaining will have ever more engrained habits. This will make reducing numbers further a

continuing challenge, as evidenced to some extent in implementation of the incentive scheme pilot.

6 Access to Information

6.1 The background papers relating to this report can be inspected by contacting the report writer:

Name: Dr Matthew Atkinson
Designation: Consultant in Public Health
Email: matthew.atkinson@cheshireeast.gov.uk

CHESHIRE EAST HEALTH AND WELLBEING BOARD
Reports Cover Sheet

Title of Report:	Better Care Fund plan 2025/26
Report Reference Number	HWB77
Date of meeting:	18/03/2026
Written by:	Alex Jones
Contact details:	Alex.t.jones@cheshireeast.gov.uk
Health & Wellbeing Board Lead:	Helen Charlesworth-May

Executive Summary

Is this report for:	Information ☐	Discussion ☐	Decision x
Why is the report being brought to the board?	The report is being brought to the health and wellbeing board for consideration and approval so that the BCF plan for 2025/26 can be implemented.		
Please detail which, if any, of the Health & Wellbeing Strategic Outcomes this report relates to?	1. Cheshire East is a place that supports good health and wellbeing for everyone ☐ 2. Our children and young people experience good physical and emotional health and wellbeing ☐ 3. The mental health and wellbeing of people living and working in Cheshire East is improved ☐ 4. That more people live and age well, remaining independent; and that their lives end with peace and dignity in their chosen place x All of the above ☐		
Please detail which, if any, of the Health & Wellbeing Principles this report relates to?	Equality and Fairness ☐ Accessibility ☐ Integration ☐ Quality ☐ Sustainability ☐ Safeguarding ☐ All of the above x		

Key Actions for the Health & Wellbeing Board to address. Please state recommendations for action.	That the HWB endorse the Better Care Fund plan for 2025/26.
Has the report been considered at any other committee meeting of the Council/meeting of the CCG board/stakeholders?	The following report has separately been distributed to the Better Care Fund Governance Group.
Has public, service user, patient feedback/consultation informed the recommendations of this report?	No
If recommendations are adopted, how will residents benefit? Detail benefits and reasons why they will benefit.	Not applicable.

1 Report Summary

1.1 The following report provides a summary of the BCF planning guidance for 2025/26 which includes a shift in focus from sickness to prevention and hospital to home. The report includes an overview of the plan finances, schemes, metric targets for 2025/26.

2 Recommendations

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

3 Reasons for Recommendations

3.1 This report forms part of the monitoring arrangements for the Better Care Fund.

4 Impact on Health and Wellbeing Strategic Outcomes

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

5 Background and Options

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

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

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

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

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

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

Metrics for 2025-2026

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

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

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

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

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

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

Reporting: Quarterly progress reports with simplified templates,

5.1 Better Care Fund priorities for 2025/26

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

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

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

5.2 Background information

1. Providing more care closer to home.

5.3 Better Care Fund

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

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

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

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

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

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

5.10 System Home First Programme

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

5.12 These evidence-based interventions are designed to keep people at home (or in their usual place of residence) following an escalation in their needs and/or to support people to return home as quickly as possible with support following an admission to a hospital bed.

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

5.14 Home First priorities for 2025/26

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

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

5.15 Better Care Fund

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

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

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

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

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

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

Crewe Care Community BCF

Scope:	**T**he service will be delivered via a One Stop Shop frailty clinic for Crewe based on the principles of and successful delivery of the Crewe Leg Club Model of multi-disciplinary team working. All HIU will be registered GP. Focus will be on high intensity users
Aim:	• Reduction in acute presentation or Emergency admission with Care Plan in place • Reduction in presentation in crisis to out of hours teams • Reduction in the number of falls which could have been prevented • Increasing Patient and Carer satisfaction rates • Continuity of care measures – District Nurse team and in Primary Care

