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North Tyneside Winter & Surge Plans 2023/24

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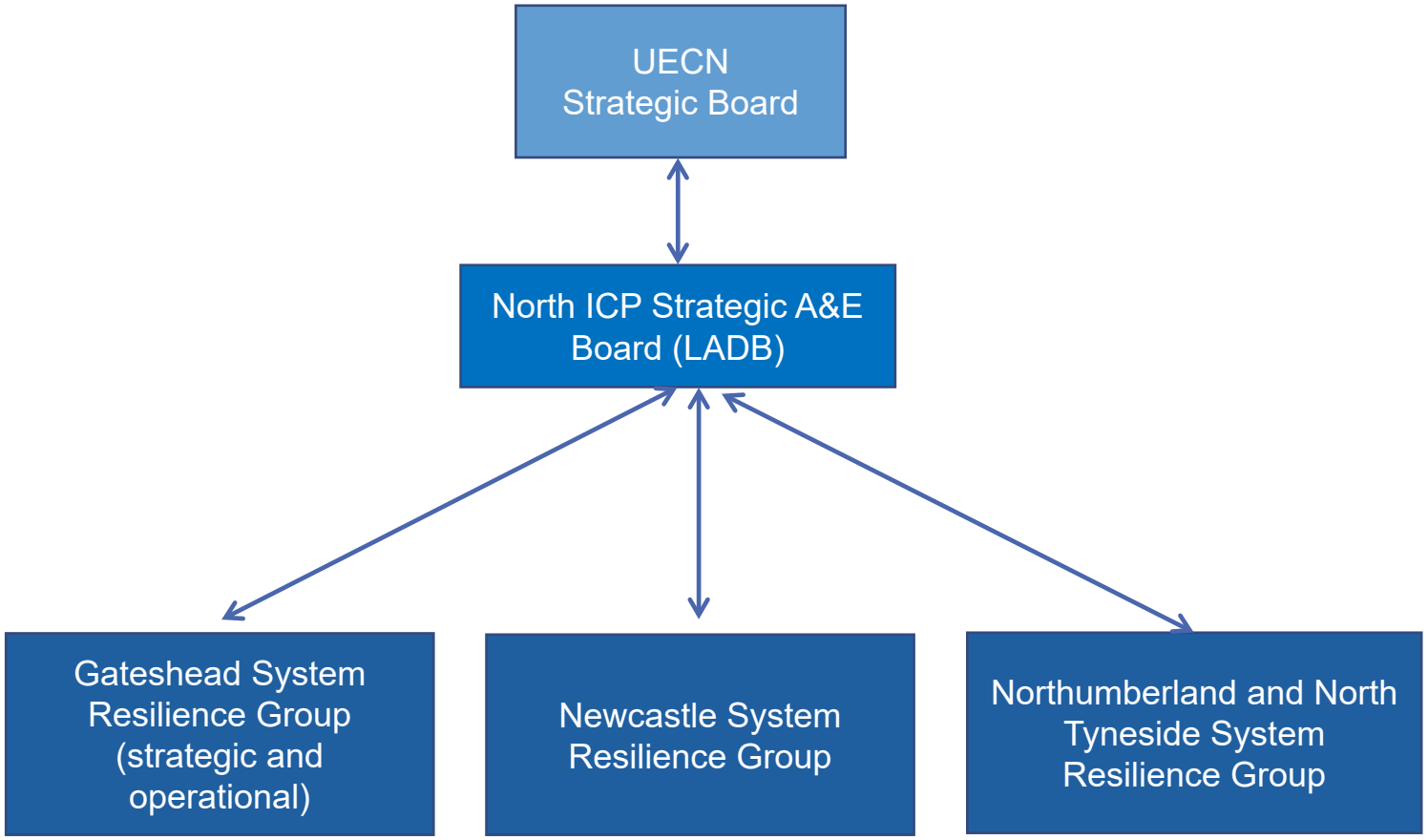
Strategic Overview

