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Cheshire East Health and Wellbeing Board

Agenda

Date:	**Tuesday, 4th November, 2025**
Time:	**2.00 pm**
Venue:	**Committee Suite 1, 2 and 3, Delamere House, Delamere Street, Crewe, CW1 2LL**

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.

Please Note: This Meeting Will Be Live Streamed. This meeting will be broadcast live and a recording may be made available afterwards. The live stream will include both audio and video. **Members of the public attending and/or speaking at the meeting should be aware that their image and voice may be captured and made publicly available.** If you have any concerns or require further information, please contact Democratic Services in advance of the meeting.

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 16 September 2025.

For requests for further information
Contact: Frances Handley
E-Mail: CheshireEastDemocraticServices@cheshireeast.gov.uk

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. **Winter Plan 2025-2026** (Pages 9 - 72)

To receive a report on the details of the Cheshire East Winter Plan 2025 – 2026 and the preparations being made to deal with the added pressures on the health and care system that the winter can bring.

6. **Commercial Determinants of Health update** (Pages 73 - 78)

To receive an update on the Commercial Determinants of Health.

7. **Better Care Fund 2025-2026 Quarter One report** (Pages 79 - 98)

To receive a report to note the Better Care Fund quarter one update for 2025/26.

8. **Terms of Reference Review**

To receive a verbal update on the Terms of Reference.

Membership: L Barry (Vice Chair), R Burgess, Dr P Bishop, A Blizard, E Dowle, Councillor L Crane, H Charlesworth-May, Councillor S Corcoran (Chair), P Cresswell, D Godfrey, Councillor J Rhodes, I Wilson, K Little, Councillor S Gardiner, Professor Rod Thomson

CHESHIRE EAST COUNCIL

Minutes of a meeting of the **Cheshire East Health and Wellbeing Board** held on Tuesday, 16th September, 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
Councillor Stewart Gardiner, Cheshire East Council (via teams)
Phil Cresswell, Executive Director of Place, Cheshire East Council
Councillor Jill Rhodes, Chair of Adults and Health Committee, Cheshire East Council
Isla Wilson, Chair, Cheshire East Health and Care Place Partnership (via teams)
Louise Barry, CEO, Healthwatch Cheshire
Kate Little, CEO CVS Cheshire East (via teams)
Richard Burgess, Interim Director NHS Cheshire and Merseyside Integrated Care Board Cheshire East
Councillor Dawn Clark (substitute for Councillor Laura Crane)
Chief Inspector Andy Baker (substitute for Superintendent Andrew Blizzard)

OFFICERS IN ATTENDANCE

Guy Kilminster, Corporate Manager, Health Improvement
Professor Rod Thomson, Interim Director of Public Health
Susie Roberts, Public Health Consultant
Hayley Antipas, Public Health Development Officer
Frances Handley, Democratic Services Officer

OTHERS
Chris Knight, programme director at Mid Cheshire Hospitals NHS Trust
Russ Favager, Senior Responsible Officer (SRO) for Mid Cheshire FT new Leighton Hospital build programme

The Chair varied the order of business. Notwithstanding this the minutes are order of the agenda.

11 **APOLOGIES FOR ABSENCE**

Dr Paul Bishop NHS Cheshire and Merseyside Integrated Care Board
Dawn Godfrey, Executive Director Children and Families, Cheshire East Council
Councillor Laura Crane, Councillor Dawn Clark attended as a substitute

Superintendent Andrew Blizzard, Chief Inspector Andy Baker attended as a substitute

12 **DECLARATIONS OF INTEREST**

In the interests of openness, Councillor Stewart Gardiner declared that he is a member of the Strategic Planning Board and it is probable that the plans for the new hospital will be presented at a meeting, however there was no conflict of interest at the present moment.

13 **MINUTES OF PREVIOUS MEETING**

That the minutes of the meeting held on 1 July 2025 be approved subject to the amendment of Louise Barry being included in the record of attendance.

14 **PUBLIC SPEAKING TIME/OPEN SESSION**

There were no public speakers.

15 **THE PHARMACEUTICAL NEEDS ASSESSMENT**

The board received a presentation which provided an update on the Pharmaceutical Needs Assessment which is an assessment of community pharmacy services available to support residents across Cheshire East. It is a statutory requirement for Health and Wellbeing Boards to maintain an up-to-date Pharmaceutical Needs Assessment, which is used by NHS England to assess applications for new pharmacy premises or dispensing appliance contractors, based on identified geographical gaps.

It was noted that Cheshire East has slightly fewer pharmacies than the national average, but feedback from pharmacy providers indicated they felt able to cope with current and projected demand, including anticipated population growth. Members queried whether this assessment fully accounted for local know variations and future developments and were assured that it did.

Concerns were raised about the potential for commercial pharmacies to cluster in areas of high footfall, possibly disadvantaging more deprived or less central areas. Officers highlighted that analysis had been undertaken on the proportion of residents able to access a pharmacy quickly, including those in the most deprived areas.

Officers emphasised that the Pharmaceutical Needs Assessment is a statutory duty of the public health department, produced on behalf of the NHS, and is reviewed every three years. The dynamic nature of pharmacy provision was acknowledged, with closures and changes in service provision being monitored on an ongoing basis.

The board queried whether the public survey addressed issues such as waiting times, prescription availability, and service quality, noting personal experiences of long waits and frequent changes in nominated pharmacies. Officers confirmed that such questions were included in the survey and that free-text comments and feedback from Healthwatch and other engagement groups were also considered. Officers offered to provide further detail on the survey questions and engagement list upon request.

It was noted that some community groups, such as dementia support groups, may not have been directly engaged in the survey process. Officers agreed to review the engagement list and ensure feedback from such groups is considered in future assessments.

RESOLVED (Unanimously):

That the Board approve the final version of the Pharmaceutical Needs Assessment (PNA) 2022-2025 prior to publication by 1 October 2025.

16 **SUPPORTING OUR EAST TIMORESE COMMUNITY**

An update was provided on the work undertaken over the past two years to support the East Timorese community, coordinated with support from the charity IVAR (funded by the National Lottery).

The board noted that work was underway to improve access to health and care for East Timorese residents, build trust with GP surgeries, raise awareness and reduce stigma around TB and increase integration with the wider Crewe community.

The board made observations regarding language barriers, with children often acting as translators for their parents, highlighting both the integration of younger generations and the ongoing need for accessible communication.
The value of cross-sector collaboration was highlighted, with the Health and Wellbeing Board bringing together representatives from the police, NHS, public health, and the Council to share experiences and coordinate support for the community.
An open invitation was extended to all members to join the newly established steering group for the East Timorese community, with the first meeting scheduled for the end of September. Members were encouraged to share their experiences and ideas for future engagement.
Officers acknowledged the need to use the work with the East Timorese community as a framework or “accessibility test” for future engagement with other groups. While capacity and resources are limited, the approach developed can inform wider efforts to understand and address the needs of minority communities in Cheshire East using the learning and framework developed through the East Timorese project.

RESOLVED:

That the board note the update.

17 **HEALTHIER FUTURES UPDATE**

The board received a presentation which provided an update on the Healthier Futures programme

The board queried the number of planning applications there would be and whether any RACC (reinforced autoclaved aerated concrete) building would be retained. It was noted that there will be a single planning application and all RAAC buildings would be demolished. Advanced discussions are ongoing with a partner organisation (not named at this stage), with a memorandum of understanding being prepared. It was noted that cancer services will not be included in the new build; instead, the funding allocated for these services will be pooled with the partner organisation to deliver the required facilities.

The board queried the number of beds in the design. The committee noted that the modelling has been undertaken for a 15-year period, with input from public health and local partners. The modelling indicates that, despite demographic changes and increased housing, the number of beds required would initially rise to around 1,000. However, due to advances in medical technology and changes in care delivery (e.g., remote monitoring), the projected number of beds returns to a figure similar to the current provision.

The board raised concerns about patient safety in relation to the silent wards. Specifically, how urgent needs would be addressed in the absence of traditional call bells. It was clarified that the new nurse call system allows nurses to view patients on a handheld device when an alert is triggered. This enables the nurse to immediately assess the patient's situation and determine the priority for attending.

The board queried how the principle of localism would be maintained if businesses involved in the project subsequently worked on hospital builds in other regions, potentially undermining the local focus. It was noted that the approach aims to encourage local businesses to participate in the development, recognising the potential for these businesses to be involved in projects elsewhere. The intention is to maximise opportunities for Crewe-based businesses, while acknowledging that some benefits may extend beyond the local area.

Members raised concerns about the impact of construction traffic and highways works over the anticipated five-year build period, particularly regarding disruption to residents and the potential for increased complaints. It was requested that there be proactive engagement with statutory utility companies and highways leads within the Council to coordinate works and minimise disruption. The importance of clear communication with residents was emphasised. It was noted that regular

meetings are being held between the project team and Council representatives to ensure ongoing collaboration and early discussion of emerging issues. It was noted that construction work will generally be limited to 8:00 am to 6:00 pm. Any need for extended hours, for example if the project falls behind schedule, would be subject to consultation with local residents.

RESOLVED:

That the board note the update.

18 **NEIGHBOURHOOD HEALTH SERVICE IMPLEMENTATION PROGRAMME**

A presentation was shared highlighting the alignment with the national 10-year plan for health and care, which emphasises three key pillars: shifting from hospital to community care, prioritising prevention, and embracing digital transformation.

The importance of developing neighbourhood models and care communities was noted and recent national policy developments reinforce the importance of this approach.

The board raised concerns about access to GP services for certain groups, including those with learning disabilities, and the need for leadership and coordination through the GP Confederation. It was noted that there was a meeting scheduled to discuss how the general practise will work together to support the needs of the communities.
The need for clarity around the definition and governance of “place” and “neighbourhood” within the Integrated Care Board was discussed and it was noted that it will be further developed.
The board emphasised the need to shift resources towards early intervention and prevention, and queried how this would be achieved in practice.
The voluntary and community sector was recognised as a key partner in delivering prevention and community-based care, with a proposal to map current engagement and identify gaps.
The importance of recognising both geographical and non-geographical communities (e.g., farming, migrant, rural, and dementia communities) was highlighted.

RESOLVED:

That the Board note the update.

The meeting commenced at 14.00 and concluded at 16.01

Councillor S Corcoran (Chair)

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Agenda Item 5

Cheshire East Council

NHS Cheshire and Merseyside

CHESHIRE EAST HEALTH AND WELLBEING BOARD
Reports Cover Sheet

Title of Report:	Cheshire East Winter Plan 2025 - 2026
Report Reference Number	HWB 88
Date of meeting:	4th November 2025
Written by:	Guy Kilminster
Contact details:	Guy.kilminster@cheshireeast.gov.uk
Health & Wellbeing Board Lead:	Rich Burgess / Helen Charlesworth-May

Executive Summary

Is this report for:	Information ☐	Discussion ☐	Decision X
Why is the report being brought to the board?	For information and endorsement.		
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 ☐ All of the above X		
Key Actions for the Health & Wellbeing Board to address. Please state recommendations for action.	To note the details of the Winter Plan and the preparations being made to deal with the added pressures on the health and care system that the winter can bring. To endorse the Cheshire East Winter Plan 2025 - 2026		

Has the report been considered at any other committee meeting of the Council/meeting of the CCG board/stakeholders?	N/A
Has public, service user, patient feedback/consultation informed the recommendations of this report?	N/A
If recommendations are adopted, how will residents benefit? Detail benefits and reasons why they will benefit.	Winter Planning takes place to try to ensure the best available provision of health and care services for residents during the winter months.

1 Report Summary

1.1 The Cheshire East Winter Plan 2025-2026 is a co-produced multi-agency plan, drafted with input from all key system partners. It is designed to prepare the health and care system for the winter months, when demand increases, to try to ensure residents who have need of services get the best possible experience, despite the pressures on organisations and staff.

2 Recommendations

2.1 That the Health and Wellbeing Board note the details within the Cheshire East Winter Plan 2025-2026 and endorse the Plan.

3 Reasons for Recommendations

3.1 To ensure the Health and Care System in Cheshire East is prepared for the winter months with the best possible Plan in place.

4 Impact on Health and Wellbeing Strategic Outcomes

4.1 Effective winter planning will help ensure good outcomes for resident's health and wellbeing.

6 Access to Information

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

Name: Guy Kilminster
Designation: Corporate Manager Health Improvement
Tel No: 07795 617363
Email: guy.kilminster@cheshireeast.gov.uk

Cheshire East Place System Winter Plan 2025/2026

Version 3: 07/10/2025

Slide Index

Review of Winter Plan 2024/25 – Reflection and Learning

Our Joint System Reflections

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

Winter Plan Risk Profile

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

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

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

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Performance Summary against system ambition for Winter 2024/25

A&E 4-Hr Standard – 76% of people admitted, transferred or discharged within 4Hrs.	A&E 4hr daily performance has decreased by 4.9% when comparing Dec 2023/24 vs Dec 2024/25.
Cat 2 ambulance mean response time <30Mins For conditions, such as stroke or chest pain.	Though this is a generally decreasing trend, Nov 2024 performance was below that of Nov 2023.
12-Hr time in department – Target of <2% Type 1 attendances over 12 hrs.	Both Cheshire East providers performed below C&M combined and below national standards.
14-day Length of Stay – Target is <25%	The trend was upwards over the winter period as expected but met targets consistently and performed slightly favourably compared to Dec 2024.
No Criteria to Reside	The combined target of 100 NCtR was not met during winter 2024/25.

Introduction - Forecast Winter 2025/26

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.

