

## BLMK Winter Strategy and Plan 2025/26

BLMK Winter Plan 2025/26						
<b>Strategic Aims &amp; Objectives</b> To ensure patient safety is maintained across all Urgent and Emergency Care (UEC) pathways, including patients awaiting a clinical response in the community, To maintain a resilient UEC system that <b>grips escalation</b> whilst avoiding a detrimental impact on <b>elective care</b> . To maximise immunisations to public and staff ahead of winter. Maximize use of alternatives to ED, including UCCH, VW, community, primary care and pharmacy capacity. <ul style="list-style-type: none"> <li>– Sustain or improve <b>A&amp;E performance</b> - working towards 78% of patients being admitted, transferred or discharged within 4 hours.</li> <li>– Improving <b>Category 2</b> ambulance response times relative to 2023/24, to under 30 minutes across 2025/26</li> <li>– Reduce <b>ambulance handover delays</b> and achieve the 45-minute <b>release to respond</b> target</li> <li>– <b>Reduce</b> the number of patients who remain in an ED department over <b>12-hours, inclusive of mental health patients</b></li> <li>– See more <b>children</b> within <b>4-hours</b> in emergency departments</li> <li>– Increasing the <b>productivity</b> of acute and non-acute services across bedded and non-bedded capacity, improving flow and length of stay, and <b>clinical outcomes</b></li> <li>– Continuing to <b>develop services</b> that shift activity from acute hospital settings to settings outside an acute hospital for patients with <b>unplanned urgent needs</b>, supporting proactive care, <b>admissions avoidance</b> and <b>hospital discharge</b></li> </ul> <ul style="list-style-type: none"> <li>• The BLMK winter plan will outline the steps that our system will take to <b>maintain resilience</b> and manage a surge in demand above anticipated winter pressures. The winter plan is being co-produced through the MK Partnership and Bedfordshire Partnership and across system providers.</li> <li>• 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.</li> </ul>						
<b>Organisational / Workstream Leads</b> Inter Director – <b>Georgie Brown</b> BHFT: <b>Cathy Jones</b> MKUH: <b>Faye Gordon</b> CCS: <b>Pete Reeve</b> ELFT (Community): <b>Robin Campbell</b> ELFT Mental Health: <b>Michelle Bradley</b> CNWL: <b>Caroline Davies</b> Vaccination Programme SRO – <b>Craig Lister</b> SCC and Winter Planning Lead: <b>Francesca Cummings</b>						
Primary Care: <b>Steve Gutteridge &amp; Amanda Flower</b> Children & Young People: <b>Simon Puchtler</b> Communications: <b>Steven Thomas</b> Mental Health: <b>Rachel Volpe</b> CBC: <b>Stuart Mitchelmore and Kaysie Conroy</b> LBC: <b>Faith Haslam and Kate Sutherland and Stephen Lonsdale</b> BBC: <b>Alex Wrack and Jodi Simpson</b> MKC: <b>Mick Hancock</b>						
<b>Key Priorities</b>						
<b>Priority 1</b> From treatment to prevention: taking steps now to reduce demand for urgent care later this year	<b>Priority 2</b> From hospital to community: increasing the number of patients receiving care in community settings	<b>Priority 3</b> High-quality emergency care: meeting the maximum 45-minute ambulance handover	<b>Priority 4</b> Improving flow through hospitals	<b>Priority 5</b> Mental health teams leading from the front	<b>Priority 6</b> A whole system approach to improving patient discharge	<b>Priority 7</b> From analogue to digital: using data and digital investment to improve flow
<b>Delivery in BLMK</b>						
<b>1 September:</b> <ul style="list-style-type: none"> <li>• Pregnant women</li> <li>• All children aged 2-3 years as of 31 August 2025</li> <li>• Primary school children (Reception – Year 6)</li> <li>• Secondary school children (Year 7-11)</li> <li>• Children aged 6 months - &lt;18 years in clinical risks groups</li> </ul> <b>1 October 2025:</b> <ul style="list-style-type: none"> <li>• Adults ≥ 65 years</li> <li>• Adults 18 - &lt;65 in clinical risk groups</li> <li>• Residents in long-stay care homes</li> <li>• Carers</li> <li>• Close contacts of immunocompromised individuals</li> <li>• Frontline social-care workers</li> <li>• All frontline healthcare workers,</li> </ul>	<ul style="list-style-type: none"> <li>• Support and identification of high risk patients to support urgent care needs</li> <li>• Increase and maximising of alternatives to ED across 111, community and primary care and pharmacy</li> <li>• Validation of ambulance Cat 3 &amp; 4 and pilot of Cat 5 calls</li> <li>• Maximising community support</li> </ul>	<ul style="list-style-type: none"> <li>• Embedding of handover 45 SOP, with regular review of processes and effectiveness of new Rapid Assessment Unit (RAU).</li> <li>• Call before you convey (CBYC) to reduce unnecessary ambulance conveyances through encouraging alternative pathways to ED.</li> </ul>	<ul style="list-style-type: none"> <li>• Optimising teams, capacity and assessments</li> <li>• Early discharge planning and Discharge Ready Dates</li> <li>• Regular LOS reviews and MADE events to support reduced LOS</li> <li>• Pathways in place for practices to refer directly into hospital specialities</li> </ul>	<ul style="list-style-type: none"> <li>• MH UEC Improvement plan in place to support flow, discharge, crisis response and support</li> <li>• Discharge processes and PTL management</li> </ul>	<ul style="list-style-type: none"> <li>• Whole system focus on discharge planning and processes, trajectories and thresholds established and monitored</li> </ul>	<b>Supporting people to live independently</b> <ul style="list-style-type: none"> <li>• RaizerChair II (Care Homes)</li> <li>• Whzan Blue Box: kit</li> <li>• SystmOne integration in place with 2 GP practices.</li> <li>• Telecare Service working collaboratively with Falls and Reablement Teams and Adult Social Care Teams ensuring timely referrals and access to telecare equipment.</li> <li>• To work with partners to identify any available technology to assist with falls management.</li> </ul> <b>Data</b> <ul style="list-style-type: none"> <li>• SHREWD and EWS forecasting</li> </ul>

