

Central East ICB Winter Resilience and Seasonal Pressures Plan

2026/27

Version	v.19
Executive Winter Sponsor	Maria Wogan
Winter Lead	Ed Knowles
Clinical Lead	Katherine Rowe
Lead Author	Caroline Zwierzchowska-Dod
ICB Board approval	25 September 2026
BAS submission	7 October 2026
Status	Working Draft: yellow-highlighted text is content to be agreed, updated or checked prior to final submission. Please note that some statements reference future statuses or events that are anticipated to be met. These are highlighted in yellow to aid final checking.

Contents *page numbers will be added at point of final submission

Section	Page	Board Assurance Statement	Content / evidence
0		-	Plan structure and document control
1		-	Executive Summary and Winter Readiness
2		Section A	Governance, Quality and Assurance
3		B1	Prevention and Vulnerable Cohorts
4		B2	Flow, Occupancy and Discharge
5		B3	Demand, Capacity and Surge Management
6		B4	Primary Care, NHS 111 and Admission Avoidance
7		B5, B6	Community Capacity and Whole-System Response
8		B7	Leadership, Operational Grip and Resilience
9		B8	System Co-ordination Centre
10		-	Winter Readiness, Risks and Public Outcomes

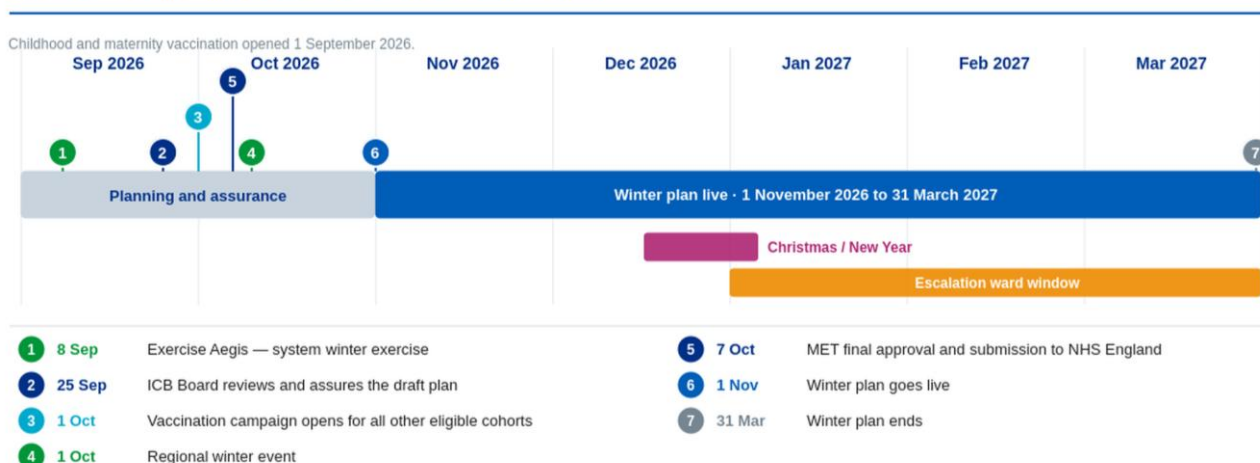
Appendix	Title	Content / evidence
Appendix A	BAS evidence overview	Overview of evidence and rating of BAS statements.
Appendix B	Central East Demand & Capacity Model (STILL IN DEVELOPMENT)	Normal winter, surge and extreme-surge assumptions; detailed methodology and service-level modelling.
Appendix C	ICB Winter Stress Test	Event Overview, summary and actions.
Appendix D	Quality and Equality Impact Assessment (STILL IN DEVELOPMENT)	Full QEIA findings.

0.1 Document Control and Approval Pathway

Group / activity	Date	Outcome / action
BAS statement lead allocation	31 July 2026	Complete
CE executive team meeting	19 August 2026	Complete
Expected provider draft plan receipt	30 August 2026	CNWL outstanding
CE scenario exercise	8 September 2026	Complete
BAS statement lead confirmation of evidence template	11 September 2026	Complete
CE ICB Board assurance	25 September 2026	
Regional winter event	1 October 2026	
MET delegated final approval & submission	7 October 2026	
Winter plan goes live	1 November 2026	
Winter plan ends	31 March 2027	
Review period	April 2027	
Winter 2027/8 planning commences	May 2027	

The winter in one view

Key dates, assurance milestones and pressure periods, September 2026 to March 2027



0.2 How this plan is structured

The plan is structured around the questions in the NHS England 2026/27 ICB Board Assurance Statement. Section A is brought together in one governance and assurance chapter. Sections B1-B8 then form the operational spine of the plan. Detailed models, evidence, provider plans and supporting operating procedures sit in the appendices/evidence library rather than being repeated in the main narrative.

- Core plan: what demand is expected, what capacity and arrangements exist, what will change for winter, what happens at surge, and what residual risk remains.
- Evidence library: how Central East can demonstrate that the assurance is supported by validated plans, data, testing, governance and partner confirmation.
- Each chapter follows the same format: current position/baseline; winter requirement or gap; winter response; assurance/evidence; residual risk and action. Detailed assurance summaries for every Board Assurance Statement are held in Appendices A and B, so that the core plan carries the narrative position and the appendices carry the supporting detail.

1. Executive Summary and Winter Readiness

1.1 Purpose and scope

This plan sets out how Central East Integrated Care Board, working with NHS providers, local authorities, social care, primary care, ambulance services and other system partners, will prepare for, respond to and recover from increased seasonal pressures during winter 2026/27.

It is the whole-area winter plan for Central East ICB, including expected winter demand, usable commissioned capacity, material gaps, planned mitigations, surge and extreme-surge arrangements, operational coordination and residual risk. It is also the principal document through which the ICB will evidence its response to the NHS England 2026/27 Board Assurance Statement.

1.2 ICB responsibilities for winter

Under the 2026/27 arrangements the ICB is accountable for the whole-area winter plan; for commissioned capacity in primary care, community services and mental health; for jointly commissioned social care and intermediate care; for coordination of the winter response through the System Co-ordination Centre; for assurance of infection prevention and control; and for leading prevention, vaccination of flu, COVID-19 and RSV uptake and proactive support for those most at risk. These six responsibilities frame the chapters that follow: the ICB is not assuring provider plans alone, but the sufficiency of what it has commissioned.

1.3 Central East winter approach

Central East ICB aims to do the following through its winter plan:

- Prevent avoidable winter illness, deterioration and admission, with particular focus on vaccination (flu, COVID, RSV) and people at greatest risk.
- Treat people closer to home wherever clinically appropriate and reduce avoidable conveyance, emergency department attendance and admission.
- Maintain safe flow through ambulance, emergency, acute, community and discharge pathways, minimising prolonged waits and corridor care.
- Respond as one system where demand exceeds planned capacity, with clear clinical leadership, escalation, mutual aid and System Co-ordination Centre oversight.

It has taken the NHSE suggested approach of using the Board Assurance Statements as the heart of the plan and asking questions for each that relate the plan back to our population. Some winter contributions cut across every assurance domain rather than sitting under one statement. Medicines and prescribing are the clearest example and the Medicines and Prescribing Winter Assurance Map was used to assure several areas of the plan.

1.4 Our population

Scale and footprint

Central East is the second largest integrated care board in England, serving 3.5 million people across Cambridgeshire and Peterborough, Hertfordshire, and Bedfordshire, Luton and Milton Keynes, with an annual budget of £8.5 billion. The footprint contains 22 local authorities and three ambulance services. Any system-level winter decision therefore has to work across three legacy ICB footprints at once, which is why this plan places weight on consistent escalation thresholds and a single shared risk picture rather than three parallel local responses.

The people we serve

Nineteen per cent of the population are children and 17% are aged 65 or over, including 74,000 people aged 85 and over who are the group most likely to be admitted, to stay longest and to need a Pathway 1 to 3 discharge. Recorded long-term condition prevalence is 15% hypertension, 9% depression, 7% asthma and 7% diabetes; respiratory and cardiovascular prevalence at this scale is what turns a cold snap into bed pressure within days. 337,755 residents (9.6%) live in the 20% most deprived communities in England. 68% of the population is

recorded as white with ethnicity not recorded for 12% of the population, which limits the ICB's ability to demonstrate equitable access and is reflected in the quality and equality impact assessment at 2.2.

Winter demand does not fall evenly across this population. The plan therefore prioritises older people living with frailty, people living in the most deprived communities, children and young people, people with a learning disability or autism, and people from ethnic minority backgrounds.

1.5 Current position and overall winter readiness

Central East enters winter 2026/27 without having recovered from sustained summer pressure. Providers report remaining in escalation areas and boarding patients through the summer months, a position previously seen only during the depths of winter. Acuity is rising, discharge delays persist, and escalation space has been used outside periods of peak seasonal demand.

Provider winter plans have been assessed against the Central East statement set, and the detailed assessment is held at Appendix A. **Of the thirty-five Board Assurance Statements, twenty-eight are assured, one is not assured, five are awaiting provider resubmissions or returns and are expected to assure, and one — Board assurance of the plan itself — falls to this Board.**

Three gaps are common to the system rather than specific to any one provider, and each is the subject of a requested resubmission. Corridor care baselines and safety thresholds are absent at several acute sites. Pre-Christmas occupancy reduction is planned in a dated, agreed form by one provider only. Patients not meeting the criteria to reside are reported by pathway by one provider only, and pathway-level reporting becomes a winter requirement for every acute provider from 1 November 2026. Separately, three community providers have recorded that bed escalation capacity is not available to them without additional commissioning; those are agreed positions rather than gaps in agreement, and are held by the System Co-ordination Centre so that capacity is not sought at OPEL 4 that does not exist.

BAS	Assurance area	Question
A	Governance, quality and assurance	How do we know this plan is deliverable, who is accountable for it, and how do we protect quality and equity for our population when the system is under pressure? How will we protect pathways and populations that can become particularly vulnerable when the system is under winter pressure?
B1	Prevention and vulnerable cohorts	What winter demand can we prevent, and how do we protect the people in our population at greatest risk?
B2	Flow, occupancy and discharge	How will patients move safely through the urgent and emergency care pathway and back home during winter?
B3	Demand, capacity and surge management	What demand are we planning for, what capacity do we have, and what happens at surge and extreme surge?
B4	Primary care, NHS 111 and admission avoidance	How do we keep people safely closer to home and avoid unnecessary conveyance, ED attendance and admission?
B5	Community health capacity	How do we ensure people have access to community care and out of hospital capacity to reduce avoidable admissions?
B6	Whole-system response	
B7	Leadership, operational grip and resilience	Can Central East staff, coordinate and sustain the winter plan, and what will we do when demand exceeds it?
B8	System Co-ordination Centre	Can the SCC proactively resolve operational pressures in hours with ICB on call functions out of hours?

