NHS
North East and
North Cumbria

NENC ICS Winter Plan 2025/26

DRAFT

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Better health
and wellbeing for all...

NENC ICS Winter Plan 2025/26

This report outlines the system Winter Plan for 2025/26 including an overview of the process that has been followed and the key priorities that have been identified. This is for approval by Executive Committee Members.

Contents

1. Winter Planning Process 2025/26

1.1 NENC Winter Preparedness

Preparing for winter has been identified as a key organisational priority of NENC ICB for 2025/26. We know that the current performance of urgent and emergency care (UEC) services does not meet the standards our patients need or our frontline staff want to deliver. Nationally it has been over 5 years since the 18-minute response to Category 2 ambulance calls standard was met, and over a decade since the service delivered the standard for 95% of patients waiting 4 hours or less in A&E. As a result, our public and patients continue to feel the impact of poor UEC delivery and satisfaction with the NHS and A&E services have deteriorated even further and are declining at a faster rate than before. In addition to this, the burnout that frontline staff feel is clear and we must do everything we can to significantly improve UEC services this winter compared to what our patients and staff have experienced in recent years.

The aim of the NENC ICS from the outset has been to develop a whole-system approach to the winter planning process, which can successfully deliver safe and effective patient care across our complex, multi-agency UEC system. We are building on from a strong platform, with comparatively strong performance across the key UEC metrics in our area, however there is still more we can and should be doing to improve. We also have a history of strong system and clinical leadership in NENC, supported by well-established and functioning local governance structures (Local A&E Delivery Boards – LAEDBs) overseen by the **NENC Urgent and Emergency Care Network**, working together to deliver the network's vision of providing safe, effective, quality and equitable healthcare to our whole population. We will do this by reducing unwarranted variation and improving the quality, safety and equity of urgent and emergency care provision by bringing together all stakeholders to radically transform the system at scale and pace.

The NENC ICS winter plan reflects national UEC requirements and is underpinned by an extensive programme of work to deliver improvements across urgent and emergency care that are currently in the process of being implemented. This plan, along with our NENC primary care and elective recovery plans, and the broader strategic and operational plans and priorities for the NHS, provides a firm basis for preparing for the 2025/26 winter period.

Whilst our partners across the ICS are undertaking significant programmes of work to recover and improve services there is a collective responsibility to ensure that all parts of our system have robust plans in place to remain as resilient as possible and maintaining the ability to respond to operational pressures over what is sure to be another challenging winter period.

1.2 Learning from last winter – 2024/25 Winter Debrief

The **NENC 2024/25 Winter Debrief** was held on 9th May 2025 and was attended by (approx. 120) delegates from across the ICS. The purpose of the event was to bring partners from across the UEC system together to review our collective response to the 2024/25 winter period, identify the specific pressures experienced and how these were managed across the system, identify areas of good practice and opportunities for shared learning, and to begin to identify our system priorities for winter 2025/26.

The system co-ordination centre (SCC) and LAEDBs provided reflections on those things that went well, what didn't go well, any gaps that were identified in our winter planning, and the lessons learned that have been used to inform our approach to winter planning in 2025/26.

The insights shared throughout the winter debrief confirmed the need for a proactive process, starting as early as possible, to develop a resilient winter plan for 2025/26. Challenges were acknowledged and successes were celebrated with all parties committed to learning from each other in the spirit of collaboration and being the best at getting better. It was clearly articulated and agreed by all that the focus must remain on patient safety, system-wide collaboration, and risk-based planning, and that our plans must be deliverable, accountable, and impactful.

Colleagues from across the wider system also came together on 14th May for the first **NENC ICS Elective and UEC Spring Conference.** This session heard from national, regional, and local leaders with compelling insights on regional performance, the power of collaboration, and the opportunities to use the Getting It Right First Time (GIRFT) approach to drive clinical improvement across elective and UEC services.

1.3 National Guidance – UEC Plan 2025/26

On 6th June 2025 NHS England (NHSE) and the Department of Health and Social Care (DHSC) published the **Urgent and emergency care plan for 2025/26** which set out the things we can and must do now to ensure our patients receive a better service this coming winter. The plan identified 7 priorities that will have the biggest impact on UEC improvement this coming winter. As a minimum these are:

- patients who are categorised as Category 2 – such as those with a stroke, heart attack, sepsis or major trauma – receive an ambulance **within 30 minutes**
- eradicating last winter's lengthy ambulance handover delays to a maximum handover time of **45 minutes**
- a **minimum of 78%** of patients who attend an A&E to be admitted, transferred or discharged within 4 hours
- reducing the number of patients waiting over 12 hours for admission or discharge from an emergency department compared to 2024/25, so that this occurs **less than 10%** of the time
- reducing the number of patients who remain in an emergency department for longer than 24 hours while awaiting a mental health admission.
- tackling the delays in patients waiting once they are ready to be discharged
- seeing more children **within 4 hours**

Additionally, the plan asks system leaders to commit to developing and testing collective winter plans, which will be signed off by every board and chief executive within each system by 30 September 2025. NHSE regions will work with local systems and providers on exercises to stress-test and refine their plans in September 2025 and will continue to oversee improvement support to the most challenged organisations in the run up to and throughout this winter.

As a minimum, each plan should show how, by this winter, systems will:

- improve vaccination rates,
- increase the number of patients receiving care in primary, community and mental health settings,
- meet the maximum 45-minute ambulance handover time standard,
- improve flow through hospitals with a particular focus on patients waiting over 12 hours and making progress on eliminating corridor care,
- set local performance targets by pathway to improve patient discharge times and eliminate internal discharge delays of more than 48 hours in all settings.

The plan outlines the need for a whole-system approach to improving UEC performance and system plans should evidence how:

- **ICBs and primary care** are demonstrably improving access to primary and community care and driving stretching system-wide improvement to prevent avoidable admissions and discharge rates.
- **community providers** are quantifying demonstrable improvement in admission avoidance, making more effective use of community beds and care home facilities, and using technology to support people to stay well at home.
- **trusts** are using all available tools to improve patient flow, including: optimising triage and appointment systems to direct less urgent cases to same day emergency care (SDEC); optimising the use of urgent treatment centres (UTCs) and Hot Clinics; ensuring medical directors and chief nurses are applying clinical operational standards to ensure all specialties – not just UEC – lead UEC improvement.
- **ambulance trusts** are rapidly adapting best practice to maximise improvement opportunities this winter.

1.4 Winter Planning Assurance & Delivery Group

In order to enhance our approach to, and oversight of, winter planning across NENC we have established the Winter Planning Assurance & Delivery Group to co-ordinate the production of our system plan and monitor its delivery throughout 2025/26. The group was established on 15th May, in advance of the publication of national UEC guidance and is directly accountable to the ICB Executive Committee and also reports into the Urgent & Emergency Care Network (UECN) and Living & Ageing Well Partnership (LAWP). Co-ordination is provided by the ICB Planning & Performance team, working closely with our LAEBDs and with teams right across the ICB, to ensure a whole-system and whole-organisation approach.

The Group is responsible for:

- Oversight and coordination of the development and delivery of plans across the system - focussed on clear, time-bound actions that support readiness and improvement for Winter 2025/26
- Identification of risks and barriers, resolving and escalating as needed to enable timely response and proactive management

- The production of a coherent, measurable winter plan, aligned with national expectations and local strategic priorities. The plan will cover proactive interventions and initiatives to make improvements pre-winter, agreed actions and escalation protocols during the winter period and will include lessons learned from the previous winter

The Group will deliver its responsibilities in two phases:

- **Phase 1** - development of the plan which requires broad system input with a tight group holding the ring on co-ordination, with the plan ready for review by the ICB Executive & Board by the end of July,
- **Phase 2** - monitoring the implementation and delivery of the plan from July onwards and co-ordinating our participation in the 'stress testing' of plans with NHS England colleagues during September and sign-off by Trust & ICB Boards (by 30 September).

The group will also ensure engagement with existing and established forums that will support the review, development and implementation of winter priorities as appropriate.

- CAG (Clinical Advisory Group) - The CAG will provide expert, multi-disciplinary clinical advice about clinical pathways that will support transformation and improvement in UEC and community services
- SROG (System Resilience Operational Group) – The SROG includes senior managers from provider services across the ICS, along with various ICB teams, focussing on the delivery of UEC services

1.5 LAEDB Winter Readiness

Following the national publication of the Urgent and emergency care plan the ICB Planning & Performance team outlined the approach that would be taken to assess Winter Readiness across NENC at a LAEDB level to support production of the system winter plan.

Building on the process which was undertaken in 2024/25 we developed a template consisting of 51 'readiness checks' which were structured around the UEC requirements within the 2025/26 operational planning guidance, supplemented by any new priorities from the Urgent and emergency care plan, and aligned to our local UECN priorities.