## Key Actions to Support Delivery

- A. Robust escalation processes with SCC (System Coordination Centre) management and system oversight and co-ordination of operational challenges. Review of OPEL and escalation processes. Established team and rhythm to lead de-escalation alongside system partners. Excellent support from all parts of the system, including local authorities and expect this to continue throughout winter. 7-day system calls across BLMK when at OPEL 3-4
- B. Development of early warning signals tool and forecasting performance on SHREWD allowing for early interventions to decompress challenges
- C. MADE events being pre-planned to proactively address historic challenged periods.
- D. Bedfordshire UCCH in the community is transferring care from the ambulance stack to avoid unnecessary conveyances to hospital.
- E. Across BLMK, Virtual wards are wrapping community and medical led care around individuals at home. This supports both admission avoidance and reduced length of stay. Focus areas include frailty, respiratory and paediatric care.
- F. The ICB is piloting a mobile x-ray in the community to assess if residents who have fallen have a fracture and/or need taking to hospital.
- G. Release to respond' ensuring acute Trusts transfer patients into their A&E department as soon as possible (and no later than 45m) to release the paramedics to manage other residents' needs.
- H. 111 triaging of low complexity calls that have come through to the ambulance service explores alternative ways of meeting the residents' needs other than an ambulance.
- I. New Central Bedfordshire Falls prevention service will offer a coordinated, evidence-based approach to reducing falls among older residents – improving outcomes, preserving independence, and reducing system pressure
- J. New Redrooms in acute hospitals will provide isolation space for patients with infections such as influenza, norovirus, MRSA, CPE, and C. diff, and will enable hospitals to isolate infectious patients without the need to close bays.
- K. New robotic arms will support dispensing of medications, shortening the time patients wait for their discharge medication and releasing hospital beds.
- L. Integrated Discharge Team development in all Trusts – Milton Keynes model maturing in readiness for Winter. Multi-organisation approach within the same environment is unblocking flow challenges. Model will support the reduction in patients with 7+ and 21+ days length of stay.
- M. Developing local targets for each pathway (P0 - P3) – with focus on gap between Discharge Ready Date and date of discharge to drive reductions in LOS. This is instead of a focus on which pathway residents are on as we perform well on this.
- N. Continued support from VCSE who provide a 'hospital aftercare service', supporting patients settle at home following an acute hospital admission. VCSE also support with transport where PTS provides don't have the capacity or cannot respond in a timely manner.
- O. Increasing focus on Mental Health flow – both in Acute and through community settings. Escalation call rhythm being implemented now to ensure parity with physical health. Enhanced PTL oversight now to improve resilience ahead of winter. Lessons learnt exercise complete and partners working through actions
- P. Bedfordshire potential of additional Mental Health Capacity with 9 beds across 4 wards, phased from Q3 into Q4. MH crisis assessment service and implementation of crisis text line for MH for mobilisation by Q4.
- Q. Targeted and focused Winter Communications planned from September.
- R. Full immunisation and vaccination strategy and plan
- S. Performance trajectories for each provider which will improve outcomes for our residents i.e. discharge ready dates, length of stay, mental health flow (all to be monitored by individual organisations and oversight via SCC)
- T. Maternity and mental health OPEL indicators on SHREWD and Mental Health OPEL action cards
- U. Strengthening 7-day working across partners to deliver improved weekend discharge profile
- V. Commissioning of 10 Dementia Discharge to Assess beds for Bedfordshire
- W. ELFT in-reach team at BHFT to reduce delays across P1-P3
- X. Zero tolerance to bedding of SDECs
- Y. Bedfordshire UCCH optimised with paramedics, ED Consultants and Frailty teams co-located with an embedded call avoidance helpline
- Z. New Bedford Hospital SDEC (unable to use as bedded area)