BAS Self Assessment Dashboard

Overall Assessment Rating: 5 - Full assurance			
Section A	Governance	Rating	
Section B	Prevention and vulnerable cohorts	5 - Full assurance	
	Flow, occupancy and discharge	3 - Moderate assurance	
	Demand, capacity, and surge management	3 - Moderate assurance	
	Primary Care, NHS 111 and admission avoidance	5 - Full assurance	
	Community Health Capacity	5 - Full assurance	
	Whole System Response	5 - Full assurance	
	Leadership, operational grip and resilience	5 - Full assurance	

1.6 Rationale for the overall grading of each Board Assurance Statement section**Section A: Governance, quality and assurance ASSURED**

The governance spine is complete and tested: a named Executive Winter Sponsor, a clear route from statement leads through the Winter Assurance Group and Management Executive Team to the Board, and a plan tested at Exercise Aegis on 8 September 2026 with four NHS England regional colleagues present. ~~The partial grading rests on three things outside that spine.~~ The Quality and Equality Impact Assessment panel finding is outstanding but in progress with a dedicated panel, and infection prevention assurance across providers is in place, with aspects for improvement and in place within the ICB.

B1: Prevention and vulnerable cohorts ASSURED

This is the strongest section in the plan. Uptake in 2025/26 exceeded the national 75% ambition for both adults aged 65 and over (75.93%) and care home residents (75.40%), and the 2026/27 programme is commissioned, resourced and already delivering. Confidence is medium rather than high only because healthcare worker uptake remains below ambition and issues regarding vaccination and inequalities persists in Luton and Peterborough. Both elements are addressed through targeted action rather than representing a gap in commissioned provision.

B2: Flow, occupancy and discharge PARTIAL

B2.2 around corridor care, B2.4 on baselining discharge arrangements against the model discharge plan and B2.5 about pre-holiday occupancy reduction plans are currently not assured. This leads to an overall section judgement of 'partial'. Additional evidence has been requested from providers to address this national ask so this is expected to be assured prior to submission. Seven-day flow arrangements and joint discharge planning are described by all assessed providers and evidenced strongly in Hertfordshire and Cambridgeshire and Peterborough.

B3: Demand, capacity and surge management PARTIAL

The requirement for whole-system demand and capacity modelling to have informed the winter plan is in progress. Historic trends and forecasts of expected, surge and extreme surge scenarios are in progress and will inform commissioning decisions going forward and iterative changes to the plan. Workforce, mutual aid and NHS 111 arrangements are evidenced via provider returns and are assured. Bed escalation arrangements have been agreed and were tested in Exercise Aegis. Where providers noted that no capacity was held, this intelligence has been brought into surge planning so that asks are not made of services where no capacity is available.

B4: Primary care, NHS 111 and admission avoidance ASSURED

Six of seven statements are fully evidenced: contractual compliance, enhanced access across every Primary Care Network, mandated urgent dental allocation, community pharmacy, the Directory of Services and system

winter communications. B4.1, which relates to whether commissioned general practice capacity matches expected winter demand remains under review and is subject to further work around capacity/demand.

B5: Community capacity ASSURED

Urgent community response, virtual wards, Hospital at Home and community diagnostics are live and fully operational across all areas, and 12-hour, seven-day senior clinical cover through single points of access is confirmed by all community and mental health providers. As a new organization the ICB is building its ability to demonstrate from its own data that capacity is sufficient and being used effectively. The constraint is oversight infrastructure but confidence is high once data flows and a designated oversight function are in place; this is anticipated to be in place prior to submission and is noted here as an expected deliverable.

B6: Whole-system response ASSURED

As a newly restructured organisation, work is ongoing to centralise and equalise approaches based on an 80/20 model of system vs local personalisation. The legacy ICB areas have established system-wide approaches to optimise admissions avoidance pathways and support timely discharge, and work is ongoing to ensure a system-wide approach or full visibility on this. There is a digital 'control centre' in development which will give a whole-system view across winter and beyond, allowing commissioned capacity to be monitored and optimised. This is anticipated to be in place prior to submission and is noted here as an expected deliverable.

B7: Leadership, operational grip and resilience ASSURED

All five statements are assured. On-call arrangements have been used in live incident response including the Bedford train crash and major fire incidents across the area, command and OPEL escalation was exercised at Exercise Aegis, and the System Co-ordination Centre establishment is increasing from 4.0 to 6.0 WTE Band 8a, making minimum value product deliverable across the larger footprint. The residual risks are timing rather than capability: recruitment to the two additional posts, and a Business Continuity Plan not yet exercised with directorate business impact assessments planned to be completed before winter.

B8 — System Co-ordination Centre ASSURED

The System Co-ordination Centre operates 08:00 to 18:00 seven days a week across the whole footprint, monitors OPEL through SHREWD, convenes system calls and brokers mutual aid, with the ICB 24/7 on-call function providing out-of-hours oversight and a regional representative now joining the Winter Assurance Group. The qualification carried from B7 applies: the operating model is right and rehearsed, and it is the resilience of a small team through a sustained winter that is being actively managed, through the establishment increase and an extreme surge cadre activated at seven or more sites at OPEL 4.

2. Governance, Quality and Assurance (BAS A1.1-1.8)

BAS REQUIREMENTS: A1.1-A1.8

The plan is Board assured and informed by a robust QEIA; system partners have actively contributed; a named Executive Winter Sponsor is accountable; the regional exercise has tested the plan; clear governance and escalation are in place; and IPC, PPE, fit-testing and health-protection arrangements are assured.

BAS	RAG	Board assurance area	Rationale
A1.1	DUE 25/9	Board assured plan	Sign-off due at this Board on 25 September 2026, with delegated action to Chair's action on the advice of the deputy CEOs on 7 October the Management Executive Team by 7 October 2026 .
A1.2	IN PROGRESS	QEIA	QEIA assessment in progress with regular panel meetings. Expected to be assured.
A1.3	ASSURED	System partner development	Evidenced
A1.4	ASSURED	Executive winter sponsor	Named
A1.5	ASSURED	Winter exercise	Complete
A1.6	ASSURED	Governance arrangements	Documented
A1.7	ASSURED	Infection protection and control	ICB arrangements assured. Provider position varies: vaccination planning is the strongest element and is quantified by most providers, while fit testing and PPE are the weakest — four providers state a current compliance figure and one states a PPE stock position.
A1.8	ASSURED	Health protection governance	ICB arrangements assured. Nine providers evidence sound governance with named committees, outbreak policies and board reporting routes. The gap is concentrated rather than general.

2.1 Board assurance (BAS 1.1)

This plan is recommended to the Board for approval at the meeting of 25 September 2026. Approval will be noted in the minutes of this meeting, alongside an agreement that where further activity and assurance is required prior to submission on 07 October this will be made through Chair's action with advice from the deputy Chief Executives.

2.2 Quality and Equality Impact Assessment (BAS 1.2)

The ICB's Quality and Equality Impact Assessment (QEIA) panel has reviewed the providers' submitted QEIAs and those completed by the ICB for ICB-delivered elements of the plan. The findings are held at Appendix D and represent a robust and independent assessment of the individual QEIAs submitted. The assessment has explicitly considered whether conclusions differ across Cambridgeshire and Peterborough, Bedfordshire, Luton and Milton Keynes, and Hertfordshire.

The panel will identify any material patient-safety, safeguarding, equality or health-inequality risks and mitigations and document them here.

The named Clinical Lead provides assurance that the winter plan is clinically sound on behalf of the Winter Assurance Group and through the involvement and oversight of the Strategic Clinical Collaborative Forum. The Strategic Clinical Collaborative Forum has reviewed both provider plans and the wider ICB winter plan through a safety and quality lens. This meets the NHSE requirement to ensure that the plan has been developed with clinical oversight.

2.3 System partner engagement and validation (BAS 1.3)

Development of the plan includes active engagement and validation from the partners relied upon for capacity, workforce, mobilisation and escalation. Provider input has been sought through receipt of provider plans which form the basis of much of the ICB's plan, discussion and testing through the winter exercise, and through the local place-based or health and care partnerships. Engagement from Primary Care is an area which **should will** be strengthened before winter.

Provider and partner landscape

Central East commissions or coordinates the following provider landscape. Provider winter plans from all fourteen NHS trusts providing acute, specialist, community and mental health services have been assessed as part of the Central East assurance statement set; these are held in full locally. In addition, engagement has been sought from the **Place-Based and** Health and Care Partnerships which have representation from primary and secondary care alongside the voluntary, community, social and enterprise sector, with evidence held locally.

Sector	Scale	Organisations
Acute and specialist	7 NHS trusts operating 9 sites	Bedfordshire Hospitals · Cambridge University Hospitals · East & North Hertfordshire Teaching · Milton Keynes University Hospital · North West Anglia · Royal Papworth · West Hertfordshire Teaching
Community and mental health	7 NHS trusts	Cambridgeshire & Peterborough · Central London Community Healthcare · Central and North West London · East of England Community Health and Care · East London · Hertfordshire Community · Hertfordshire Partnership University
Ambulance	3 trusts	East of England Ambulance Service · East Midlands Ambulance Service · South Central Ambulance Service
NHS 111 and integrated urgent care	7 providers	Herts Urgent Care · DHU Healthcare · Granta PCN · Greater Peterborough Network · East of England Community Health and Care · Cambridgeshire & Peterborough Foundation Trust · Central London Community Healthcare
Non-emergency patient transport	3 providers	EMED Group · East of England Ambulance Service · South Central Ambulance Service
Primary care	267 GP practices	Organised through primary care networks and place-based partnerships
Local government	22 local authorities	Including seven upper tier authorities: Bedford Borough, Central Bedfordshire, Cambridgeshire County, Hertfordshire County, Luton, Milton Keynes City and Peterborough City councils
Health & Care Partnerships / Place-based Partnerships	6 partnerships	North Place Partnership Cambridgeshire & Peterborough, Cambridgeshire South Care Partnership, South & West Herts Health and Care Partnership, East and North Herts Planning & Transformation Delivery Group, Bedfordshire System Leaders Group, Milton Keynes Improving System Flow Group.

2.4 Executive Sponsorship (BAS 1.4)

The ICB's Winter Executive Sponsor is Maria Wogan.