The readiness checks covered 10 priority areas:

- Treatment to prevention
- Hospital to community
- High-quality hospital care
- Hospital flow
- Ending 12-hour waits in corridors
- Mental health teams leading from the front
- Improving patient discharge
- Enhancing the respiratory pathway
- Analogue to digital
- Surge & System Co-ordination

Each LAEDB was asked to work across their system partners to self-assess their readiness for winter against each of the 51 checks. The criteria for self-assessment were:

- Blue – already in place/alternative in place or standard met
- Green – actions in place and on track to be implemented within timeframes
- Amber – in plans, but risks associated with delivery
- Red – no evidence of existing implementation or in system plans

LAEDB's were also asked to supplement their assurance rating with additional detail to support the identification of key deliverables, responsible leads, target dates, risks and mitigations to enable robust monitoring in the future. This was enhanced from the process implemented during 24/25 in order to help ensure a more detailed, measurable, and impactful set of winter plans.

LAEDB's were required to submit their completed winter readiness template by Friday 11th July. Submissions were then consolidated and a NENC-wide readiness assessment was made, using the same criteria above, with the rating determined by the 'lowest' assurance rating across each LAEDB area, in line with the principle that we are only as strong as our most challenged area. This was presented to system partners at the Winter Readiness Workshop on 17th July, which was attended by members of the UECN, LAWP, and Clinical Advisory Group (CAG).

The summary assessment for NENC ICS is shown below:

NENC ICS	
Assurance Check	NENC Self Assessment
Blue = already in place/alternative in place or standard met	3
Green = actions in place and on track to be implemented within timeframes	3
Amber = in plans, but risks associated with delivery	41
Red = no evidence of existing implementation or in system plans	4
	51

- Red: 4/51 (7%) areas where there is no evidence of existing implementation or in system plans
- Amber: 41/51 (80%) areas where there was risk associated with delivery

NENC Summary					
Priority Area					Total
From Treatment to Prevention	0	0	7	0	7
Hospital to Community	0	0	8	1	9
High Quality Emergency Care	0	0	2	0	2
Improving Flow Through Hospitals	0	0	4	1	5
Ending 12hr Waits in Corridoors	0	0	2	1	3
MH Teams Leading from the Front	1	0	2	1	4
Improving Patient Discharge	0	0	6	0	6
Enhancing Respiratory Pathway	0	0	4	0	4
Analogue to Digital	0	0	2	0	2
SURGE & System Coordination	2	3	4	0	9
Total	3	3	41	4	51

Of the 4 areas flagged as red:

- 1 is linked to hospital to community
- 1 is linked to improving hospital flow
- 1 is linked to ending 12-hour waits in corridors
- 1 is linked to MH teams leading from the front

The summary results across LAEDB footprints are shown below:

NENC ICS					
Assurance Check	North Cumbria	North	STS	CDD	Tees Valley
Blue = already in place/alternative in place or standard met	10	8	13	9	16
Green = actions in place and on track to be implemented within timeframes	16	20	22	18	22
Amber = in plans, but risks associated with delivery	23	22	16	24	12
Red = no evidence of existing implementation or in system plans	2	1	0	0	1
	51	51	51	51	51

NENC Summary	North Cumbria				North				STS				CDD				Tees Valley			
Priority Area																				
From Treatment to Prevention	2	4	1	0	0	3	4	0	3	2	2	0	0	3	4	0	1	5	1	0
Hospital to Community	0	5	3	1	1	2	6	0	1	3	5	0	1	3	5	0	2	6	1	0
High Quality Emergency Care	0	0	2	0	0	2	0	0	1	0	1	0	0	1	1	0	0	2	0	0
Improving Flow Through Hospitals	1	1	2	1	0	2	3	0	1	3	1	0	0	3	2	0	1	2	2	0
Ending 12hr Waits in Corridoors	0	0	3	0	0	1	2	0	0	1	2	0	1	0	2	0	0	2	0	1
MH Teams Leading from the Front	2	2	0	0	1	0	2	1	1	3	0	0	3	1	0	0	3	1	0	0
Improving Patient Discharge	0	0	6	0	0	5	1	0	0	4	2	0	1	1	4	0	1	1	4	0
Enhancing Respiratory Pathway	0	2	2	0	2	2	0	0	0	2	2	0	0	0	4	0	0	1	3	0
Analogue to Digital	0	0	2	0	0	0	2	0	0	1	1	0	0	1	1	0	1	0	1	0
SURGE & System Coordination	5	2	2	0	4	3	2	0	6	3	0	0	3	5	1	0	7	2	0	0
Total	10	16	23	2	8	20	22	1	13	22	16	0	9	18	24	0	16	22	12	1

As part of the process, opportunities for shared learning have been identified and LAEDBs are encouraged to continue to seek peer review of their plans and share areas of best practice to support collaboration and improvement. The key local priorities and actions that were included within the LAEDB submissions have been incorporated into our strategic plans as articulated in the sections that follow.

Acknowledging the tight timescales within which the readiness self-assessments were undertaken, there will be an opportunity for LAEDBs to carry out further 'check and challenge' with local system partners during August to provide further assurance, before participating in the nationally and regionally co-ordinated stress testing exercises planned during September.

1.6 System Co-ordination, Resilience, and Oversight

Since December 2022, the NENC System Coordination Centre (SCC) has effectively provided oversight and escalation management for organisational pressures and risks along with the coordination of an integrated system response on key system issues that influence patient flow. This includes a concurrent focus on UEC and the system's wider capacity, including but not limited to; NHS 111, Primary Care, Intermediate Care, Social Care, Urgent Community Response and Mental Health services.

The SCC facilitates collaboration within and across the system through its operational and clinical leadership. The SCC is the single point of contact (SPOC) for local system partners and NHS regional and national stakeholders. The Director of System Resilience is accountable for the System Coordination Centre whilst clinical input is provided by senior ICB clinicians led by the Chief Medical Officer and Executive Director of Nursing.

During the hours of 08.00 – 20.00, 7 days a week, the SCC provides system senior leadership, constructive challenge, and where necessary a system level response to manage the escalation and de-escalation processes at system level especially those where ICB intervention is needed to avoid or mitigate organisation or system pressure, and where external support might be required in accordance with agreed system escalation frameworks and plans detailed in the System Resilience Framework:

- Keeping in touch with the operational situation across the area using the UEC RAIDR application to see in real time how the local urgent and emergency care system is working (including number of patients in each of the A&E departments, waiting times, number of beds available, number of ambulances at each site/ on route etc).
- Being aware of any developing issues which may result in coordination arrangements being implemented as OPEL increase across agreed thresholds.
- Managing any significant incidents such as industrial action, provider critical incidents (e.g. IT outages/cyber-attacks, supply chain restrictions or business continuity issues), outbreaks of communicable disease or most recently civil unrest within local communities.
- Brokering agreements across the system to ensure mutual aid is available if required to re-balance pressures (e.g. acute and community services).
- Liaising with bordering ICB's on any issues which may impact upon their own pressures and advise NHSE if there are any actions that cannot be taken locally in partnership.
- Commissioning additional resources (beds, staff etc.) and ensure local system demand management initiatives are working during times of surge.
- Ensuring a full investigation and debrief takes place following a system-wide escalation to Critical Incident, sharing findings with all ICS partners, and ensure actions are implemented.
- Liaising with NHSE North East and Yorkshire Regional Operations Centre (ROC) in alignment with the OPEL Framework.
- Leadership of the NENC System Resilience Operational Group which meets regularly with partners from across the UEC system to share best practice, foster collaboration, move towards standardisation of local policies and procedures, and identify key transformational priorities to enable continuous improvement.

In line with the requirements set out in the *'Implementing the Model ICB: Frequently asked questions'* which was published on 23rd June, ICBs remain responsible for EPRR and System Co-ordination Centres and must ensure they continue to operate effectively. NENC ICB will continue to provide system co-ordination throughout winter 2025/26 which gathers real-time situational awareness of operational pressures, this is a key part of ensuring a safe winter, with early alerts shared between providers and to NHS England in relation to escalating pressures.

ICBs are required to nominate a Winter Director with the specific accountable role of convening executives from across providers in a system to mitigate pressure between providers. The ICB Chief Strategy Officer will take this role on whilst the Director of System Resilience will be Senior Responsible Officer for the ICB.

As we continue to operate in a period of transition across our local, regional, and national systems the SCC will continue to provide robust leadership, manage escalation, and convene system colleague throughout the 2025/26 winter period and will work closely with our regional

ICB and NHSE colleagues, in the spirit of the 4+1 arrangement, to help ensure that we take a consistent, collaborative, and proportionate approach to the management and escalation of winter pressures.