## Key Timelines

- |   |                                 |
|---|---------------------------------|
| ➤ Winter Template shared  | 23 June 2025                    |
| ➤ Draft Winter Plan submission from all Partners                                      | 7 July 2025                     |
| ➤ Plan Trajectories Submitted by all Partners   | 14 July 2025                    |
| ➤ Draft Winter Plan Presented to CEOs for sign off                                    | 24 July 2025                    |
| ➤ Regional Review with focus on winter  | 4 August 2025                   |
| ➤ Draft Plan Submission to NHSE   | 5 August 2025                   |
| ➤ Begin rollout of flu vaccine to pregnant women and all eligible children            | w/c 8 <sup>th</sup> September   |
| ➤ Final Winter Plan and Board Assurance Framework presented to ICB Board              | 26 <sup>th</sup> September 2025 |
| ➤ Commence flu and COVID-19 vaccine rollout to all eligible adults                    | 1 October 2025                  |
| ➤ Last available appointment on NBS and Flu autumn/winter vaccination programme ends. | 31 March 2026                   |
| ➤ Stress Test Winter Exercise   | 29 September 2025               |

**Risks/Challenges and Mitigation**

- EEAST HALO cover
- UCCH – Community capacity to support admission avoidance
- Mental Health – CRFD numbers, flow, S136 delays, data management
- IPC management and cohorting
- Paediatric ED, Virtual Ward and UCCH dashboard/data oversight
- Potential IA disruption
- Weather conditions and impact on providers/service delivery
- ICB SME's/on-call rota through ICB cluster transition process
- SCC workforce and resilience/sickness/leave

**Governance and Monitoring**

ICB UEC Group (fortnightly)  
Bedfordshire System Leaders  
MK Improving System Flow  
BLMK UEC Board  
Bedfordshire Chief Executive Officer Group