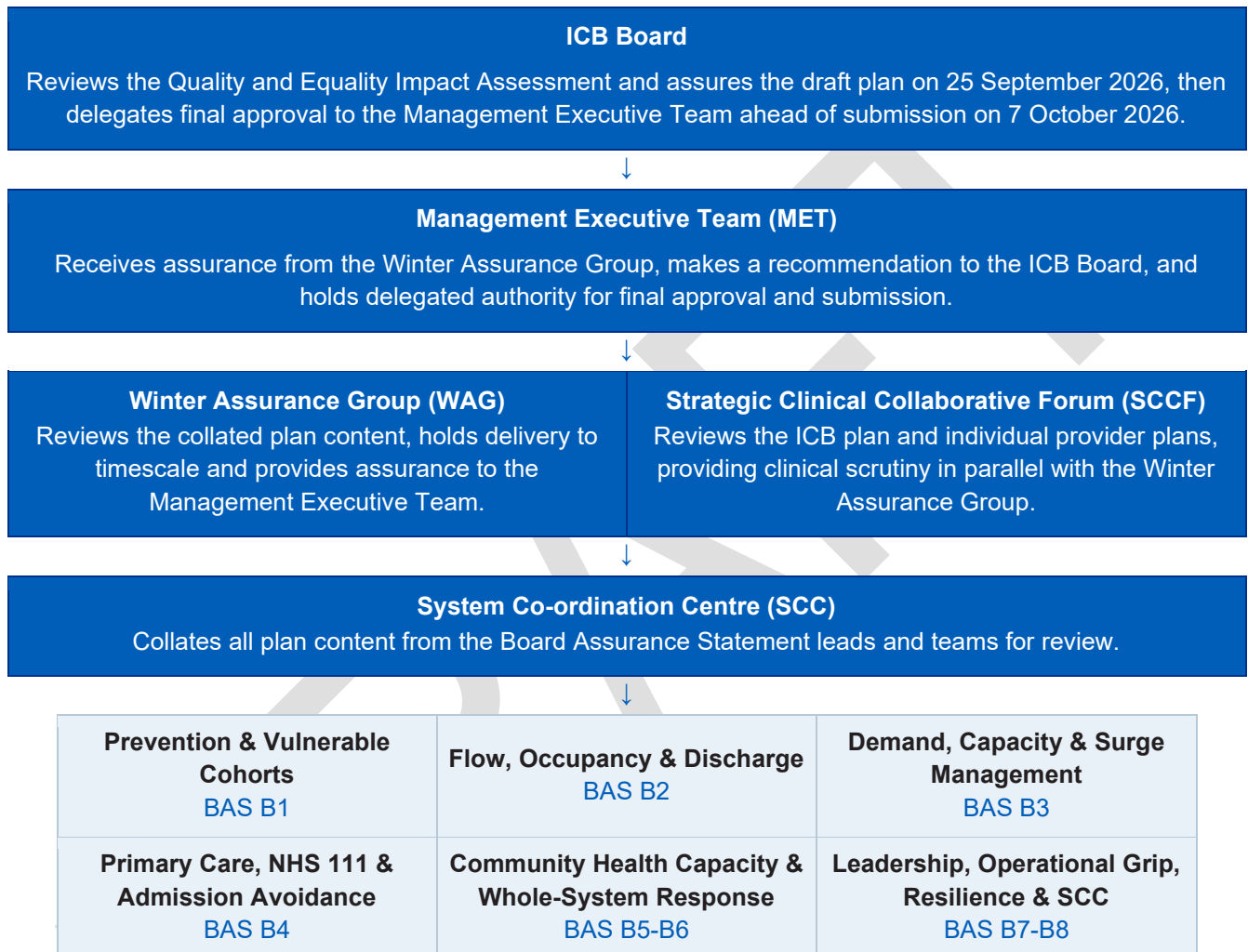
2.5 Testing of the plan (BAS 1.5)

Exercise Aegis 2026 was the exercise specified regionally and nationally for winter 2026/27 assurance and is complete. Held on 08 September 2026 and attended by four NHS England regional colleagues alongside acute, community, mental health, ambulance and local authority partners, it tested the system through a baseline shared risk picture and three injects: community discharge and flow failure; a mental health and primary care surge; and workforce exhaustion with industrial action. The report identifies ten priority risks, ten gaps, thirteen commissioning opportunities and an eighteen-action plan phased against a November start. The Winter Assurance Group has reviewed the outcome and the lessons are incorporated throughout the plan and in the winter risk register. **The ICB also attended the regional winter event on 1 October 2026.**

Representation gaps at the exercise, covering primary care, the voluntary community, faith and social enterprise sector, hospices and the children and young people response, are being addressed through place-based partnership involvement and system call membership ahead of winter. The full report is at Appendix C.

2.6 Governance and accountability (BAS 1.6)

Central East ICB will use the NHS England Board Assurance Statement as the principal framework for development, challenge and final assurance of this plan. Each Board Assurance Statement has a dedicated lead or team. The System Co-ordination Centre collates all plan content, which is then reviewed by the Winter Assurance Group, alongside review of the ICB plans and individual provider plans by the Strategic Clinical Collaborative Forum. The Winter Assurance Group reports to the Management Executive Team, which, through the Winter Executive Sponsor/Accountable Officer makes a recommendation to the ICB Board.



2.7 Medicines and prescribing governance

Medicines and prescribing cut across every assurance domain and are therefore governed as a single cross-cutting workstream rather than within one chapter. The medicines contribution to the winter plan is led through the ICB's medicines and prescribing function and its Quality Use of Medicines governance route, providing assurance to the Winter Assurance Group on the same cycle as the Board Assurance Statement leads. Clinical scrutiny is provided by the Strategic Clinical Collaborative Forum, which reviewed medicines-related winter planning on 3 September 2026 and identified gaps in frailty medication review, high-risk medicine monitoring and use of the Discharge Medicines Service. The Medicines and Prescribing Winter Assurance Map (held locally) records the full position across all Board Assurance Statement domains and is cross-referenced from each chapter it supports.

2.8 IPC, PPE, fit testing and health protection (BAS 1.7, 1.8)

WHAT CENTRAL EAST ICB IS DOING

- Reporting a weekly system IPC winter surveillance and exception report covering outbreaks, HCAI, respiratory viruses, capacity, staffing and emerging threats, providing a single system picture through winter.
- Coordinating a seven-day escalation matrix across the ICB, providers, UKHSA and local authorities, tested before winter and maintained as a live contact directory, with response times and completed actions recorded.
- Targeting IPC support and communications for care homes and wider care settings, directed by surveillance, with outbreak notification and response times monitored.
- Routinely monitoring of flu, COVID & RSV vaccination, workforce readiness, IPC training and fit testing by provider, staff group and relevant inequality cohort, with recovery actions required for exceptions.
- Outbreak learning shared across the system, with the Winter Assurance Group requiring executive recovery plans where surveillance, vaccination, care-sector support, outbreak response or mutual-aid arrangements fall below the required standard.
- Completing standardised IPC winter readiness reviews across all commissioned providers before winter plan sign-off, refreshed monthly, and will validate isolation, cohorting, diagnostics, ventilation, PPE and workforce contingencies through stress testing before peak winter.

BEST PRACTICE IN IPC IN PROVIDER TRUSTS

Cambridge University Hospitals will introduce seven-day IPC working from 1 November 2026 to 31 March 2027, procure five HPV and three UV decontamination machines from 1 November, and mobilise additional deep-cleaning staff from 1 December to 31 March which is a combined estimated benefit of six beds.

West Hertfordshire will run a fortnightly multidisciplinary IPC Winter Preparedness Meeting from September and provide six-day on-site IPC cover at Watford from November to the end of January.

North West Anglia operates a four-level IPC escalation framework linking outbreak pressure and bed loss to visiting controls, mask use, meeting cadence and situation reporting, supported by a winter masterclass in September 2026 and IPC Awareness Week in October 2026.

Bedfordshire Hospitals will roll out point-of-care testing for winter viruses in ED, maternity and paediatrics, with twice-daily IPC calls during outbreaks and risk-based isolation decisions taken by the DIPC, Director of Nursing and Medical Director.

Milton Keynes will operate daily infection control reviews with rapid bay closure and reopening protocols and daily monitoring of closed beds, and will finalise and test its Pandemic and HCID plans.

Fit testing, PPE and Infection prevention and control (A1.7)

Every assessed provider has infection prevention and control arrangements embedded in its winter plan, with clinical leadership from the Director of Infection Prevention and Control or a nominated deputy. Core surveillance, respiratory and gastrointestinal pathways, outbreak management, isolation and cohorting, and escalation arrangements are in place across Central East.

The estate varies materially across Central East and is a significant determinant of infection prevention and control risk. Side-room and specialist ventilation capacity differ considerably between providers: some sites have predominantly single-room accommodation and strong isolation capacity, while others have limited side-room provision and may need to use cohort wards or temporary isolation facilities during periods of increased infection. Escalation arrangements, including reverse boarding and extremis capacity, may further reduce the space available for effective separation of patients.

Fit-testing compliance is the most consistently underdeveloped area across the system. Reported compliance varies substantially, from approximately one third of high-risk staff at some providers to over four fifths at others, with several positions still awaiting confirmation. Few providers have yet supplied a quantified improvement trajectory with clear milestones. Further assurance is therefore required on current compliance, the staff groups covered, minimum acceptable standards and the timetable for improvement.

Health protection governance, escalation and outbreak response (A1.8)

Central East ICB leads system infection prevention and control through the ICB IPC Team, which maintains oversight of outbreaks, healthcare-associated infection and respiratory virus activity, emerging threats, vaccination against flu, COVID-19 and RSV, workforce readiness and provider exceptions. System forums allow risk and learning to be shared, with escalation through quality, winter and operational coordination routes.

Geography shapes delivery. Local authority arrangements, care-home support models, provider footprints, laboratory pathways and cross-boundary patient flows differ across the three legacy ICB footprints, so the ICB applies common minimum expectations while maintaining locality-specific contacts and response arrangements.

At provider level, infection prevention and control governance is clinically led and connected to Trust Board assurance. Providers maintain oversight through established infection control committees, quality and safety governance, Board Assurance Frameworks and executive management arrangements. During periods of increased pressure, this is supported by daily operational oversight, EPRR arrangements and executive on-call structures. Available assurance indicates that established governance arrangements supported effective management of healthcare-associated infection and outbreaks during the previous winter.