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

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

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

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

Forecast for Winter 2025/26

The following challenges have already been identified

- Cost of living rises
- System workforce challenges across the ICS.
- Care Home beds capacity challenges (dementia nursing beds)
- Seasonal flu vaccination remains a critically important public health intervention and a key priority for 2025 to 2026 to reduce morbidity, mortality and hospitalisation associated with flu at a time when the NHS and social care will be managing winter pressures whilst continuing to recover from the impact of the coronavirus (COVID-19) pandemic.
- This year's Autumn flu and Covid vaccine programmes will start later. Vaccinations began in October 25 for those most at risk
- Mental Health – ED & In patient mental Health delays
- Primary Care collective action
- Urgent care recovery
- Elective Recovery
- Additional NHS funding is not expected in Quarter 3 & 4
- Providers have identified additional high impact interventions.
- Active decommissioning of services/financial recovery programme, which will result in a reduction in capacity (including challenges in VCFSE sector)

Delivering operational resilience across the NHS this winter

January 2025

Recovering Urgent & Emergency Care (UEC)

Primary Care Recovery Plan

Elective Recovery Plan

} Strong basis to prepare for winter

Key Ambitions 2025/26:

(1) 95% of patients being admitted, transferred, or discharged within 4 hours

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

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

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

Key Focus

- UEC recovery plan – ensuring high-impact interventions are in place
- Operational surge planning
- Effective system working across all parts of the system
- Supporting our workforce
- Provider Market Sustainability & Oversight
- Good quality care and support for people
- Improve flow through hospitals with a particular focus on patients waiting over 12 hours and making progress on eliminating corridor care

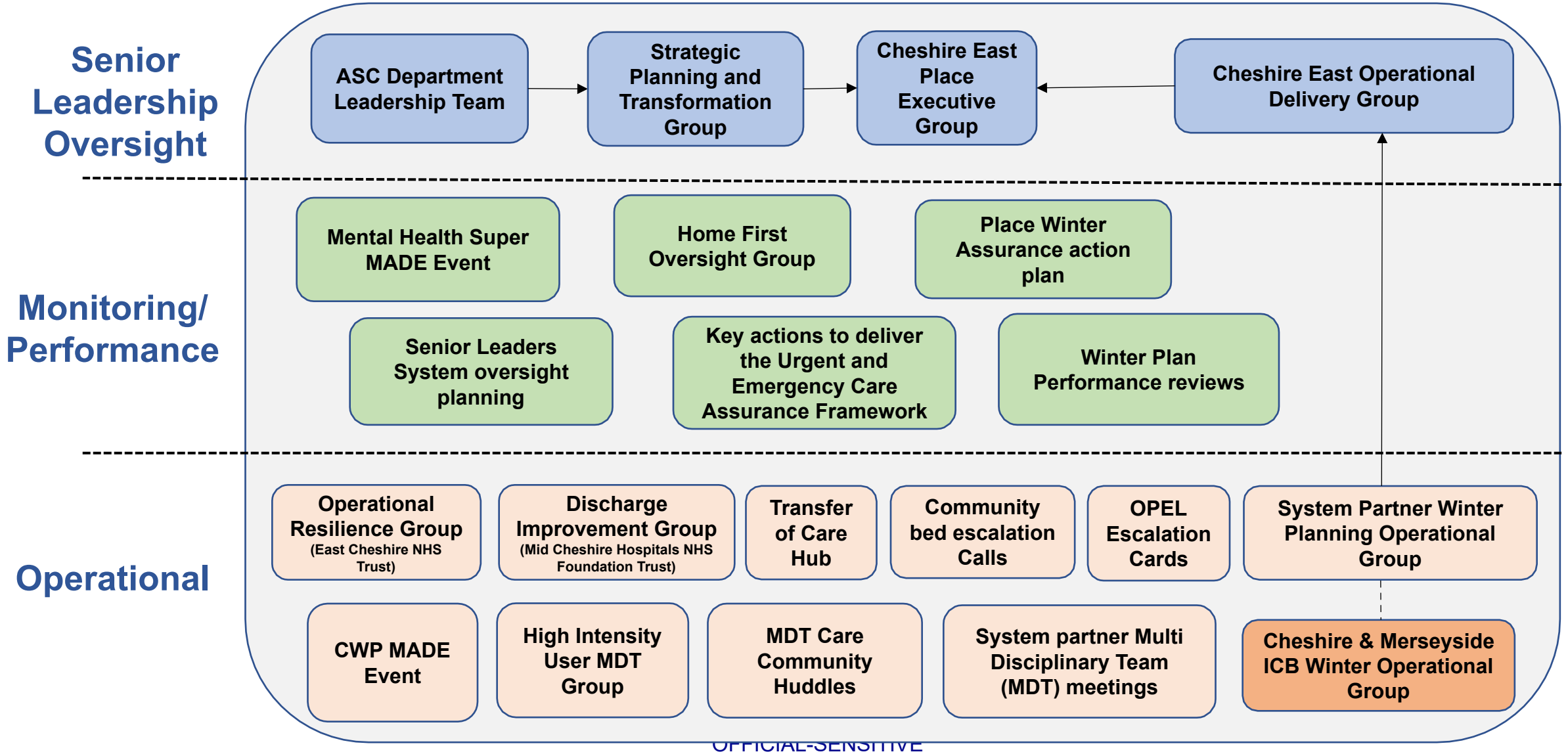
Ambition for Winter 2025/26 UEC Metrics

A&E 4-hour standard	• 95% of patients being admitted, transferred or discharged within 4 hours
Cat 2 ambulance mean response time <30 minutes	• Category 2 ambulance calls are for condition such as stroke or chest pain that require rapid assessment
12-hour time in department	• The percentage of people (type 1 attendances) who are delayed over 12 hours from arrival to the ED. Target is <2%
14-day LOS	• target is <25%

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

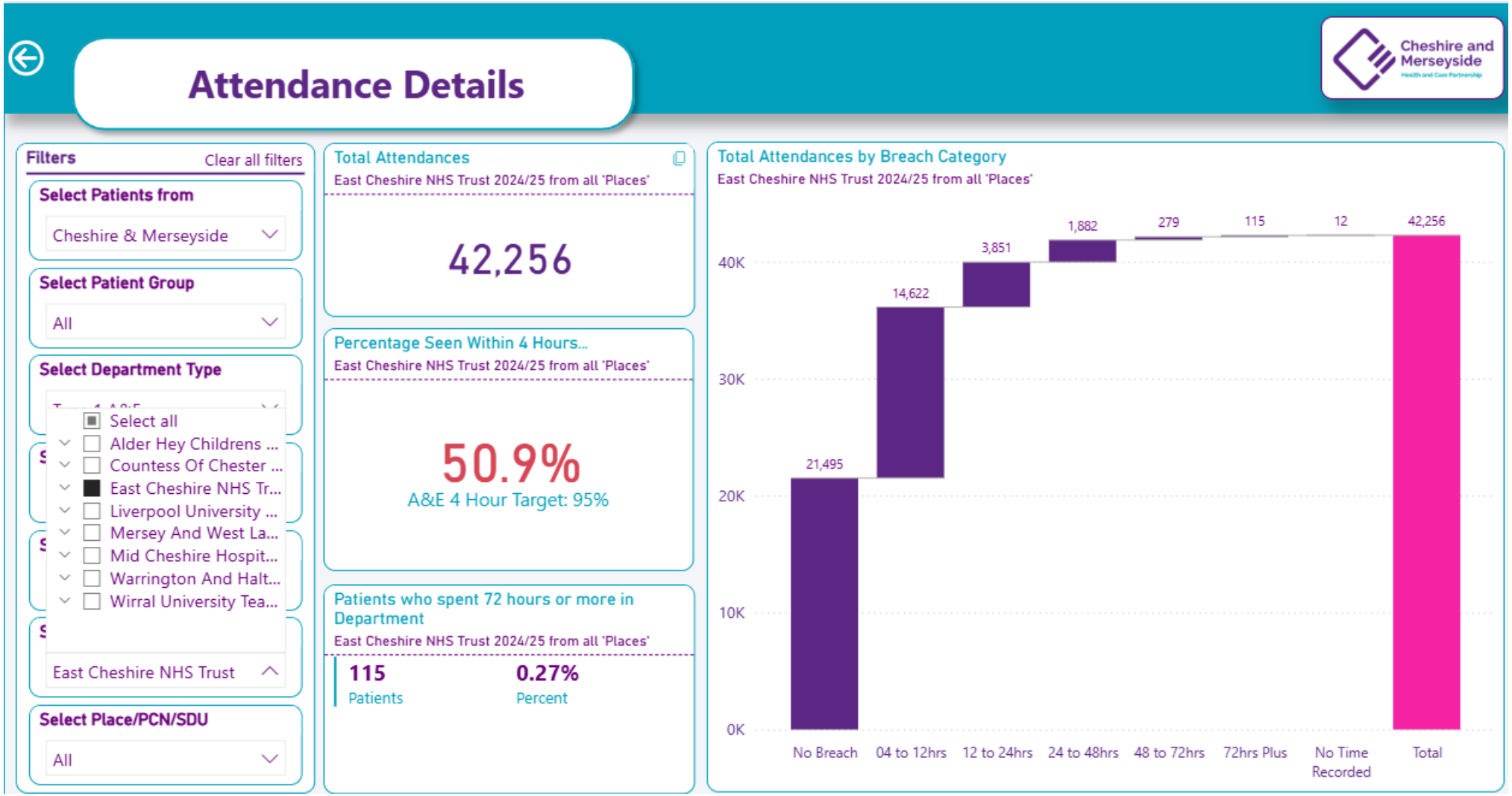
Monitoring, Oversight and Governance Structure