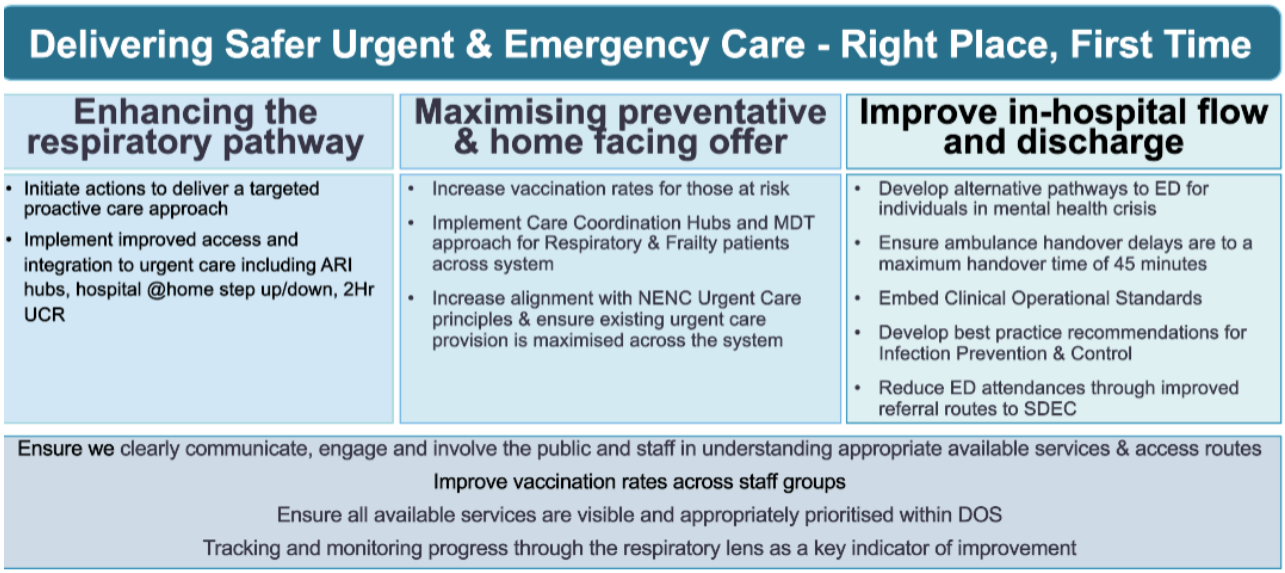
2. Delivering the asks for 2025/26

2.1 Development of NENC UECN system priorities

Winter continues to be a high-pressure period for the NHS and social care, particularly in urgent and emergency care. Services are stretched all year round but the peaks of activity seen in Winter create a real challenge for our system. Through an inclusive planning process, the NENC UECN has identified three key UEC System Priorities for Winter 2025/26, now submitted for Executive Committee approval.
These proposed System Winter priorities have been developed alongside our system partners and considered in the following groups:

- Clinical Advisory Group of the Urgent and Emergency Care Network and the Living and Ageing Well Partnership (LAWP) on 10 July 2025
- Winter Planning Assurance & Delivery Group on 16 July 2025
- Urgent and Emergency Care Network (extended membership to LAWP, System Resilience Operational Group, CAG) on 17 July 2025

The proposed winter priorities for 2025/26 are as follows:



The slide deck attached at Appendix 1 outlines the NENC ICS 2025/26 Winter Priorities and were presented to the extended UECN Board meeting held on 17 July 2025. It details the proposed initiatives aimed at enhancing the respiratory pathway, maximising preventative and home-facing offers, improving in-hospital flow and discharge, and finally to deliver a targeted proactive care approach. The presentation emphasises the importance of improving access and integration to urgent care, increasing vaccination rates for those at risk and for NHS front line staff, and developing alternative pathways to the ED for people in mental health crisis. Additionally, it highlights the need for effective communication, engagement, and involvement of the public and staff in understanding available services and access routes.

The progress and effectiveness of the initiatives outlined in the NENC ICS 2025/26 Winter Priorities will be closely monitored by the Winter Planning Assurance & Delivery Group on a regular basis. This group will ensure that all actions are being implemented as planned and will track key performance indicators to measure success. Regular reviews and updates will be conducted to assess the impact of the initiatives, identifying any areas that require adjustments, and ensuring that the objectives are being met. This continuous monitoring will help maintain accountability and drive the successful delivery of the winter priorities.

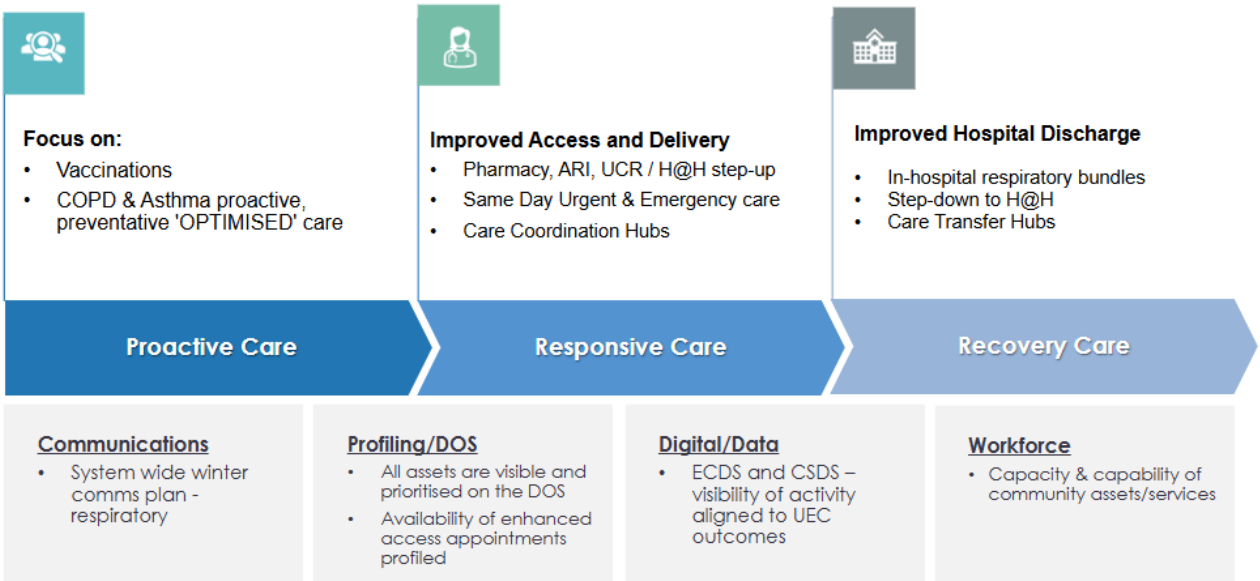
The following sections of this document summarise each of the initiatives that will support delivery of the 2025/26 winter plan. Detailed milestone plans are being developed for each priority and will be shared across the UECN and LAWP during August and September to support the 'check and challenge' and stress-testing of our system plans. This will include identification of robust evaluation metrics which will be collated into a Winter Planning Dashboard which is being developed by the ICB Insight Team. This data will be used to monitor the implementation of our winter plans and ensure that interventions are measurable, accountable, and impactful.

Transformation highlight reports will be shared by the ICB UEC Transformation Team monthly via the appropriate governance routes (e.g. UECN and LAWP) throughout winter and LAEDBs will provide progress updates via local highlight reports. Escalation of opportunities for shared learning, risks and issues, and areas of under delivery will be managed through the Winter Planning Assurance & Delivery Group, reporting into the ICB Executive Committee, UECN, and LAWP as appropriate.

2.2 Enhancing the Respiratory pathway

We know that respiratory conditions present a significant health challenge in the North East and North Cumbria (NENC) especially during the winter period. We have the highest prevalence of Chronic Obstructive Pulmonary Disease (COPD) in England, at 2.8% compared to the national average of 1.86%. Approximately 134,000 patients are affected, with many residing in areas of high deprivation. A concerted focus on enhancing the respiratory pathway this winter will support improvements to the management of respiratory illness from proactive care, responsive care and through to recovery care. The diagram below illustrates the focussed programme of work supported by several key enablers.

Respiratory Pathway Winter Focus



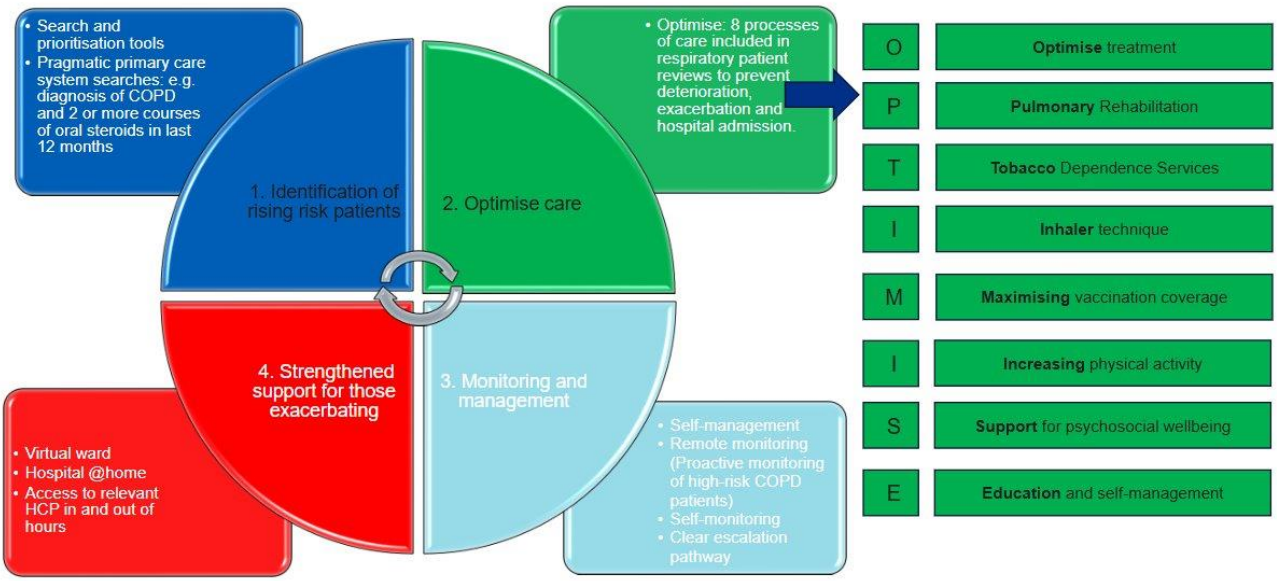
2.2.1 A targeted proactive care approach

This project drives the launch of a pilot aiming at enhancing COPD proactive management across the region. By leveraging a risk-guided approach, the project intends to identify practices and patients identified as being at high risk of an exacerbation and potential admission to hospital utilising a new CDRC COPD stratification tool.