3. Prevention and Vulnerable Cohorts (BAS B1)

BAS REQUIREMENTS: B1.1-B1.2

Eligible people can access priority vaccination programmes, including childhood vaccinations, RSV, pneumococcal, flu and COVID-19; and a risk-stratified approach identifies and supports people at increased risk of winter-related deterioration or admission.

BAS	RAG	Board assurance area	Rationale
B1.1	ASSURED	Vaccination	Robust plans, last year's targets exceeded
B1.2	ASSURED	Risk Stratification	Specific measures in place including DELPHI role out

3.0 What winter demand can we prevent, and how do we protect the people at greatest risk?

WHAT THIS MEANS FOR OUR POPULATION

A woman of 78 living alone in a Luton flat who did not receive her flu vaccination. A child under two admitted with bronchiolitis. A man with chronic obstructive pulmonary disease who exhausted his rescue medication over a bank holiday weekend.

Each represents an admission that earlier intervention could have prevented. The measures set out in this chapter are directed at reaching these individuals early rather than treating them in hospital later on.

WHAT CENTRAL EAST ICB IS DOING

- Enacting Flu, COVID-19 and RSV programmes across all three areas, with area Vaccination Hubs and vaccination a standing item at each area's NPCCS.
- Reporting weekly uptake against the five vaccination objectives through the Central East Vaccination Programme Board and Quality Use of Medicines governance.
- Commissioned targeted outreach for underserved groups and holds providers to improving on last year's healthcare worker uptake.
- Funding and extending the DELPHI risk stratification tool beyond Hertfordshire, and commissioning of antivirals and COVID-19 treatments through HUC, MKUC and general practice.
- Identifying frail older people through the Electronic Frailty Index and local frailty registers.
- Planning Neighbourhood multidisciplinary team reviews for those at highest risk of admission and personalised care planning for people with complex needs.
- Supporting care homes through the Enhanced Health in Care Homes Primary Care Network Directed Enhanced Service.
- Extending access to the Healthier Together website to support prevention in children through health advice to parents.

BEST PRACTICE IN VACCINATION

In Hertfordshire, Central London Community Healthcare provide a vaccination status check at admission, board round and discharge, turning vaccination into an operational flow action rather than a separate campaign. A named flu lead for each clinical service unit reviews uptake weekly by ward, team and staff group, with an unvaccinated list maintained for recall and extra clinics triggered in lower-uptake areas.

At Milton Keynes University Hospital a peer-to-peer vaccination model, vaccination champions and monthly prize draws are planned, with uptake tracked through RAVS and ESR reconciliation against a 60% target from a 48% baseline.

In the North West Anglia Foundation Trust, frontline workers who find it hard to get to a vaccine clinic are being prioritised first, with clinics for staff and public at both hospitals, with satellite clinics at Stamford and Doddington/Ely. Joint working with Herts Community Trust will support vaccination for long-staying inpatients.

3.1 Vaccination (B1.1)

Winter position

Uptake exceeded the 75% national ambition in 2025/26 for adults 65+ (75.93%) and care home residents (75.40%). The 2026/27 coordinated programme delivers from 1 September for children and pregnant women and 1 October for all other cohorts. Healthcare worker uptake and inequality in Luton and Peterborough remain the residual risks.

Vaccine strategy

Central East has five objectives within its vaccination strategy.

Objective	Description	Action
Maximise Uptake	Increase uptake of Flu, COVID-19 and RSV vaccinations across all eligible cohorts, with a particular focus on those at greatest risk of serious illness, hospitalisation and death.	Maintain: - Adults aged 65 years and over ≥75% (stretch ambition 80%) - Care home residents ≥75% (stretch ambition 85%) Improve: - Adults aged 18–64 years in clinical risk groups - Pregnant women - Household contacts of immunosuppressed individuals - Children aged 2–3 years - Children in clinical risk groups - School-aged children - Frontline healthcare workers
Reduce Health Inequalities	Improve uptake amongst underserved populations using targeted interventions informed by local intelligence and community engagement	Reduce variation in uptake between: - Places - Neighbourhoods - GP Practices - Communities - Population groups
Protect the Workforce	Improve frontline healthcare worker flu vaccination uptake to reduce sickness absence and maintain workforce resilience throughout winter.	Every provider organisation will be expected to improve on previous year performance
Improve Access	Ensure vaccination is available closer to home and utilise opportunities where residents are receiving healthcare.	Ensure vaccination opportunities are available through: - General Practice - Community Pharmacy - School Aged Immunisation Services - Care Homes - Housebound Services - NHS Trusts - Community Outreach Services - Mobile Clinics - Pop-up community venues
Reduce Winter Pressures	Support wider system resilience and urgent and emergency care objectives.	Reduce: - Flu outbreaks - COVID-related admissions - RSV-related admissions - Staff sickness absence - Winter service pressures - Respiratory admissions

Geographical variation

Vaccination priorities differ by geography:

- Bedfordshire, Luton & Milton Keynes: recovery across older adults, care homes, childhood flu and workforce vaccination, with a particular focus on reducing inequalities in Luton.
- Cambridgeshire and Peterborough: maintain strong performance, reduce variation in Peterborough, improve access for traveller, homeless, inclusion health and rural communities, and share workforce vaccination best practice.
- Hertfordshire: improve maternity, early years and workforce uptake, reduce locality variation and maintain strong school-age programme performance.

3.2 Risk stratification (B1.2)

The ICB will use risk stratification and neighbourhood working to identify and proactively support people most vulnerable to winter deterioration. It will also set and monitor quality expectations for medicines, treatment access and provider improvement where risks or inequalities are identified.

Key interventions include frailty identification, personalised and anticipatory care planning, long-term condition reviews, medicines optimisation, vaccination, care home support and multidisciplinary review of those at highest admission risk. Community, pharmacy, virtual ward/UCR and commissioned antiviral/COVID treatment pathways are used to support people at home and reduce avoidable hospital use. Risk stratification runs through GP clinical systems, the electronic Frailty Index, local frailty registers and the DELPHI tool, feeding neighbourhood multidisciplinary teams for anticipatory care planning, medicines review and care home support. A residual risk is the consistency of MDT coverage across the new footprint.

This winter, the ICB has procured an ICB-wide Healthier Together website so that all parents, carers and professionals across Central East ICB have access to consistent advice and guidance on managing childhood illness irrespective of where they live.

4. Flow, Occupancy and Discharge (BAS B2)

BAS REQUIREMENTS: B2.1-B2.5

Seven-day operational flow and discharge arrangements reduce avoidable occupancy; corridor care is eliminated or safely mitigated; discharge is jointly managed with local authorities/social care; providers have baselined against the model discharge pathway; and pre-Christmas/holiday occupancy reduction plans are agreed.

BAS	RAG	Board assurance area	Rationale
B2.1	ASSURED	Flow, discharge and occupancy	Effective operational oversight and processes documented
B2.2	AWAITING	Corridor care	Provider resubmissions requested following feedback on absent baselines, safety thresholds and Board oversight. Expected to assure.
B2.3	ASSURED	Joint discharge planning	3x area-based TOC Hubs supporting joint planning
B2.4	AWAITING	Baselines against model discharge pathway	Baseline against the model discharge pathway requested from the remaining providers. Expected to assure.
B2.5	AWAITING	Pre-Christmas occupancy reduction	Occupancy reduction to be agreed at each area with a target, dates and named owner. Expected to assure.

4.0 How will patients move safely through the urgent and emergency care pathway and back home during winter?

WHAT THIS MEANS FOR OUR POPULATION

A patient held in an ambulance. A patient assessed in a corridor. A patient declared medically ready for discharge four days ago and still waiting for a package of care.

Delay experienced by one patient is transmitted directly to those behind them. Flow is therefore both a quality and a safety issue, and depends on the ICB, its providers and seven upper-tier local authorities acting as a single system.

WHAT CENTRAL EAST ICB IS DOING

- Holding seven-day oversight of flow, occupancy and no-criteria-to-reside through SHREWD, with daily system calls convened where pressure requires.
- Commissioning Continuing Healthcare and intermediate care, and jointly commissions discharge capacity with seven upper-tier local authorities.
- Making no-criteria-to-reside reporting by pathway 1 to 3 a winter reporting requirement for all acute providers from 1 November 2026.
- Reviewing corridor care, model discharge pathway baselines and holiday-period occupancy plans at the Winter Assurance Group, has issued feedback to providers whose returns lacked a baseline, a safety threshold or evidence of Board oversight, and is collecting resubmissions ahead of submission on 7 October 2026.
- Recruiting to a non-emergency patient transport coordinator post to take accountability for provision against contract and day-to-day delivery of the NEPTS service.

BEST PRACTICE IN FLOW AND DISCHARGE

At West Hertfordshire Teaching Hospital Trust, corridor care is excluded from the escalation procedure and requires Chief Nurse authorisation, reported through the Trust Integrated Performance Report. Discharge to Assess capacity increased from 38 to 60 beds across nine homes for South West Hertfordshire residents,

85% block commissioned for seven-day access, with a weekly Discharge Acceleration Group chaired by an Executive or Director with delegated authority addressing delays over 14 days.

At North West Anglia Foundation Trust, there is a core operational standard of a minimum ten patients to the discharge lounge before 10:00, daily ward discharge targets are embedded in operational oversight, and weekly patient tracking lists with system partners review every no-criteria-to-reside patient by pathway 1 to 3.

At Cambridge University Hospitals, a five-step long length of stay method of identifying patients over seven days is in place, with weekly divisional review, escalations for patients over 21 days, and fortnightly compliance audit with executive oversight.

At Cambridgeshire and Peterborough NHS Foundation Trust, a centralised patient flow team acts as a single point of coordination for all inpatient bed requests and capacity decisions.

In Hertfordshire, a combination of discharge planning from admission and strong partnership working with system-wide discharge workstreams supports compliance with the model discharge pathway. There are planned system flow weeks where all South and West Herts partners work together to maximise flow and trial new ways of working.

At Bedfordshire Hospitals NHS Foundation Trust, Decompression events are scheduled for the pre and post-Christmas period, with senior support provided by external partners focusing on medically fit for discharge complex patient discharges, to minimise patients with no criteria to reside pre-Christmas and provide maximum bed capacity.

4.1 Assurance position by statement (BAS 2.1–2.5)

B2.1: Seven-day flow and discharge arrangements are described by all assessed providers but demonstrated in operation by few. There are well established procedures for operational management of flow and reduction of avoidable bed occupancy both within provider trusts and within the ICB through the System Coordination Centre. Some areas of discrepancy are around seven-day discharge provision not being available in every council area, and some specific care home barriers in terms of discharge acceptance.