NHS
Cheshire and Merseyside



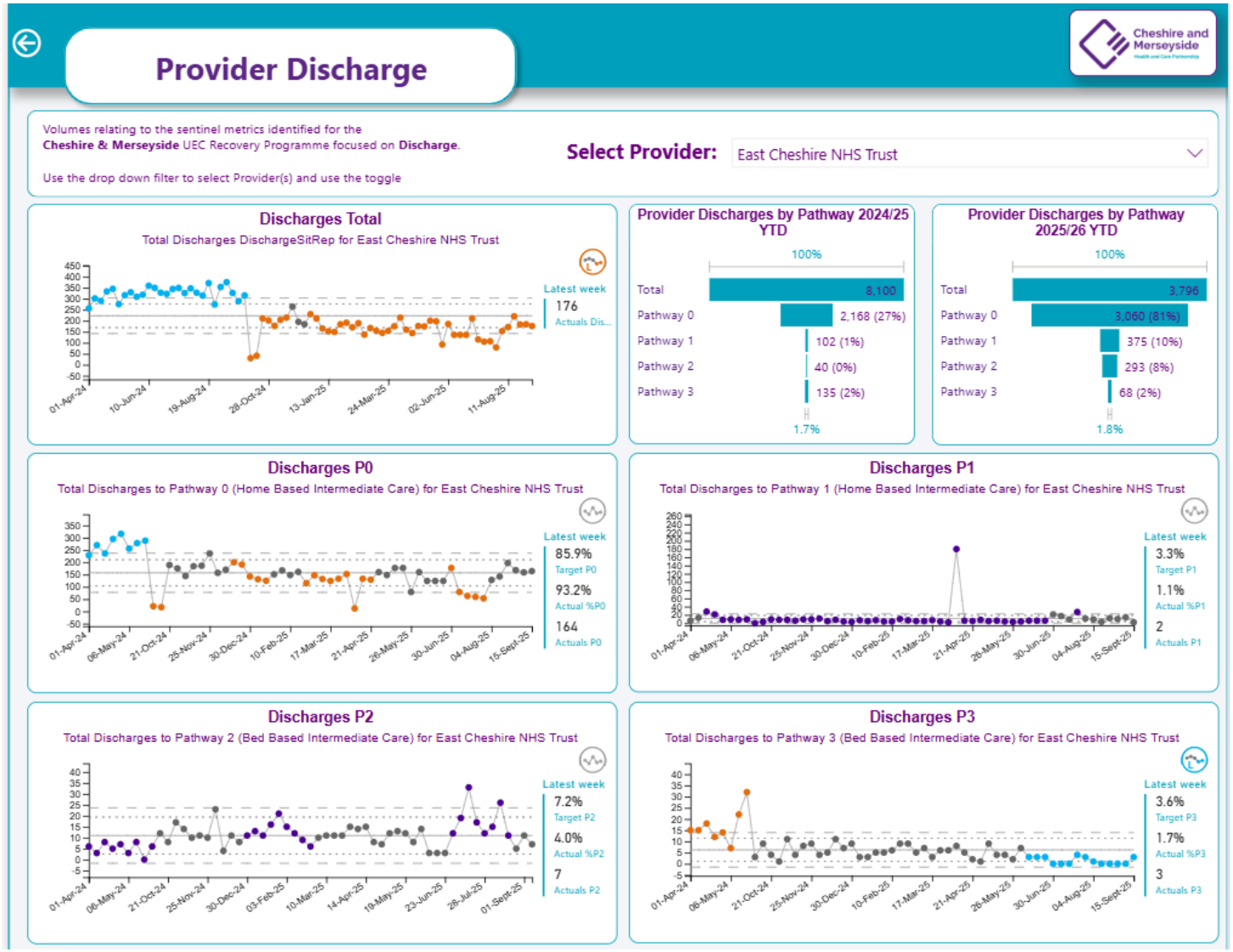
Attendance Details

East Cheshire Trust - ED



Data Source: ECDS & SUS inpatients

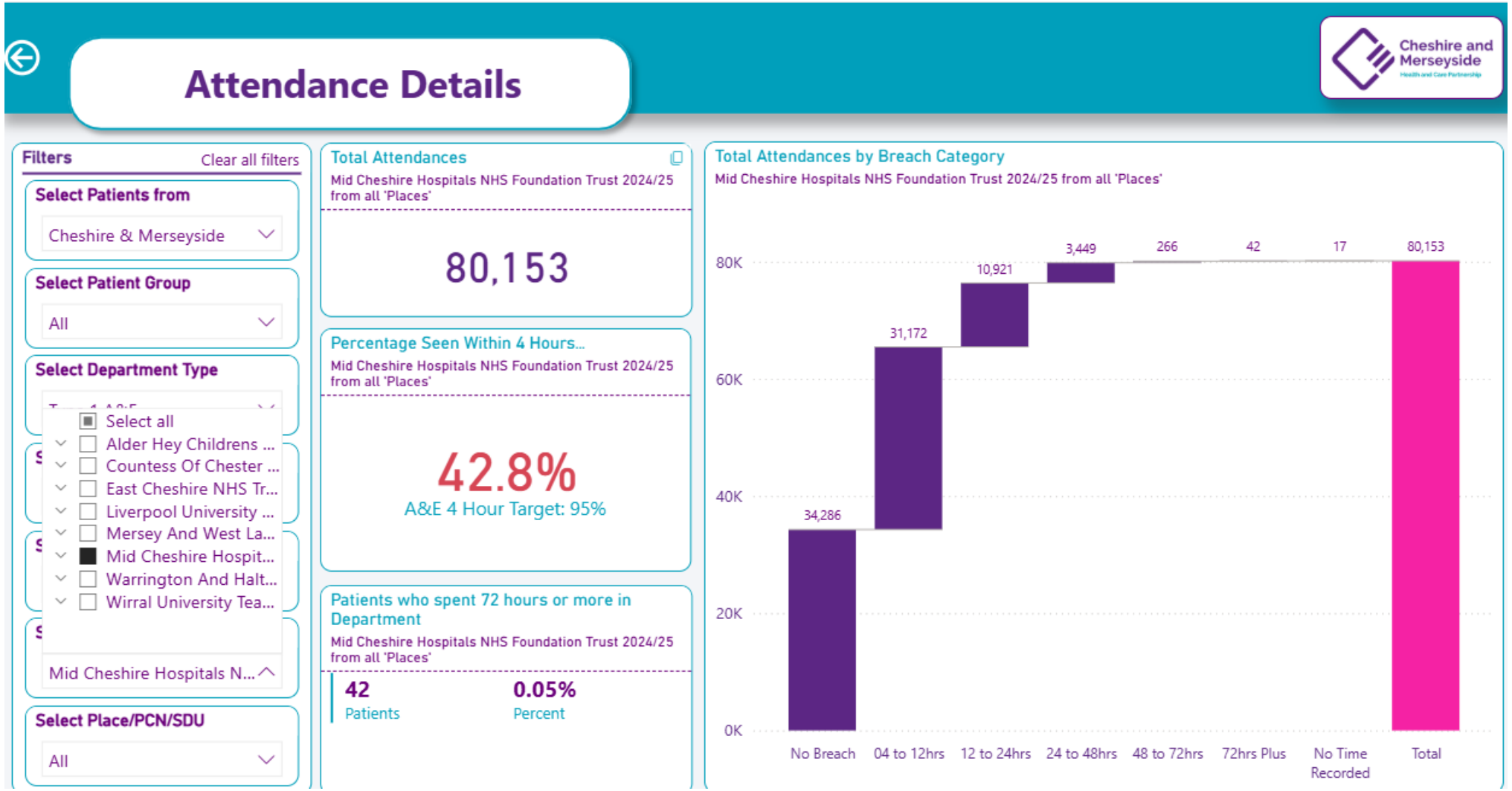
East Cheshire NHS Trust – Discharges



Data Source: ECDS & SUS inpatients

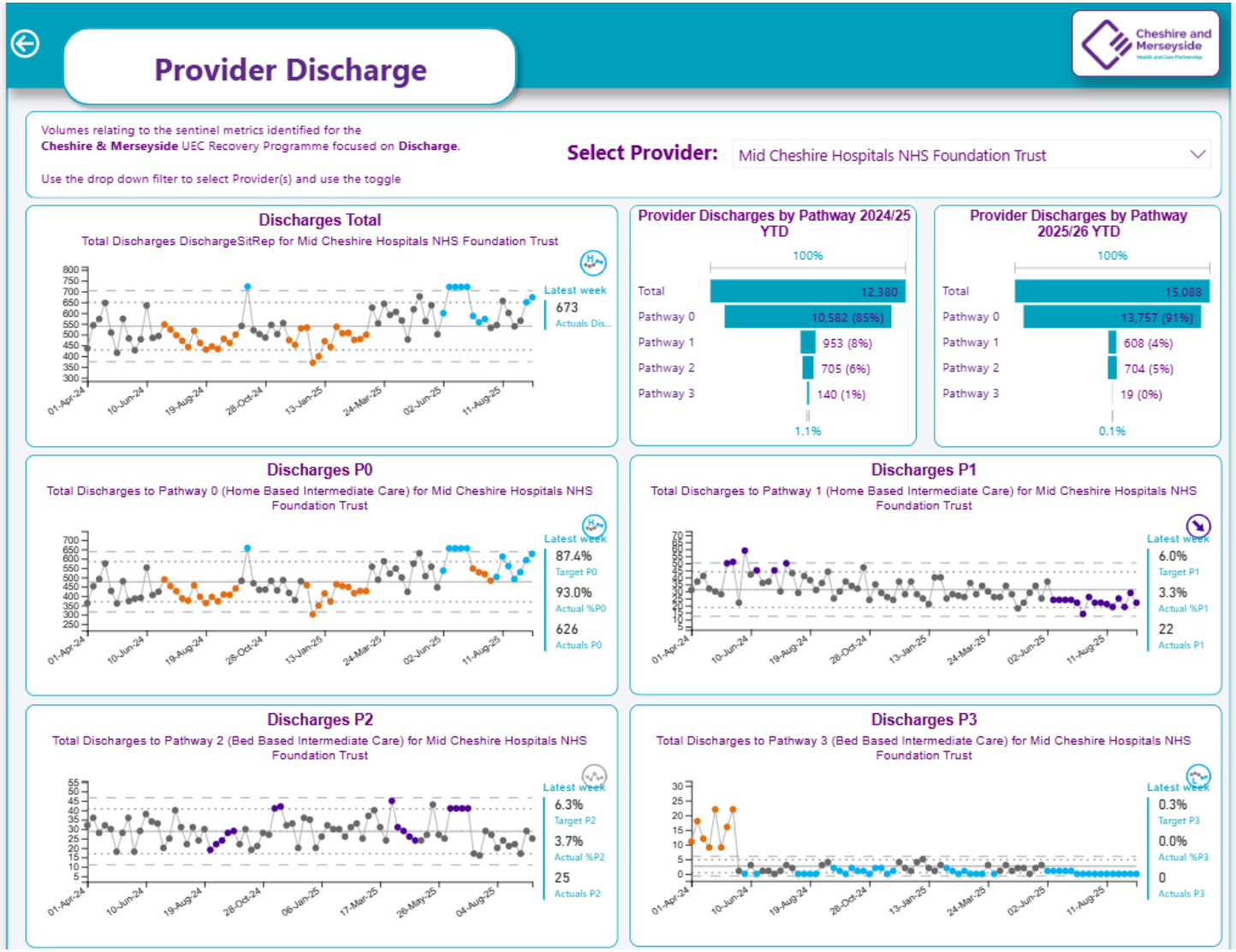
Attendance Details

Mid Cheshire Hospitals Foundation Trust - ED



Data Source: ICB UEC Recovery Dashboard

Mid Cheshire Hospitals Foundation Trust - Discharges



Data Source: ECDS & SUS inpatients

Performance Management & Escalation

Cheshire East Assurance:

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

Winter Planning Escalation

System Co-ordination Centres

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

Integrated OPEL Framework 2024 to 2026

The 2024 to 2026 framework for the management of operational pressures is for NHS acute trusts, community health service (CHS) providers, mental health (MH) service providers, NHS 111 providers, ICSs, and NHS England regional and national teams.

- The integrated OPEL Framework 2024 to 2026 now provides a unified, systematic and structured approach for a co-ordinated response to operational pressures at system, regional and national levels
- As a minimum, every provider (acute, CHS, MH, NHS 111) must complete an OPEL assessment once every 24 hours or more frequently in response to changes in assessments.
- The acute OPEL now has 10 parameters:
- Real time data system in place - SHREWD
- ICB level OPEL will be determined automatically by the Trust declarations, with a proportion of the score for each acute site going towards the OPEL score for the ICS
- C&M SCC will operate daily calls through winter, likely minimum 2x OPEL declarations per day
- Action cards are defined nationally, ICBs need to define their triggers and action cards for system actions with local partners e.g. at Place level
- **Further work required to agree what the key actions are for Place at each OPEL stage, at ICB level and beyond, in particular escalation with local partners at OPEL 3 and 4**

High Impact Actions	Overarching principal of the winter plan Link to the High Impact Actions – Cheshire East Place
Same Day Emergency Care	Maximise the use of the Same Day Emergency Care triaging model for people, thus ensuring that people are fast-tracked to the right specialist at the start of their visit to hospital. SDEC will continue to reduce hospital admissions and in turn improve the person experience and help the hospital manage patient flow.
Frailty	Specialist nurses are deployed in the EDs across Cheshire East as part of the frailty response with the aim of avoiding hospital admissions. Falls – Steady on your Feet (SYOF) launch and roll out of MFAC training to Community Teams.
Inpatient Flow & LOS	
Community bed productivity and flow	Cheshire East's specific focus on Pathway 2 cluster model Length of Stay and P3 self-funding patients Length of Stay through Transfer of Care Hubs and multi-disciplinary team meetings, and transformation support to review community Length of stay pathways. A significant investment has been committed from the Adult Social Care Discharge Investment Fund to support the implementation of the Discharge to Assess model along with providing funding to purchase additional spot purchased bed base capacity when required, to meet the deficit indicated within the Demand and Capacity analysis. The funding has supported some initial double running costs, thus allowing the model to be fully implemented and support the reduction of a number of beds across the system.
Care transfer hubs	The Transfer of Care Hubs in ECT & MCHFT IS THE system-level place whereby (physically or virtually) all relevant services (for example, acute, community, primary care, social care, housing and voluntary) are linked to coordinate care and support for people who need it – during and following discharge and to prevent acute hospital admissions. Daily Transfer of Care Hub escalation calls take place focus is to progress discharges (including community beds) in real time escalation.
Intermediate care demand and capacity	Cheshire East place are fully engaged in the 12-week programme to identify gaps in the system.
Virtual wards	Roll out of intravenous and sub cutaneous therapy provision to virtual wards has been completed with a number of areas increasing their intravenous at home offer. Continue to promote Virtual Wards and pathways and increase bed occupancy targets. A heart failure VW specialty will also be added.
Urgent Community Response	Monitoring Performance impact and effectiveness against a bespoke set of UCR metrics.
Single Point of Access	To support patients to access care more easily, Care Community Services have Single Points of Access for patients and referrers to access support and care. The single point of access aligns to the care community (neighbourhood) footprint. Dedicated SPOC for NWAS from Sept 25.
Acute Respiratory Infection Hubs	We don't have any acute respiratory hubs in Primary Care in Cheshire East. The two locations that were mobilised last year ceased at the end of the funding.

	High Impact Interventions – Actions .	System Roles & Responsibility
1	**Same Day Emergency Care**: reducing variation in SDEC provision by providing guidance about operating a variety of SDEC services for at least 12 hours per day, 7 days per week.	East Cheshire NHS Trust Mid Cheshire Hospitals FT
2	**Frailty**: reducing variation in acute frailty service provision. Improving recognition of cases that could benefit from specific frailty services and ensuring referrals to avoid admission.	East Cheshire NHS Trust Mid Cheshire Hospitals FT
3	**Inpatient flow and length of stay (acute)**: reducing variation in inpatient care (including mental health) and length of stay for key iUEC pathways/conditions/cohorts by implementing in-hospital efficiencies and bringing forward discharge processes for pathway 0 patients	Cheshire & Wirral Partnership FT East Cheshire NHS Trust Mid Cheshire Hospitals FT
4	**Community bed productivity and flow**: reducing variation in inpatient care and length of stay, including mental health, by implementing in-hospital efficiencies and bringing forward discharge processes.	Cheshire & Wirral Partnership FT East Cheshire NHS Trust, Central Cheshire Integrated Care Partnership
5	**Care transfer hubs**: implementing a standard operating procedure and minimum standards for care transfer hubs to reduce variation and maximise access to community rehabilitation and prevent re-admission to a hospital bed.	Transfer of Care Hubs System Partners
6	**Intermediate care demand and capacity**: supporting the operationalisation of ongoing demand and capacity planning, including through improved use of data to improve access to and quality of intermediate care including community rehab	ICB & System Partners
7	**Virtual wards**: standardising and improving care across all virtual ward services to improve the level of care to prevent admission to hospital and help with discharge and increasing the specialities supported. Maintain % utilisation of 60 beds, Extending scope to include Heart Failure offer and Palliative	East Cheshire NHS Trust, Central Cheshire Integrated Care Partnership
8	**Urgent Community Response**: increasing volume and consistency of referrals to improve patient care and ease pressure on ambulance services and avoid admission. Maintain 2hr 70% compliance and ensure full utilisation inc. NWAS referrals & Care Homes	East Cheshire NHS Trust, Central Cheshire Integrated Care Partnership
9	**Single point of access**: driving standardisation of urgent integrated care co-ordination which will facilitate whole system management of patients into the right care setting, with the right clinician or team, at the right time. This should include mental health crisis pathways and alternatives to admission, eg home treatment	Cheshire & Wirral Partnership FT Central Cheshire Integrated Care Partnership
10	**Acute Respiratory Infection Hubs**: We don't have any acute respiratory hubs in Primary Care in Cheshire East. The two locations that were mobilised last year ceased at the end of the funding.	Primary Care East Cheshire NHS Trust, Central Cheshire Integrated Care Partnership

Primary Care

Primary Care will continue its business as usual over the Winter months to support residents

- ✓ Primary Care Network led Extended Hours for evening and Saturdays
- ✓ Primary Care Access Recovery Programme including transition to a new model of modern General Practice.
- ✓ Robust and resilient General Practice Out of Hours service including Acute Visiting Service.
- ✓ Care Communities Business cases to extend Primary Care Assessment – Respiratory, Frailty, High Intensity Users, Falls – Subject to additional funding
- ✓ The nationally commissioned Community pharmacy consultation service (CPCS) as this will have a potentially bigger and synergistic impact with the Pharmacy First minor ailments service on lower acuity conditions. CPCS takes referrals from general practice and NHS111, while Pharmacy First provision also takes walk ins
- ✓ Primary Care resilience and activity data
- ✓ Exploring initiatives to enhance the falls prevention programme, including access to falls exercise classes and care homework (System)
- ✓ Health & Wellbeing services for Asylum seekers and Refugee communities
- ✓ Full implementation of the Primary / secondary care interface recommendations
- ✓ Roll out of the General Practice OPEL system to support system pressures reporting
- ✓ Care home & house bound vaccinations – CCICP Supporting Primary Care in delivery of COVID & Flu
- ✓ Cheshire East Place has been using the John Hopkins population segmentation for the past year to risk stratify all patients in our community. Active programmes of work centre around complex frailty, risking risk of emergency admission or A&E Attendances as well as those patient at the end of life.
- ✓ GP practices have digital tools and staff trained to re-direct patients to the most appropriate clinicians/service including pharmacy first, community opticians for urgent eye conditions etc. Through the winter communications, patients will also be encouraged to use the NHS App and NHS 111 as well as the Catch App for CYP.
- ✓ My Digital Health Passport promoted in all GP practices. Comms to be continually circulated from Mid August to embed messages. Info to be shared with 0-19 service and 3rd sector organisations such as Koala to push messages within their local Groups
- ✓ LA/ICB social media - promote public health messages and ICB messages around warm home, breath health , national campaign. Add footer to email signature with further information

Cheshire East Discharge to Assess Model of Care (by Hospital Footprint) for 2025/26

The current Discharge to Assess bed model for ECT and MCHFT for 2025/2026

Key areas of focus:

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

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

The Home for Christmas Campaign

*The D2A beds at Cavendish Court will increase to 6 and The Belvedere will increase to 4 beds (October/November 2025). These beds are to replace the 10 beds at Wilmslow Manor.

	Provider	No beds	Bed Type
East Cheshire Trust	Eden Mansions	5	Nursing Dementia
	Henning Hall	4	Nursing
		2	Nursing Dementia
	The Rowans	4	Nursing
	Tabley House	3	Nursing
	Leycester House	6	Residential
	The Willows	4	Nursing
	Prestbury House	6	Nursing/Resi/Dementia
	Cavendish Court	4*	Nursing / Nursing Dementia
	The Belvedere	2*	Nursing / Nursing Dementia
	Aston Ward	27	Rehab
Mid Cheshire Trust	Clarendon Court	8	Nursing/Resi/Dementia
	Telford Court	8	Nursing Dementia
	Station House	10	Nursing D2A
		2	CIB
	Alexandra Mill	4	Nursing/Nursing Dementia
	The Elms	3	Residential SRB
	Turnpike Court	2	Residential Dementia SRB
	Elmhurst	30	Nursing/Nursing Dementia
	Total Beds	134	

Care Community Investment 2025-2026:

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

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

- **Crewe Care Community** The service will be delivered is the Community Frailty One Stop Shop in the model of multi-disciplinary team working. Focus will be on identifying those at risk. Aim: Holistic review to support deconditioning, reduction in acute presentation or Emergency admission with Care Plan in place, Reduction in presentation in crisis to out of hours teams,
- Health Neighbourhood Voluntary Infrastructure and Model of Support, see attached paper for further reference of the invested schemes and funding allocation: Projects were categorised based on service provision under the following themed areas.
    - Universal Community led social prescribing.
    - Provide targeted advice, guidance, and support.
    - Mental Health Targeted Health and Wellbeing Cafes
    - Physical Health Targeted Community Clinics

Care Communities

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

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

These schemes will support to lower admission to hospital and enabling people to live safe and well at home and in their communities.