North Strategic Surge Planning

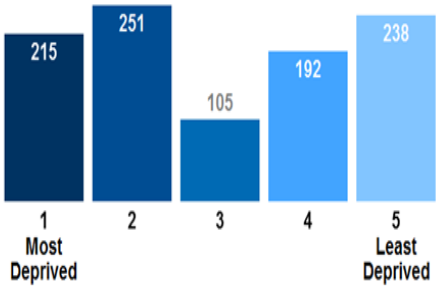
- The North Tyneside & Northumberland System Resilience Group is multi-organisational and undertakes the operational leadership of local ‘place’ based services and delivery. It brings together key stakeholders from across the North Tyneside and Northumberland Place health and social care economy to shape operational resilience and place based service delivery.
- The focus of the SRG has been on the ICB priorities and the 10 High Impact Interventions and how we work as a system to ensure resilience in service provision over the winter period
- The work of the SRG feeds into the North Strategic A&E Delivery Board

North Tyneside UEC Governance

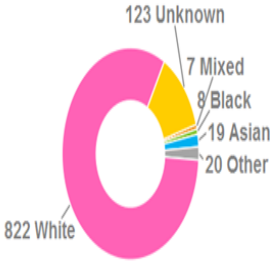


If **North Tyneside** contained 1,000 people... *...(actual population ~226,400)*

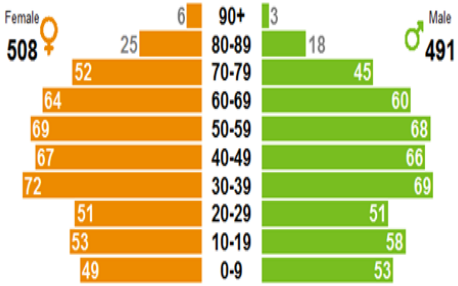
Deprivation



Ethnicity



Population



Life Expectancy

Female 82.5
Male 78.3
Life Expectancy at Birth (Years)

Female +9.6
Male +11.1
Difference in Life Expectancy between Most & Least Deprived Areas (Years)

Education

46.7
Average Attainment 8 Score

5 *of 135*
(3%)
Pupils with Social, Emotional & MH Needs

6 *of 11*
(60%)
'School Ready' at End of Reception

Employment

1 *of 22*
(4%)
16-17 Yr Olds Not in Education, Employment or Training

2 *of 601*
(0.3%)
Adults Long Term Unemployed

Households

12%
of Households in Fuel Poverty

1.1%
of Households with Children are Classed as Homeless

34 *of 171*
(20%)
Under 16s Live in Low Income Families

Carers

181 *of 829*
(22%)
Adults with a Caring Responsibility

Loneliness

156 *of 829*
(19%)
Adults who Feel Lonely Some, Often Or All Of The time

73 *of 204*
(36%)
Aged 65+ Living Alone

Smoking

121 *of 807*
(15%)
Adults Currently Smoke

8.3%
of Mothers Smoke at Time of Delivery

Alcohol

8
Alcohol Admissions (All Ages)

78 *per 100k*
Alcohol Admissions (Under 18)

Physical Activity

499 *of 796*
(63%)
Adults are Physically Active

205 *of 796*
(26%)
Adults are Physically Inactive

66 *of 131**
(50%)
5-16 Year Olds* are Physically Active
**with data*

Obesity

157 *of 807*
(19%)
Adults are Obese

5 *of 22*
(22%)
Children in Year 6 are Obese

2 *of 21*
(11%)
Children in Reception are Obese

How to read this...
If the population of North Tyneside were shrunk to just 1,000 people then 21 would be aged 4 to 5. Of these, 2 would be classed as obese. That means that 11% of those in reception are obese.

Core20+5 Children & Young People

7 *of 193*
(4%)
With Asthma (Age < 18)

23 *of 125*
(19%)
7 to 17 Year Olds with Probable MH Disorder

0 *of 193*
(0.2%)
With Diabetes (Age < 18)

1 *of 193*
(0.4%)
With Epilepsy (Age < 18)

1 *of 9**
(16%)
3 Year Olds* with Visually Obvious Tooth Decay
**with data*

Core20+5 Adults

45 *of 807*
(6%)
With Cancer (Age 18+)

26 *of 807*
(3%)
With COPD (Age 18+)

168 *of 807*
(21%)
With Hypertension (Age 18+)

10 *of 807*
(1.2%)
With Severe Mental Illness (Age 18+)

Frail & Housebound

18
Moderately Frail

8
Severely Frail

14
Housebound

Based on the population registered with GP practices in North Tyneside. Figures may not sum to 1,000 due to rounding.

