Cheshire East Place System Winter Plan 2025/2026

Version 3: 07/10/2025

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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

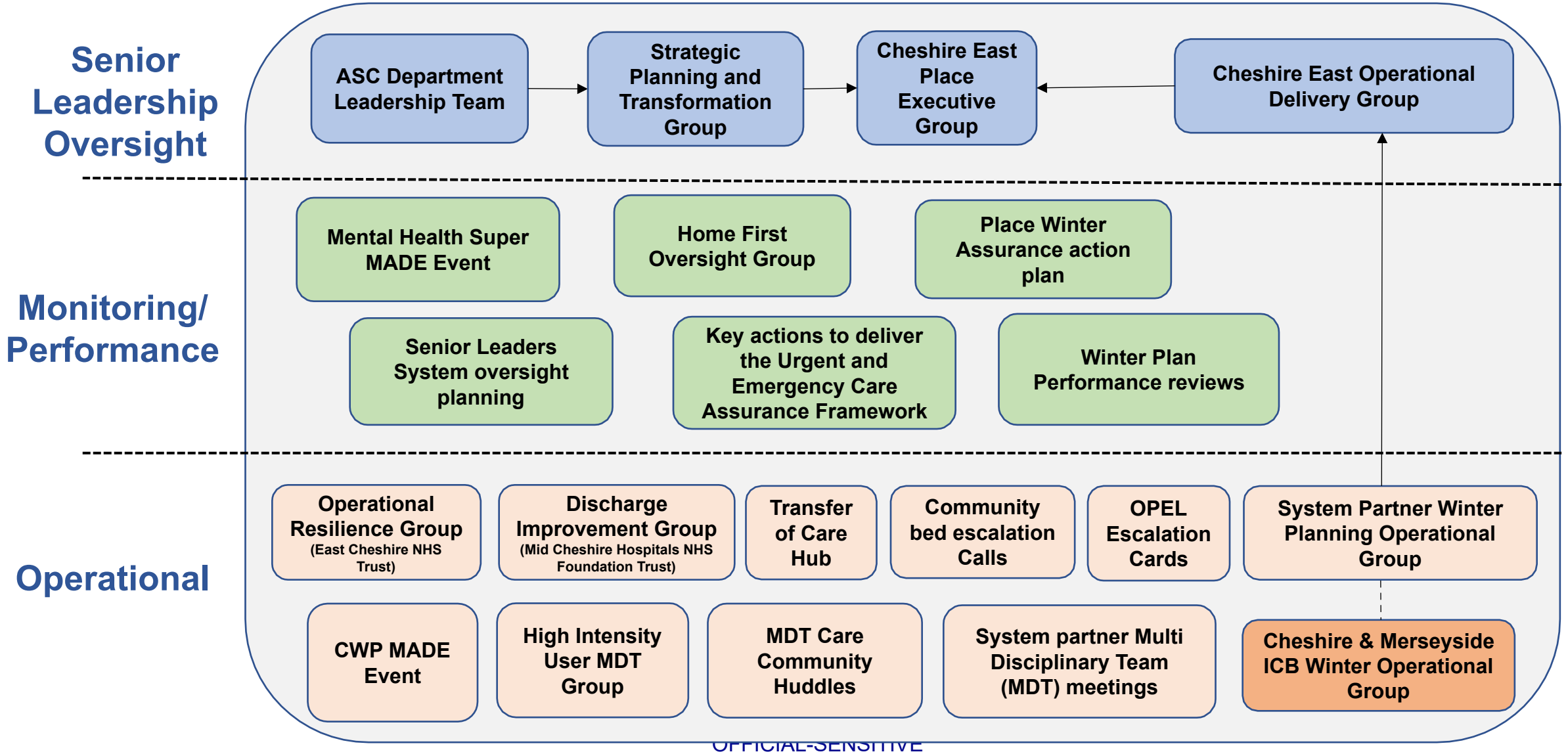
Ambition for Winter 2025/26 UEC Metrics

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.