The project will be delivered through a joint working arrangement between HINENC and AstraZeneca with practice re-imbursement. Those patients would be invited to clinic where the practitioner will conduct a review with the OPTIMISE approach (see diagram below) to provide standardised, guideline-directed care, ultimately aiming to improve clinical outcomes and reduce health disparities within this vulnerable population. Practices taking part with receive support and training on the use of the OPTIMISE approach. An initial cohort of 50 GP practices will be identified, with a focus on those with the highest prevalence rates and those identified as 'deep end' practices.

This approach had provided very positive results when trialled at a number of ICBs nationally including Hull University Teaching Hospital Trust, Cornwall Partnership NHS Foundation Trust and Kings Healthcare Partners. Although cases reviewed were relatively small, outcomes included a 33% reduction in A&E attendances and a 55% reduction in hospital admissions for the control group.

COPD patient identification and management pathway



2.2.2 Acute Respiratory Infection (ARI) Hubs

ARI hubs build upon existing structures at place level and provide additional capacity to support primary and secondary care pressures. These hubs have been mobilised annually since the publication of the 'Going further on winter resilience' letter published by NHS England in October 2022. This set out actions to be taken at system level to respond to peak demands driven by external factors, e.g., high rates of influenza, COVID-19 and potential industrial action. The roll out of ARI hubs was identified as one of the 10 High-Impact Interventions. Reports from NHS England and UK Health Security Agency (UKHSA) Emergency Department Syndromic Surveillance show that ARI are one of the most common reasons for emergency attendance and admission. We need therefore to continue to build capacity and resilience to respond to these pressures.

The ARI hub model is a system approach that drives a collective objective to provide timely and appropriate care to the population and helps reduce pressure on other parts of the system. The hub model may be best suited to those with acute, episodic needs.

The ICB has agreed to allocate £1.5m recurrently for the development of combined adult and paediatric community-based ARI hubs to support the ICS in managing increasing demand over the winter period and the proposal was presented to the ICB executive in June 2025.

This service will be commissioned to support a sustainable recurrent integrated ARI hub model aligned with other out of hospital and front of house services including SDEC, hospital at home and UCR which will help deliver on the ICBs commitment to achieve positive health outcomes for patients and a core care co-ordination component of integrated neighbourhood health. Tackling health inequalities by establishing hubs in communities with high social deprivation is also a key outcome in a recurrent model.

An ARI Hub working group has agreed the specification and service delivery requirements which has been co-designed with a group of ARI Hub leads. A key objective will be to ensure visibility of each hub on the Directory of Service (DoS) which will enable greater integration with the wider system over time. By November all procurement and contracting will be complete. All ARI hub services will be mobilised in mid-November running until the end of February.

2.2.3 Hospital @ Home (Virtual Wards)

Virtual wards delivered at scale for appropriate patients aim to provide better patient experience and improved outcomes compared to inpatient hospital care. The desired outcome of the service is to narrow the gap between demand and capacity for hospital beds by preventing attendances and admissions, shifting acute care into the community, or reducing length of stay through early discharge.

In 25/26 all trusts are contractually required to deliver respiratory and frailty H@H services in line with the national specification and supply KPIs as per contract mandates. For this winter we want to ensure that all trusts are offering 'acute care' at home, including the access to specialist diagnostics and treatment options for patients who would have otherwise needed a hospital admission.

Over this Winter we will monitor all access routes into respiratory H@H services, with a particularly focus on step-up from all sources (providing a better offer than a hospital bed) as well as early discharges of patients who will continue 'acute care' stabilisation on a H@H service (reducing length of stay within a hospital bed and associated complications):

- **Step-up care**: a patient becomes acutely unwell and is offered the choice between being treated at home or in hospital. Patients are typically referred directly from their usual place of residence and can be admitted from sources such as a single point of access (SPoA), same day emergency care (SDEC) or ED

- **Step-down care**: is where a virtual ward can facilitate an earlier discharge or transfer from an inpatient ward, enabling individuals who are not medically optimised for discharge to continue to receive medical treatment, oversight and diagnostics at home.

As of 11th July 2025, 70 people resided on a respiratory H@H services with a capacity of 173 H@H beds. Therefore, the occupancy rate was 40.5% (with a national target of 80%). Of these people, 53.2% access the H@H services as step-up. Therefore, key deliverable over Winter will be an overall increase in activity and occupancy of respiratory H@H. In line with planning trajectories, all trusts will be delivering on the contractual requirements to offer respiratory H@H by October 25. Quarterly contractual monitoring will also assessment the 'offer' making sure the right people (with acute care needs) are using H@H services.

2.2.4 2hr Urgent Community Response

Urgent Community Response is part of the acute trust contracts; all trust should be offering a 2hr MDT response to people who could need a hospital admission within the next 24hours. The national specification describes 9 pathways that should be available, in which the management of an exacerbation of long-term condition or illness (not needing immediate acute specialist care) should be supported at home. Therefore, this Winter our focus is to ensure that UCR services are widely understood and accessible directly or via our Single Points of Access (Care Coordination Hubs) with a particular focus on managing respiratory illness and avoiding unnecessary hospital bed utilisation.

In the month of May 2025, there were 11,112 referrals made to UCR across NENC. Of these contacts, after 72hours 13.6% of people attended ED and 9.3% were admitted to hospital. Of the 11,112 referrals, 782 were made for respiratory illness. Therefore, key milestone over Winter will be an overall increase in activity in UCR services (especially a focus on the growth of respiratory illness being managed via UCR), improving all sources of referrals especially from hospital front-door and ambulance services (via direct or Single Point of Access). In line with planning trajectories, all trusts should be delivering on the contractual requirements to offer an increasing capacity to UCR.

2.2.5 Improved Access to Community Pharmacy

Patients will be able to gain easier access to specialist advice and treatment by the promotion of Community pharmacies to support neighbourhood health by:

- Promoting Pharmacy First - increasing the referrals to pharmacy from; self-presentations, 111, GP practices, UTC and A&E for all minor ailments and illnesses included in the Pharmacy first scheme.
- Promoting pharmacies expanding services such as for contraception and hypertension diagnosis and monitoring.
- Exploring Discharge Medication Service – to ensure pharmacies are quickly informed of changes to repeat medications to avoid medication errors leading to subsequent readmissions.

The ICB shall continue to support campaigns to improve public and professional awareness of what community pharmacies are now able to offer. We shall facilitate more robust referrals and working relationships between community pharmacies, Trusts, GPs, PCNs, NEAS and other providers of NHS services.

Our overall aim is to improve awareness and embed pharmacies as the first point of contact for most common ailments and health related queries, thus reducing overall demand and reliance upon primary care and other urgent care services.

2.3 Maximising the preventative and home-facing offer

2.3.1 Increasing vaccination rates for those at risk

To protect the most vulnerable and keep vital health and care services running when respiratory viruses surge, there is more we can do to reduce the effects of the flu, COVID, and RSV. Oversight of seasonal vaccinations across NENC is provided by the ICS Vaccination Strategy and Partnership Group, reporting into the Senior Responsible Officer, who is the ICB Chief Medical Officer.

During 2024/25 Local Immunisation Steering Groups (LISGs) were set up, led by designated place leads across the ICB footprint and are responsible for coordinating vaccination planning. These are multi-agency groups with the purpose of identifying local priority populations and generating hyper-local activity to engage with communities and improve uptake and coverage. These groups support preparation for winter through collaborative approaches involving NHS England, Trusts, GPs, and local authorities. Primary Care Engagement Events have also been held to inform PCN and Community Pharmacy partners about the key details of the 2025/26 campaigns.