5.18 Objectives

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

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

5.19 Cheshire East Health and Wellbeing Board

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

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

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

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

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

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

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

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

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

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

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

3. Harnessing digital technology to transform care.

Strategic context

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

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

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

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

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

5. Reviewing our approach to Discharge to assess.

Better Care Fund

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

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

5.34 The current operating model is delivering:

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

5.35 Options Appraisal:

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

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

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

5.38 Better Care Fund

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

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

5.39 BCF finances

Cheshire East

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

Required Spend

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

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

5.40 BCF schemes

Scheme ID	Activity	Description of Scheme	Primary Objective	Area of Spend	Provider	Source of Funding	Expenditure for 2025-26 (£)
1	Home-based intermediate care (short-term home-based rehabilitation, reablement	Reablement	5. Reducing the need for long term residential care	Social Care	Local Authority	NHS Minimum Contribution	£ 5,752,665
2	Assistive technologies and equipment	Supporting care homes	2. Home adaptations and tech	Social Care	Local Authority	NHS Minimum Contribution	£ 187,153
3	Housing related schemes	AT & Community equipment & Handy person	2. Home adaptations and tech	Social Care	Local Authority	NHS Minimum Contribution	£ 334,888
4	Other	NEW business case: gateway (£48k), system winter plan (£588k), falls prevention	4. Preventing unnecessary hospital admissions	Social Care	Local Authority	NHS Minimum Contribution	£ 715,888
5	Support to carers, including unpaid carers	Carers	3. Supporting unpaid carers	Social Care	Local Authority	NHS Minimum Contribution	£ 715,888
6	Wider local support to promote prevention and independence	Proportionate care	1. Provision care in those with complex needs	Social Care	Local Authority	NHS Minimum Contribution	£ 155,154
7	Home-based intermediate care (short-term home-based rehabilitation, reablement	British red cross	3. Timely discharge from hospital	Social Care	Local Authority	NHS Minimum Contribution	£ 636,651
8	Home-based intermediate care (short-term home-based rehabilitation, reablement	CHA	3. Timely discharge from hospital	Social Care	NHS Acute Provider	NHS Minimum Contribution	£ 565,384
9	Bed-based intermediate care (short-term bed-based rehabilitation, reablement	Beds short and long term	3. Timely discharge from hospital	Other	Local Authority	NHS Minimum Contribution	£ 1,288,888
10	Wider local support to promote prevention and independence	Mental health support	1. Provision care in those with complex needs	Other	Private Sector	NHS Minimum Contribution	£ 388,584
11	Wider local support to promote prevention and independence	Mental health professionals	1. Provision care in those with complex needs	Other	NHS Acute Provider	NHS Minimum Contribution	£ 85,888
12	Discharge support and infrastructure	Social workers	3. Timely discharge from hospital	Other	Local Authority	NHS Minimum Contribution	£ 246,888
13	Discharge support and infrastructure	Transfer of care hub	3. Timely discharge from hospital	Other	NHS Acute Provider	NHS Minimum Contribution	£ 388,888
14	Discharge support and infrastructure	Occupational therapists	3. Timely discharge from hospital	Other	NHS Acute Provider	NHS Minimum Contribution	£ 126,888
15	Wider local support to promote prevention and independence	Care + communities	1. Provision care in those with complex needs	Other	NHS	NHS Minimum Contribution	£ 588,888
16	Wider local support to promote prevention and independence	Volunteers	4. Preventing unnecessary hospital admissions	Other	Charity / Voluntary Sector	NHS Minimum Contribution	£ 458,153
17	Home-based intermediate care (short-term home-based rehabilitation, reablement	Homefirst	3. Timely discharge from hospital	Community Health	NHS Acute Provider	NHS Minimum Contribution	£ 28,757,855
18	Housing related schemes	Community equipment	2. Home adaptations and tech	Social Care	Local Authority	Additional LA Contribution	£ 558,888
19	Other	Grants	4. Preventing unnecessary hospital admissions	Social Care	Charity / Voluntary Sector	Additional NHS Contribution	£ 182,858
20	Enablers and enabling integration	Programme management	1. Provision care in those with complex needs	Social Care	Local Authority	Local Authority Better Care Grant	£ 246,888
21	Other	Social workers	1. Provision care in those with complex needs	Social Care	Local Authority	Local Authority Better Care Grant	£ 1,846,175
22	Short-term home-based social care (including rehabilitation, reablement	Care at home	1. Provision care in those with complex needs	Social Care	Local Authority	Local Authority Better Care Grant	£ 8,577,348
23	Discharge support and infrastructure	Care planning	3. Timely discharge from hospital	Social Care	Local Authority	Local Authority Better Care Grant	£ 878,888
24	Disabled Facilities Grant related schemes	Disabled Facilities Grant	2. Home adaptations and tech	Social Care	Local Authority	DFG	£ 2,906,341
25	Housing related schemes	Community equipment	2. Home adaptations and tech	Community Health	Local Authority	NHS Minimum Contribution	£ 2,855,548