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

Overview of Schemes

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

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

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

Macclesfield - High Intensity User project – Macclesfield Care Community are focusing on high intensity users of services to reduce the number of unplanned or crisis contacts by proactively case managing patients with a higher than expected level of ED attends through extended GP appointments and a holistic approach to care. Next steps will incorporate an wider MDT approach.

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

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

Care Communities continued

Crewe – The Community Frailty One Stop Shop will continue to support those identified as at risk to apply a holistic approach to assessment. The approach has been adapted to contribute towards reducing winter pressures to avoid admission and deconditioning on-going pressures for primary care, secondary care, and community services.

Sandbach, Middlewich, Alsager, Scholar Green, Haslington, Brereton (SMASH) - High Intensity User - Falls Prevention - SMASH are looking to expand out to an app which will be used for patients over the age of 65. Our first port of call would be to send a message to our patients through Accurx to gain data on falls prevention. Using population health data and identification through MDT's focussed patient approach is taken to target high risk patients to support holistic assessment and sign posting which also includes post treatment review to monitor impact.

Nantwich - High Intensity User - Falls Prevention - Nantwich and Rural are looking to expand out to an app which will be used for patients over the age of 65. Our first port of call would be to send a message to our patients through Accurx to gain data on falls prevention. Using population health data and identification through MDT's focussed patient approach is taken to target high risk patients to support holistic assessment and sign posting which also includes post treatment review to monitor impact.

Aims

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

System Impact, benefits

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

Anticipated Quality Outcomes

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

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

Mid Cheshire Hospital Foundation Trust Winter Plan

A high-level overview of the winter plan that has been developed for 2025/26 to ensure the Trust has sufficient operational capacity and capability to meet expected demand. This year's plan has taken into consideration the following points:

- RAAC remedial work will continue through 25/26.
- The UEC Transformation Programme and Tier 1 UEC Recovery Programme continue to develop services, e.g. AECU, MNP, UEC Sprint, etc.
- Maintaining elective performance, to reduce waiting list backlogs, will continue to be a priority.
- The health and wellbeing of our workforce must continue to be a top priority.

It is important to note that MCHFT's Winter Plan is in addition to, and complements, the Winter Plan which will be developed at ICB / PLACE level.

Winter Plan - Scheme Updates

The Winter Plan is intended to provide additional resilience in the hospital system to support an increase in demand on urgent and emergency care services and to also recognise and respond to the operational context described above. The focus of the plan, and the funding available, is therefore around improving flow and discharge.

The Winter Plan schemes will focus on acute sector that will be delivered by MCHFT and is based upon evidence and learning from previous years on what has had the greatest impact on improving ED performance and hospital flow. The plan includes a provision of some increased core bed-based services and a tranche of non-bed-based schemes which can be flexed based on mobilization feasibility, demand and in response to the current 12-week critical issues programme.

Bed Based Services **Purpose:** to offer planned increase in core bed base across the busiest months of the year and preserve elective inpatient capacity for Orthopedic services.	
Scheme	**Plan**
Winter ward (13 and then 32 beds)	13 beds are planned to be opened from 1st November, increasing to 32 beds from 22nd December until the end of March '26.
Discharge Lounge (13 beds)	To be opened for 4 nights per week from 1st November until the end of March '26.
Elective service resilience	
Ward 19 – Inpatient Elective Orthopaedics	Ward 19 to remained as an Orthopaedic inpatient elective service.

The expected impact of Winter on the Trust is anticipated to see increased admission demand and number of Super Stranded patients. The plan is to mitigate this is to open a 'Winter Ward' as well as provide a number of enhanced capacity provisions in non-bed-based schemes. The Winter schemes financially balance to the £2.5m budget without adding to the financial deficit within the Trust. By maintaining the elective Orthopaedic inpatient ward, the Trust aims to continue to support the elective performance targets and patient care.

Hospital Services (Non-Bed-Based Services) **Purpose:** to meet additional demand, mitigate need for additional bed capacity (e.g. escalation space).		
Scheme	**Duration (Months)**	**Plan**
CAU Paediatric Nursing	2	To support increased acuity.
CAU Paediatric Medical Support	4	Additional consultant ward time to support earlier discharges during the evening.
Additional Transport Discharge Vehicles	6	To avoid failed discharges 'on the day' and support a higher level of discharges resulting from additional beds being open.
Pharmacist support for Wards	3	Reduce LOS due to increased support for discharge arrangements and care planning.
Therapy Support	4	Reduce LOS due to increased support to deliver care / treatment plans.
Transfer Team	4	More timely movement of patients from ED to the wards.
GP Out of Hours	5	ED attendance avoidance.
Ward 3 Additional Nursing	4	Additional nursing staff overnight to support acuity. One feature of a Respiratory Enhanced Care Unit - RECU.
Prescribing Pharmacist	3	Pharmacy cover between 17:00 and 20:00 to support TTOs and avoid failed discharges.
4th Consultant @ the weekend	3	Additional 9 hrs (Sat and Sun) of Acute Consultant time to facilitate discharges.
SDEC	3	Sat and Sun Service with nursing staff to avoid admissions and time in ED.
Frailty Chairs	3	Sat and Sun Service with nursing and AHP staff. 4th consultant to support if appropriate specialism to avoid admissions and time in ED.
ST1/2 General Surgery to support ED	3	Additional surgical doctor between 08:00 – 20:00 (Sat and Sun) to support ED and facilitate earlier discharges.
ED 2nd Reg	4	Mon – Sun night shifts to support waiting times over night
Pharmacy Dispensary	4	Extended opening times for dispensary to avoid failed discharges due to TTOs arriving late in the day.
Reto Care	4	To provide additional packages of care and facilitate discharges and LOS.

East Cheshire Trust

NHS East Cheshire NHS Trust

UEC Programme	Workstream	Description	Benefits	Timeline
Hospital Inpatient Flow	Ward Systems	ECIST support to improve ward and board round principles and in hospital flow	Reduce LOS Senior clinical leadership and oversight Timely discharge planning	Sept 25 – March 26
Hospital Inpatient Flow	SDEC Pathways	Chest Pain Pathway ECIST baseline pathway benchmarking Implement further pathways as identified via benchmarking	Reduction in the number of patients attending ED Safety – corridor care	Sept – Oct 25
Hospital Inpatient Flow	Discharge Lounge	Reconfigured Discharge Lounge Pathway redesign review revise and update Improve Utilisation (measure progress)	Early flow from wards / discharge Ability to finish off treatments in the DL	Oct 25 (Opening) Oct – Dec 25 Pathway reviews
Hospital Inpatient Flow	Discharge	Pharmacy Discharge Team	Early flow from wards / timely discharge	Oct 25 – March 26
Hospital Inpatient Flow	Outliers	Surgical / Orthopaedic / Medical Outlier Drs	Clinical review of outliers and safe management of patients	Jan 26 – March 26
Hospital Inpatient Flow	Escalation Capacity	Increase inpatient bed capacity by 12 beds	Safety – reduction in corridor care	Dec 25 / Jan 26
Keeping Patients well at home	AMRU – Pathway design	AMRU Capital Build Pathway redesign review revise update Direct Primary Care Referrals	Redirection and streaming away from ED Safety – corridor care	March 26
Keeping Patients well at home	AMRU / Acute Medicine Workforce	Acute Medicine SPR investment proposal	To provide dedicated timely senior reviews within the Emergency Department and promote H@H principles / admission avoidance	Oct 25 – Jan 26
Keeping Patients well at home	ED Workforce Investment	Invest to save proposal approval via executive board	ED TID / LOS Ambulance turnaround times 4 hours Ed Safety – Corridor care	Commence substantive recruitment October revised rota implementation Dec 25 / Jan 26
Keeping Patients well at home	UCR / VW / AVS Integration	Further embed SPOA and Home 1st Principles Integration of workforce	Improved utilisation of SPOA and reduction in attendances to ED	Sept 25 Sept – Jan 26
Keeping Patients well at home	Admission Avoidance – Care Homes Investment	Education and training to care home including Nutrition / Hydration, Managing the deteriorating pt, Pressure Area care	Reduction in care home attendances to ED	Oct 25 – March 26
Discharge & Optimising Intermediate Care	P1 – P3 Processes	Review of D2A principles and streamline assessment process	Reduce LOS and bed days lost to No CTR	September – Dec 25

Cheshire & Wirral Partnership Mental Health Winter Plans

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

The established bed base across Cheshire and Wirral Partnership NHS Foundation Trust is 320 beds for 2025/26.

Number of beds available:

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

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

Richmond Fellowship and	14
ECHC Crisis Beds	3

Cheshire & Wirral Partnership Mental Health Winter Plans

How do you intend to mitigate the risk of mental health patients spending >24 hours in ED this winter?	Improve flow within MH Acute wards, these actions are: *60/90 days reviews to commence for all patients with extended LOS *Improving 7 day discharge profile *Increased focus on discharge at the point of admission that must be reviewed systematically throughout the admission and increased capacity and capability to deliver high clinical standards enhanced MDT with skills and expertise. *Introduction of a senior clinical team with a focus on LOS/CRFD *Improvement methodology developed through CWPi and SMH focus weeks to continue through winter to support improvements within Acute and Crisis pathways * New LOS process now live ED focused * Ensure that appropriate observational support is available for patients waiting in emergency department and that police can handover patients detained under section 136 of the MH Act within a maximum of 4 hours * ISL in reach support to each ED. * Community Consultant/Keyworker availability for assessment in ED as a standard across CWP patch *Daily patient priority meetings and patient flow support with patient prioritisation *Established Whatsapp groups for all 4 General Hospitals and CWP for senior operational leaders to escalate concerns about LOS in ED depts Children and Young People Children and Young Peoples Urgent Support Team in place across Cheshire and Wirral.
How will the Provider ensure fewer patients who need a mental health admission wait in the Community, and what 'waiting well' patient safety processes and support is in place?	24/7 community offer for patients after discharge via Home Treatment Teams, referral to appropriate third sector partner or transferring to the appropriate Crisis Café to receive the same assessment by a professional that would have happened in AED following extended waits. CWP has a waiting well policy that cover all services. Harm reviews will be conducted if a patient has been in the dept for more than 12 hours. Daily patient priority meeting that clinically reviews each patient on the admission list in terms of prioritisation or least ristrictive options to turn around back into a community setting. CMHT to bolster HTT Children and Young people - The Children and Young Peoples Urgent Support Team in place across Cheshire and Wirral. This is a 24/7 provision.
How does the Provider intend to expand access to urgent care services at home, in the community and in mental health settings, so patients don't need to attend hospitals unnecessarily? Including ensuring community assertive outreach and crisis intervention teams are working with acute providers to support patients who attend an emergency department with mental health-related issues?	A dedicated Section 136 suite will provide a dedicated place of safety for individuals detained under Section 136. URC lite modules are currently being explored for other General Acute sites but are dependent on capital bids. Within each acute trust there is currently a Psychiatric Liaison Department who assess people who present in mental health crisis. Supporting effective assessment is side-by-side triage when people present at the department. The aim is that only people who have a medical need should be supported within the ED. Wider 7 day community SMH services are now being developed. Phase 1 of the programme to commence Q4 VCFSE Crisis Cafe are available across the 3 place areas. CWP will develop further communications for system partners, primary care and members of the public on what the Crisis Cafe offer is, where and how to access.

Cheshire & Wirral Partnership Mental Health Winter Plans

How does the Provider plan to ensure that when mental health patients are admitted to an inpatient setting, their stay will be as short as possible. (This should include producing % reduction target of re-admissions for their highest intensity users, how the number of patients in out-of-areas placements will be reduced, how to reduce the number of patients who are CRFD and how to reduce those who need a mental health admission waiting over 24 hours)	50% reduction in OBD for readmissions within 30 days of discharge 100% reduction in OOA beds by March 26 10 High-impact actions for MH discharges monitored and sustained 15% reduction in LOS Q4 25/26 <10% CRFD 10% reduction in 12hr breaches Implement the C&M patient choice policy to reduce CRFD *60/90 days reviews to commence for all patients with extended LOS *Improving 7 day discharge profile *Increased focus on discharge at the point of admission that must be reviewed systematically throughout the admission and increased capacity and capability to deliver high clinical standards enhanced MDT with skills and expertise. *Introduction of Senior lead oversight of cohort of CRFD patients Children and Young People: • Reduce the number of young people (under 18) from Cheshire with mental health, learning disability and / or neurodevelopmental needs being admitted to Tier 4 CAMHS. • Reduce the length of stay in Tier 4 CAMHS, where admission is clinically appropriate. • Reduce the length of stay for young people in Acute Paediatric Wards where there are unmet mental health and/or social care needs. • Reduce the need for out-of-borough placements and specialist mental health placements for our Children Looked After • The Cheshire West Place, Wirral Place and Cheshire East Place takes collective responsibility for the care and welfare of their young people. • Any identified unmet needs, including parent/carer support needs will be met as a matter of urgency. • Any young people who are already in a Tier 4 CAMHS unit will be supported to leave as soon as inpatient treatment goals have been met.