Integrated Frailty – North Tyneside

- Integration of several staff units into one Community Response Staff group that can deliver Carepoint, Virtual Wards and 2HCUR. This has enabled the sharing of skills across the larger group and a more flexible staff group for the needs of the service. Staff unit includes MDT practitioners including pharmacy.

- The community response service incorporates the integrated frailty model including the Community Nurse Practitioners, proactive care, Elderly Assessment Centre. We continue to be aligned with the Jubilee Day Hospital.

- The community Response service is an integrated team with Care point Health & Social care model with Reablement, Discharge to Assess, admission avoidance, Crisis Response, and planned pathways of care.
- Development of a Single Point of Access for Community Response team, District Nursing and 2HUCR.
- Development of a joint post between the Frailty Assessment Service and Community Response Team. This is a rotational post that will enable more seamless integration and sharing of specialist knowledge.
- A priority within the community is addressing falls and we have implemented a community business unit falls strategy which we are implementing alongside the wider falls' strategic workflow.

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Winter Plan

Capacity and Demand Modelling

North Tyneside

- Our philosophy is to provide care at home or in the community where possible but, using analysis of beds commissioned in 2022/23, we have used ADF funding to fund 20 residential & Nursing beds, plus 10 beds at Edith Moffat and 6 beds at Havelock House to continue to provide resilience in the system moving into winter 23/24. We are also using funding to bolster provision of home care packages to improve discharge from hospital. We have also used data to analyse usage of the British Red Cross for pathway 0 work at NTGH during winter 22/23 and have decided to use funding to commission a similar service.

Northumbria

- Winter Plans for 2023 confirmed to provide additional capacity at the NSECH site to support ED. This will include increasing the Discharge Lounge space from 9 beds to 15 beds and from 5 chairs to 6 chairs. It will also be available 24/7.
- Plans to open additional winter bed capacity at the Base Sites to support flow in the system. In additional new Discharge Lounges have been implemented at NTGH and WGH.
- Additional streaming capacity at NSECH to support at key times of expected pressure.

Improving Flow (1)

- Trusts have in place Discharge Boards at which all potential discharges are discussed each morning in the Site Brief. Length of Stay meetings take place, the frequency of which depends on system pressures but can be daily if required and as part of internal incident processes. A discharge lounge has already been established at NSECH, WGH to facilitate early patient transfer and discharge. NHCT has a dedicated transport system in place to facilitate movement from NSECH to a general hospital site.
- Local authority discharge teams work very closely with Trusts to ensure that the onward transfer from discharge area is undertaken as promptly as possible, aiming to meet national requirements for the majority of patients to be transferred in 2 hrs or same day.
- At NHCT, social circumstances and care needs are included in the admission sections of all nursing and medical documentation in Nervecentre. Community discharge teams are involved at the earliest opportunities where any level of complexity or ongoing care is required DTA opportunities are available. Proactive assessment for referral to intermediate care settings take place. There is a process for combined sign-off with LA colleagues of any delayed transfers of care. Where required, data validation exercises are undertaken to ensure that the Trust and local information both match
- All reporting is undertaken as required including integration of daily reviews into electronic PAS - live lists, available to all agencies, number and % discharge and reasons for anyone not going noted. Updates to the Acute and Community Daily Discharge Situation Reporting Questions is provided.

Improving Flow (2)

- Mechanisms are established on management of any future discharge funding through agreements between health and local authorities. Full implementation of the Discharge to Assess model in line with discharge policy percentages are in place. Data from NHSI reporting is being reviewed to ascertain if the national discharge funding had an impact on flow and to inform discussions with partners on the challenges in the systems and work towards solutions. NHCT has confirmed that DTA opportunities are available from all its in-patient sites and metrics are monitored.
- In North Tyneside, the Trusted Assessor model has been piloted with 4 care homes and ADF funding is being used to recruit an additional Nurse Assessor post which will enable the trusted Assessor model to be rolled out across the borough. It is expected that this will support timelier discharges.
- Work in the community with UCR / Rapid response team, virtual wards, care homes and palliative care teams as well as NEAS will support admission avoidance of patients that perhaps can stay at home with additional support. This will also help improve flow.