B2.2: With regard to the NHSE aim to eliminate corridor care, two acute providers do not offer this as escalation capacity within their emergency departments. Where improvement plans are in place, these will be used to track planned reductions in usage across the winter period. **The ICB is gathering quantified corridor care usage at other trusts and a request to supply baselines, safety thresholds and Board oversight is awaiting completion. This statement is expected to be assured on receipt.**

B2.3: Joint discharge planning with local authorities is established through area-based Transfer of Care Hubs and Integrated Care Hubs. Improvements to pathway access are ongoing and real-time visibility is being strengthened through use of the OPTICA system across some geographies. Unresolved delays can be escalated via the SCC once due process has taken place, or where particular complexities are found. An action from Exercise Aegis is a webinar by the local authorities giving clarity on their role and processes to support system understanding.

B2.4: Baselineing against the model discharge pathway is complete at two providers with **baselines requested from the remaining providers. This statement is expected to be assured on receipt.**

B2.5: Decompression events and other targeted reduction strategies are documented in some providers plans. **Occupancy reduction is to be agreed for each provider with a target, dates and a named owner, and a submitted strong model has been offered across Central East as system learning. This statement is expected to be assured on receipt.**

4.2 Frailty

Frailty is among the largest drivers of avoidable admission and delayed discharge in the Central East population. It is treated in this plan as a system commissioning question rather than an additional provider assurance requirement, because the capacity that determines whether a frail person is admitted is commissioned across a system rather than held by any single provider.

Central East ICB is rolling out use of the Summary Acute Medicine Indicator Table (SAMIT) toolset which is a Getting It Right First Time initiative to better understand, track and address metrics related to admission and occupancy in frail patients. Initial findings show a marked improvement in early discharge in Bedford, Luton and Peterborough with a reduction in long length of stay achieved in Luton. This is learning which can be passed to hospitals experiencing increasing lengths of stay such as Hinchingsbrooke and Watford. It has also scheduled frailty reviews in each hospital site pre-winter and held well-attended frailty-focused conferences championing best practice.

The commissioned frailty position across Central East comprises personalised care planning for severely frail, housebound and end-of-life patients through the High Intensity User tier 2 programme in C&P North Place, with approximately 500 plans in place at month 4; Pathway 1 additional capacity funded at £2.5m per annum from 1 August 2026, supporting a coordination hub and recruitment of home-based rehabilitation staff; proactive care teams using the DELPHI tool, established in Hertfordshire and extending across the remaining Places; frailty virtual ward and Hospital at Home capacity operating seven days including weekends in Hertfordshire; frailty same-day emergency care and short-stay provision at Peterborough City Hospital; and frailty in-reach to emergency departments at Milton Keynes, extended to weekends for winter, and at West Hertfordshire through consultant presence at the front door each afternoon. Clinical review through the Strategic Clinical Collaborative Forum on 3 September 2026 identified inconsistent treatment of frailty in provider plans.

The gap is consistency rather than provision. Frailty capacity differs materially across the Central East geography and the ICB does not yet hold utilisation data at system level. Frailty is carried as a named cohort in the quality and equality impact assessment and in the winter risk register.

4.3 Continuing Healthcare

All Age Continuing Care is a direct ICB responsibility covering NHS Continuing Healthcare, NHS-funded Nursing Care and Children and Young People's Continuing Care. The winter plan will protect continuity of assessment, eligibility decision-making, Fast Track, case management, care-package commissioning, safeguarding and urgent review functions across Central East.

Assessments will normally take place outside the acute setting where clinically appropriate, in line with the National Framework and Discharge to Assess principles. Continuing Healthcare teams will work with acute, community and local authority partners to support timely discharge and avoid transferring operational risk to individuals, families, providers or partner organisations without an explicit, documented and clinically assured decision.

A common Central East oversight approach will be used while retaining locality-level operational routes and provider-market intelligence. Workforce arrangements will include clinical decision-making cover, deputies, cross-locality mutual aid, prioritisation arrangements and contingencies for staff absence or system failure. During escalation, Fast Track, discharge-related cases, safeguarding concerns and unstable packages will be prioritised, with non-critical activity deferred where necessary.

Daily exception management during periods of surge will monitor referrals, Fast Track demand, discharge-related cases, overdue assessments, unallocated work, placement delays, packages awaiting brokerage, staffing and incidents. Weekly assurance will cover demand and capacity, statutory timeliness, backlog, package mobilisation, locality variation, quality, complaints and finance.

Where a package cannot be sourced, teams will use current intelligence on nursing, residential, domiciliary and complex-care capacity. Provider capacity, quality and safeguarding concerns will be managed through the relevant brokerage, commissioning, contracting and quality routes. Material safety, capacity, workforce, funding, mobilisation or cross-system dependencies will be escalated through the appropriate Central East winter governance arrangements.

The principal winter risks are workforce shortfall, insufficient provider-market capacity, unsafe delay or backlog growth, digital or telephony failure, unwarranted variation between localities and increased cost without assured benefit. Mitigations include cross-locality cover, deputy arrangements, risk-based prioritisation, daily exception management, additional capacity where available, provider-market escalation, business continuity arrangements and executive oversight.

4.4 Discharge medicines and prescribing

BEST PRACTICE IN DISCHARGE MEDICINES

East and North Hertfordshire will open the Swift Pharmacy Hub by mid-October to enable earlier discharge of elective and emergency trauma and orthopaedic patients through timely medicines provision and will provide daily specialist frailty pharmacist cover in the emergency department.

West Hertfordshire is expanding its Surgical Floor satellite pharmacy model to include controlled drug dispensing, enabling a more comprehensive take-home medicines service.

Discharge medicines are a recognised cause of delayed discharge and of avoidable readmission. The Discharge Medicines Service is a nationally commissioned community pharmacy service into which providers refer, so the ICB lever is the reliability of the referral route and the sufficiency of community pharmacy capacity to receive referrals, rather than provider-side process. Commissioning arrangements and monitoring are set out at B4.5 and in the Medicines and Prescribing Winter Assurance Map.

Review of the documents submitted by providers found no reference to the Discharge Medicines Service, to electronic prescribing at discharge, or to FP10 use, in any plan.

The winter actions are to confirm a working Discharge Medicines Service referral route from every acute provider, with referral, acceptance and completion monitored, and to test electronic prescribing at discharge as a means of reducing waits for take-home medicines.

4.5 Discharge transport

Non-emergency patient transport is commissioned by the ICB and is a recurring cause of failed and delayed discharge. It is recorded here as a system dependency rather than a provider assurance requirement, because no individual provider can be assured against a service it does not commission.

Provider plans consistently identify transport and timely access to equipment as dependencies for discharge, although arrangements are not yet fully resolved across the system. Proposed mitigations include reviewing transport processes, considering dedicated transport capacity, and aligning transport with additional discharge and community support. In some areas, additional resources have been secured to extend equipment delivery capacity and reduce delays caused by patients waiting for essential equipment.

The winter actions are a joint review of the patient transport service specification and performance, using the procurement background to identify the causes of failed and delayed discharge; and confirmation of the out-of-hours escalation route when transport is unavailable, alongside engagement of VCSE partners to support where appropriate. The escalation plan for the non-emergency patient transport provider has been tested as part of winter readiness and remains a risk in terms of utilisation and capacity. A new 1.0 WTE post to manage NEPTS across the system will be recruited to before winter.

4.6 Mental health crisis response

The winter requirement as set out in the NHS England winter planning letter is for integrated care boards to commission resilient all-age crisis services, including urgent mental health helplines accessible through NHS 111, crisis alternatives and liaison psychiatry, with crisis plans in place ahead of winter for high-risk patients and frequent attenders.

The Central East Mental Health Urgent and Emergency Care Assurance Framework, completed by all four mental health providers in June 2026, gives the commissioned position. The front door is in place across the whole footprint: all four providers operate an NHS 111 mental health option routing to local crisis services, a 24/7 crisis resolution and home treatment team that gatekeeps admission and offers intensive home-based alternatives, 24/7 liaison mental health with emergency department assessment, a Section 136 suite, Section 12 doctor arrangements and Right Care Right Person protocols. Self-referral is accepted by all four regardless of diagnosis or previous contact, and same-day face-to-face assessment capacity is confirmed by all four. The commissioned mental health bed base across Central East is 625.

Coverage of crisis alternatives is more variable. Crisis cafés or recovery lounges operate in all four areas, but safe havens, crisis houses and step-down beds are variable depending on geography. Mental health ambulance provision is in place in two areas only. Discharge pathways are rated partial by all four providers. Step-down provision (rehabilitation beds, supported housing and complex placements) is an area of challenge, along with patients who are clinically ready for discharge but are delayed. As a result, mental health crisis provision was also the most frequently raised gap at Exercise Aegis 2026, arising in the baseline risk picture, in two of the three injects and in two live requests during the exercise.

5. Demand, Capacity and Surge Management (BAS B3)

BAS REQUIREMENTS: B3.1-B3.3

Whole-system demand and capacity modelling has informed the plan; surge and extreme-surge arrangements are tested; workforce, NHS 111 and mutual aid can sustain increased demand; and bed escalation capacity is agreed and tested.

BAS	RAG	Board assurance area	Rationale
B3.1	PENDING	Demand and capacity modelling	The five-year data analysis was not complete in time to write and influence this plan, so the statement is not recommended for assurance. Findings will feed into the plan iteratively and into subsequent commissioning decisions.
B3.2	ASSURED	Workforce, NHS 111 & mutual aid	Workforce plans are strong in acute trusts, NHS 111 providers confirm contingency and surge arrangements, and mutual aid is available, though variable.
B3.3	ASSURED	Bed escalation capacity tested	The statement asks whether arrangements are agreed and tested, not whether capacity is sufficient. Central East carries the same commissioned capacity that supported last winter, and the arrangements were exercised at Exercise Aegis on 8 September 2026. Data in process will further strengthen this assurance.

5.0 What demand are we planning for, what capacity do we have, and what happens at surge and extreme surge?

WHAT THIS MEANS FOR OUR POPULATION

A man having a heart attack on the second Monday in January, the busiest day of the system's year. A woman in Fenland who needs admission for a chest infection on a Sunday in February, in the middle of a flu wave nobody forecast. Neither of them chose when to become ill.