We are guided by hyper-local data when designing services and promotions to focus on accessibility, often in the most deprived wards and areas. LISGs have worked to create local action plans for the delivery of seasonal vaccinations including identification of those wards which present the biggest challenges and are working with system partners to develop initiatives which will reduce inequality and improve uptake.

Some examples of the initiatives being undertaken include:

- Updated comms materials and targeted messages to promote the benefits of vaccination to at risk cohorts, based on uptake data and insights evidence
- Mapping the maternity vaccination picture across NENC to understand the mix of delivery options including GP practices, family hubs and opportunities for vaccination in acute settings
- Understanding the vaccine supply and ensuring that there is sufficient availability of doses across the entire NENC footprint
- Ensuring weekly uptake data is shared to help identify, in real time, if there are any issues with particular at-risk cohorts or in specific geographical areas
- Early distribution of electronic consent forms to schools before summer to allow for timely clinical triage and targeted support for schools with lower return rates
- Collaboration with public health, educational establishments, and GP services to focus on increasing uptake among children and young people
- Out of hours and walk-in clinics for working age adults in the at-risk cohorts with appropriate comms put in place to promote vaccination sites
- Promoting the use of community pharmacy sites for those groups who do not generally engage with a local GP
- Working with public health teams to create vaccination promotion resources in alternative languages and using trusted voices and community champions to target the distribution of these resources

The NENC Learning Disability and Autism Network have developed a specific Learning Disability Winter Plan for 2025/26 with the primary goal to increase flu vaccination uptake among people with learning disabilities and their carers/social care staff.

The scheme involves collaboration with local day services (social care providers) and community pharmacy/PCNs to offer flu vaccination clinics that support people with a learning disability to receive flu vaccinations in-situ within day services where they congregate in numbers. Family carers and social care staff will also be offered vaccinations at these clinics. Additionally, links will be established with local Community Learning Disability Teams to ensure appropriate support for those requiring additional reasonable adjustments including any ‘desensitisation’ work and supporting the day services to ‘get ready’ by busting myths and building confidence.

Designed by the NENC Learning Disability Network, the concept has been tested with wide significant stakeholder engagement. The Network has sought and gained support from NHSE/ICB screening & immunisations team and place-based vaccination steering groups, senior pharmacy leads, community learning disability nursing teams. Clear milestones have been identified, and the Network will be working proactive with partners throughout the summer months to create a suite of appropriate communications tools and resources (including 'easy read' materials and specific toolkit for children and young people to support the SEND school-based immunisation teams).

2.3.2 Improving staff vaccination rates

Over the past few years, there has been a noticeable downward trend in the flu vaccination uptake among Frontline Healthcare Workers (FLHCW). This decline has raised concerns among public health officials, policymakers, and healthcare institutions. Understanding the reasons behind this trend, its potential impact on public health, and strategies to reverse the decline is essential for ensuring the health and safety of both healthcare workers and the patients they serve.

The national urgent and emergency care plan sets an expectation that systems improve vaccination rates for frontline staff towards the pre-pandemic uptake level of 2018/19. This means that in 2025/26, we aim to improve uptake by at least 5 percentage points on 2024/25 and will make every effort to improve beyond this target. This is crucial in order to reduce staff sickness and build resilience across essential services during winter.

Each Trust lead has given its level of confidence to exceed this 5% target. NEAS is Red, most are Amber and 3 are Green. Performance will be proactively reported and monitored throughout the winter period and targeted support will be provided to organisations that are failing to deliver. Discussions are ongoing around how best to effectively incentivise vaccination uptake amongst FLHCW and promote individual employee responsibility and the importance of role-modelling good behaviours.

The ongoing vaccination programs are focused on enhancing the uptake of flu and RSV vaccines among healthcare workers and preparations for the autumn flu campaigns are underway. Key initiatives include early consent collection, data quality improvements, and the development of a flexible booking system to increase accessibility. The aim is to

improve uptake across all staff roles through accessible occupational health offers, enhanced communication strategies and a flexible booking system to increase accessibility. As part of local plans, a series of webinars will be held during Sept and Oct to inform, myth bust and give confidence to the very large community of professionals and active promoters of flu & COVID vaccinations in families and communities. Links to FAQs will also be available on the ICB website.

Other initiatives taking place across the organisation are development of peer vaccination models, staff clinics, roving vaccination teams and temporary hubs (4-6 weeks), signposting to community providers (e.g. pharmacies) and the national booking system (NBS) and 'jabathons' held in communal areas during the early weeks of the campaign launch to increase visibility and promote early vaccination.

2.3.3 Implementing Care Co-ordination Hubs

There have been ongoing developments to delivery of care co-ordination hubs across the region, however, they are in varying levels of maturity across the ICB.

The following shows a summary (following recently conducted self-assessment of all care co-ordination hubs) of where all local places are at with regards to our focus for winter against the core components as set out the national policy guidance for Single Points of Access:

	Single telephone number which clinicians can use to contact the SPoA	Service operating 7 days per week, 365 days a year - aligned to locally agreed need and typically be at least 12 hours a day	Plans in place to promote single number for SPoA/CCH	SPoA provide clinical advice and guidance/ assessment, with access to a senior clinical decision-maker maker	Senior clinical decision makers manage clinical risk/ 'hold' clinical risk while arranging appropriate diagnostics and/or follow-up and care	SPoA able to refer into alternative offers - range of receiving services	Able to capture activity and outcomes (e.g. clinical presentation (incl. respiratory, onward referral)
SOUTH TYNESIDE AND SUNDERLAND NHS FOUNDATION TRUST	Partial **Number established, in process of being used**	Yes **24/7**		Yes **Not at the level of ACP/Dr Plans in place**	Not started **Work aligned to step-up VW**	Partial **UCR, scoping referral pathways into SDEC**	
NORTH CUMBRIA INTEGRATED CARE NHS FOUNDATION TRUST *	Yes	Not started **Pilot 5/7 10:00-18:00**		Yes **Team will incl. Cons, Sr nurses & AHs**	Partial	Yes **MATCH will incl. ref to urgent & comm services**	
GATESHEAD HEALTH NHS FOUNDATION TRUST	Yes ****UCR only****	Yes		Yes	Partial **UCR takes referral**	Partial **UCR only**	
THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST	Yes	Yes		Partial **Nurse Practitioner & PT Geriatrician**	Yes	Yes **Working on SDEC ref pathway**	
NORTHUMBRIA HEALTHCARE NHS FOUNDATION TRUST	Yes	Yes **24/7 with call divert in place 23:00-07:00**		Yes	Yes	Yes	
SOUTH TEES HOSPITALS NHS FOUNDATION TRUST	Yes	Yes **Plans to shift to 24/7**		Yes	Yes **H@H function rather than iSPA**	Yes	
NORTH TEES AND HARTLEPOOL NHS FOUNDATION TRUST	Yes	Yes **24/7**		Yes	Yes **H@H function rather than iSPA**	Yes	
COUNTY DURHAM AND DARLINGTON NHS FOUNDATION TRUST	Yes	Yes		Partial **Geriatrician/Cons advice line in development**	Not started	Partial **UCR and some UTC**	Detailed analysis on attendances from care homes

There is a Care Home Working Group, working with ADASS and aligned to the wider Urgent Responsive Care Group, that is overseeing this work, following of from analysis that identified people living in care homes were the most likely (but not exclusively) to benefit from early Care Coordination into a better offer of support at home.

For this winter we will focus on ensuring there is improved awareness of Single Point of Access for all professionals, a reduced variation in delivery of the core components with senior level oversight within the hub for patient assessment, navigation and support. A critical interface with our Care Coordination Hubs will be the aligning and working together with ambulance services to help avoid unnecessary ambulance dispatching and

conveyancing to hospital. Key milestone will include tracking of Categories 3 and 4 ambulance conveyances to hospital and activity in UCR, H@H and ARI as well as hospital use for people living in care homes and presenting with respiratory illness.

As part of the national Single Point of Access specification and core components, the alignment and close working with Care Transfer Hubs for supporting hospital discharge is also critical. There is variation in our Care Transfer Hub models and their alignment with SPOAs. For this Winter, we will monitor progress on alignment and tracking of patients being discharged from hospital with a respiratory illness in line with the national respiratory bundle assessment and actions needed to optimise the care of people from being admitted to hospital with COPD and asthma, preventing further exacerbations of illness including step-down to hospital @home services.

The national COPD and Asthma Care Bundle is a set of proven interventions mandated by the CQC and run by the Royal College of Physicians. These interventions, when implemented in secondary care, significantly reduce the risk of readmission for patients with COPD and asthma. The bundle includes ensuring patients are on the right medication, have a self-management plan, and are aware of alternatives to hospital admission.

2.4 Increase Alignment with NENC Urgent Care Principles and ensure current services are maximised

The System Resilience Operational Group is responsible for leading on the delivery of system-wide improvements in UEC services and ensuring effective flow and patient safety at all times, working closely with the System Coordination Centre Team. Chaired by the Director of System Resilience, it includes senior managers from provider services across the ICS along with ICB strategic leads and enabling teams and. The group also engages additional leads as needed.