Plans for managing for peaks in demand over weekends and bank holidays

- Demand and capacity plans are ongoing currently, including consideration of likely impact such issues as industrial action, flu etc on workforce and hospital admissions over winter
- Hospital based social care teams are on site to support hospital discharges. 7 day services are already in place. Analysis of weekend discharges is being undertaken across all hospital sites to consider if further improvements can be made to pathways to enable more weekend discharges where appropriate.
- PCN Capacity and Access Plans have been prepared to help manage demand and improve patient experience of access. In North Tyneside, a contract with the GP Federation exists for Extended Access on Bank Holidays and weekends. The contract with LIVI is also available offering online GP consultations also available on Bank Holidays and weekends.
- Care home capacity has increased or plans are in place to increase capacity in all places. Capacity is being carefully monitored to enable response to potential spikes in demand over the winter period.
- Reablement capacity is being reviewed at place to develop both short and long term plans. Reablement teams are able to work flexibly to prioritise hospital discharge referrals and to ensure social work can cover other teams at times of high demand
- Work is ongoing at place level to develop domiciliary care provision, although it acknowledged that this is an area of challenge.
- Increased NHS 111 CAS capacity has been confirmed.
- Additional capacity will be sought to support NTGH and WGH UTC during peak times e.g. bank holidays with additional GP capacity. This will also be sought for NSECH to aid streaming.

Primary Care – North Tyneside

- Enhanced access appointments Mon to Sat, providing extra capacity. In 2022/23, all PCNs delivered above and beyond contracted requirements and we are supporting them to maintain this
- We have funded Tynehealth GP Federation to provide enhanced access cover on Bank Holidays and Sundays
- Continue to support PCNs to maximise ARRS recruitment thereby increasing overall capacity e.g., NEAS home visiting team in 2 North Tyneside PCNs. All PCNs have plans in place to spend total budget in 2023/24, maintaining 2022/23 position.
- Livi in my Practice has been rolled-out
- Livi is commissioned to provide additional on-line GP patient appointments including weekends, out of hours and bank holidays
- We are working with practices and PCNs to realise funding and access support associated with the Primary Care Access Recovery programme
- We have ensured that practices have sufficient IT equipment to support remote/flexible working when necessary e.g. adverse weather
- Practices have business continuity plans
- Practices signed-up for NECS sitrep process
- Regular meetings established between primary and secondary care to identify challenges and to reach agreement on how they will be managed
- Work commenced with PCNs to establish ARI Hubs during 2023/24 if funding is received

2 Hr Urgent Community Response – North Tyneside & Northumberland

- This service is open 7 days a week, 24 hours. The service reports via the Community Service Data Set (CSDS) and is currently achieving the 2HUCR response in over 80% of calls triaged to the 2HUCR service. The service is on the Directory of Services for NEAS/111/999 and takes direct referrals from any service including ED via the Single Point of Access phone line. All services that look after 2HUCR patients are onboarded to this service.

- We are working with NEAS on the installation of the NEAS stack software into our triage room to allow the team to pull category 3 and 4 patients directly off the stack. Most team members have been fully trained in this software.

- The team take referrals for the original nine clinical conditions but also for all patients that are suitable for assessment in the community and may need to be seen within a two- hour timeframe. The service is open to any patient living within North Tyneside and Northumberland.

- The service has developed links with North Tyneside Council regarding their Falls Response which will allow the teams to work together to get a patient up off the floor and for them to receive a clinical assessment if warranted.

Ambulance & 111 response (1)

There are robust plans for ambulance services providers to deal with known activity peaks in demand across the period.