How will the Provider proactively identify and reduce the re-admissions of high intensity users of crisis pathways?	CWP has undertaken an extensive review of re-admissions under the CWPi Improvement Programme which then resulted in a week long RPIW (Rapid Process Improvement Workshop) that had a particular focus on 30 day readmission which the HIU cohort forms part of. EUPD and Psychosis are the two diagnosis areas that have the highest number of readmission and now have projects monitored over 30, 60 and 90 improvement targets. Readmission reports and dashboards have been developed within PowerBI and are monitored via CWP Performance Assurance Framework and core governance structures

Cheshire & Wirral Partnership Mental Health Winter Plans

How do you intend to improve flu vaccine uptake among your staff ahead of this winter?	Coordination group set up included Living Well being services, comms pharmacy , IPC, matron rep, care group rep and staff side. Clear comms strategy detailed vaccination offer - both clinic and mobile offer. Well being champions network to promote vaccination as well as social media outlets and staff networks. Vaccination uptake reports provided at least weekly and oversight of campaign and % uptake reported at IPC sub committee and People Committee.
What target uptake rate (%) for staff flu vaccination are you aiming for this year (25/26), noting the expectation set out in the national UEC plan for 25/26 for all providers to set an ambition of at least a 5% improvement in 25/26 compared to 24/25?	last year uptake was 43.1% - ambition aim is to exceed 48.1%
What systems and processes will be in place this winter to mitigate against delays in discharge and other related pressures caused by increases in infection rates?	IPC team works closely with care homes across cheshire to support outbreak management and support risk assessments for safe admission, discharge and transfers to and from care homes/CWP inpatients settings to acute healthcare providers. Training and education is provided through the IPCT link practitioner programme.
How will the provider ensure adequate staffing levels are in place to meet anticipated demand this winter?	CWP has a Trust Oversight Group weekly meeting chaired by the Director of Operations. All urgent care and acute services provide weekly safer staffing numbers via the emergency planning team into this meeting with Heads of Operations providing assurance or escalations via this function. All rotas are planned 6-8 weeks in advance and managed via eroster. BCPs are updated prior to winter and planned services can be reduced when and if required to bolster urgent care services if staffing is challenged.
How will staff wellbeing be improved or maintained across winter?	CWP has an extensive Workforce Wellbeing covering mental health crisis support, physical health support as well as wider support forums through Schwartz Rounds, improvement huddles and 'Kitchen Table' discussions. All CWP employees can access OH. Staff survey action plans are in place. Sickness absence is monitored via Care Group meetings and deep dives and actions are implemented and supported by HR in any areas where sickness absence is high
How will the provider maximise the role of VCSE partners this winter?	CWP has invested significantly into our VCFSE sector across the community, crisis and acute pathway. Place areas have established Crisis Cafés (4 total), and a recovery college offer. CWP has specifically commissioned services to support discharges for patients back into their community settings and avoid readmission. Community investment into the VCFSE has centred on recovery and prevention pathways with teams have clear referral pathways into commissioned organisations
What are the top three key things that your organisation is going to do differently this year to effectively manage mental health winter pressures?	Established MH OPEL process/protocols - with ICB Priority programme chaired by Deputy CEO/Director of Operations to accelerate UEC MH plan actions and align to winter plan Accelerate Community Transformation programme with the focus on expanding a wider 7 day community MH offer.
How does the Trust ensure equitable access to urgent mental health crisis support, in particular for patients attending EDs?	Access to urgent mental health crisis is through the FRS service and Crisis Line/NHS 111 MH option. Patients within ED's are assessed via the Liason Psychiatry Team. A daily clinical patient review meeting supports decision making for who will access the next available inpatient bed. All access points are available to every member of public. CWP Autism strategy ensures that the principles of our approach to any autistic person need to be the same across every service and all ages.
What initiatives exist to prevent repeat ED attendances for patients with severe mental health conditions?	Community MH transformation programme is focused upon improving access routes into wider community services, the programme is also developing 7 day neighbourhood based community services with clearly defined pathways with a easy in approach reducing the need for new assessments and referrals if previously known to services, through which this will provide more options for service users to access and reduce potential ED attendances. Harm review procedures have been developed for patients that have waited in EDs for longer than 12 hrs, within the reviews are critical learning points to support with understanding if the attendance was necessary, this process will be rolled out across all EDs before Winter

Mental Health & Community Collaborative Priorities

Cheshire East Place

Mental health support communications toolkit to find the right support

http://webstore.cwp.nhs.uk/smh/toolkits/cheshireeastsept23.pdf

Key headlines for Winter 2025/26

- ✓ The Crisis Line receives around 4,000 calls per month.
- ✓ Wider 7-day community SMH services are now being developed
- ✓ Working with both Cheshire and Merseyside Police to ensure appropriate observational support is available for people being detained on Section 136
- ✓ 4 Crisis Cafes are now established & a recovery college
- ✓ CWP has commissioned services to support discharges for patients back into community settings.

East Cheshire Hospice Contribution to Cheshire East Winter Plan 2025-26

Overview

East Cheshire Hospice (ECH) provides services for the population living in the northern locality of Cheshire East. It offers a specialist 15-bed in-patient unit staffed by a Multi-Disciplinary Team (MDT) for both palliative and end of life care patients, four community teams delivering care @Home 24/7/365, living well services for all disease groups and a range of family support services such as Carer Wellbeing programmes and all age bereavement support. It is fully integrated with the Specialist Palliative Care Team in North Cheshire East. Through Palliative Advice Centre East (PACE), the Hospice is further supporting the system by providing ANP cover 8am-8pm across all seven days with the ability to attend a patient's home to resolve crisis and prevent admission. Rapid Response @Home cover is available 9pm-8am 7 days. The 24/7 palliative care advice line for healthcare professionals can be used to access support for deteriorating patients.

All of the above resource will be deployed to support the System through Winter 2025-26.

What is different from Winter 2024-25 that will improve performance in 2025-26

Daily 9am MDT huddles for Palliative and End of Life Care (P&EoLC) patients can be used to check bed availability and spare capacity in Hospice IPU to alleviate system bed pressure
Friday 3pm MDT huddle to identify patients at risk of deterioration/ due for discharge over the weekend
24/7 Advice Line can facilitate home visits/support patients being discharged from hospital if necessary
Use this link to join the daily huddle Teams call: Click here to join the meeting Meeting ID: 379 594 880 010 To contact Palliative Advice Centre East (PACE) 24/7 Tel: 01625 666 999.

Action Plan for winter 2025-26

Daily MDT Huddles to early identify patients who are deteriorating and who would benefit from admission to ECH or receive care at home to avoid hospital admissions
Subject to availability, a winter pressure step down bed can be offered following discussion with the Hospice team
Ensure all referrers are aware of and practiced in the referral process for ECH
Four fully staffed care teams are now operating across all five Care Communities in Northern Cheshire East, offering a level of rapid response
Subject to capacity there will be ad hoc facilitation of late afternoon rapid discharges from hospital to home outside of normal Specialist Palliative Care Team's hours of operation
Specialist assessment of long-stay hospital patients who do not reach the threshold for Specialist Palliative Care Team (SPCT) invention but who could benefit from optimisation during an ECH in-patient stay
Use ECH resource to ensure the SPCT is staffed seven days per week throughout the winter
Support Care Homes through ECH 24-hour Advice line 01625 666 999

Infection Prevention Control provided by Cheshire & Wirral Partnership Foundation Trust

Infection Prevention & Control measures are as follows:

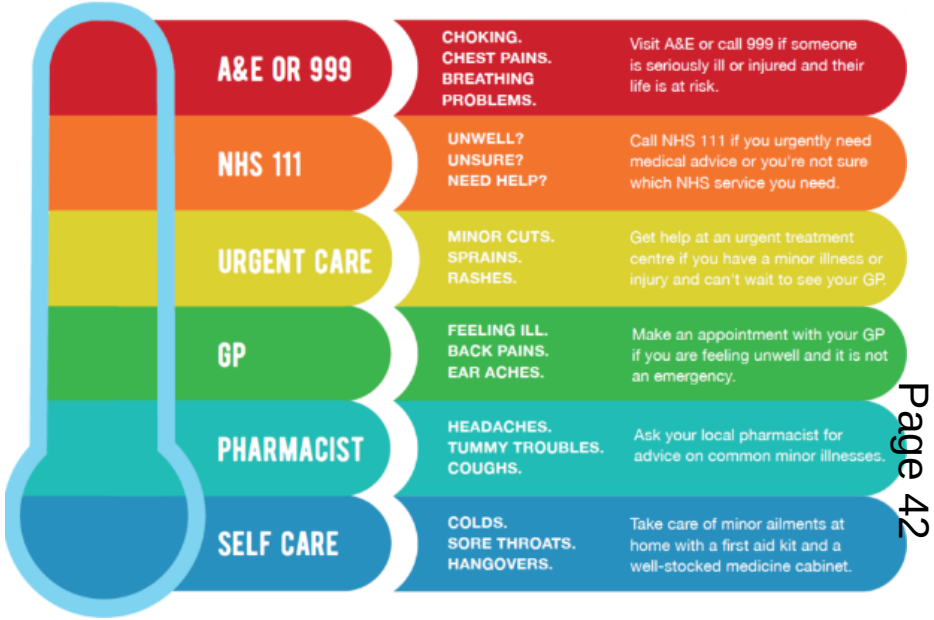
- ✓ Single Point of Contact for all telephone requests for advice & support from the IPC Team – Tel: 01244 397700 (Mon – Friday between 9am & 5pm, except BHs)
- ✓ Single point of contact for all e-mail communications – cwp.ipct.admin@nhs.net
- ✓ IPC link Meetings – held quarterly, with emphasis on outbreak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

North West Ambulance Service

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

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

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



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

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

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

West Midlands Non Emergency Patient Transport

In Hours

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

Out of Hours – Details of transport Services organised by

East Cheshire Trust

Mid Cheshire Hospital NHS Foundation Trust

Mental Health

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

Cheshire Police

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

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

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

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

Safer Streets
Working together for even safer streets in Cheshire

Hollie Guard

Cheshire Constabulary

Cheshire Fire & Rescue Service

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

Cheshire
Fire & Rescue Service

Communications

Strategic Approach for UEC Communications 25/26

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

Cheshire and Merseyside UEC Communications Group
From October 2025, the existing System Pressures Cell will be repurposed into the UEC Communications Group in line with this strategic approach and in response to the UEC Recovery Plan.

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

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

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

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

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

Risks

Risk Title	Risk Description
System Financial Challenges and Savings Targets	Continued temporary funding is resulting in a fragmented system and risk to recruitment as annual shortfall along with ongoing financial savings targets to be delivered across Place.
Covid and Flu Impact	Covid and flu Impact resulting in staff absenteeism within Health and Care with significant impact on the Home Care market. Also patients within the system affecting hospital flow.
Mental Health	(00013) People requiring admission for a Mental Health condition, may have to wait longer than 4 hours in A&E for a Mental Health bed
Staff Health and Wellbeing	There is a risk the emotional impact of working under pressure can impact staff in terms of their resilience and health and wellbeing. This includes the workforce of external providers.
National Living wage Increase	There is a risk Domiciliary care providers loose staff to Health as they are unable to compete in terms of salaries. This will be impacted from 1st April when the National Living Wage increase is applied. There is risk of market failure and provider collapse due to the ongoing financial challenges of the living wage and NI contribution.
International Recruitment	Several providers utilise IR, some with a high % of workforce. Risk of suspension or revocation of licences. The gv't are looking at making overseas recruitment harder which could have an impact on providers workforce and therefore capacity
Reduction in Housing	Insufficient housing stock to adequately meet the population of people being supported across Cheshire East for example, Metal Health, Homelessness, Housing Condition, Special Housing Needs (Adaptations)
D2A Modelling Work	Reduction in Beds
Primary Healthcare	Capacity within Primary Care. No additional funding.

Cheshire East Council
Adult Social Care Winter Plan 2025/2026

Introduction

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

The overall purpose of the Winter plan is to ensure that the system is able to effectively manage the capacity and demand pressures anticipated during the Winter period which this year runs from November 2025 to 31 March 2026.

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

The planning process considers the impact and learning from Winter 2025/25, as well as learning from the system response to Covid-19 to date. Plans have been developed on the basis of robust demand and capacity modelling and system mitigations to address system risk.

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

Adult Social Care Winter Priorities and Responsibilities

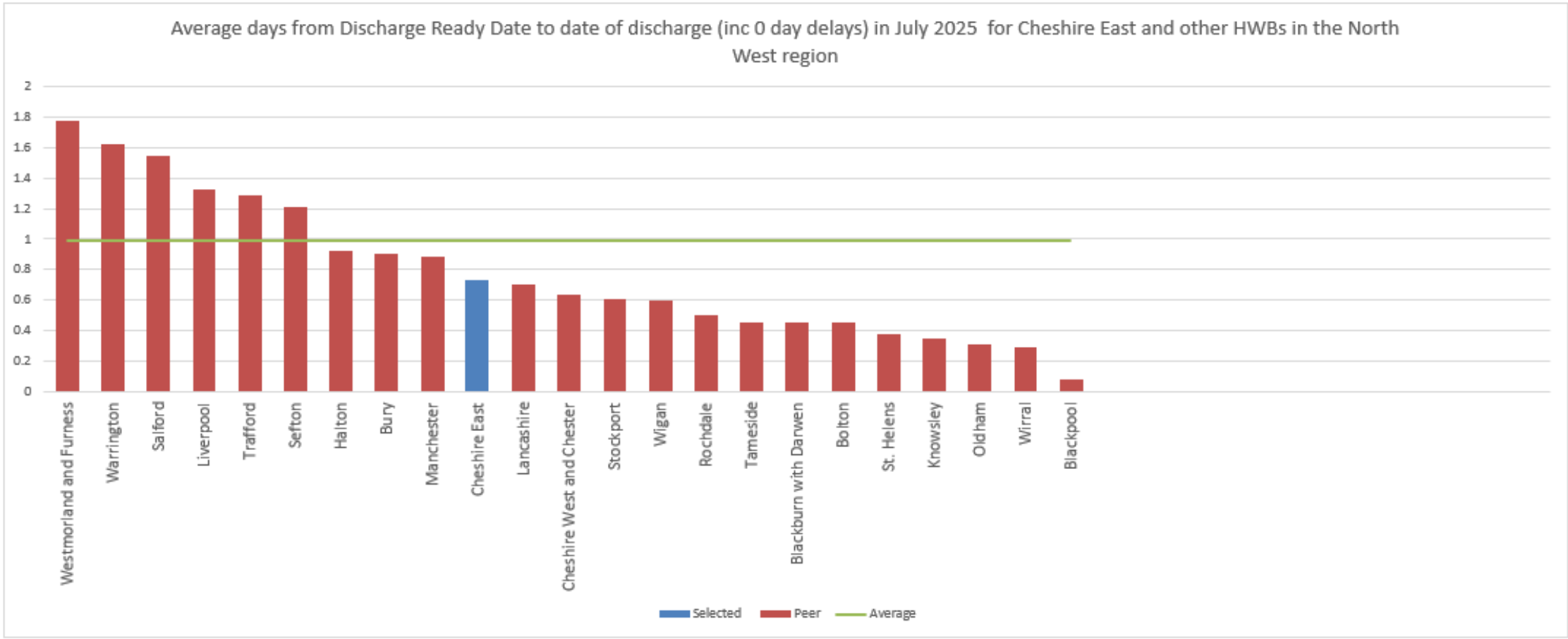
Local Adult Social Care Priorities 2025/26
Workforce Capacity, Market Sustainability and Improvement
Intermediate Care and Discharge from Hospital – including Transfer of Care Hubs (TOCH)
Better Care Fund Capacity and Demand
Unpaid Carers
Public Health and Infection Prevention and Control (IPC)
Energy and Adverse Weather
Reablement and Shared Lives
Mental Health
Governance and Oversight