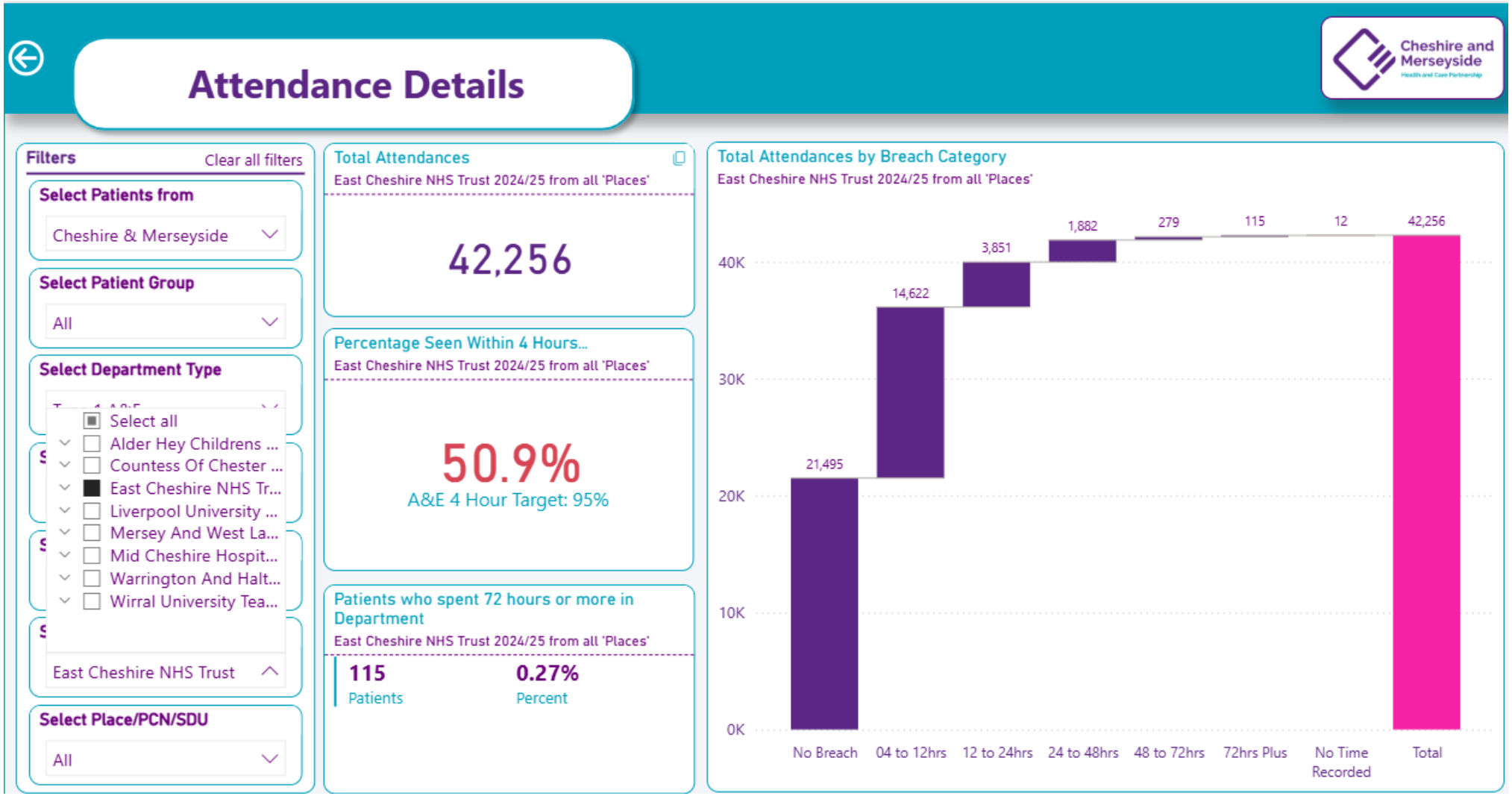
Monitoring, Oversight and Governance Structure