- Known activity peaks are managed using the national REAP, local Clinical Safety Plan, and Dispatch Clinical Risk Assessment Procedure.
- Additional hours are being provided by third party providers over Winter
- Instigate surge management meetings around key dates, particularly bank holiday weekends and supplement this with an operational order plan.
- Post-event de-briefs to identify learning and improve future plans is ongoing.
- Adverse weather and other business continuity plans to mitigate business interruptions.
- Monitor the wider system performance/pressures utilising RAIDR and explore proactive options to mitigate system pressures.
- Production of an Operational Order to cover the holiday period
- A C2 Recovery plan focusing on demand reduction, increasing capacity, and improving efficiency. This includes validation of C2 calls by rotational clinicians, HCP triage, and C3/4 validation (demand reduction); increasing third party provision and increasing overtime (increasing capacity); vehicle cleaning process and downtime management (improved efficiency).

Ambulance & 111 response (2)

- Participating in local/regional improvement activity around hospital handover and access to alternative services.
- Actively recruiting additional staff to reduce the current vacancy factor.
- Pre-planned increased Private provider provision
- Introduction of an Operations Co-ordination Centre 24/7 to provide system oversight and responsibility for the management of vehicles including intelligently conveyancing and deflecting.
- Review of the Divert Policy providing clear escalation processes
- Continuing recruitment of Health advisors and clinicians
- Seasonal initiatives such as extension of the Alcohol Reception Centre and Operation Ginger
- Review of the internal escalation plans
- Actively recruiting and training to vacancies.
- Clinical Safety Plans to manage local activity and national contingencies to support national 111 service delivery. Copy below:

Microsoft Word Document

- Local BCPs.
- Consideration of payment of enhanced rates to incentivise shifts
- Reduction of Annual Leave and training
- Flexible rostering to meet the demand
- Alliance working with other providers
- Agile working expanded.

Ambulance Handover delays, plans in place to ensure no delays > 59 minutes

- Trusts were funded to ensure they could put systems and resources in place to manage ambulance handovers within the 59 minute threshold and all are currently working to reduce this further to the national target of under 15 minutes and as per the ICB priority.
- NHCT – implemented a rapid triage process on Nerve Centre to expediate handover process
- Procurement of trolleys to ensure NEAS are able to hand over safely and efficiently
- Increasing the capacity of the Discharge Lounge for Winter.
- Particular pressures have arisen which has resulted in some handover delays of over 59 minutes although analysis has shown that this has dropped in recent months.

ED Front Door Streaming

- Pilot at NSECH undertaken over 17 days to stream walk-in patients at ‘front door’ to ensure patients get to the right place. Options for potential disposition included ED, primary care, SDEC and Urgent Treatment Centre. ED was a potential disposition point rather than first port of call.
- Streaming being undertaken by UTC staff and Trust is considering training further staff.
- Pilot now being rolled out 3 days pw to triage patients before booking into ED and booking appointments where possible or signposting to alternative dispositions.
- Noted benefits include no unnecessary investigations when patients are streamed away from ED. Saves investigation and Junior Doctor time.

Virtual Wards
North Tyneside & Northumberland

- There are now 9 Virtual Wards open across Northumbria Healthcare trust for patients from North Tyneside and Northumberland

  1. Frailty 2. Respiratory 3. Community 4. Colorectal Surgery 5. Trauma and Orthopaedic Surgery
  6. Uro Gynae Surgery 7. Rehabilitation 8. Lung Cancer 9. Heart Failure