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

Demand Forecasting

Better Care Fund 2025 - 26

Metrics Report - Charts



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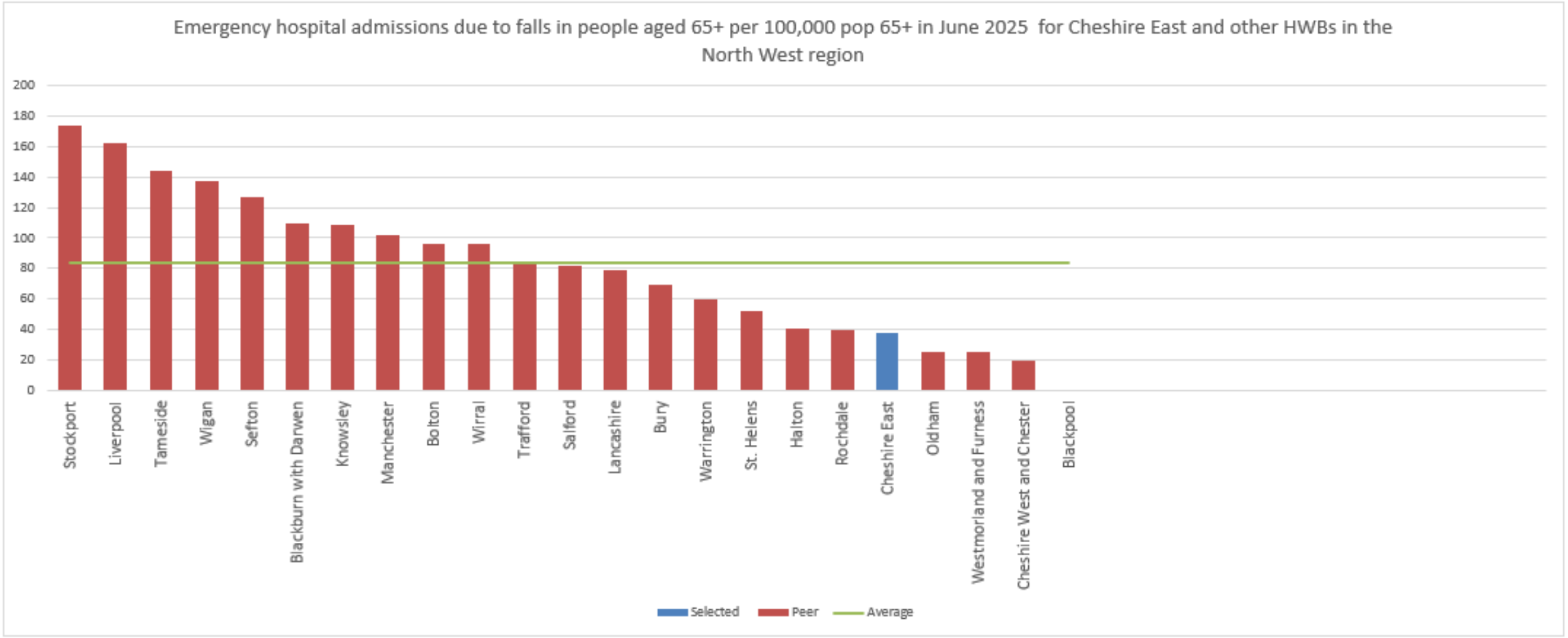

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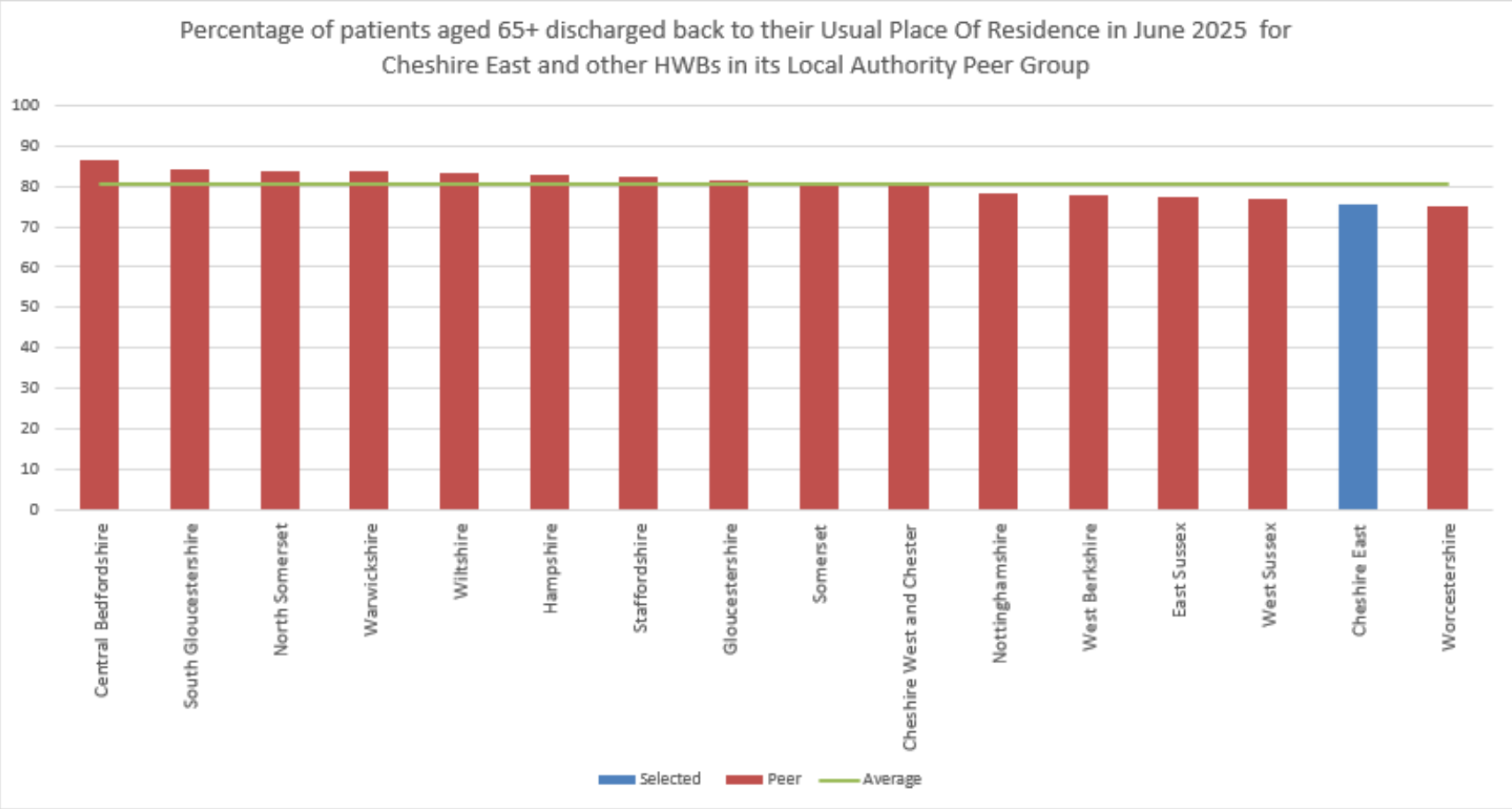

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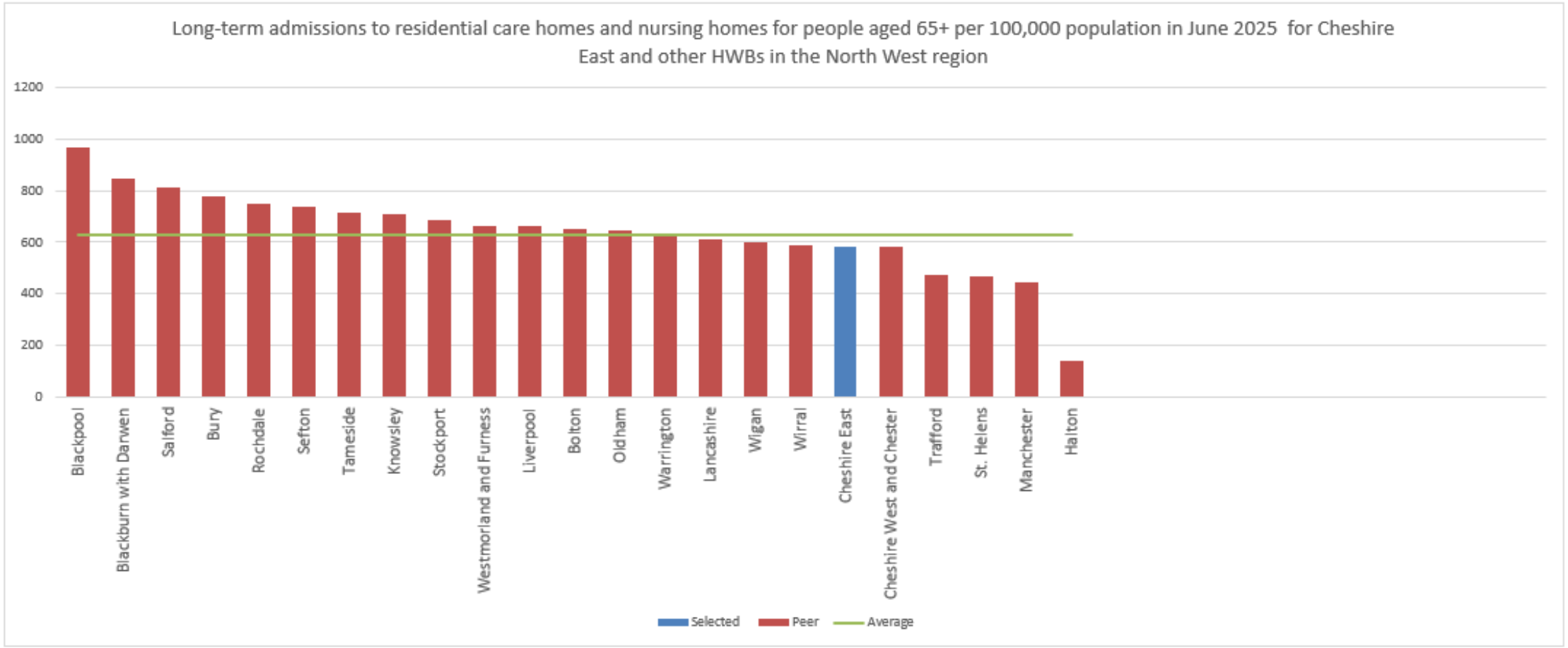

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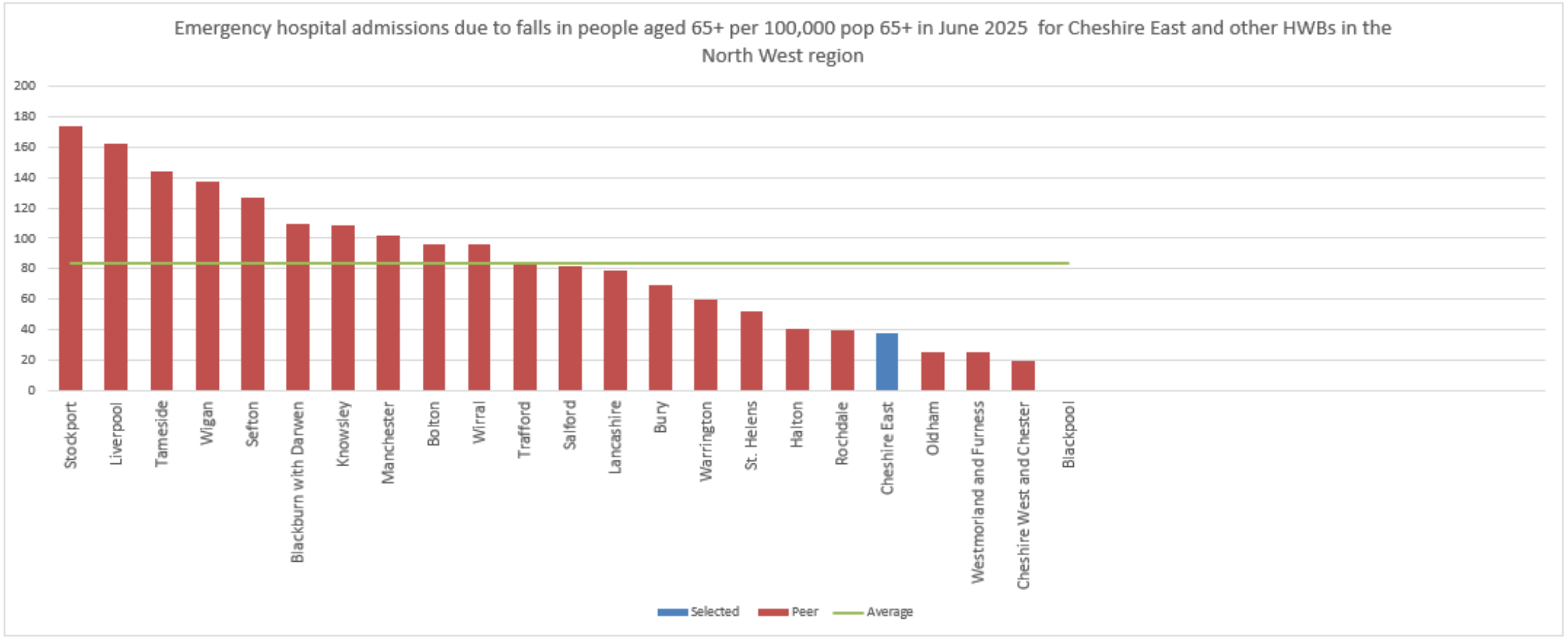


Market Capacity, Sustainability and Improvement

Cheshire East Council

Cheshire and Merseyside

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

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

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

We will also hold:

- Regular and effective contract management meetings with our Adult Social Care providers (ensuring winter plans and contingency plans are in place)
- Targeted contract management and quality assurance input, when risk is identified
- IPC risk management calls
- Provider Forums

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

Cheshire East Council has launched a new recruitment campaign to inspire people to consider a career in adult social care – with the message: 'We need someone like you… to care for someone like you.'

The campaign, entitled 'Someone Like You', features staff and councillors in a short film which captures the compassion, dedication and impact of their work in adult social care.

From helping with meals and medication to offering companionship and dignity, the campaign showcases the everyday acts of kindness that really can make a life-changing difference.

https://www.cheshireeast.gov.uk/council_and_democracy/council_information/media_hub/media_releases/council-launches-'someone-like-you'-adult-social-care-recruitment-campaign.aspx

https://www.cheshireeast.gov.uk/jobs_and_careers/jobs-in-adults-social-care.aspx

Intermediate Care and Discharge from Hospital

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

System Resilience blocked booked beds (formerly referred to as Winter Pressure beds) are in place to aid pressures - 5 blocked booked system resilience beds are available until 31st March 2026.

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

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

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

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

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

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

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

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

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

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

Cheshire East Cluster Model of Care by Hospital Footprint

	Provider	No beds	Bed Type
East Cheshire Trust	Eden Mansions	5	Nursing Dementia
	Henning Hall	4	Nursing
		2	Nursing Dementia
	The Rowans	4	Nursing
	Tabley House	3	Nursing
	Leycester House	6	Residential
	The Willows	4	Nursing
	Prestbury House	6	Nursing/Resi/Dementia
	Cavendish Court	4*	Nursing / Nursing Dementia
	The Belvedere	2*	Nursing / Nursing Dementia
	Aston Ward	27	Rehab
Mid Cheshire Trust	Clarendon Court	8	Nursing/Resi/Dementia
	Telford Court	8	Nursing Dementia
	Station House	10	Nursing D2A
		2	CIB
	Alexandra Mill	4	Nursing/Nursing Dementia
	The Elms	3	Residential SRB
	Turnpike Court	2	Residential Dementia SRB
	Elmhurst	30	Nursing/Nursing Dementia
	Total Beds	134	

Cheshire East Council – Additional Discharge Fund

Better Care Fund – Discharge Fund 2025/26 Winter Plans	
1.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.
2. 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.
3. Mental Health Professionals	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.
4. 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. Social Work Support • Provide social work capacity for a number of settings which includes Station house, Stepping Hill, Leighton Hospital, Macclesfield Hospital. Advice and Signposting • To include supporting with funding pick ups Adult contact team • Support CHC referrals

Cheshire East Council – Additional Discharge Fund

5.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.
6. 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. • 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.
7. 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 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.
8. 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.