5.41 BCF metric targets

8.1 Emergency admissions

		Apr 24 Actual	May 24 Actual	Jun 24 Actual	Jul 24 Actual	Aug 24 Actual	Sep 24 Actual	Oct 24 Actual	Nov 24 Actual	Dec 24 Actual	Jan 25 Actual	Feb 25 Actual	Mar 25 Actual	Rationale for how local goal for 2025-26 was set. Include how learning and performance to date in 2024-25 has been taken into account, impact of demographic and other demand drivers. Please also describe how the ambition represents a stretching target for the area.
Emergency admissions to hospital for people aged 65+ per 100,000 population	Rate	1,498	1,536	1,471	1,466	1,503	1,390	1,525	1,525	n/a	n/a	n/a	n/a	Locally the ambition is to reduce the number of admissions, we have a number of schemes focused on admission avoidance. Community connectors - As a critical part of the Transfer of Care Hub (TOCH). With the support of the BCF funded Integrated Community Support Commission, and an array of VCSFE groups, the Community and Discharge Support Team enable discharge of patients from each location, leading to improved through put in the hospital. In addition, the wrap around support is provided in the Community leading to
	Number of Admissions 65+	1390	1,425	1,365	1,360	1,395	1,290	1,415	1,415	n/a	n/a	n/a	n/a	
	Population of 65+*	92,798	92,798	92,798	92,798	92,798	92,798	92,798	92,798	n/a	n/a	n/a	n/a	
		Apr 25 Plan	May 25 Plan	Jun 25 Plan	Jul 25 Plan	Aug 25 Plan	Sep 25 Plan	Oct 25 Plan	Nov 25 Plan	Dec 25 Plan	Jan 26 Plan	Feb 26 Plan	Mar 26 Plan	
	Rate	1,614	1,655	1,585	1,579	1,620	1,498	1,643	1,643	1,605	1,605	1,605	1,605	
	Number of Admissions 65+	1497.877	1535.593	1470.937	1465.549	1503.265	1390.116	1524.817	1524.817	1489.122	1489.122	1489.122	1489.122	
	Population of 65+	92,798	92,798	92,798	92,798	92,798	92,798	92,798	92,798	92,798	92,798	92,798	92,798	

8.2 Discharge Delays

*Dec Actual onwards are not available at time of publication

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

8.3 Residential Admissions

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

6 Access to Information

6.1 The background papers relating to this report can be inspected by contacting the report writer:

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Appendix 1 – BCF schemes 2025/26

1. Care communities

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

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

Nantwich and Rural and SMASH Care Community BCF Application

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

Crewe Care Community BCF Application

- Scope: The service will be delivered via a One Stop Shop frailty clinicc for Crewe based on the principles of and successful delivery of the Crewe Leg Club Model of multi-disciplinary team working. All HIU will be registered GP. Focus will be on high intensity users
- Aim: Reduction in acute presentation or Emergency admission with Care Plan in place, Reduction in presentation in crisis to out of hours teams, Reduction in the number of falls which could have been prevented, Increasing Patient and Carer satisfaction rates, Continuity of care measures – District Nurse team and in Primary Care

2. Volunteers and grants

VCFSE Grants - Health and Wellbeing Grants

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

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

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

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

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

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

Community connectors

As a critical part of the Transfer of Care Hub (TOCH). With the support of the BCF funded Integrated Community Support Commission, and an array of VCSFE groups, the Community and Discharge Support Team enable discharge of patients from each location, leading to improved through put in the hospital. In addition, the wrap around support is provided in the Community leading to avoidance of readmission to hospital and increased care packages in the Community.

3. Disabled Facilities Grant

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

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

4. AT & Community equipment & Handy person

Assistive technology

Assistive technologies are considered as part of the assessment for all adults who are eligible for social care under the Care Act where it provides greater independence, choice and control and is cost-effective for individuals. The provision of assistive technology is personalised to each individual and is integrated within the overall support plan. This will entail: Increasing the independence of people living with long term conditions and complex care, Supporting carers to maintain their caring role, Improving access to the right service at the right time.