NHS
Cheshire and Merseyside



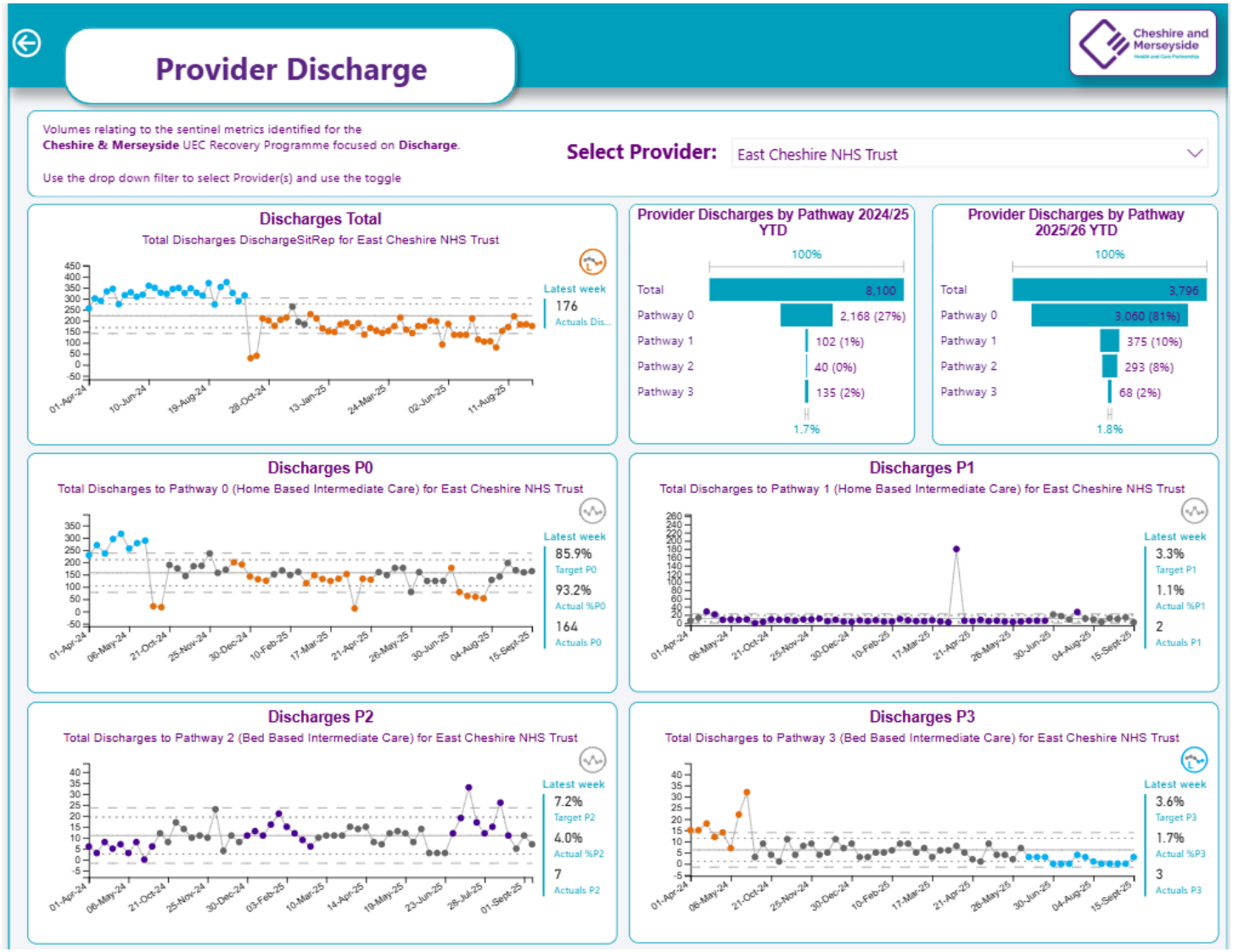
Attendance Details

East Cheshire Trust - ED



Data Source: ECDS & SUS inpatients

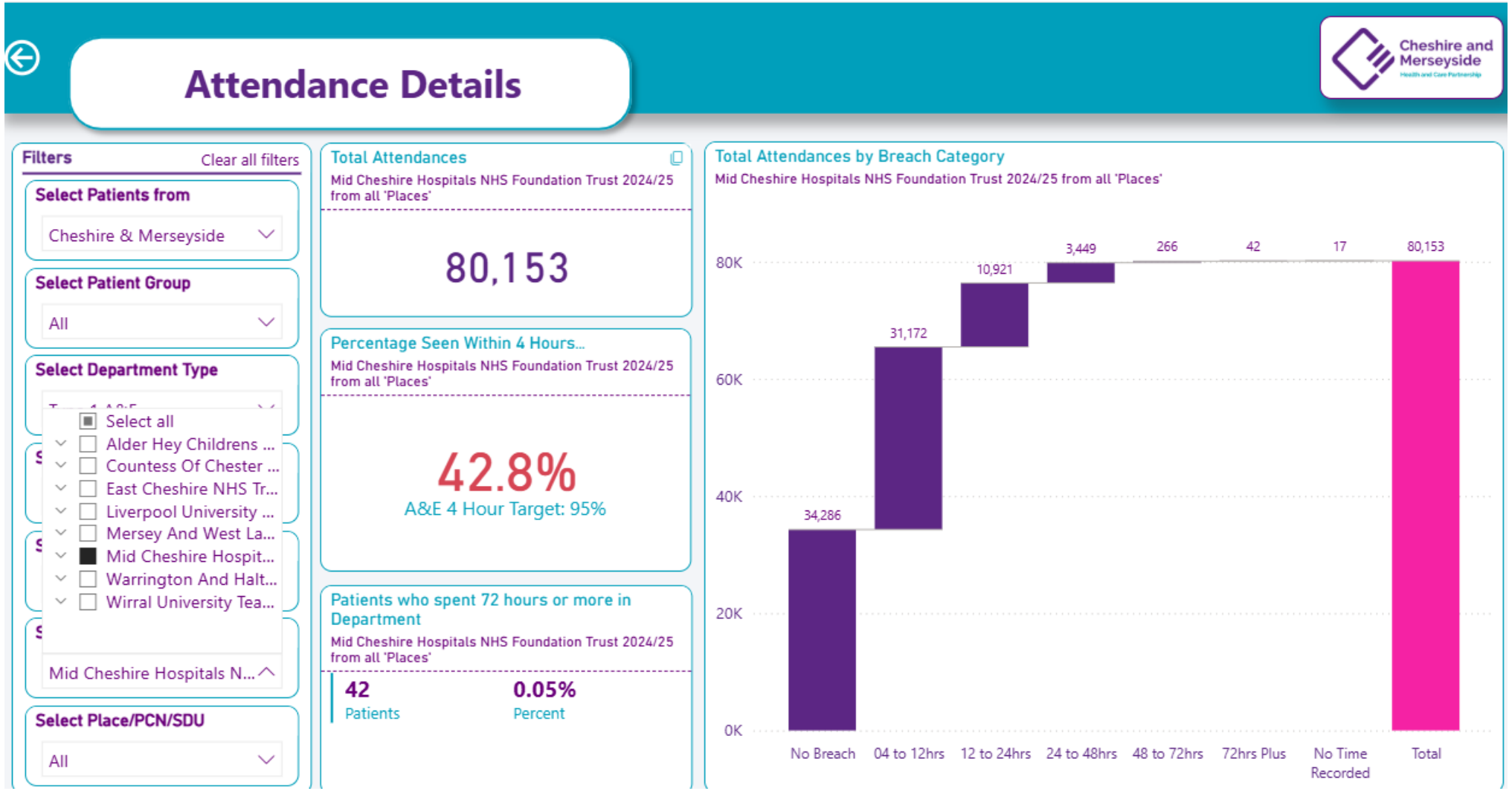