**Priority 1 - From treatment to prevention: taking steps now to reduce demand for urgent care later this year**

Initiatives	Date (Start and End)
<ul style="list-style-type: none"> <li>Focus on pregnant women, children (6m-17y), Adults &gt;65, frontline health &amp; social care workers, care home residents and staff</li> </ul>	Oct 2025-Feb 2026
<ul style="list-style-type: none"> <li>Improve vaccination rates for our population and front-line staff</li> </ul>	Oct 2025-Feb 2026
<ul style="list-style-type: none"> <li>Bookable and walk in appointments, roving clinics and department specific clinics (Oct-Feb)</li> </ul>	Oct 2025-Feb 2026
<ul style="list-style-type: none"> <li>Targeted and coordinated campaigns including comms, email invites and signposting</li> </ul>	Oct 2025-Feb 2026
<ul style="list-style-type: none"> <li>MKUH 'Protect and Reflect' event which includes flu vaccination campaign</li> </ul>	
<ul style="list-style-type: none"> <li>Flu vaccine offers to frontline council staff with regular promotional newsletters across the social care sector</li> </ul>	Oct 2025-Feb 2026
<ul style="list-style-type: none"> <li>Vaccination support to care homes, inclusive of RSV</li> </ul>	Oct 2025-Feb 2026
<ul style="list-style-type: none"> <li>Vaccinations offered within mental health inpatient units</li> </ul>	Oct 2025-Feb 2026
<ul style="list-style-type: none"> <li>EEAST ensuring availability of flu fridges</li> </ul>	Oct 2025-Feb 2026
<ul style="list-style-type: none"> <li>General practice and Primary Care Networks will be facilitated to manage urgent and same day demand (at scale) through a single point of access same day primary care 'Hub' approach</li> </ul>	
<ul style="list-style-type: none"> <li>Local call and recall initiatives in place for parents with school-aged children</li> </ul>	
<ul style="list-style-type: none"> <li>Working with GP practices to switch on Enhance Data Sharing Model so children with outstanding immunisations can be identified and vaccinated</li> </ul>	
<ul style="list-style-type: none"> <li>EPRR outbreak exercise planned</li> </ul>	September 2025
<ul style="list-style-type: none"> <li>Community catch-up clinics covering patient groups, schools and LAs, community pharmacy</li> </ul>	Oct 2025-Feb 2026
<ul style="list-style-type: none"> <li>Fire &amp; Rescue Service Home Safety Checks, free home to those over 65, who live alone or might be vulnerable. The checks provide fire safety advice and equipment depending on risk. Also identify risks related to frailty and mobility and connect residents to appropriate services e.g. BRCC, Age UK, Tibbs Dementia, Carers in Beds, Falls Prevention Service</li> </ul>	In place and ongoing
<ul style="list-style-type: none"> <li>Full ICB vaccination and Immunisation Plan</li> </ul>	Oct 2025-Feb 2026

**Priority 2 - From hospital to community: increasing the number of patients receiving care in community settings**

<b>Initiatives</b>	<b>Date (Start and End)</b>
• Reviews for complex patients within each neighbourhood	In place and ongoing
• Monthly virtual case conferences	In place and ongoing
• Acutes working with LA colleagues to embed robust MDTs to support the most complex of patient's discharge	01-11-2025
• Early identification of high need / high risk cohorts – risk stratification	In place and ongoing
• Frailty pathways in place to support admission avoidance across BLMK	In place and ongoing
• 10 x Dementia beds approved	October 2025 - ongoing
• Falls response teams in place to minimise conveyance rates to hospital	Sept 25
• CBC First Response pathway within the UCCH for urgent patient assessment at their own home	8 <sup>th</sup> September 2025
• Flexing of available community, VCSE and local authority capacity throughout winter to meet demand	July 2025 - ongoing
• Optimising SDEC pathways with ambulance services and maximising bookable appointments for rapid assessment	In place and ongoing
• Palliative care coordination service accessible via 111	In place and ongoing
• Bedfordshire/Luton - EDs now enabled to refer patients to GP OOH base appointments to support EDs with managing capacity	In place and ongoing
• Natural language processing technology to improve 111 call streaming	October 2025
• Review of urgent care DOS profiles and increase in directly bookable appointments	October 2025
• Increase streaming opportunities	In place and ongoing
• Increase the % of patients directly booked into their GP practice by 111	In place and ongoing
• Increase the % of patients referred to pharmacy first from 111	In place and ongoing
• Cat 3 & 4 validation via 111	In place and ongoing
• Cat 5 validation via 111 – Pilot	October 2025
• To increase UCCH activity to drive further VW and UCR responses together with utilisation of remote monitoring technology	In place and ongoing
• Increase access to the stack (A2S), coupled with increased calls completed.	March 2025 – ongoing
• Hear & Treat / see & treat improvement	March 2025 - ongoing
• Mental Health embedded daily huddles, MaDE events and early LA engagement	September 2025 - ongoing
• Community Matrons and AHF co-ordinators supporting system partners to deliver an MDT approach to proactively manage patients to remain within their own homes ( e.g. frail / LTC / care home cohorts)	October 2025 - ongoing