The group will therefore have a specific focus on enhancing front door models including navigation, streaming and ambulance handover programmes as well as ensuring NHS 111 effectively support service delivery models. By fostering collaboration and shared learning, the SROG aims to improve ambulance handover times by accelerating the implementation of the 45-minute ambulance handover directive to enhance overall patient safety and experience and understand the implementation of additional UTCs across the region. This approach involves engaging stakeholders, leveraging improvements across the UEC pathway and implementing targeted initiative to address specific challenges.

A review is currently underway focussing upon GP-led urgent care services to map the relationship between urgent treatment centres, GP out of hours, enhanced GP access provision and core general practice. Early findings have revealed different commissioning and contracting models for UTCs, GP out of hours and local commissioned GP-led services. The consequence of this is that some services overlap, causing duplication and inefficiency. There is variable use and availability of core general practice NHS 111 appointments and those for enhanced access.

Draft proposals have been drawn up to address these issues for Winter 25/26 and for the longer term. These proposals have not yet been formally ratified by the UEC governance structures however, the proposed interventions include:

Winter 25/26

- Ensure that DoS profiling is present for all GP-led services and that 111 GP appointments for 111 are spread more evenly throughout the day
- Improved GP access to SDEC
- Greater visibility of ARI hubs on the DoS

Longer-term improvement proposals

- Trusted assessor model to streamline patient referrals
- Establish place-based “out of hospital” provider collaboratives
- Common front door navigation and streaming principles to the most suitable service
- ICB-standardised UEC commissioned models for UTC, GP OOH and other GP-led services
- ICB LIS/LES principles for UEC
- Standardised data sharing and collection protocols
- ICB designed patient experience surveys for provides to utilise.

2.4.1 Improving in-hospital flow and discharge

National and regional discussions concerning patient flow have developed in recent years and there is greater alignment in terms of strategy. Patient flow should be seen as a continuum. The potential for an individual patient being managed in the community instead of a conveyance to hospital is the opportunity gain that needs to be realised. The front door of our hospitals should no longer be its emergency department, instead it should consist of an experienced navigator function which can direct that patient to the most appropriate service whether that be a collocated UTC, SDEC, a frailty team or indeed the emergency department. Decompressing the waiting rooms of our emergency departments is a goal and will help to achieve a number of the national asks, for example treating more children and young people within the 4-hour target.

Patient flow through our hospital is complex and multiple factors can affect it. Hospital trusts work hard to address these issues within the constraints that present themselves whether that be patient demand, their elective programme, estates or workforce challenges. However, there are opportunities as a UEC network to share best practice further. The initiatives detailed below are aimed at improving in-hospital flow and ultimately discharge, ensuring that patients receive appropriate and timely care.

2.4.2 Alternative pathways to ED for Mental Health crisis

The recently published Urgent and Emergency Care plan for 25/26 has clearly set out the expectation for our system to keep mental health teams leading from the front with potential extra resources available in-year.

Liaison psychiatry services support all of the emergency departments in NENC to assess patients in crisis and whilst our performance compares more favourably than other parts

of England more can still be done. All LAEDBs have submitted their plans which address the key issues which include intensive case management of SMI patients to reduced relapse and developing interventions for those who attend repeatedly.

The drive to reduce 24 hour waits for those awaiting a mental health admission remains a priority as well as reducing the need for out of area placements. Greater visibility and use of community resources such as safe havens and alternative community crisis beds (where available) must be realised. Optimisation of the 111 option 2 pathway will remain under focus in terms of capacity versus demand and dispositions of clients.

The NHS 10-year plan has laid out a level of ambition for mental health with potential capital investment for dedicated mental health emergency departments. Crisis Assessment Centre's are currently in place in the south of the patch hosted by TEWV. In the coming months a concerted effort will be made as a network, to understand the configuration of these “crisis assessment suites”, how they will integrate with existing Type 1 emergency departments and what workforce can be deployed to support them.

In addition, there are a wide range of crisis support and crisis alternatives across the NENC footprint including, but not limited to Crisis Resolution and home Treatment, 24/7 crisis response line, crisis text support and peer support. These services cover both adults and children. There are also a range of community delivered services available which scaffold core provision and aim to keep people well in the community and prevent exacerbation of symptoms.

2.4.3 Meeting the maximum 45-minute ambulance handover

A significant programme of work continues across NENC in order to reduce average ambulance handover times and eliminate the longest waits for ambulances in line with the 45-minute expectation in the 2025/26 UEC plan. Building on the work undertaken in 2024/25 in partnership with the Advancing Quality Alliance (AQUA), system partners have continued to implement changes in order to reduce handover delays and there is close collaboration between ambulance and hospital providers across NENC to identify and overcome the particular operational challenges at specific sites to help enable consistent delivery of timely ambulance handovers.

Whilst average handover performance is strong across NENC, patients still experience occasional long delays in being handed over from ambulances and there is more work to be done to eliminate these delays as prepare for and approach winter. The System Resilience Operational Group (SROG) meets regularly with partners from across the UEC system and is co-ordinating the work to implement 45-minute ambulance handover processes consistently across NENC. The two existing 'immediate release' procedures which form part of the System Resilience Framework will be consolidated into one '45-minute release policy' to ensure we have a standardised approach which all partners will sign up to with clearly defined triggers for escalation and implementation during times of extreme pressure. This will be complete by 1 August 2025 with engagement across both our UEC Clinical Advisory Group and UEC Network Board before being circulated for approval and adoption by the system.

There are a number of risks and operational constraints which will impact on our ability to eliminate handover delays over 45 minutes including physical estate capacity, staffing and resource, and the availability of beds 'back of house' in hospitals to facilitate efficient and effective flow of patients through ED. Some capital monies have been allocated to NENC providers through the 'return to constitutional standards' which will support additional capacity and remodelling of estates to enable timelier handover however given the timescales for delivery of some of these improvements we may not see the benefits until towards the end of the winter period.

By the end of August, over half of NENC provider organisations will have implemented 45-minute ambulance handover procedures and have effective processes in place to avoid long delays. During the remainder of July and August we will be working closely with all of our acute providers and NEAS to discuss their implementation plans in more detail, provide practical support to bring forward implementation timescales wherever possible, and facilitate the sharing of learning and best practice from those organisations who have already implemented 45-minute processes. By the end of September, all providers will have implemented 45-minute processes and will be supported by the wider system to manage and mitigate handover delays as part of the ongoing operational oversight and escalation arrangements led by the SCC.

We are also harnessing the power of the digital tools we have at our disposal to help the system proactively monitor and manage ambulance activity and tailor their responses appropriately. Enhancements are being made to the UEC RAIDR tool to utilise artificial intelligence capability to support the predictive modelling of ambulance arrivals, providing real-time analysis which will enable receiving organisations to prepare more effectively and allow the SCC to implement appropriate escalation responses (e.g. diverts, mutual aid etc.).

There are also a range of initiatives being implemented by our ambulance providers and system partners to reduce demand for emergency vehicles and eliminate inappropriate conveyances. There is an emphasis on increasing 'hear and treat' rates and implementing consistent 'call before you convey' processes across NENC which, alongside continued improvement in the rates of validation of 111 dispositions, will combine to reduce demand.

2.4.4 Embedding Clinical Operational Standards

In recent years, members of the UEC network have identified Clinical Operational Standards (previously known as Internal Professional Standards) as a key component which ensures that patient flow can occur in a safe, effective and timely way. This is relevant to all departments within large NHS trusts but is currently most salient when focussed upon emergency care and winter planning for 25/26.

NHSE and DHSC have highlighted this as an issue and the GIRFT Further Faster programme has demonstrated the positive impact that implementing these standards can have. The GIRFT (Getting it Right First Time) Clinical Operating Standards, published in June 25, provide standardised best practices based on national and local guidance, and expert clinical opinion.

Regionally, the SDEC improvement event in November 2024 and the ICB CAG/LAWP group in June 2025 identified that this should be a system priority for this winter. Many foundation trusts in NENC have identified and developed their own standards, however further impetus is required to embed and drive change further. The perception that patient flow being only a problem for emergency departments to solve is no longer tenable. All staff have a role to play in supporting solutions to improve patient flow through the hospital.

Essentially the standards should be succinct and unambiguous and written by clinical leaders with open and active support of the full executive team. The standards are designed to address non-standardised inefficient referral pathways, negate speciality to speciality disputes and improve patient visibility within the hospital pathways.

In preparation for winter 25/26, following endorsement by the UEC Network, foundation trusts will be asked to provide answers to the following questions:

- Do you have Clinical Operational standards in place?
- Were they written by & agreed with clinical leaders (medical/nursing)?
- Are they openly and actively supported by trust executive teams?
- Are they succinct & unambiguous?
- What plans are in place for implementation?
- Are operational and clinical teams working together to identify gaps & collaborate on solutions?
- Is there evidence of inter-speciality working & bipartisan agreements?
- Are digital tools for patient tracking & visibility in place?
- What other changes can be implemented ahead of this winter?
- What support is needed from the UEC Network and the wider system?