East Cheshire NHS Trust – Discharges



Data Source: ECDS & SUS inpatients

Attendance Details

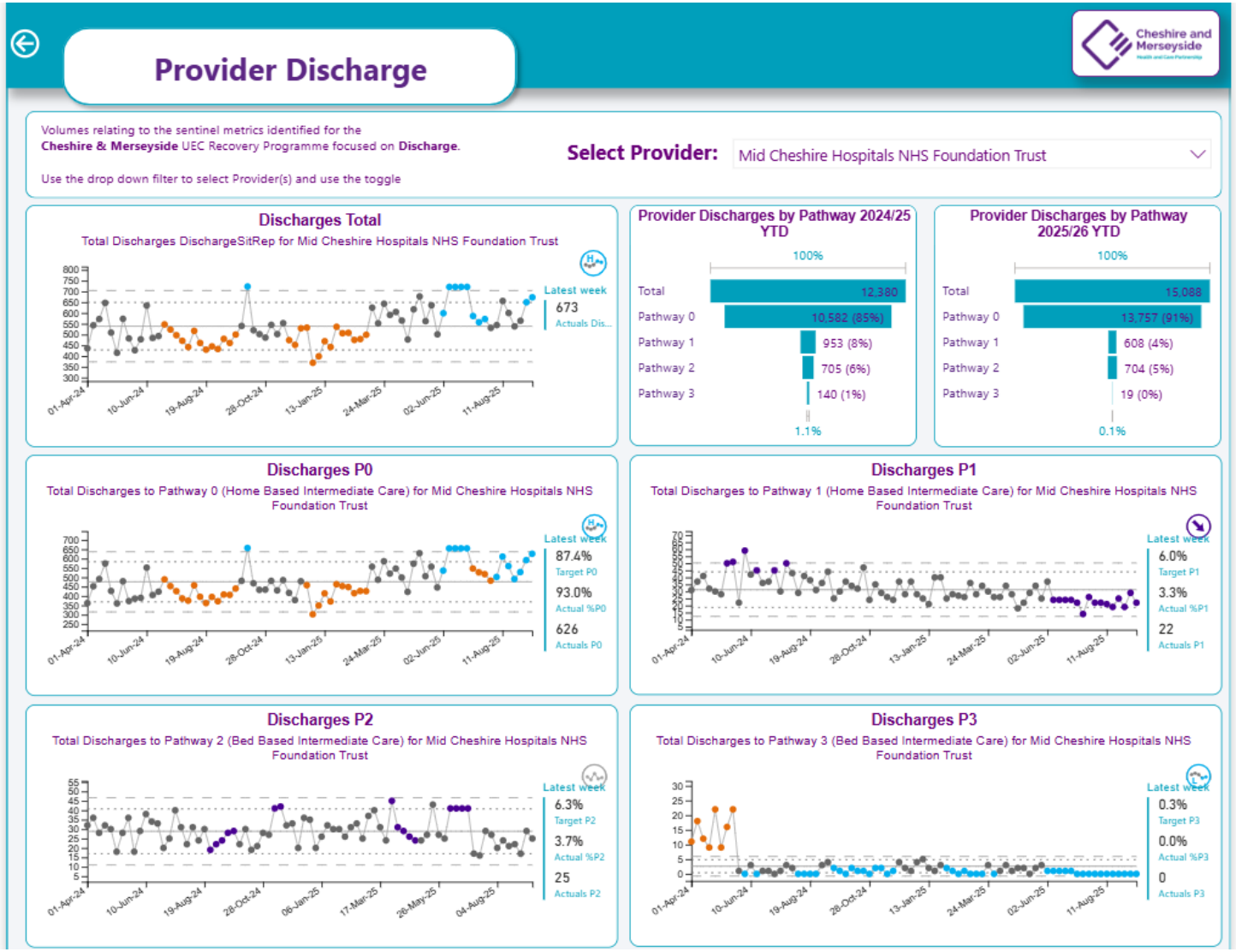
Mid Cheshire Hospitals Foundation Trust - ED