- All these wards predominantly support step down patients from acute wards to enable the patient to leave the acute hospital earlier than previously possible. The Frailty ward support step up and step-down patients. Between 12th December 2022 and 1st September 2023 619 patients have been treated on a virtual ward.
- All wards are based on a three-tier model with Tier one delivering the highest level of hospital care (previously Hospital at Home) and Tier three patients requiring less intensive or monitoring only level of care. The care is delivered by Nurse Specialists in Respiratory, Frailty and Heart Failure, Community Nurse Practitioners, Nurse Practitioners, Physiotherapists, Occupational Therapists and District Nurses. This team is supported by Pharmacists, ACP's, Nurse educators and a team of technical assistants.
- All patients are under the care of a named consultant with an agreed escalation criteria and plan.
- The Virtual ward programme team are focusing on pathways for step up patients. Step-up pathways are for patients that are identified in the community and the aim is to avoid admission. These patients will be assessed, and a defined plan of care developed for this acute episode. The virtual ward will only accept patients within clearly defined Treatment Escalation Plans and Emergency Healthcare plans with agreed pathways for common conditions. There will be regular monitoring of patient's condition including observations by staff and reviewing of appropriate levels of intervention. This may include de-escalating treatments and moving towards end-of-life care or escalating to hospital admission. The service would consist of a multi-disciplinary teams equipped to carry out assessment and management alongside therapy and care. Responsibility for the patient would be shared between the Virtual Ward team and the patient's GP or consultant.
- As per the winter planning guidance the frailty virtual ward is aligned with the Elderly Assessment Centre (Care Hub) to allow patients to seamlessly pass onto the Virtual Ward without admission to hospital.
- Work is underway with the paediatric team at the Trust to scope the development of a paediatric virtual ward.

Mental Health/Learning Disabilities/Autism Provision (1)

- Partnership working between CNTW and NHCT is ongoing across several workstreams to ensure that Urgent and emergency care, including the services for those with mental health, Learning Disabilities and Autism are met in the most effective and timely way.
- ICB funding for UCT to support alternatives to admission and inpatient flow continues and we are looking at how we broaden the multidisciplinary offer to ensure all aspects of service user need at the point of transition are met.
- Older Peoples Services Psychiatric Liaison service offers a 7 day service.
- Bed pressures impacting all Access Pathways continue to present as challenging for all within the system. Regular interface meetings and strategy meetings occur for complex care issues, which expedite issues as they arise. Daily flow meetings occur to look at bed pressures across all pathways and to find resolution as quickly as possible.
- In Northumberland and North Tyneside there is increased access to Together in a Crisis for people who currently need direct support for an urgent non-clinical crisis. The service has now been extended to CNTW Home Treatment, Transitional Discharge and Addictions Teams, Psychiatric Liaison (PLT) and to accept referrals from the ARRS posts in Primary Care and the support line offered by Tyneside Northumberland Mind.

Mental Health/Learning Disabilities/Autism Provision (2)

- Ageless Psychiatric Liaison Team (PLT) and Universal Crisis Team (UCT) services continue to work within Northumberland and North Tyneside.
- PLT moved into clinical accommodation on the NSECH site which is located to support rapid response to ED. PLT are being supported to use a quality improvement programme to ensure waiting times are to national standards.
- Also in Northumberland and North Tyneside, an Enhanced Pathway Liaison and UCT collaborative pathway for children & young people for those up to age 25, between PLT & UCT, offering up to 3 follow up appointments with UCT following assessment with the Liaison Team.
- Place based areas are looking to develop crisis café/safe havens in line with Community Mental Health Transformation Programmes. There is identified accommodation for both Northumberland and North Tyneside and the service model has been agreed in partnership with Everyturn Mental Health and the voluntary sector. Newcastle will imminently be launching its adult Crisis Café.

Discharges and flow; robust systems in place to support 7-day discharge via a multi-agency approach

- System Leadership is well established at place, comprising of appropriate personnel with authority and responsibility for working with colleagues across the health and social care system to improve discharges identifying challenges in the system and developing and agreeing solutions to overcome those challenges.
- Collect home situation details on admission, communicate discharge process with families and carers
- The 3 stage D2A model implemented (review, agree plan to transfer, follow up by assessment at home) is in place
- Criteria to Reside and 'Home First' approach is our ethos and which the Trusts implement
- Discharge action cards have been shared with and are used by staff involved in the discharge process. Systems are in place to identify where additional staff education or training would be appropriate e.g. communications at NUTH are underway to improve knowledge of ward staff of right to reside criteria and system flow for patients, encouraging earlier planning for discharge. NHCT is currently reviewing action cards in use as part of the discharge pathway board work.
- Information on pathway 0 to pathway 3 - numbers, % and any reasons patients didn't go home - is collated a minimum of 3 days per week but, when in surge, this is available daily
- Local Authorities work with Community & Voluntary sector organisations to ensure that service users and discharged patients have all of the necessary needs met e.g. food in their home, to enable them to return home safely
- Other influences on improving discharges will include further development of 2 hour urgent responses at place