The scheme will continue to support the existing assistive technology services. But will also involve piloting assistive technology support for adults with a learning disability (both living in supported tenancies and living in their own homes). Assistive technology has predominately been focused on maintaining the independence of older people in a community setting.

Community equipment

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

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

Handyperson

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

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

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

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

5.Supporting care homes

Residential care home competence nurse

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

The Competency Nurse has worked alongside care home managers and care staff to develop and deliver bespoke face-to-face training sessions providing clinical expertise and demonstrating evidenced based clinical skills and best practices to achieve this.

Practice development nurse

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

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

6.Mental health support

Mental Health Reablement – Rapid Response Service

Follow an acute stay, the service aims to support patients with mental health support needs who would benefit from some outreach support at home to support them with medication management, establishing routines, connecting with other services, welfare checks, attending health or social care related appointments and reintegrating back into their local community.

This service is available support individuals with mental health support needs who are fit for discharge and are delayed due to awaiting care package and would benefit from a short-term intervention.

AED in reach

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

Approved mental health professionals

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

8. Carers

Carers

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

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

9. Proportionate care

Proportionate care

The aims of this scheme are to: Reduce the number of existing disproportionate packages of care with double handling, ensuring people are in receipt of proportionate care packages to meet needs safely. Reducing care packages will also release financial efficiencies for the council, contributing to the MTFS for 24-25. Drive the standards of manual handling up across domiciliary care agencies within Cheshire East footprint. enable domiciliary care agencies to deliver single handed care competently and able to offer increased care provision with single handed care practice.

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

10. GNA

General Nursing Assistant

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

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

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

Increased GNA

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

11.Reablement

Combined reablement service

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

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

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

Reablement system investment

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

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

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

12.British red cross

This contract is for two services:

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

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

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

13.Care at home

Care at home investment increase

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

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

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

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

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

Right at home service

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

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

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

14.Beds short and long term

Spot purchase beds and cluster model

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

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

15.Homefirst

Homefirst

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

They are evidence-based interventions designed to keep people at home (or in their usual place of residence) following an escalation in their needs and/or to support people to return home as quickly as possible with support following an admission to a hospital bed.
The Home First schemes mainly support older people living with frailty and complex needs to remain independent, or to regain their independence following deterioration in their medical, social, functional or cognitive needs.

16.Social workers

Homefirst social workers

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

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

Social work support

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

Advice and signposting

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

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

Adult contact team

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

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

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

17.Programme management

The delivery of the Better Care Fund relies on joint commissioning plans already developed across the health and social care economy. The scheme covers the following:

- Programme management.
- Governance and finance support to develop s75 agreements, cost schemes and cost benefit analysis.
- Financial support.
- Additional commissioning capacity might be required to support the review of existing contract and schemes and the procurement of alternative services.
- To provide enabling support to the Better Care Fund programme, through programme management and other support, as required.
- To develop and maintain adherence to governance arrangements including the s75 agreement and commissioning capacity.
- The delivery of the Better Care Fund relies on joint commissioning plans already developed across the Cheshire East Health and Social Care economy.
- Submission of all financial information on time of all NHSE and other central returns.
- Financial support for remedial action / development of new initiatives where needed to maximise the impact of the BCF investment (including performance against the national metrics).
- Financial administration to support the BCF, invoicing etc.
- Financial advice and support to scheme managers as required.
- Contribution to budget papers and other reporting to governing bodies/cabinet/OSC as required.
- Contribution to governance mechanism’s such as S75 statements, BCF Governance Group.
- Production of year-end information, notes to the accounts etc.

18.Care sourcing

Care sourcing team

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

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

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

19.Transfer of care hub

Transfer of care hub

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

20.Occupational therapists

Occupational therapists

The role of the Occupational Therapist (OT) is part of the Home First model with a primary focus on ensuring that we continue to keep people at home following an escalation in their needs and/or to support people to return home as quickly as possible. The OT does this by facilitating graded leave and discharge home visits. The OT educates colleagues and teams on risk management and using specialist equipment.

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