Data Source: ICB UEC Recovery Dashboard

Demand Forecasting

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.

Safer Streets
Working together for even safer streets in Cheshire

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

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

Hollie Guard

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

Cheshire Constabulary

Cheshire Fire & Rescue Service

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

Cheshire
Fire & Rescue Service

Communications

Strategic Approach for UEC Communications 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

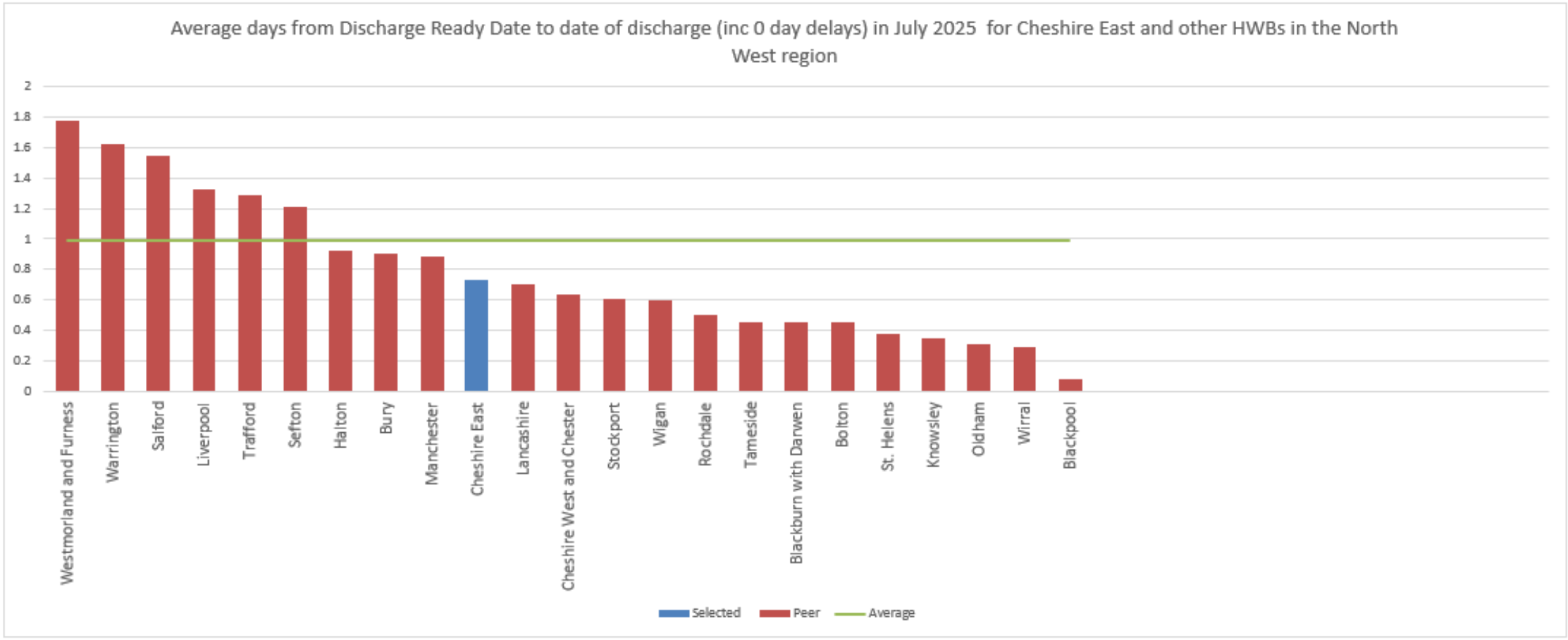
Local Adult Social Care Priorities 2025/26
Workforce Capacity, Market Sustainability and Improvement
Intermediate Care and Discharge from Hospital – including Transfer of Care Hubs (TOCH)
Better Care Fund Capacity and Demand
Unpaid Carers
Public Health and Infection Prevention and Control (IPC)
Energy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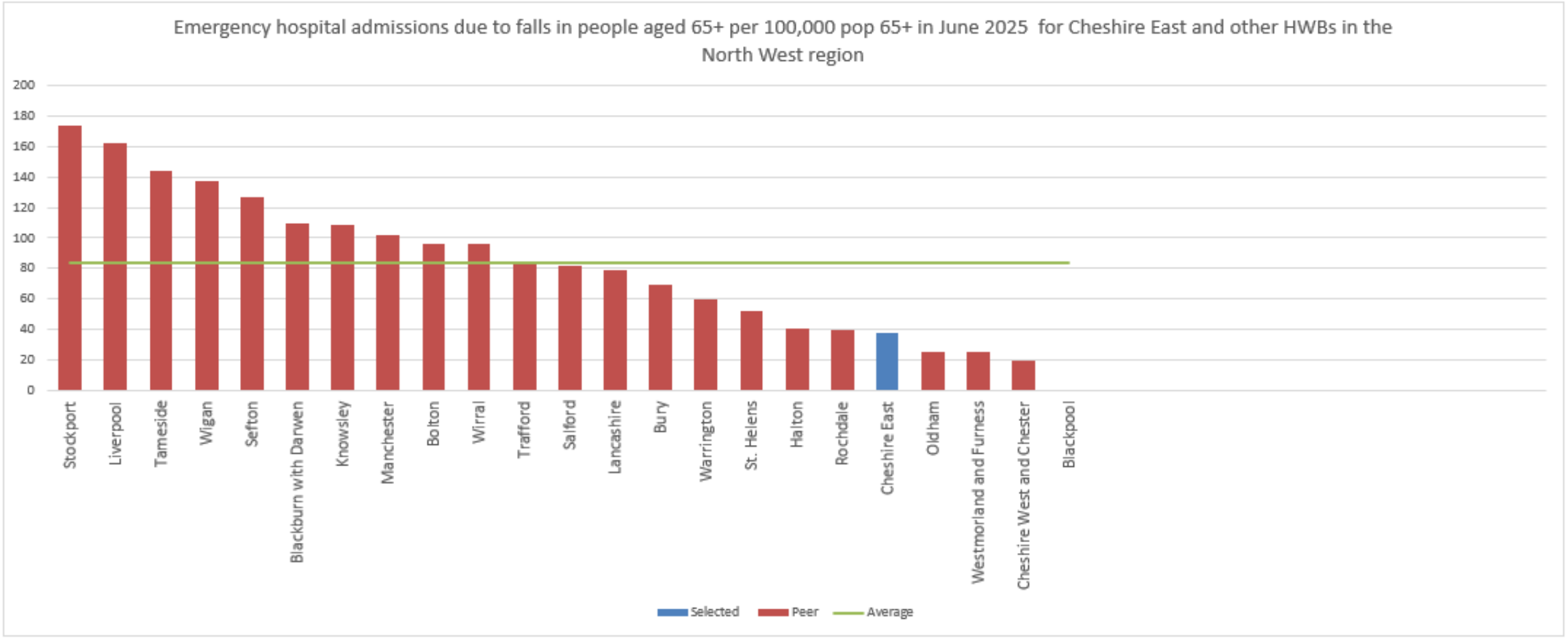