Discharges and flow; robust systems in place to support 7-day discharge via a multi-agency approach

- Established a North Tyneside Discharges Group which includes representatives from ICB, LA, NHCT and CNTW Trust. Meets regularly to review discharges and flow. Care Point, as the Discharge Hub for North Tyneside, is embedded at NTGH. Joint commissioning in North Tyneside of 20 residential and nursing home places and 16 Extra Care flats as step down facilities, plans to recommission vol sector pathway 0 support to aid discharges and flow. Also rolling out Trusted Assessor model to reduce the need for Care Homes to assess patients being discharged into their care. A rolling recruitment drive is underway for additional domiciliary workers.
- Agreement to use non-recurrent funding with voluntary sector (VODA) in North Tyneside to work with local communities to provide support over the winter period.

Discharge Fund allocations:

£'s	2023/24	2024/25 (TBC)
LA Funding	1,342893	
ICB Funding	863,656	
Total	**2,206,548**	**3,662,8741**

Discharge schemes include:

- Step down residential beds
- Step down extra care
- Expanding homecare capacity
- Project management
- Assistive Technology
- Contingency for additional winter capacity
- Voluntary sector support
- Supporting workforce issues
- Trusted assessor
- Ambulance service

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SURGE PLANNING

Programme in place for high intensity users

- Each Trust has a process to help manage high intensity users. These have been shared with commissioning colleagues.
  For example, in Northumbria Healthcare Trust, an emergency department high impact user team was created in 2018 to ensure consistency in the care of patients who attend the department frequently or have additional care needs. This can involve identifying any unmet needs via an MDT approach and addressing these collaboratively. The ED team meets regularly and attends the Trusts bi-monthly Frequent Attender meeting chaired by the Adult Safeguarding team. The team has recently reviewed its process and identified specific actions for development including standardising its approach to the Duty of Candour, potentially expanding the Safeguarding team and to programme explore further audit and quality improvement work to objectively assess the impact of the High Impact User Service and introduction of ED Patient Care Plans in terms of potential effect on overall number of attendances, length of stay in the department and reduction in incidents.
  NuTH has existing plans in place for several high intensity users. The HIU steering group restarted August 2023.

ICP Surge and Escalation (Extremis plans)

- System partners participated in and helped develop ICB Extremis Plans with Surge Team
- Updated Primary care OPEL scoring providing daily indicator of general system pressures developed
- National OPEL scoring developed and being introduced. New OPEL Action Cards developed
- Weekly ICB-wide Surge meeting to discuss pressures and agree any actions, including mutual aid requests and offers
- ICP-wide Surge calls on standby to take place as necessary – frequency is variable depending on levels of pressure in the system. Areas of escalation feed into ICS surge meetings when necessary
- Trusts provide sitreps seven days a week from December.
- Systems advise NHSE/I when one partner escalates to OPEL 3 or REAP 3.
- RAIDR U&EC app provides summary of system pressures including Trusts, Primary Care, Care Homes and Ambulance Service

COVID Strategy

- This winter the function of SVOC linking with the Regional and National COVID Vaccination Programme will still be in place. This includes the central supply and delivery of vaccine via the Foundry system, the data and monitoring of all vaccines delivered across NENC, with a mechanism to monitor and performance manage provider and community activity.

- SVOC links closely with the NENC Vaccination Board chaired by Neil O'Brien (ICB Medical Director) and NHSEI colleagues – again this is attended by locality COVID (and Flu) leads and providers.

- There are weekly meetings with have continued throughout the pandemic which has Place representation for all areas in NENC. This meeting is used to raise matters by exception and discuss ongoing plans to be shared within local systems and meetings at place. This group would be able to escalate surge planning from the National Team should this be necessary.

- Each locality then has a vaccine delivery/ planning board linking all providers, to ensure the ongoing planning and delivery of the COVID vaccine (and flu and other vaccines) is managed inline with JCVI guidance and National Strategies. These would manage Surge planning should it be necessary due to outbreaks, new variants, or increased demand.