Support for Unpaid Carers

Identifying Carers

Carers need to be identified as early as possible to ensure that appropriate support, advice, and information are offered to them. Often carers only seek or are offered support once they reach a crisis point. Early identification can support the carer with the tools, knowledge, and confidence to enable them to manage their caring role, while still having a life of their own and maintaining their own health and wellbeing. Mobilise, has been commissioned until the end of November 2025 to deliver a digital platform for carers across the Cheshire and Merseyside footprint (including Cheshire East), providing free online support and a peer-to-peer community for unpaid carers, enabling carers to access support at any time in a way that works for them. From December 2025 residents will still be able to access several resources on Mobilise digital platform.

From November 2025 commissioners will be commencing an in-depth period of engagement and coproduction to codesign the future carers offer beyond 2026. This will include engaging with a wide of stakeholder's including carers and families, residents, adult social care and health and voluntary and community sector. This will address key challenges and gaps identified in the current offer and strengthen the future service delivery model ensuring it meets the needs of unpaid carers in Cheshire East.

Carer Respite Scheme

Commissioners and adult social care operations are currently developing a revised approach to supporting unpaid carers to take a break, through providing care and support for the cared for in their home to reduce and/or prevent crisis escalating or as a planned carer break.

Support to Carers this Winter

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

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

Carers Strategy 2021-2025

As part of the carers service redesign the Council will be undertaking a refresh of the Carers Strategy in partnership with key stakeholders, including carers. Work to coproduce the refreshed strategy will commence during November 2025.

Support for Unpaid Carers

Commissioned Adult Carer Respite

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

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

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

Bucklow Manor – Residential Respite

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

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

X2 Beds – Bucklow Manor – Residential/ Dementia

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

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

Public Health & Infection Prevention Control

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

- Promote and support the seasonal flu vaccination programme (led by the NHS). The campaign started on 1st September 2025 for pregnant women and eligible children and will be available for all other eligible groups from 1st October 2025. Flu vaccinations will be available until 31st March 2026. In support of this, we're looking at the communications used for the flu programme to help alleviate confusion linked to other vaccinations programmes which run concurrently (e.g. COVID-19, Pneumococcal).

- Cheshire East Council staff flu vaccination programme - free flu vaccines will be available for all staff who wish to have it. This will be via community pharmacies as well as clinics held across corporate buildings (Crewe Municipal, Delamere House, and Macclesfield Town Hall). We have worked with CWaC colleagues to include CWaC pharmacies in a bid to increase accessibility. Staff only need to use their Cheshire East Council ID badge as proof of eligibility. The programme is also extended to Cheshire East maintained schools – staff from these schools can access any of the pharmacies signed up to our service.

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

- Winter messaging will include:
✓ Washing hands (including respiratory hygiene – 'catch it, bin it, kill it'
✓ Sanitising surfaces
✓ Getting seasonal flu and COVID-19 vaccinations
✓ A healthy diet - good nutrition **and** hydration
✓ Antimicrobial Resistance (AMR) – We will be supporting Antimicrobial Awareness Week in November to help with education linked to safe antibiotic use and also the risk of AMR.

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

- Health Improvement colleagues will be supporting 'Keep Warm this Winter' messaging and 'Keep Warm Kits' will be distributed, as per need and vulnerability.

- A series of 'Seasonal Flu' webinars have started being delivered to Care Home and Care4CE colleagues to dispel any misinformation and provide colleagues with flu vaccine facts. The aim is to ensure staff understand the importance of flu vaccination and can make a well-informed decision about receiving their seasonal immunisation.

Infection Prevention Control

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

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

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

Energy and Adverse Weather

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

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

Cheshire East Council Reablement

Community Reablement – Short-term intervention

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

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

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

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

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

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

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

. Supporting the Prevent/Reduce Enable Programme. PRE- is a 72-hour assessment from referrals from First Point of Contact, we look at signposting to other services if required and carry out Reablement if required. Following the assessment recommendations are sent to PRE and they take these on board and if required carry out the Adults needs assessments and send to Brokerage to source packages of care.

Cheshire East Council Reablement

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

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

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

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

Dementia Reablement – Short-term intervention (12 weeks)

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

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

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

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

Cheshire East Council Shared Lives

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

Mental Health

	Mental Health Operational Services Supporting People and the System
1.	Mental Health Floating Support delivered by Making Space, providing support in both the North and South of Cheshire East. This service is has been recommissioned and will build on the successful model which is in place as part of a low-level mental health pathway. -
2.	Complex Needs DPS – A framework containing over 150 providers, which contains providers who can support people with MH Support Needs. Services commissioned under the framework include supported living (including step down provision) and outreach provision. This is currently being reviewed with a new framework to be developed. This has a timeline of go live by 1 April 2027.
3.	Mental Health Rapid Response Reablement funded via the ASC discharge funding supporting facilitated discharge provided by ISL has been extended until 31 March 2026. This along with the Mental Health Floating Support Service and Reablement Service forms part of the low-level mental health pathway. This service is consistently at full capacity (46 hrs per week) and is playing a vital role in providing short term interventions -
4.	3 Mental Health Crisis beds which are located in Crewe, Macclesfield and Congleton delivered by East Cheshire Housing Consortium. These crisis beds support step up/down referrals and are in place until 31 March 2026. A review of crisis beds is underway covering Cheshire West, Cheshire East and Wirral to look at future delivery models.
5.	ISL in reach support to each ED. This is highly effective and provides 1to1 support to people supporting with de-escalation support and 1to1 bespoke support for people. It also offers additional staffing support within each ED. A further £250k has been approved via the BCF for a bespoke model for each hospital ED (Macclesfield and Leighton) from 1 April 2025 to 31 March 2026 proving 8am till 8pm cover 7 days a week. -
7.	Crisis Cafes Crewe and Macclesfield and a pathway has been developed between the domestic abuse service directly to crisis cafes and trained the staff in DA awareness. These contracts are currently in place until March 2026 and CWP (as the contract holder) are looking at conducting a procurement exercise in the near future.
8.	60 DPS Providers currently providing provision

Communities

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

Cheshire East Winter Plan Stress Testing

Cheshire East Winter Plan Stress Testing	
Operational Scenario	**System Mitigation**
Lack of Capacity within General Practice to meet winter demand	Nil planned
Lack of Acute Hospital beds leading to Overcrowding in Emergency Departments	Cancellation of lowest risk Elective procedures to release bed capacity for Urgent Care.
	Enact spot purchasing of Discharge to Assess (D2A) bed capacity across existing D2A cluster model.
	Opening of acute sector G&A beds escalation / winter ward beds (Unfunded)
No Criteria to Reside & Length of Stay (LOS)	Frequent Length of Stay reviews and identified nurses working closely with system partners for all patients who have a prolonged LOS. Staff to expedite discharges to reduce the level of deconditioning.
	Daily MDT calls with system partners to monitor system capacity and flow.
	Senior Leaders system calls
	Care Community Huddle
	Community D2A community meetings to monitor capacity and flow.
	UCR system performance metrics
	Multi Agency Discharge Events (MADE) scheduled every month throughout Winter commencing in September.
	Oversight of people delayed in community beds MADE will take place for those individuals

Cheshire East Winter Plan Stress Testing

Cheshire East Winter Plan Stress Testing	
Mental Health Pressures in ED and bed based place	Effective Mental Health escalation procedures in place that ensures all MDT partners are actively supporting discharge plans for any patient within ED
	Bed management 4 x daily calls via Cheshire & Wirral Partnership Foundation Trust
	ISL In reach model of support in place
	Increased ISL Mental Health Outreach capacity aligned to each ED
	High Intensity User support model being worked up by each Care Community
	Weekly MADE events and Super MADEs
Infection Control (IPC) Outbreak within care homes	Vaccination Programmes Adopt the IPC Risk Assessments protocol that supports early admissions into Care Homes on a risk-based approach
Workforce Challenges	Mutual Aid via system partners and providers
	Agency staff for key roles to support the system and a robust staff induction in place
	Organisational repurposing of staff to support system pressure and emerging risk areas
	Joint working between General Nursing Assistants and Reablement to increase workforce and staff capacity
	Heath and Wellbeing programmes to support staff wellbeing
Winter Schemes Opportunities	Expediate any agreed funded scheme to support with any additional capacity that supports the system
System Communication Strategy	Place comms cell in place with key organisational comms reps
	Tactical coordination of the system comms plan. Trigger points and comms messages procedure in development
	Development of a Cheshire East Resident Winter Wellbeing Booklet to be dispatched promoting self-care options
	Cheshire East Council Communities Team Winter Communications offer

The Commercial Determinants of Health

Joel Hammond-Gant

04/11/25

Enabling prosperity and wellbeing for all

Cheshire East Council

Journey to Date

December 2024

January 2025

Cheshire East Council

NHS Cheshire and Merseyside

CHESHIRE EAST HEALTH AND WELLBEING BOARD
Reports Cover Sheet

Title of Report:	Cheshire East Director of Public Health Annual Report 2024
Report Reference Number:	HWB71
Date of meeting:	21 January 2025

August 2025

Cheshire East Council

Corporate Policy Committee

Agenda

Date:	**Wednesday, 6th August, 2025**
Time:	**5.30 pm**
Venue:	**The Capesthorne Room - Town Hall, Macclesfield SK10 1EA**

Obtained support to take forward and deliver the series of recommendations below:

1. Develop a Cheshire East position statement on CDoH.
2. Explore collaborating and working with C&M partners (and hopefully) work towards a sub-regional position statement on CDoH.
3. Explore enhancing how our planning and licensing powers are used to restrict the presence and influence of unhealthy commodity industries.
4. Work across our health and care system to provide as many residents as possible with healthier ingredients and meals, and reduce reliance on HFFS products and meals.
5. Explore developing and implementing a Health in All Policies approach.

Enabling prosperity and wellbeing for all

Cheshire East Council

The Issue – A Reminder

Commercial actors (industries and businesses) continue to have a greater influence on shaping the way our health and lives are shaped.

We know that there are many health-harming industries that use a very clever and adaptable playbook of tactics to influence our living environments, which foods/drinks we access, and to spend our money on unhealthy commodities like tobacco, alcohol, gambling and vapes.

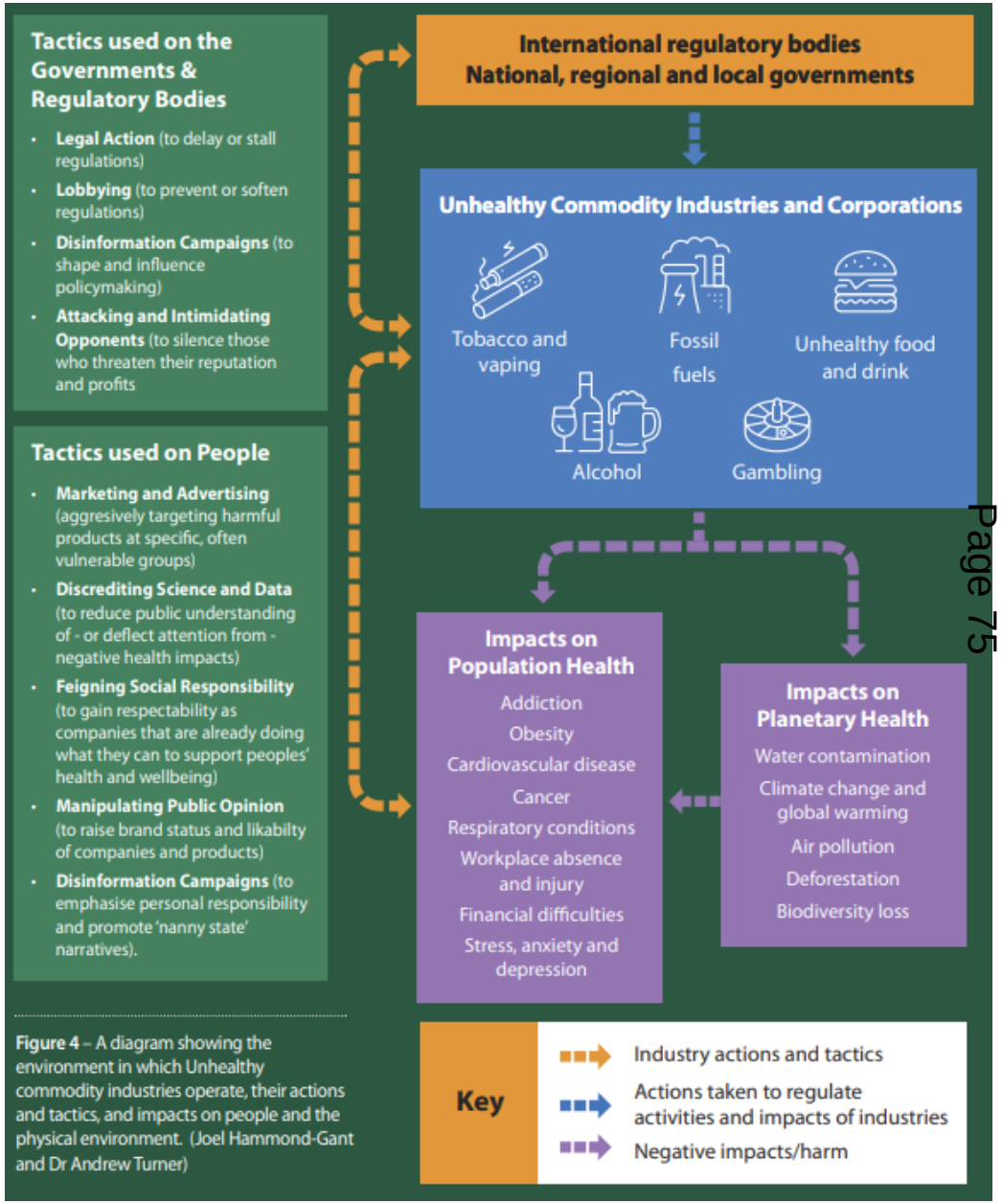


Figure 4 – A diagram showing the environment in which Unhealthy commodity industries operate, their actions and tactics, and impacts on people and the physical environment. (Joel Hammond-Gant and Dr Andrew Turner)

National Context

The most effective way to reduce the influence of unhealthy commodity industries, and the harmful impacts to health they cause, would be through **national changes to legislation and regulations to more effectively govern how these industries and corporations operate**

Policy paper

High stakes: gambling reform for the digital age

Published 27 April 2023

Policy paper

A UK government food strategy for England, considering the wider UK food system

Published 15 July 2025

Policy paper

Licensing taskforce report: government response

Updated 14 August 2025

A pro-growth vision for licensing reform

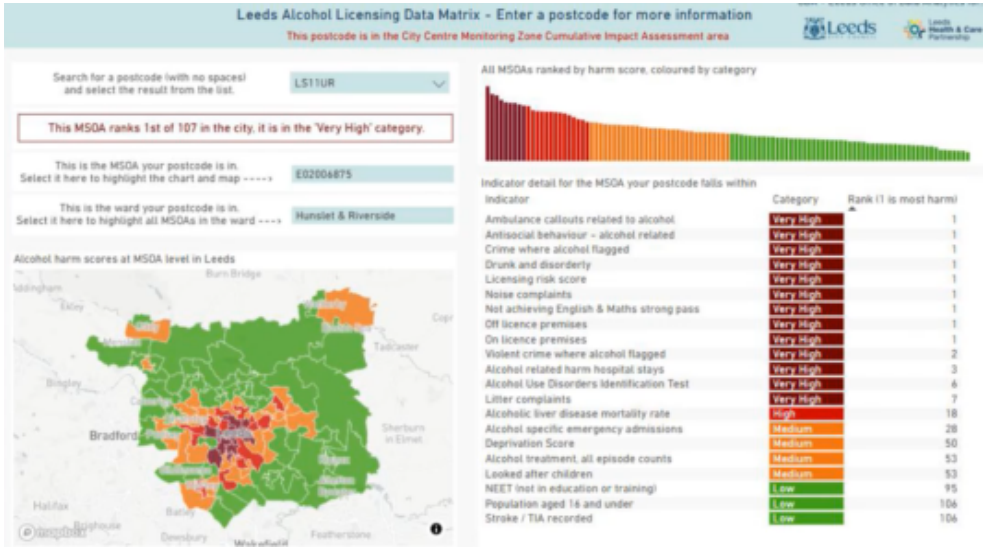
Ministry of Housing, Communities & Local Government

National Planning Policy Framework

December 2024

Enabling prosperity and wellbeing for all

Building on Proven Successes



Cheshire East takes a stand for healthier communities with new advertising policy

24 October 2024

Next Steps

- CDoH Position Statement for Cheshire East Council.
- Linking in with relevant groups in Cheshire and Merseyside and establishing a regional CDoH Group to drive this work forward.
- Continue to work with ADPH on their national project to counteract the negative impacts of health harming industries.
- Work across the council to explore the development and implementation of a Health In All Policies (HIAP) approach.
- Commence discussions with planning and licensing on how we can enhance existing, or implement new, policies/strategies to use our local powers to promote health by reducing the influence of health harming industries.