**Priority 3 - High-quality emergency care: meeting the maximum 45-minute ambulance handover**

<b>Initiatives</b>	<b>Date (Start and End)</b>
<ul style="list-style-type: none"> <li>• Embedding of handover 45 SOP, with regular review of processes and effectiveness of new Rapid Assessment Unit (RAU).</li> </ul>	November 2024 - ongoing
<ul style="list-style-type: none"> <li>• OPEL escalation processes in place to ensure early actions taken to prevent delays.</li> </ul>	In place and ongoing
<ul style="list-style-type: none"> <li>• Reconfiguration/use of space in EDs.</li> </ul>	
<ul style="list-style-type: none"> <li>• Call before you convey (CB4C) to reduce unnecessary ambulance conveyances through encouraging alternative pathways to ED.</li> </ul>	March 2025 - ongoing
<ul style="list-style-type: none"> <li>• Intelligent Conveyancing across acute sites in place via SCC to support demand and reduce handover delays</li> </ul>	In place and ongoing
<ul style="list-style-type: none"> <li>• Mental Health – S136 process to minimise delays</li> </ul>	In progress – completion date end of Sept 2025

**Priority 4**  
Improving flow through hospitals

<b>Initiatives</b>	<b>Date (Start and End)</b>
<ul style="list-style-type: none"> <li>• ED streaming and assessment</li> </ul>	Ongoing
<ul style="list-style-type: none"> <li>• SDECs in place</li> </ul>	Ongoing
<ul style="list-style-type: none"> <li>• Frailty support and assessment on arrival: Optimise frailty teams and pathways to ensure a comprehensive geriatric assessment is initiated or amended early in the patients frailty journey</li> </ul>	Ongoing
<ul style="list-style-type: none"> <li>• Discharge ready dates (DRD) for medically optimised patients across the acute sites and reviews</li> </ul>	Nov 2025 - ongoing
<ul style="list-style-type: none"> <li>• Regular LOS reviews and MADE events to support reduced LOS</li> </ul>	Ongoing
<ul style="list-style-type: none"> <li>• Discharge planning and focused improvement work across P0-P2 pathways</li> </ul>	Ongoing
<ul style="list-style-type: none"> <li>• 7 day working in place (capacity dependent)</li> </ul>	
<ul style="list-style-type: none"> <li>• IDT in place and work ongoing to enhance/develop</li> </ul>	September - ongoing
<ul style="list-style-type: none"> <li>• To work with care homes to identify ways in which they can be supported to receive patients across weekends</li> </ul>	November - ongoing
<ul style="list-style-type: none"> <li>• Hospital triage to PLS /HLT</li> </ul>	Ongoing
<ul style="list-style-type: none"> <li>• Pathways already in place for practices to refer directly into hospital specialties</li> </ul>	In place and ongoing
<ul style="list-style-type: none"> <li>• Pilot Referral Software: Conduct a pilot and implement integrated referral software to streamline the referral process between healthcare providers</li> </ul>	
<ul style="list-style-type: none"> <li>• Optimise use of Discharge Lounge</li> </ul>	December - ongoing
<ul style="list-style-type: none"> <li>• Embed 'Criteria to admit' standards in ED</li> </ul>	November 2025