2.4.5 Developing best practice recommendations for Infection Prevention & Control (IPC)

Places via LAEDBs have been asked to develop their winter plans for IPC which is linked to maximising the prevention and home facing offer. These plans have been submitted and are centred around immunisation of at-risk groups, frontline staff and care home residents. However, it also includes the focus upon IPC strategies within foundation trusts in the development of their own plans for example patient cohorting, expanding community bed capacity and winter virus resilience stress testing.

The ICB Infection Prevention & Control working group (a subgroup of the NENC AMR & HCAI subcommittee) have identified opportunities to improve the spread of best practice through recommendations which will be developed in the coming months.

2.4.6 Reduce ED attendances through improved referral to Same day Emergency Care (SDEC)

Winter 24/25 developed the pathways required for paramedics to have clearer routes of access into SDEC units across NENC. This was achieved through collaborative working

between the ambulance services and each SDEC unit. Issues that needed to be addressed were around visibility of the SDEC units on the Directory of services (DoS) and clarifying the clinical inclusion/exclusion criteria for each unit. The ability for a clinician-to-clinician conversation is vital and both ambulance services are now recording instances when there is a failed encounter to ensure improvements continue this year.

For Winter 25/26 this work will be extended to general practice to ensure that access is optimised. The benefits will be in multiple ways. Increased access to SDEC by GPs will reduce the chance of patients being sent inappropriately to busy emergency departments with the inherent risk of inappropriate investigations or admission occurring. Patients experience of urgent care is enhanced by the care that SDEC units offer. Improving clinical hand-over of patients between GPs and hospital medical teams will build team working and drive up the quality of clinical care being provided. A plan with key milestones has been developed.

LAEDB submissions have detailed how multi-speciality SDECs are being developed and expanded to prepare for next winter.

2.4.7 Improving flow through hospitals

The Urgent and emergency care plan 2025/26 sets out a priority for providers to improve flow through hospitals through provision of clear pathways ensuring patients are treated in the most appropriate setting. The system will respond to this ask via the additional initiatives listed below:

Urgent Treatment Centres (UTC)
The system continues to move toward implementation of the core ICB UTC principles as agreed in June 2023. For this winter we will:

- Complete building works for 2 new urgent treatment centres
    - NCIC (Carlisle Site) scheduled to open January 2026
    - RVI scheduled to open December 2025
- Include senior streamers to optimize navigation for type 3 patients in co-located UTCs.
- Enhance patient navigation, particularly for type 3 patients.
- Improve the paediatric pathway through reduced paediatric waiting times by streaming children appropriately between co-located UTCs and paediatric assessment units.

Frailty Care Integration

- Frailty Team Integration: Focus on frailty care, same-day emergency care (SDEC), and urgent treatment centre's (UTCs) to optimize patient flow, reduce waiting times, and uphold patient dignity and safety thus improving frailty team integration.
- Frailty Services: Provide frailty services five days a week.
- Frailty Therapies: Implement frailty therapies front of house and rapid access clinics.
- CGA in ED: Implement Comprehensive Geriatric Assessment (CGA) in the Emergency Department with electronic patient flagging.
- Utilize a Frailty SDEC and Geriatrician of the Day to achieve prompt triage and ongoing organizational improvements focused on patient safety and flow.

- Ensuring frailty teams are present in emergency departments and SDEC areas to assess and proactively manage patients over 65.
- Integrated Neighbourhood Health: Establish integrated neighbourhood health approaches and frailty pathways in secondary care.
- Pilot Programs: Implement pilot programs for frailty GPs in emergency settings.
- Compliance and Review: Ensure high compliance with performance standards, supported by continuous review and improvement meetings.
- Digital Tools: Use digital tools to support ongoing monitoring of patient flow and safety.

2.4.8 Ending 12-hour waits in corridors for a bed

The Urgent and emergency care plan 2025/26 sets out the ambition to reduce the number of patients waiting over 12 hours for admission or discharge from an emergency department compared to 2024/25, so that this occurs less than 10% of the time. 25/26 operational plans, submitted by each of our FT providers, meet this requirement with a clear reduction on 24/25 baselines and whilst we are on track to deliver these plans in year and currently reporting well below the national 10% ambition, we will continue to robustly monitor and manage throughout the year.

To support the achievement of this our Providers are focussing on:

- Rapid Assessment and Treatment model
- Consultant reviews
- Early discharge planning through models like the Home First Team and Age UK well@home Service
- Bed reconfiguration
- Workforce optimisation including locum clinicians
- Increased footprint utilisation to improve patient flow
- Adherence to professional standards supported by collaboration with GIRFT

2.5 Elective Care and Diagnostics

The NENC Provider Collaborative (PvCv) leads the Elective Care programme, and this is delivered predominantly through the work of our 8 Acute Trusts with commissioner support where appropriate. Although we are the best performing system for 18-week referral to treatment (RTT) performance in the country, we are not complacent in this regard and recognise the need to be well placed to ensure the elective programme and corresponding elective operational planning trajectories are delivered as we prepare for winter 25/26.

We will manage pre-admission demand by embedding specialist advice as BAU through advice & guidance (A&G) and full clinical referral triage. A systemwide Task & Finish group will implement the Specialist Advice Operational Delivery Framework, optimise referral management, and reduce unnecessary referrals into secondary care.

We will expand the range of triage pathways to ensure that outpatient first appointments (OPFA) are only offered to relevant patients and continue to expand roll out of one stop clinics. We will ensure that referrals comply with Value Based Commissioning (VBC) guidance, and that A&G is included into clinician job plans. Building on the success and experience of the Q1

sprint validation exercise all providers have prioritised maintaining the momentum in Q2 for the second sprint validation; this is essential preparation in terms of waiting list management ahead of winter.

We will expand outpatient transformation initiatives to reduce within-pathway demand. This includes ensuring patients are discharged appropriately, deploying appropriate digital solutions to replace traditional follow-up, and continuing to optimise and streamline the patient-initiated follow-up (PIFU) pathway. Outpatient productivity will be improved by standardising clinic templates in line with national GIRFT recommendations and by focussed work to reduce missed appointments (DNAs). This will include supporting trusts to share best practice and harness digital innovations, implementation of the Remote Consultation toolkit, and streamlining access policy content across NENC Trusts. Group clinics and super clinics are being scoped across appropriate specialties. Reduction of DNAs is being addressed through expanded uptake and functionality of the patient engagement portal, targeted interventions for vulnerable patient groups, and contacting patient's pre-appointment where DNA rates are high.

We will maximise inpatient productivity through day-case rate and theatre utilisation improvements. Key pre-operative work areas will include improving capacity within face-to-face assessment, development of a digital platform to streamline pre-surgical management and support tailored interventions, and integration with NHS systems for early risk assessment. We will maximise the appropriate use of current Elective Hubs and identify requirements for future sites. Ongoing work continues to convert elective overnight operations to day case or outpatient procedures for patients where clinically appropriate, and utilising British Association of Day Surgery (BADS) rates and GIRFT recommendations to help identify opportunities for improvement.

A Health Inequalities Steering Group has recently been established with a work programme including targeted interventions to reduce DNAs in vulnerable groups, poverty proofing, and health literacy. The RAIDR digital platform for Early Screening and Risk Assessment will allow identification of specific patient cohorts, and the NENC Waiting Well programme will support those already on the waiting list. This is expected to reduce cancellations of elective procedures, while also reducing demand on non-elective care.

Community Diagnostic Centres are providing additional diagnostic capacity for imaging, cardiac and respiratory diagnostic tests, supporting the delivery of DM01 (Diagnostic Waiting Times and Activity) targets, RTT, and cancer pathways, releasing capacity on acute sites to support enhanced patient flow.

We will deliver cancer performance improvement through increased diagnostic capacity to enable earlier diagnosis, as well as prioritising surgical capacity to support cancer pathways. This is underpinned by tumour group pathway reviews and action plans to create care pathways that are compliant with access standards by-design, to be developed and implemented throughout 2025/26.

2.6 Communications, Engagement, and Involvement: Supporting our communities to stay well and access the right care this winter

The following sets out a high-level summary of region-wide communication and campaign approaches for winter 2025/26. A detailed tactical comms plan is currently being developed. This winter, working with partners across the system we will take a co-ordinated, joined-up approach to communications, ensuring that the public receives clear, consistent advice on staying well this winter and accessing NHS services appropriately.

Experience tells us that a consistent approach in region, fully supported by partners across health, local authorities, public health and social care, enables us to create a joined-up approach to both behavioural change and communications when needed most.
Our activity also includes raising awareness about the actions we are taking as a region to prepare for winter and our plan's three priority areas to deliver care in the right place.
As well as specific public and 'system-facing' communications during times of surge/pressure, working closely with Strategic Control Command (SCC) and NHS comms network (as well with partners) across the health and care system.