Planning assumptions decide whether there is a bed, a crew and a clinician ready when they arrive. Getting those assumptions wrong does not surface as a planning error — it surfaces as a longer wait for somebody who had no say in the timing. And when demand exceeds even the planned position, it is the surge arrangements that determine whose care is affected and how, which is why those thresholds are agreed in advance rather than in the moment.

WHAT CENTRAL EAST ICB IS DOING

- Consolidating demand, capacity and performance data across three predecessor ICBs into a single Central East view.
- Tested surge and extreme surge arrangements at Exercise Aegis on 8 September 2026 and is implementing the resulting eighteen-action plan.
- Reviewing five years of historic data to compare winter and non-winter demand against commissioned activity, with scenario testing against a worse-than-usual winter, to quantify any capacity deficit and inform commissioning decisions.
- Maintaining mutual aid through the Incident Response Plan and the NHS England East of England Mutual Aid Framework, with a capability register to be held by the System Co-ordination Centre.

BEST PRACTICE IN DEMAND AND CAPACITY MODELLING

North West Anglia: separate bed modelling for each site with a published worst-case scenario as well as a forecast, and escalation capacity quantified ward by ward with opening aligned to agreed escalation triggers and workforce availability.

East and North Hertfordshire: escalation capacity quantified precisely — 13 Plus One areas, 24 reverse boarding areas and 20 escalation spaces — with an internal approval route through the Chief Operating Officer, Chief Nurse and Medical Director.

Cambridgeshire and Peterborough NHS Foundation Trust: the only community provider to publish a complete bed base, itemised unit by unit, reported to the system daily through SHREWD and the Operational Dashboard.

Central East is planning for its first winter as a single organisation of 3.5 million people. Whole-system demand and capacity modelling is under way and surge and extreme surge arrangements were tested at Exercise Aegis on 8 September 2026 with the findings are reflected throughout this plan. Provider-level bed demand, escalation capacity and deficit positions are being assessed as part of the winter planning exercise

5.1 Whole-system demand and capacity modelling and surge arrangements (BAS 3.1)

Demand modelling

The ICB is reviewing five years of historic data to compare winter and non-winter demand against commissioned activity, and applying scenario testing to assess the system against a worse-than-usual winter. This analysis will be completed prior to winter, will feed into the plan iteratively and will inform any subsequent commissioning decisions, including whether a capacity deficit requires additional commissioned provision. Detailed modelling methodology will sit in Appendix B.

Capacity modelling

TBC

Surge and extreme surge

For this plan, surge should mean demand above the planned winter position requiring predefined additional measures. Extreme surge should mean that planned winter and surge capacity are insufficient and exceptional system actions are required.

State	Trigger	ICB Required action	Decision authority
Surge	5+ acute sites at OPEL 4 and/or 1+ site declaring an operational critical incident and/or Ambulance service declaring CSP level 3	Activate defines SCC actions Activate provider OPEL 4 actions Communications to be circulated to reflect the seriousness of the critical incident; the requirement to act differently communicated to key stakeholders and the public. Enhanced same day access appointments being made available in Primary Care and GP support offered to review patients in Emergency Departments. Activate defined ambulance & NHS 111 actions.	Head of SCC or Operational on-call
Extreme surge	7+ acute sites at OPEL 4 and/or 2+ sites declaring an operational critical incident and/or Ambulance service declaring CSP level 4	As above, and: Deploy additional ICB surge staffing with defined action cards. Notify region detailing asks for mutual aid. Consider lowering clinical thresholds for admission to alternative pathways. Executive oversight to be put in place across the system with a recovery objective of 24 hours to de-escalate to OPEL 3. Request or require partners to flex opening, staffing or thresholds for patient access.	Head of SCC or Operational on-call

State	Trigger	ICB Required action	Decision authority
		Strong public messaging to outline current system pressures and how to access appropriate services at this busy time. Activate defined ambulance, NHS 111 and UCCH actions.	
In extremis	ICB System OPEL 4 status, and/or 3+ sites or sites in 2 different systems declaring operational critical incidents at level C2	As above, and: Clinical summit convened to review clinical risks across the system and to review the actions already taken and agree further actions to support. Alternative admission pathways re-communicated to GPs and Ambulance Crews in line with approved pre-drafted Extremis Communications Regional NHSE public messaging outlining system pressures.	Strategic on-call or director

5.2 Workforce, NHS 111 and mutual aid arrangements (BAS 3.2)

Workforce plans are strong, particularly within acute trusts, and are present but largely unquantified within community and mental health providers, where the recurring gaps are clarity of funding and staffing. Further provider information on workforce resilience has been requested.

NHS 111 providers have built in seasonal staffing arrangements into their models to manage anticipated demand and expected peaks. Measures such as employment of bank staff, targeted overtime and enhanced rates are utilised to support surge staffing requirements.

Mutual aid is variable in the plans submitted by providers but is coordinated through the System Co-ordination Centre under the ICB Incident Response Plan and the NHS England East of England Mutual Aid Framework. A mutual aid directory covering all partners will be established and held by the SCC, recording what each organisation can offer as well as what it may need, so that aid is brokered from a known position rather than by ad hoc request. Exercise Aegis recorded mutual aid headroom as thin, with some organisations reporting no remaining capacity to offer under workforce pressure.

5.3 Bed escalation and testing (BAS 3.3)

Arrangements agreed and tested

The statement asks whether bed escalation capacity arrangements have been agreed and tested across system partners. It does not ask whether that capacity is sufficient for expected winter demand — that question sits with B3.1, where the modelling is not yet complete and the statement is not yet recommended for assurance.

Central East enters winter carrying the same commissioned capacity that supported the system through winter 2025/26. The arrangements rest on delivery of the model discharge pathway, on maximising the pathways already commissioned, and on reducing length of stay so that existing beds turn over faster. On that basis the arrangements are agreed, and they were exercised at Exercise Aegis on 8 September 2026 alongside acute, community, mental health, ambulance and local authority partners.

Acute bed escalation arrangements are generally well documented, with providers identifying escalation spaces, activation thresholds, required executive approval and workforce dependencies. Some providers quantify capacity at ward level and have tested arrangements against surge and extreme-surge scenarios. The system also has examples of defined OPEL 4 support offers and additional Discharge to Assess capacity commissioned for seven-day access during winter.

Community escalation capacity is more constrained. Several community providers have confirmed that their bed base is fixed and that additional capacity cannot be made available without further commissioning or funding. These are agreed capacity positions rather than gaps in planning. Recording them clearly allows the System Co-ordination Centre to avoid seeking capacity during OPEL 4 that has not been commissioned and does not exist.

Providers activate capacity through their own internal flow and escalation arrangements, supported by acute escalation-capacity schedules. Three actions are required to establish a consistent system position for winter: bringing all available bed capacity into a single record held by the SCC; agreeing shared escalation triggers and a simplified pre-escalation process across the enlarged footprint; and confirming each provider's escalation offer and activation threshold at system OPEL 4.

Agreement and testing of escalation arrangements do not, in themselves, demonstrate that the commissioned capacity will be sufficient. Demand-and-capacity work has identified forecast bed deficits at some acute sites, including costed escalation capacity that is not currently approved. These findings will inform the analysis at section 5.1 and any subsequent commissioning decisions. They do not alter the separate assurance judgement about whether escalation arrangements are agreed, documented and tested.

DRAFT

6. Primary Care, NHS 111 and Admission Avoidance (BAS B4)

BAS REQUIREMENTS: B4.1-B4.7

General practice and out-of-hours capacity match expected demand; contractual access and NHS 111 direct booking are in place; PCN enhanced access is available; urgent dental care is monitored; community pharmacy capacity is sufficient; Directory of Services profiles are accurate; and the public is informed about available services.

BAS	RAG	Board assurance area	Rationale
B4.1	ASSURED	GP demand, surge, capacity and escalation	Demand assessed and capacity commissioned. Where gaps are identified the ICB has a commissioning plan of evidence-based interventions triggered as needed.
B4.2	ASSURED	Contractual access, online consults, same day appointments & NHS 111 direct booking	Commissioned, monitoring in place
B4.3	ASSURED	PCN enhanced access & slot release	Commissioned, monitoring in place
B4.4	ASSURED	Urgent dental care	Commissioned, monitoring in place
B4.5	ASSURED	Pharmacy	Commissioned, monitoring in place
B4.6	ASSURED	Directory of Services	Service assurance completed
B4.7	ASSURED	Public communications	Plan in place

6.0 How do we keep people safely closer to home and avoid unnecessary conveyance, ED attendance and admission?

WHAT THIS MEANS FOR OUR POPULATION

For most people in Central East, winter care begins with a telephone call, a pharmacy counter or a same-day appointment. It becomes an ambulance journey and an emergency department attendance when those routes are closed, too slow, or not visible to the person seeking help. The purpose of this chapter is to maintain accessible alternatives across all seven upper-tier local authority areas throughout the winter period, including bank holidays and the Christmas and New Year period.

WHAT CENTRAL EAST ICB IS DOING

- Commissioning enhanced access across all Primary Care Networks, out-of-hours general practice covering evenings, weekends and bank holidays, and urgent and emergency care hubs.
- Monitoring contractual compliance including same-day urgent appointments and NHS 111 direct booking at one appointment per 3,000 registered population.
- Commissioning Pharmacy First, the Discharge Medicines Service and mandated urgent dental capacity, and governing the NHS 111 Directory of Services.
- Holding a commissioning plan to mitigate any capacity gap with evidence-based interventions such as respiratory and COPD hubs, triggered on an as-needs basis, with further interventions being costed and considered.

The commissioned building blocks are in place: enhanced access through every Primary Care Network, NHS 111 direct booking into practice and enhanced access appointments, operational urgent and emergency care hubs, out-of-hours general practice covering evenings, weekends and bank holidays, a governed Directory of Services, Pharmacy First, the Discharge Medicines Service and commissioned urgent dental capacity.

No additional national winter funding has been made available for 2026/27, so winter resilience is being delivered through existing commissioned capacity and improved operational coordination rather than through

additional provision. Where demand and capacity assessment identifies a gap, the ICB holds a commissioning plan of evidence-based interventions, for example respiratory and COPD hub with options being costed.

6.1 Assurance position by statement (BAS 4.1–4.7)

B4.1: Demand has been assessed using historic activity, GPAD seasonal trends and local intelligence, and capacity reviewed through GMS, PMS and APMS contracts, PCN Enhanced Access and commissioned out-of-hours provision. Where capacity gaps are identified the ICB holds a commissioning plan to mitigate them with evidence-based interventions such as respiratory and COPD hubs, triggered on an as-needs basis, with additional interventions being costed.