Cheshire East Council

NHS Cheshire and Merseyside

CHESHIRE EAST HEALTH AND WELLBEING BOARD
Reports Cover Sheet

Title of Report:	Better Care Fund Quarter One Update 2025/26
Report Reference Number	HWB 90
Date of meeting:	04/11/2026
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 as part of monitoring arrangements for the Better Care Fund. The health and wellbeing board is asked to note quarter one performance for the period April-June 2025.		
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 note the Better Care Fund quarter one update 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 quarter one submission for 2025/26, it includes an update on finances and performance for the period: April-June 2025.

2 Recommendations

2.1 That the HWB note the Better Care Fund quarter one update 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

5.39 BCF finances

The Quarter one position on income and expenditure notes that the planned income is the same position noted in the BCF plan set in March 2025. The actual expenditure for the period April-June is £9,148,324 which is 18% of planned income for this period. The narrative included within the submission notes that monthly highlight reports for the BCF schemes are collected this includes updates on actual expenditure.

5. Income & Expenditure

Selected Health and Wellbeing Board:	Cheshire East

	2025-26		
Source of Funding	Planned Income	Updated Total Plan Income for 25-26	Q1 Year-to-Date Actual Expenditure
DFG	£2,906,341	£2,906,341	£9,148,324
Minimum NHS Contribution	£35,754,872	£35,754,872	
Local Authority Better Care Grant	£10,740,119	£10,740,119	
Additional LA Contribution	£550,000	£550,000	
Additional NHS Contribution	£182,860	£182,860	
Total	**£50,134,192**	**£50,134,192**	

	Original	Updated	% variance
Planned Expenditure	**£50,134,192**	£50,134,192	**0%**

		% of Planned Income
Q1 Year-to-Date Actual Expenditure	£9,148,324	**18%**

If Q1 Year-to-Date Actual Expenditure is exactly 25% of planned income, please provide some context around how accurate this figure is or whether there are limitations.	Monthly highlight reports are collected for schemes this includes an update on actual expenditure for the month.

If planned expenditure by activity has changed since the original plan, please confirm that this has been agreed by local partners. If that change in activity expenditure is greater than 5% of total BCF expenditure, please use this box to provide a brief summary of the change.	There have been some minor changes to the plan to reflect the liklihood of scheme implementation.

5.40 BCF schemes

The schemes included in the BCF plan for 2025-26 were as follows:

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 and	Reablement	6. Reducing the need for long term residential care	Social Care	Local Authority	NHS Minimum Contribution	£ 5,792,797
2	Assistive technologies and equipment	Supporting care homes	2. Home adaptations and tech	Social Care	Local Authority	NHS Minimum Contribution	£ 107,159
3	Housing related schemes	AT & Community equipment & Handy person	2. Home adaptations and tech	Social Care	Local Authority	NHS Minimum Contribution	£ 934,000
4	Other	NEW business case gateway (£40k), system winter plan (£500k), falls prevention	4. Preventing unnecessary hospital admissions	Social Care	Local Authority	NHS Minimum Contribution	£ 715,000
5	Support to carers, including unpaid carers	Carers	3. Supporting unpaid carers	Social Care	Local Authority	NHS Minimum Contribution	£ 713,000
6	Wider local support to promote prevention and independence	Proportionate care	1. Proactive care to those with complex needs	Social Care	Local Authority	NHS Minimum Contribution	£ 135,000
7	Home-based intermediate care (short-term home-based rehabilitation, reablement and	British red cross	5. Timely discharge from hospital	Social Care	Local Authority	NHS Minimum Contribution	£ 636,651
8	Home-based intermediate care (short-term home-based rehabilitation, reablement and	GNA	5. Timely discharge from hospital	Social Care	NHS Acute Provider	NHS Minimum Contribution	£ 565,981
9	Bed-based intermediate care (short-term bed-based rehabilitation, reablement and	Beds short and long term	5. Timely discharge from hospital	Other	Local Authority	NHS Minimum Contribution	£ 1,200,000
10	Wider local support to promote prevention and independence	Mental health support	1. Proactive care to those with complex needs	Other	Private Sector	NHS Minimum Contribution	£ 361,690
11	Wider local support to promote prevention and independence	Mental health professionals	1. Proactive care to those with complex needs	Other	NHS Acute Provider	NHS Minimum Contribution	£ 82,841
12	Discharge support and infrastructure	Social workers	5. Timely discharge from hospital	Other	Local Authority	NHS Minimum Contribution	£ 246,000
13	Discharge support and infrastructure	Transfer of care hub	5. Timely discharge from hospital	Other	NHS Acute Provider	NHS Minimum Contribution	£ 300,000
14	Discharge support and infrastructure	Occupational therapists	5. Timely discharge from hospital	Other	NHS Acute Provider	NHS Minimum Contribution	£ 126,000
15	Wider local support to promote prevention and independence	Care - communities	1. Proactive care to those with complex needs	Other	NHS	NHS Minimum Contribution	£ 494,636
16	Wider local support to promote prevention and independence	Volunteers	4. Preventing unnecessary hospital admissions	Other	Charity / Voluntary Sector	NHS Minimum Contribution	£ 486,576
17	Home-based intermediate care (short-term home-based rehabilitation, reablement and	Homefirst	5. Timely discharge from hospital	Community Health	NHS Acute Provider	NHS Minimum Contribution	£ 20,611,862
18	Housing related schemes	Communtiy equipment	2. Home adaptations and tech	Social Care	Local Authority	Additional LA Contribution	£ 550,000
19	Other	Grants	4. Preventing unnecessary hospital admissions	Social Care	Charity / Voluntary Sector	Additional NHS Contribution	£ 182,860
20	Evaluation and enabling integration	Programme management	1. Proactive care to those with complex needs	Social Care	Local Authority	Local Authority Better Care Grant	£ 246,000
21	Other	Social workers	1. Proactive care to those with complex needs	Social Care	Local Authority	Local Authority Better Care Grant	£ 1,046,179
22	Short-term home-based social care (excluding rehabilitation, reablement or	Care at home	1. Proactive care to those with complex needs	Social Care	Local Authority	Local Authority Better Care Grant	£ 8,101,274
23	Discharge support and infrastructure	Care sourcing	5. Timely discharge from hospital	Social Care	Local Authority	Local Authority Better Care Grant	£ 870,000
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	£ 2,245,679
26	Short-term home-based social care (excluding rehabilitation, reablement or	Right at home	5. Timely discharge from hospital	Community Health	Local Authority	Local Authority Better Care Grant	**£ 476,666**

5.41 BCF metric targets

The quarterly update for the national better care team includes the following metrics:

- Emergency admissions - emergency admissions to hospital for people aged 65+ per 100,000 population. Data for the period April-June 2025 shows that the performance is on-track for this metric.
- Discharge delays - 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). Data for the period April-June 2025 shows that the performance is on-track for this metric.
- Residential admissions - residential admissions – long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population. Data for this metric for the period April-June 2025 shows that this is below the planned figure which shows that performance is on-track.

4.1 Emergency admissions

Actuals + Original Plan		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
Emergency admissions to hospital for people aged 65+ per 100,000 population	Rate	1,492.5	1,524.8	1,470.9	1,465.5	1,497.9	1,379.3	1,519.4	1,535.6	1,578.7	1,514.0	1,352.4	1,476.3
	Number of Admissions 65+	1,385	1,415	1,365	1,360	1,390	1,280	1,410	1,425	1,465	1,405	1,255	1,370
	Population of 65+*	92,798.0	92,798.0	92,798.0	92,798.0	92,798.0	92,798.0	92,798.0	92,798.0	92,798.0	92,798.0	92,798.0	92,798.0
		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	1,487.5	1,487.2	1,487.0	1,486.7	1,486.5	1,486.2	1,485.9	1,485.7	1,485.4	1,485.2	1,484.9	1,484.7
	Number of Admissions 65+	1,380	1,380	1,380	1,380	1,379	1,379	1,379	1,379	1,378	1,378	1,378	1,378
	Population of 65+	92,798.0	92,798.0	92,798.0	92,798.0	92,798.0	92,798.0	92,798.0	92,798.0	92,798.0	92,798.0	92,798.0	92,798.0

Updated Plan	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	What is the rationale behind the change in plan?
Rate	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	
Number of Admissions 65+													
Population of 65+	92,798.0	92,798.0	92,798.0	92,798.0	92,798.0	92,798.0	92,798.0	92,798.0	92,798.0	92,798.0	92,798.0	92,798.0	

Assessment of whether goal has been met:	On track to meet goal
If a goal has not been met please provide a short explanation, including noting any key mitigating actions.	The data for this metric shows for April 2025 this is currently 1470 per 100,000 population which is on track.
You can also use this box to provide a very brief explanation of overall progress if you wish.	Not applicable.

4.2 Discharge Delays

Actuals	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
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	0.57	0.48	0.68	0.60
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%	93.2%	93.8%	91.0%	91.8%
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	7.05	10.04	6.19	8.29	7.72	7.52	7.24

Original Plan	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	0.65	0.65	0.65	0.65	0.65	0.65	0.65	0.65	0.65	0.65	0.65	0.65
Proportion of adult patients discharged from acute hospitals on their discharge ready date	92.2%	92.2%	92.2%	92.2%	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	8.29	8.29	8.29	8.29	8.29	8.29	8.29	8.29	8.29	8.29	8.29	8.29

Assessment of whether goal has been met:	On track to meet goal
If a goal has not been met please provide a short explanation, including noting any key mitigating actions.	In April 2025 Cheshire East had 91% where date of discharge is the same as discharge ready date for residents of Cheshire East.
You can also use this box to provide a very brief explanation of overall progress if you wish.	Not applicable.

4.3 Residential Admissions

Actuals + Original Plan		2023-24 Full Year Actual	2024-25 Full Year CLD Actual	2025-26 Plan Q1 (April 25-June 25)	2025-26 Plan Q2 (July 25-Sept 25)	2025-26 Plan Q3 (Oct 25-Dec 25)	2025-26 Plan Q4 (Jan 26-Mar 26)
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	573.3	172.4	172.4	161.6	169.2
	Number of admissions	631.0	532.0	160.0	160.0	150.0	157.0
	Population of 65+*	92798.0	92798.0	92798.0	92798.0	92798.0	92798.0

Updated Plan		2025-26 Plan Q1 (April 25-June 25)	2025-26 Plan Q2 (July 25-Sept 25)	2025-26 Plan Q3 (Oct 25-Dec 25)	2025-26 Plan Q4 (Jan 26-Mar 26)	What is the rationale behind the change in plan?
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	172.4	172.4	161.6	169.2	Not applicable
	Number of admissions	160.0	160.0	150.0	157.0	
	Population of 65+*	92798.0	92798.0	92798.0	92798.0	

Assessment of whether goal has been met:	On track to meet goal
If a goal has not been met please provide a short explanation, including noting any key mitigating actions.	The admissions for June 2025 (cumulative) shows 13 placements below the planned number. The latest actuals are estimated t
You can also use this box to provide a very brief explanation of overall progress if you wish.	Not applicable.

Summary of progress during quarter one

- Better Care Fund Plan 2025-26
  - Narrative plan produced and submitted.
  - Finance and performance plan produced and submitted.

- Better Care Fund Section 75 agreement
  - Better Care Fund main agreement reviewed and refreshed.
  - Service schedules reviewed and refreshed.
  - Officer Decision Record produced and signed-off.

- Better Care Fund performance
  - Highlight reports collected on a monthly basis and discussed at Better Care Fund Governance Group.
  - Local reporting information collected on scheme performance.
  - Local reporting information on BCF metrics collected.
  - Return on investment information collected for each scheme / Cost avoidance information produced for the programme.

- Better Care Fund finance
  - Finance sub-group meetings held.
  - Income and expenditure of scheme performance and programme performance reviewed.

- Discharge to assess project

  Aims and objectives
  Review discharge to assess beds, services that supported flow as well as wrap around and finally alternative services to support people closer to home.
  For the services in scope establish:
  - Costs – per user/bed and total cost
  - Utilisation
  - Length of stay
  - Outcomes

  Provide place leaders with recommendations for the services in scope namely the discharge to assess beds.
  Discharge to assess review Nov 2024:
  Discharge to assess beds were reviewed in Now 2024, the review included:

- Audit the community Reablement offer aligned to each hospital that supports people being discharged between 01/04/2024 – 31/10/2024.
- Verification of the actual numbers of D2A beds aligned to each hospital footprint as of today's date (01/11/2024).
- Refresh the current demand and capacity figures that were originally submitted by Trust colleagues as part of the D2A analysis.
- Review the use and purpose of the 5 system resilience beds aligned to the Mid Cheshire footprint.

Discharge to assess review Aug 2025:

- Place leaders requested an up-to-date review to consider:
- Discharge to assess beds (Aston and Elmhurst), services that supported flow as well as wrap around and finally alternative services to support people closer to home.
- Service costs, the number of people supported and outcomes where appropriate.
- Recommendations have been included.

- Winter plan

  - Contribution to winter planning

  - 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.

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

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

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

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

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.

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