Aspects of our communications will be delivered under the region-wide umbrella 'Here to Help' campaign which also includes 'Be wise, immunise' to promote vaccine uptake, and will be aligned to national campaigns and communications. This year's plan will take into account learning from last year's evaluation of our winter campaigns. It is worth noting that aspects of our campaigns have received national recognition for their impact, including the use of trusted voices in the multi award-winning #ByeByeUTI campaign and the award-winning Vaccines in Pregnancy campaign that we promote throughout the year.

Helping people to stay well and access care

At the heart of our communications is a focus on signposting people to the right service for their needs and supporting them to stay well.
We will be encouraging people to:

- Think pharmacy, NHS 111 online, or GP first for non-emergency care
- Be aware of services provided by local community pharmacists, such as treatment for seven common conditions and other minor ailments
- Encouraging use of online services, including the NHS App, across primary care
- Understand when to use urgent treatment centres (UTCs)
- How they can access support for their mental health in a crisis through NHS 111 and self-care
- Advice on general self-care – keeping warm, a well-stocked medicine cabinet and ordering prescriptions on time
- Encouraging people to take up winter vaccines to protect themselves and others
- Help stop the spread of illness – good hand hygiene, don't visit relatives in hospital if you are ill etc.
- Directing parents and carers to the right help, at the right time, via a trusted local NHS platform – Healthier Together and the Little Orange Book

We will work closely with our Strategic Command Centre (SCC) using real-time intelligence to share timely messages during periods of high demand, including updates about A&E

pressures, alternative services, and when to avoid visiting relatives in hospitals if unwell to reduce the spread of infections such as norovirus. This includes working with communications networks across LAs, Healthwatch, VCSE sector, LAEDBs and LRFs where required.

Winter vaccinations

Increasing uptake of winter vaccinations is a key priority. We will build on our region wide 'Be wise, Immunise' campaign using ‘trusted voices’. The aim will be to encourage eligible people to protect themselves and others by getting the flu, COVID-19, RSV and whooping cough vaccines.

Alongside public-facing efforts, the ICB and NHS trusts in our region will take a joined-up approach to promoting **staff flu vaccinations**, ensuring that NHS colleagues are protected and supported to stay well throughout winter. This year we will continue to take a targeted approach - using data on areas with low uptake to direct communications where they are needed most, including

- Frontline health and care staff (flu)
- People with learning disabilities
- Pregnant women (flu)
- High risk groups
- 2-3 year-olds (flu) (potential for CPs to offer nasal spray)
- Children with asthma.

We are working at scale with comms, clinical reference group, public health comms leads network to amplify messages, identify gaps, inequalities and pool resources.

A digital campaign toolkit to be shared with LAs, GP practices, PCNs, VCSE sector and pharmacies. Working with local authorities to publicise walk in vaccination clinics on digital front door. The digital front door website, bewiseimmunise.co.uk is a regional NHS website offering a simple way for members of the public to book their COVID-19/flu vaccines at pop-up clinics across the region. The website also provides information to the public about vaccine eligibility and where to seek advice.

Funding has been secured to support advertising across social media, audio, TV and targeted SEO advertising, for this aspect of our winter campaign. This will start from 1 October with weekly data updates to determine areas of low uptake to geo-target advertising across the region.

Using data and insights

Our approach will be underpinned by data (such as patterns of A&E and UTC attendance last winter) and real-time service intelligence, allowing us to adapt messaging to reflect local needs and system pressures. We’re also using insights into vaccine uptake to focus communications on the communities most at risk, with tailored messaging and targeted advertising to support access and build confidence.

Tools, channels and partnerships for system-wide impact

To support consistency and amplification of messages across our region we will develop a communication and campaign toolkits for NHS, councils, VCSE, schools, universities and other partners to use across their own channels.

Subject to budget approvals, our Here to Help campaign activity will be supported by advertising across radio, TV, digital out-of-home, social media, and programmatic advertising, reaching people across the North East and North Cumbria over a three-month period. As mentioned, funding has been secured for Be wise, Immunise campaign through SVOC.
We will continue to have a joined-up and pro-active approach to working with the media over the winter across NHS organisations in the region – as well as with wider partners where required. This has played a crucial part in helping amplify our messages. We will evaluate campaign activity on an ongoing basis and after delivery for future learning.

3. Risks to delivery of the plan

There are numerous risks across our system that could potentially impact on our delivery this Winter. These risks have been identified, built into provider specific and system wide plans and the system will endeavour to address where possible.

The key risks can be summarised into the themes detailed below:

- System capacity and lack of additional winter funding to develop specific winter schemes during the winter months
- Vaccination rates (both community and front-line health care workers) and the impact this has on demand, IPC and staff sickness
- Known and unknown healthcare worker industrial action
- Hospital flow and discharge pressures linked to demand management and community capacity
- Estates challenges
- Competing priorities over winter period – Elective Vs Non-elective
- Successful implementation of transformation schemes

Key strategic programmes of work delivered by our Transformation team will have a robust project management structure in place, including detailed risk logs that will be appropriately managed. Our LAEDB's and individual provider organisations will also ensure risks and issues are logged and managed appropriately and are escalated via monthly highlight reports where planned implementation risks occur. The Winter Planning Assurance & Delivery Group will have oversight of all system risks and as detailed in section 1.4 above will report into the UECN Board and the Living and Ageing Well Partnership, and is directly accountable to the ICB Executive Committee

4. Winter Plan Testing

By enhancing and bringing forward the start of the 2025/26 winter planning process in comparison to previous years we have created additional time and space for the thorough assurance and testing of our plans well ahead of winter. Following the Winter Readiness Workshop held on 17 July, LAEDBs have been tasked with undertaking 'check and challenge'

of their readiness self-assessments with the offer of support from ICB and UECN colleagues to facilitate peer review between local systems.

Throughout August LAEDBs will be expected to refine their plans and identify the specific actions that will be delivered to turn their proposals into reality. Progress will be overseen by the Winter Planning Assurance & Delivery Group and supported by the UECN and LAWP alongside ICB Transformation and Planning & Performance colleagues.

NHSE have set an expectation that all ICBs and Trusts stress test their draft winter plans by participating in an NHS England hosted exercise in September. NHSE regional teams will arrange these events and appropriate ICB participation will be coordinated by the SCC and Planning & Performance team.

5. Timeline for Board Assurance

Following completion of the regional testing exercises in September, NHSE have mandated that ICB and Trust Boards should sign-off winter plans and submit a **Board Assurance Statement**. Whilst NHSE do not require organisations to submit their detailed plans for review, they do require assurance that Boards have robustly tested the specific key lines of enquiry to make sure that patients can access the care they need this winter.

The ICB Board Assurance statement asks for confirmation that the following steps have been undertaken:

- The Board has assured the ICB Winter Plan for 2025/26.
- A robust quality and equality impact assessment (QEIA) informed development of the ICB's plan, and this has been reviewed by the Board.
- The ICB's plan was developed with appropriate levels of engagement across all system partners, including primary care, 111 providers, community, acute and specialist trusts, mental health, ambulance services, local authorities and social care provider colleagues.
- The Board has tested the plan during a regionally led winter exercise, reviewed the outcome, and incorporated lessons learned.
- The Board has identified an Executive accountable for the winter period, and ensured mechanisms are in place to keep the Board informed on the response to pressures.
- The Board is assured that the ICB's plan addresses the key actions outlined in the 2025/26 Winter Plan checklist
- The Board has considered key risks to quality and is assured that appropriate mitigations are in place for base, moderate, and extreme escalations of winter pressures.
- The Board is assured there will be an appropriately skilled and resourced system control centre in place over the winter period to enable the sharing of intelligence and risk balance to ensure this is appropriately managed across all partners.

Completed Board Assurance Statements, signed off by ICB Chairs and Chief Executive Officers, need to be submitted to the national UEC team by **30 September 2025.** Trust Board Assurance Statements do not need to be assured by the ICB before submission; however, we will be asking for sight of these documents from all of our trust partners in the spirit of collaboration and system working.

The Winter Planning Assurance & Delivery Group will work with Governance colleagues to ensure that a final version of the ICB Winter Plan is reviewed by the ICB Executive Committee and recommended for sign-off by the Board in line with the national timeline and following the completion of the regional testing exercises alongside providing assurance that the each of key actions outlined in the 2025/26 Winter Plan checklist have been addressed.

6. Recommendations

The Board are asked:

- **to note** the planning process undertaken in preparation for winter 2025/26 across NENC, led by the ICB alongside partners across the Integrated Care System
- **to note** the expectation that a final version of the 2025/26 NENC Winter Plan will be submitted for Executive Committee and Board approval during September and that a Board Assurance Statement needs to be submitted to NHS England **by 30 September 2025**

Name of Author(s):
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- ICB Primary, Community, Urgent & Emergency Care Transformation Team
- ICB System Coordination Centre
- ICB Winter Planning Assurance & Delivery Group

Name of Sponsoring Executive(s):
- Jacqueline Myers, Chief Strategy Officer
- Dr Neil O'Brien, Chief Medical Officer

Date: 22 July 2025

Appendices

Appendix 1 – Winter Priorities

Appendix 1 - Winter Priorities.pdf