B4.2 : Contractual compliance is monitored through routine assurance and the Primary Care Action Plan, covering core hours, online consultation, same-day urgent appointments and NHS 111 direct booking at one per 3,000 population.

B4.3: All Primary Care Networks provide Enhanced Access under the PCN DES, some through federations and alliances,, with unused on-the-day slots released to NHS 111.

B4.4: Mandated urgent dental appointment allocation is monitored with recovery actions where under-delivery is identified. The dental oversight dashboard is still in development.

B4.5: Pharmacy demand and capacity is assessed, with Pharmacy First and Discharge Medicines Service referrals monitored and palliative medicines access mapped. Geographical and out-of-hours gaps in palliative access remain.

B4.6: Directory of Services profiles are accurate and governed through the Clinical Advisory and Population Risk Directorate. Exercise Aegis found awareness was inconsistent among provider staff; an awareness campaign is a pre-winter action.

B4.7: System winter communications are coordinated with providers and partners, covering service access, self-care and vaccination.

7. Community Capacity and Whole-System Response (BAS B5 and B6)

BAS REQUIREMENTS: B5.1 and B6.1

Sufficient urgent community capacity is commissioned and effectively used for admission avoidance and discharge, including access to senior clinical decision-making through SPOAs for at least 12 hours a day, seven days a week; and the whole system optimises out-of-hospital capacity and admission-avoidance pathways.

BAS	RAG	Board assurance area	Rationale
B5.1	ASSURED	Urgent community care	Services live and fully operational across all areas, with 12/7 SPOA senior clinical cover confirmed by all community and mental health providers. ICB data flows and oversight function being established.
B6.1	ASSURED	Whole system response	Urgent Care Coordination Hubs operating in all three areas. Clearer ICB oversight of hub utilisation being established.

7.0 How do we ensure people have access to community care and out of hospital capacity to reduce avoidable admissions?

WHAT THIS MEANS FOR OUR POPULATION

An older person in Fenland, or a frail person in south-west Hertfordshire, treated at home rather than conveyed twenty miles to an emergency department. Urgent community response, virtual wards or Hospital at Home and effective discharge pathways determine whether that is possible. Out-of-hospital capacity is the principal means by which avoidable admission is prevented.

WHAT CENTRAL EAST ICB IS DOING

- Commissioning urgent community response, virtual wards, Hospital at Home and community diagnostics across all three areas.
- Establishing the data flows and designated oversight function needed to evidence that commissioned community capacity is sufficient and being used effectively.
- Has submitted a schedule of winter opportunities to the Management Executive Team and established an ICB working group to assess deliverability and impact.
- Taking clearer ICB oversight responsibility for the three Urgent Care Coordination Hubs so that out-of-hospital admission avoidance services are fully utilised.
- Developing a control centre to monitor and optimized commissioned out of hospital care capacity.

BEST PRACTICE IN OUT-OF-HOSPITAL CARE

At Bedford Hospital a Home First Transformation Pilot providing maximal support in the first 72 hours at home has been extended to October 2026 with full evaluation to determine impact and long-term sustainability.

In Watford hospital, Central London Community Healthcare provide a senior urgent community response clinician co-located at the Emergency Department front door alongside the EEAST HALO, taking calls directly from ambulance crews and redirecting to urgent community response, virtual hospital, SDEC or community pathways.

Hertfordshire Community Trust run a daily capacity report covering every urgent and emergency care service, reported internally and through SHREWD, with quantified triggers at every OPEL level.

East London NHS Foundation Trust maintain mental health long-stay oversight against specific measures of 60 days for working age and 90 days for older adults, with daily monitoring.

7.1 Community capacity and utilisation (BAS 5.1)

Urgent community response, virtual wards and/or Hospital at Home and community diagnostics are live and fully operational across all areas, and SPOA senior clinical cover at 12 hours a day, seven days a week is confirmed by all community and mental health providers. All three areas operate an Urgent Care Coordination Hub, and escalation routes are established through OPEL, SHREWD, daily safety huddles and system flow calls.

The remaining work is on ICB oversight rather than frontline provision: establishing the data flows and the designated oversight function that will let the ICB evidence utilisation from its own data and taking clearer responsibility for the three Urgent Care Coordination Hubs so that every out-of-hospital admission avoidance service is fully used. A schedule of winter opportunities has been submitted to the Management Executive Team and an ICB working group established to assess deliverability and impact.

Workforce is the principal dependency. Delivery of Pathway 1 capacity in Cambridgeshire and Peterborough is dependent progressing recruitment to the agreed additional posts, and the pace of recruitment will determine the additional home-first capacity available this winter. Equivalent understanding of Pathway 1 provision across Bedfordshire, Luton and Milton Keynes and across Hertfordshire remains under development.

7.2 Whole-system admission avoidance and out-of-hospital response (BAS 6.1)

All three areas have a functioning UCCH (Urgent Care Coordination Hub) supported by urgent community response, virtual wards, Hospital at Home, Pharmacy First, NHS 111 and out-of-hours general practice. This ensures that out-of-hospital urgent care services are utilised to avoid acute attendance or admission where possible. There are still gaps in ICB understanding of discharge support mechanisms/pathways in some areas across Central East. Greater understanding of current service models, activity and performance oversight, provider engagement is needed to ensure collaboration and clear lines of escalation for risks and issues are required to be fully assured heading into Winter.

The system maintains oversight of operational pressures through a shared MS Teams coordination approach, enabling providers and system partners to communicate emerging issues and capacity pressures in real time. Where significant system pressures arise, including OPEL 4 escalation, system calls can be convened to support coordinated operational decision-making and patient flow.

The ICB also works collaboratively with local authorities and other system partners to use population health, quality and intelligence data to identify medicines-related risks affecting care-home residents; agrees joint commissioning priorities and prevention approaches where services are jointly commissioned; seeks assurance through relevant contractual and partnership governance arrangements and escalates material system risks and gaps. The ICB sets and coordinates a single system framework for medicines communications; assures messages are evidence-based, accessible and consistent; evaluates reach and addresses gaps through responsible commissioning and communications leads.

During winter, monitoring and optimisation of commissioned capacity will initially take place manually and later through a digital 'control centre' which is being developed to provide a system-wide view of the utilisation of commissioned capacity.

8. Leadership, Operational Grip and Resilience (BAS B7)

BAS REQUIREMENTS: B7.1-B7.5

Tested on-call arrangements provide access to medical and nursing leaders; the system coordination model is skilled and resourced; command, control and OPEL/EPRR escalation are tested; mutual aid, business continuity, severe weather and industrial-action contingencies are reviewed; and staff welfare is supported.

BAS	RAG	Board assurance area	Rationale
B7.1	ASSURED	On call arrangements	In place
B7.2	ASSURED	SCC resource	Assured against demand data
B7.3	ASSURED	Command, control & escalation	Surge and escalation policy documented and tested
B7.4	ASSURED	EPRR and contingency planning	Plans documented and tested
B7.5	ASSURED	ICB staff welfare	Programme of support in place

8.0 Can Central East staff, coordinate and sustain the winter plan, and what will we do when demand exceeds it?

WHAT THIS MEANS FOR OUR POPULATION

A patient deteriorating at three in the morning on a bank holiday, when the ward needs a decision that cannot wait until Monday. An ambulance crew holding outside an emergency department at midnight. A family told that a discharge will not happen this weekend because nobody with the authority to agree it is available.

None of these people will ever see a command structure or an on-call rota. They experience it only as whether an answer came quickly, and came from someone with the authority to give it. That depends on there being enough people awake and reachable to give it, which is why this chapter is as much about the staff who carry winter as about the arrangements they work within.

WHAT CENTRAL EAST ICB IS DOING

- Maintaining 24/7 on-call with a minimum of two Tactical Commanders and one Strategic Commander available at all times.
- Increasing the System Co-ordination Centre senior duty manager establishment from 4.0 to 6.0 WTE Band 8a, with expedited recruitment ahead of winter.
- Recruiting internally an extreme surge cadre of ICB staff, issued with action cards for activation at seven or more acute sites at OPEL 4.
- Holding the Incident Response Plan, Adverse Weather Plan, outbreak and mass vaccination annexes and industrial action standard operating procedure, available 24/7 via the EPRR Vault.

BEST PRACTICE IN RESILIENCE AND STAFF WELFARE AT PROVIDER TRUSTS

At Royal Papworth there is a three-tier on-call system providing 24/7 command cover with Strategic, Tactical and Operational Commanders supported by trained loggists, validated through exercise and live activation, and a documented OPEL 4 support offer to system partners.

At West Hertfordshire an IPC Trust Winter Preparedness meeting is held from September, meeting fortnightly, bringing together Operations, Health and Safety, Clinical Procurement, Occupational Health, Estates and divisional nursing.

At North West Anglia the staff wellbeing offer including NeuroAccess (an occupational therapy pathway for neurodivergent staff and those with long-term conditions), alongside professional advocates providing

restorative clinical supervision. There is also a winter training principle to stand down non-essential face-to-face training through November to January to return time to care, while protecting core skills and safeguarding.

Exercise Aegis 2026 tested leadership, grip and resilience arrangements on 8 September 2026 and its findings are incorporated in this plan. The overall assessment was that the system is not short of services or local workarounds, but lacks a single operating model understood consistently across the enlarged Central East footprint. Pressure was attributed to the interaction of workforce fragility, inconsistent pathways, limited seven-day capacity and poor visibility of commissioned services, with the system weakest out of hours, at weekends and bank holidays, and at the handoffs between organisations.

Actions to be completed before winter include agreement of shared escalation triggers and a simplified pre-escalation process; clarification of who holds clinical risk out of hours, with published senior decision-maker on-call arrangements; communication of Section 136, place-of-safety and approved mental health professional arrangements including cross-border mutual aid and a Directory of Services awareness campaign for provider staff.

8.1 Assurance position by statement (BAS 7.1–7.5)

B7.1 — The ICB maintains 24/7 on-call with a minimum of two Tactical and one Strategic Commander at all times. Plans have been used in live incident response, including the Bedford train crash and major fire incidents across the ~~area~~ ~~free~~ ~~counties~~, alongside national, regional and local communications tests over the past five months. Exercise Aegis identified that out-of-hours clinical risk ownership requires strengthening; publication of a statement confirming the agreed position to partners is a pre-winter action.