Actions Identified to deal with COVID-19

- As always, NT is putting considerable focus on and effort the Autumn/winter 2023 vaccination programme and doing so within JCVI advice
- Multi agency place based Vaccination Boards meet regularly. The Boards coordinate such activities as the approach to vaccination for patients who are housebound or live in care homes and keep an overview of practices and partners plans. They also review uptake by practice and PCN and agree appropriate intervention when uptake is lower than expected.
- COVID-19 vaccination leads meet regularly with colleagues across the ICS to ensure that place system leads are fully appraised on national and local issues.
- In North Tyneside, there is a good range of vaccine providers across the borough.
- There is a focus on delivery of vaccinations in wards where there are higher levels of inequalities. Ward based plans are regularly submitted.
- Opportunities to co-administer with flu vaccine are being taken where possible
- Take up of the COVID vaccine compares very well in North Tyneside to the rest of the ICB. Targeted work takes place undertaken where required and take-up rates are continually monitored to identify and address any areas of concern

Influenza Strategy

Influenza strategy with links the NENC Vaccination Board

- Each locality had a Flu (and Covid) Lead – to connect with the local providers to ensure the flu targets are being met and monitored via the Local Vaccination Boards.
- Local Vaccination Boards consists of GP/PCN lead, maternity services, children's services/school Imms Team, a rep from the Trust, rep from Pharmacy/LPC and a link to NHSEI Flu team to share local and regional breakdown of data.
- Collaborative planning is enabled with this approach at local Place levels.
- The Flu (and Covid) Leads will also report to the NENC Vaccination Board to connect the local deliver plans to the regional plans, reporting anything by exception.
- There are monthly / two weekly meeting for Flu (Covid) leads hosted by NHSEI colleagues, again to share information, raise issues by exception, discuss areas of good practice and areas that need development to meet targets outlined in the National Flu Letter.
- Specific work areas include:
  - Community pharmacies continue to offer vaccinations
  - Extended Access appointments to support flu
  - Review of maternity services provision for pregnant women
  - Developments with the Collaborative partners to strengthen the offer to 2-3 year olds
  - Healthy 50 – 64 yrs being offered flu vaccine.

Adverse Weather Plan

- Each Place has business continuity plans in place as part of their statutory responsibilities which cover impacts of adverse weather, updated regularly and has a Major Incident & Business Continuity Plan which includes specific appendices on adverse weather, close of premises and staff attendance.
- Plans and priorities have been set for all Adult Social Care & Integrated Services Buildings in terms of business continuity.
- An adverse weather plan is in place in Local Authorities which covers co-ordinating a response to issues such as floods, ICT failure, power failure, extreme weather, snow. In Newcastle, there is a City-wide Major Incident Duty Officer on call at all times. In North Tyneside, the Care Call Crisis Response Team is available 24/7.
- GP Practices in each place have business continuity plans. Formally, there is Local Health Resilience Partnership that provides 'a route of escalation for the LHRP in respect of commissioned provider EPRR preparedness' .
- Equally, provider organisations also have major incident and business continuity plans in place
- There are also national cold weather and heatwave plans. Alerts are received and disseminated to provider organisations.

Advance Warnings

An adverse weather plan which includes the clinical impact of cold weather and snow and also the impact on business continuity (continued)

Regional

- At a national level NHS England Cold Weather plan provides trigger levels and examples of good practice for organisations to implement
- Individual health and social care providers put in place their own adverse weather and business continuity plans detailing trigger points and appropriate actions to be put in place when required
- Provider organisations are required to provide copies of their adverse weather and business continuity plans to NECS for sharing on the surge management and winter website across the health and social care economy

Operational Management

- The SRB will again provide operational oversight of the whole health and care system, paying particular attention to the impact of system pressure. In times of sustained periods of adverse weather, Local resilience groups will coordinate the local response, to rapidly and seamlessly react to local pressures and problems so that the provision of high quality patient care is not adversely affected through effective partnership and collaborative working. This local response will include the liaison with NHSE/I (inc. commissioners of independent contractors such as primary care, pharmacy and dentistry), PHE and Local Authorities.