**Priority 5**  
Mental health teams leading from the front

<b>Initiatives</b>	<b>Date (Start and End)</b>
<ul style="list-style-type: none"> <li>• HIU identified and pathway work/improvement</li> </ul>	Ongoing
<ul style="list-style-type: none"> <li>• MH UEC Improvement plan in place to support flow, discharge, crisis response and support</li> </ul>	Ongoing
<ul style="list-style-type: none"> <li>• Discharge processes and PTL management</li> </ul>	Ongoing
<ul style="list-style-type: none"> <li>• Improve patient flow, reduce numbers of CRfD and improve discharge rates, reduce length of stay, reduction in inappropriate Out of area placements.</li> </ul>	Ongoing
<ul style="list-style-type: none"> <li>• Improve patients' access to timely support to improve patient flow and avoid unnecessary admissions.</li> </ul>	Ongoing
<ul style="list-style-type: none"> <li>• Improve patient experience of care.</li> </ul>	
<ul style="list-style-type: none"> <li>• Ensure holistic care promoting recovery without bias or stigma.</li> </ul>	
<ul style="list-style-type: none"> <li>• Ensure hospital staff are confident to manage the mental health needs of patients.</li> </ul>	
<ul style="list-style-type: none"> <li>• crisis assessment centre/s could be mobilised within BLMK. T&amp;F group to be established</li> </ul>	
<ul style="list-style-type: none"> <li>• In Milton Keynes, CNWL's aim is to address discrepancies in patient wait times and data quality between CNWL and MKUH.</li> </ul>	
<ul style="list-style-type: none"> <li>• Opportunity for CNWL to be involved in co-triaging to speed up referrals and aid side-by-side assessments</li> </ul>	
<ul style="list-style-type: none"> <li>• Revision to OPEL framework and escalation processes and actions</li> </ul>	Ongoing – end Oct 2025
<ul style="list-style-type: none"> <li>• Reducing re-admissions for High Intensity Users</li> </ul>	Ongoing

**Priority 6 - A whole system approach to improving patient discharge (OPEL Action Cards in place)**

Initiatives	Date (Start and End)
<p><b>Bedfordshire</b></p> <ul style="list-style-type: none"> <li>• MDT discharge planning and daily board rounds</li> <li>• Streamlining of complex processes – Delayed Discharge Escalation SOP embedded</li> <li>• Daily internal reviews</li> <li>• Trajectories set: LoS, P1-P3, DRD setting and reduction of days between DRD and actual discharge (2-day reduction standard across all pathways), weekend discharges</li> <li>• ELFT complex care in-reach team for P2 pathway to reduce delays</li> <li>• Daily review of all medically optimised patients</li> <li>• 7-day system/escalation calls in place</li> </ul>	<p>Deadline for all – 1<sup>st</sup> October 2025</p>
<p><b>MK</b></p> <ul style="list-style-type: none"> <li>• Integrated Discharge team in-reach to SDEC and ED with extended hours of service in place</li> <li>• Dedicated ward Discharge Officer to ensure early IDH review.</li> <li>• Discharge dashboard to support data capture</li> <li>• Trajectories set: LoS, P1-P3, DRD setting and reduction of days between DRD and actual discharge (2-day reduction standard across all pathways), weekend discharges</li> <li>• Bi-weekly mini MaDE events planned – September 2025 – 29<sup>th</sup> May 2026</li> <li>• Trust UEC working group focussing on internal delays</li> <li>• Diagnostics – tracking times from referral to diagnostic completion, set KPIs and reduce delays</li> <li>• 7-day system/escalation calls in place</li> <li>• Dedicated evening/weekend focus on driving next day and next 72-hour discharges</li> </ul>	<p>Deadline for all – 1<sup>st</sup> October 2025</p>
<p><b>LAs</b></p> <ul style="list-style-type: none"> <li>• Regular review of BCF demand and capacity plans</li> <li>• Partnership working between discharge hubs &amp; on-site social care teams 7-days per week</li> <li>• CBC – enhanced workforce at L&amp;D to support demand and flow – in place and ongoing</li> <li>• Provider capacity review and flex as required</li> <li>• Understand discharge ‘run-rate’ and any deficit to this on a daily basis – led by SCC</li> <li>• MKCC – at times of surge will be able to approve cases outside of case assurance meetings</li> <li>• MKCC - flexibility within the team to carry out social care roles across the acute and the community</li> <li>• Attendance at 7-day system/escalation calls</li> </ul>	<p>1<sup>st</sup> November 2025 - ongoing</p>