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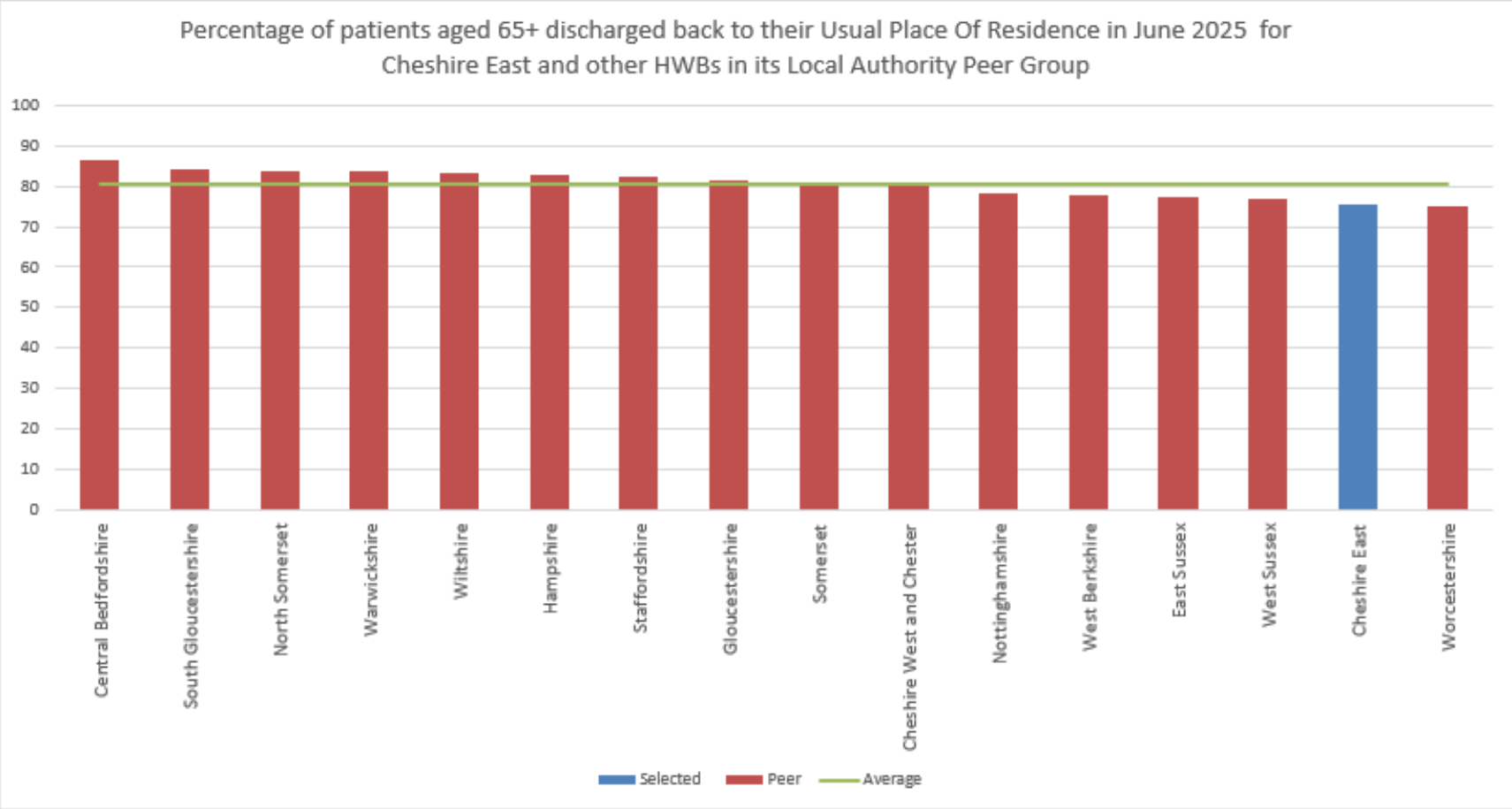

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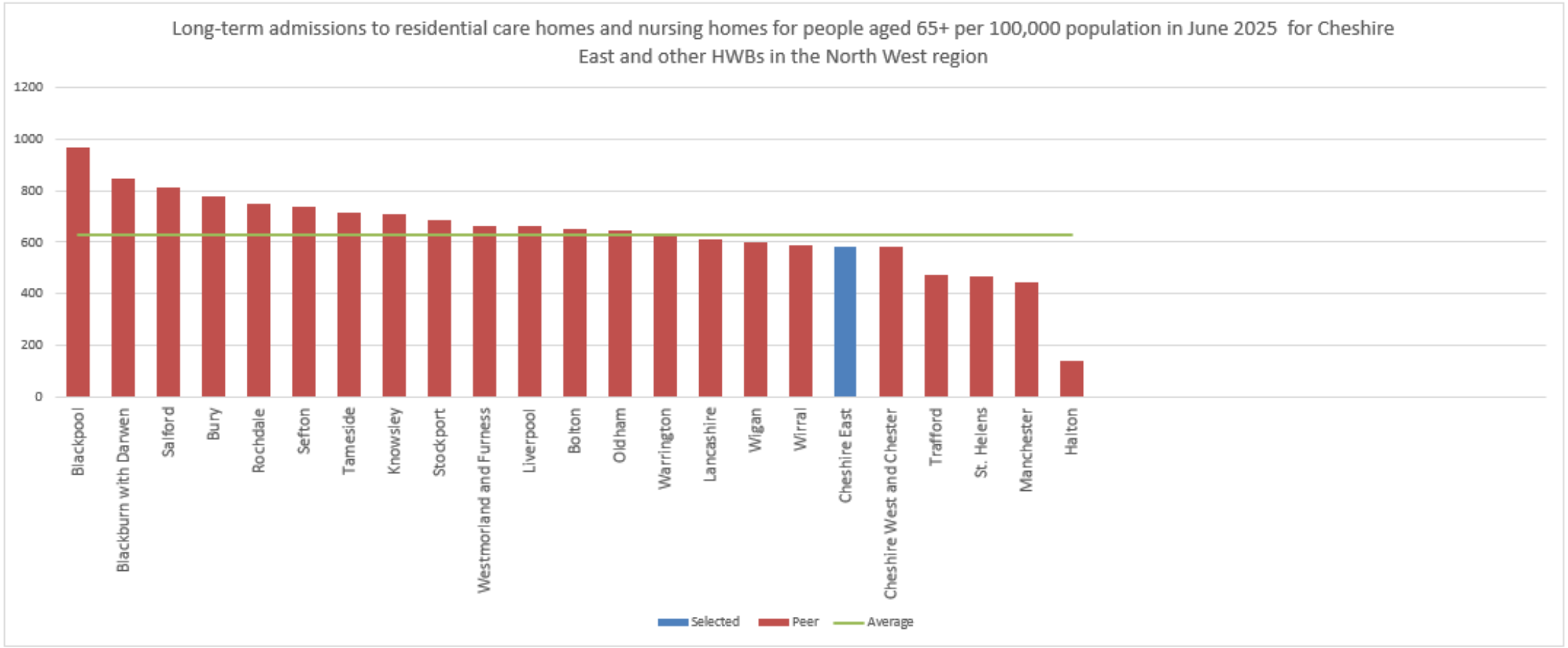