<p><b>Community</b></p> <ul style="list-style-type: none"> <li>• Review of MDT processes</li> <li>• Review pathway models and commissioned capacity</li> <li>• Use of MADE events ahead of expected busy period to ensure decompression and capacity (both acute and community beds)</li> <li>• Review community beds offer including specialist dementia beds, complex care in-reach and ensuring consistency of approach for discharge into P2 across both hospitals and between local authorities to reduce LOS and delay.</li> <li>• Monitoring of discharges out of community beds is through LOS, 4-week discharge target for all IP beds. nCTR/DRD monitored and reported (issues escalated on a daily basis)</li> <li>• Understand discharge 'run-rate' and any deficit to this on a daily basis – led by SCC</li> <li>• Attendance at 7-day system/escalation calls</li> <li>• Support the acute through a combination of increased step down of patients into VW where appropriate</li> <li>• WICU discharge coordinator to manage discharges across WICU/Seacole beds</li> <li>• Mental Health OPEL action cards</li> </ul>	<p>1<sup>st</sup> November 2025 – ongoing Deadline – end of September 2025</p>
<p><b>SCC</b></p> <ul style="list-style-type: none"> <li>• Manage daily system calls and escalation calls when required – stepped up to 7-days per week through winter</li> <li>• Development of specialist escalation SOPS i.e. maternity/paediatrics, mental health</li> <li>• Maintains oversight of all capacity across providers and the factors influencing any deterioration in provision via forecasting and early warning signal tools</li> <li>• Actions undertaken and monitored through OPEL action cards and extremis actions if required inclusive of surge capacity</li> <li>• System trajectories in place as per winter plan and performance against these will be monitored 7 days a week by the SCC allowing for intervention/escalation if agreed delivery is not being met.</li> </ul>	<p>1<sup>st</sup> November 2025 7th October 2025</p>

**Priority 7 - From analogue to digital: using data and digital investment to improve flow**

Initiatives	Date (Start and End)
<p><b>Supporting people to live independently</b></p> <ul style="list-style-type: none"> <li>• RaizerChair II (Care Homes):174 chairs across 145 care locations</li> <li>• RaizerChair II (Domiciliary Care: 20 chairs across 18 care locations</li> <li>• Whzan Blue Box: kit with 9 D2A homes with 2 further homes scheduled for training and delivery. 53 kits deployed to care homes supporting 1779 people. SystmOne integration in place with 2 GP practices.</li> <li>• Miicare: 75 kits deployed</li> <li>• RoboPets: 811 devices deployed to individuals</li> <li>• PainCheck: 994 licenses live</li> <li>• GaitSmart : live in 4 locations</li> <li>• Nobi Smart Lights: Plan: Up to 4 lights in up to 8 care provider locations</li> <li>• Doccla to support patients to manage their LTC at home.</li> <li>• Telecare Service working collaboratively with Falls and Reablement Teams and Adult Social Care Teams ensuring timely referrals and access to telecare equipment.</li> <li>• To work with partners to identify any available technology to assist with falls management.</li> <li>• Established falls response service and TEC offer to enable independent living and reduced risk of falls</li> </ul>	
<p><b>Data</b></p> <ul style="list-style-type: none"> <li>• SHREWD and EWS forecasting and oversight by SCC</li> <li>• UCCH infrastructure in place with Power BI wallboards shared with SCC colleagues. LOC Nov-Feb.</li> <li>• CCS to share CAH Bi data access with EEAST partners for improved performance management</li> <li>• BHFT - Use of PHEW and NerveCentre to assist with identification of trends and appropriate escalation to meet service demand             <ul style="list-style-type: none"> <li>• MKUH - Implementation of care view white boards- pilot 3 wards initially to support care and timely flow, role out across the rest of the hospital by Dec 25.</li> </ul> </li> </ul>	