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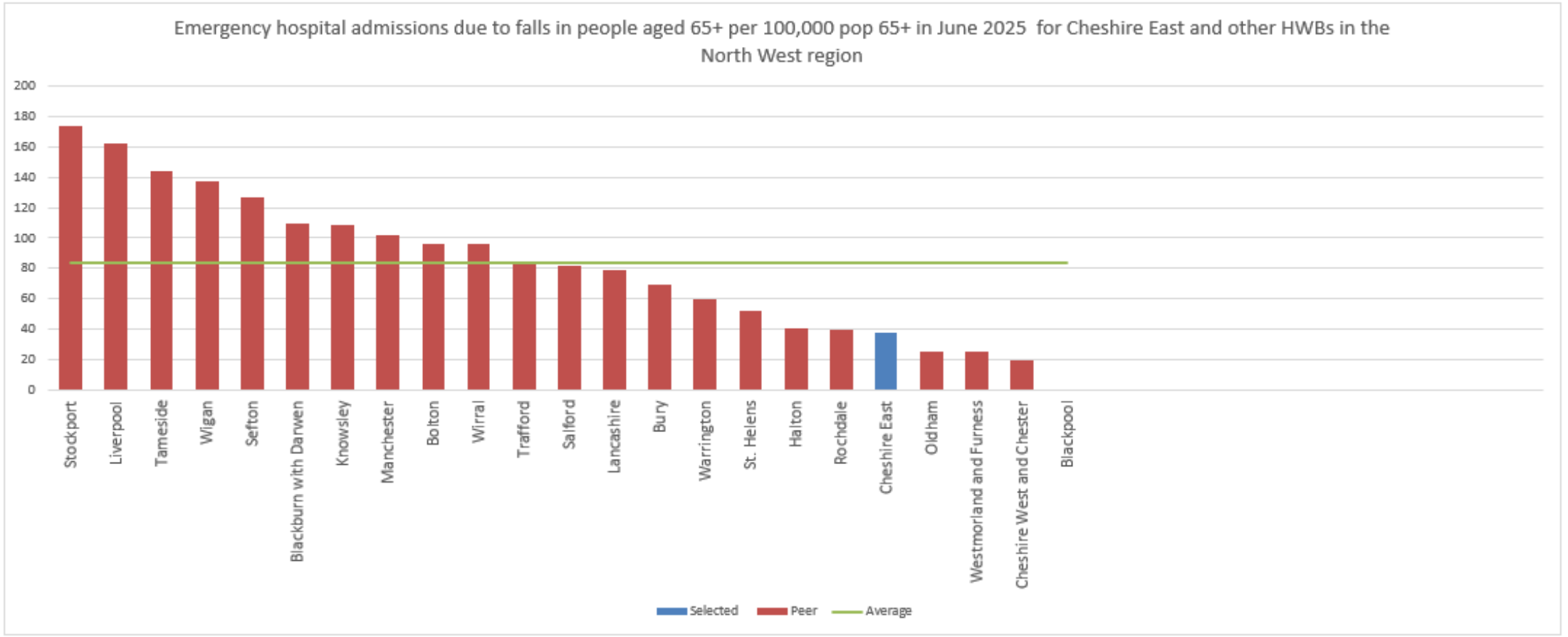

Market Capacity, Sustainability and Improvement

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