B7.2: The System Co-ordination Centre has a 4.0 WTE complement of trained and embedded staff and an established operating model. All staff are appropriately trained with established procedures for on-boarding new recruits. The business plan to increase the senior duty manager establishment has been approved, and two additional Band 8a posts have been agreed, taking the establishment from 4.0 to 6.0 WTE. Expedited recruitment is in place to bring both posts into service ahead of the winter period. The practical effect is a material improvement in surge capability: the Centre can hold extended hours through a sustained escalation, maintain oversight across the whole Central East footprint while managing a concurrent incident, and reduce the fatigue and burnout risk previously carried on the winter risk register.

A further tier of resilience is planned for extreme surge. Where seven or more acute sites are at OPEL 4 concurrently, a defined cadre of ICB staff outside the System Co-ordination Centre is stood up against pre-allocated tasks under written action cards such as provider liaison and status chasing, SITREP and SHREWD collation, mutual aid brokerage support, system call logging and communications distribution. This means that core coordination is protected rather than displaced. Staff are identified and briefed before winter and activated by the SCC Lead or the on-call tactical commander.

B7.3: OPEL and EPRR escalation is monitored through SHREWD and the Surge and Escalation SOP was exercised at Exercise Aegis. Agreement of shared escalation triggers and a simplified pre-escalation process is a pre-winter action. The Federated Data Platform is planned to roll out over winter but will not be the primary mechanism for OPEL reporting until April 1 2027.

B7.4: Mutual aid runs through the Incident Response Plan and the NHS England East of England Mutual Aid Framework. The Adverse Weather Plan was enacted during the summer 2026 heat events with learning embedded, and an industrial action SOP is in place. The ICB overarching Business Continuity Plan is in place but has not yet been exercised; exercising is scheduled for early 2027. Team and directorate business impact assessments are not complete, with EPRR and the System Co-ordination Centre prioritised for completion before 1 November 2026.

B7.5: Staff welfare arrangements are established and assured. Formal support comprises a confidential Employee Assistance Programme available 24 hours a day and an Occupational Health service covering physical health, mental wellbeing and workplace adjustments. Peer support is delivered through trained Wellbeing Champions and accredited Mental Health First Aiders, alongside a year-round wellbeing programme

and flexible working where operationally feasible. Managers hold regular one-to-ones covering workload and wellbeing, reinforced during periods of increased demand, and wellbeing is monitored through staff survey feedback, sickness absence and workforce indicators, kept under review by the People and Culture team. These arrangements have been tested during the recent restructure process.

DRAFT

9. System Co-ordination Centre (BAS B8)

BAS REQUIREMENTS: B8.1-B8.3

The SCC proactively resolves operational pressures in hours; ICB on-call arrangements provide out-of-hours oversight and resolution; the SCC operates 08:00 to 18:00 seven days a week and can extend during extreme pressure; and proactive engagement with NHS England Regional teams is maintained.

BAS	RAG	Board assurance area	Rationale
B8.1	ASSURED	SCC resolves operational pressures	Polices and practices documented
B8.2	ASSURED	SCC operational hours	Evidence documented
B8.3	ASSURED	Regional engagement	Evidence documented

9.0 Can the SCC proactively resolve operational pressures in hours, with ICB on-call functions out of hours?

WHAT THIS MEANS FOR OUR POPULATION

A man waiting in the back of an ambulance outside a Peterborough emergency department, while forty miles away in Watford there are beds free. A woman in Bedford whose care package has been agreed but whose discharge has stalled because the delay sits with a partner nobody in the hospital can reach.

Neither of them can see the rest of the system, and neither can the team standing beside them. Somebody has to be able to see the whole of Central East at once, know who to call, and have the standing to ask, otherwise a problem that one organisation cannot solve alone simply continues. That is what this chapter is for.

WHAT CENTRAL EAST ICB IS DOING

- Operating the System Co-ordination Centre 08:00 to 18:00, seven days a week, across the whole Central East footprint.
- Increasing the Whole Time Equivalent Duty managers establishment from 4 to 6 to provide whole-system cover at OPEL 3+
- Monitoring OPEL through SHREWD throughout the operating day, meets providers to identify pressure, and issues a daily close-of-play report.
- Brokering mutual aid and coordinates resource flexing where pressure cannot be resolved locally.
- Working closely with NHS England, with regional representation on the Winter Assurance Group for winter 2026/27.

BEST PRACTICE IN SYSTEM COORDINATION

The Exercise Aegis 2026 utilised table-top game cards to clearly identify system asks and offers, mirroring the new approach to escalation where providers are required to bring more clarity to escalations making them quantifiable and actionable.

Enhanced use of open intelligence channels via Microsoft Teams such as those in place for ICB to provider communication was suggested to Regional NHS colleagues by CE ICB. This now provides access to regional intelligence in real time, optimises requests and asks and enhances working across-systems.

9.1 Assurance position by statement (BAS 8.1–8.3)

B8.1: The SCC resolves operational pressure in hours through SHREWD monitoring, provider meetings and mutual aid brokerage, escalating clinical and patient-safety matters to the escalating provider with ICB command engaged as required.

OPEL Reporting through SHREWD is monitored regularly throughout the working SCC day to maintain oversight of system performance. The SCC also has established escalation processes, meeting with providers to identify local pressures, mitigations and support from the wider system required in order to improve performance and alleviate pressure. The SCC has a Surge and Escalation Standard Operating Procedure (SOP) which is currently being reviewed following testing at Exercise Aegis in September 2026. The SCC maintain communications with providers through a variety of routes including live channels. This allows for timely escalation and resolution of pinch-points impacting operational performance.

The ICB's 24/7 on-call capability will provide out-of-hours route for operational pressures and patient safety escalations during the winter period. At all times, there are at least 2 Tactical and 1 Strategic commanders on call for the ICB, providing resilience should there be concurrent incidents. Roles and Responsibilities are clearly defined in the ICB On Call Guidelines.

The October 2026 – March 2027 On-Call rota is under development and updated on-call guidelines are due to be published by the end of September. Development of Central East Action Cards for operational escalations and training for commanders are due to be completed by mid-October 2026.

B8.2: The System Co-ordination Centre is staffed to operate 08:00 to 18:00, seven days a week across the whole footprint, with minimum daily cover of two duty managers and administrative support. This is extendable and sustainable at 6.0 WTE, with start and end times flexed to extend coverage in line with the Minimum Value Product and three managers routinely in place weekdays to cover the demand across three geographies. The extreme surge cadre activated at seven or more acute sites at OPEL 4. Outside those hours the ICB 24/7 on-call function provides the escalation route. Alongside the SCC sits a designated Ambulance Local Operational Oversight Cell with a dedicated manager 12h a day, seven days a week. This role supports ambulance management and deployment, handover delays and provides a single point of contact for EEAST.

The resilience position recorded in chapter 8 applies equally here. The operating model is appropriate and the arrangements are rehearsed, and the agreed increase to 6.0 WTE senior duty managers removes the establishment gap that previously limited the Centre's ability to sustain extended hours. The residual risk is now the recruitment timescale rather than the establishment itself, and is being managed through expedited recruitment and active rota control.

B8.3: Regional engagement is routine through tactical calls (at least three times a week), SHREWD reporting, daily close-of-play reports and a monthly Heads of Service meeting alongside an open channel for real-time intelligence on ambulance delays and emerging pressure, operating across the East of England. For winter 2026/27 a regional representative has accepted an invitation to join the Winter Assurance Group, adding a further layer of engagement and communication with the regional team.

9.2 System Co-ordination Centre staffing model 2026/27

The staffing model below reflects the agreed establishment for winter 2026/27, including the two additional Band 8a senior duty manager posts and the extreme surge tier.

Head of SCC — 1.0 WTE

Strategic leadership of the Centre. Reports to the Winter Assurance Group; escalates to the on-call tactical commander and the Management Executive Team.

**Senior Duty Managers — 6.0 WTE, Band 8a (increased from 4.0 WTE)**

Minimum three on duty weekdays, two on duty weekends, 08:00 to 18:00, seven days a week, across the whole Central East footprint. Expedited recruitment in place to the two additional posts ahead of winter.

**SCC Administrators — 4.0 WTE**

Minimum two on duty daily. SITREP and SHREWD collation, system call administration, logging and action tracking.

**Extreme surge tier — ICB staff cadre (activated, not established)**

Stood up at seven or more acute sites at OPEL 4 concurrently. Pre-allocated tasks under written action cards: provider liaison and status chasing; SITREP and SHREWD collation; mutual aid brokerage support; system call logging and action tracking; communications distribution. Identified and briefed before winter. Activated by the SCC Lead or the on-call tactical commander.

The extreme surge tier protects core coordination by ensuring that surge activity is absorbed by additional capacity rather than displacing routine oversight. It is an activation arrangement rather than a permanent establishment, and does not form part of the 6.0 WTE senior duty manager complement.

9.3 Winter operational rhythm

Cadence	Purpose	Content
Daily	SCC operational oversight	SHREWD overview of system risks Receipt of operational and site reports Enact OPEL 3 actions and support required Support patient transport requests and general system queries and asks
During escalation	OPEL response	Ask providers for escalations and invite relevant partners to operational escalation call Hold an action focused operational escalation call (s) Complete system actions, document and respond to providers within 2 hours Review site position and review outcomes of escalations
Weekly	Winter oversight	System-level provider meetings (locally or SCC convened) Regional escalation calls (M, W, F) Winter Assurance Group review (fortnightly moving to weekly when required) Escalations from WAG to MET (weekly)
Monthly	Thematic review	Support neighbourhood review of metrics and themes

10. Winter Readiness, Risks and public outcomes

10.1 Outstanding readiness action plan

The actions below are drawn from the provider winter plan assessment, the Board Assurance Statement returns and the Exercise Aegis 2026 action plan. They are phased against a winter start of 1 November 2026. Owners suggested in the exercise report are to be confirmed by the Winter Assurance Group. Progress is reported to the Winter Assurance Group, with material slippage escalated to the Management Executive Team.

PHASE 1 — to be completed before winter, by 1 November 2026

Ref	Action	Source	Owner	Completion measure
1	Agree shared escalation triggers, a framework for system asks and a simplified pre-escalation process aligned to OPEL and SHREWD	Aegis A1	SCC with providers	Framework agreed and tested on a system call
2	Review system call frequency, membership and terms of reference to include primary care, local authorities, VCSE and hospice	Aegis A2	SCC team	Revised terms of reference in use
3	Agree who holds clinical risk out of hours and publish senior decision-maker on-call arrangements, with policy and legal cover for risk sharing	Aegis A3	ICB medical and nursing directors	Out-of-hours risk ownership statement issued
4	Communicate Section 136 and place-of-safety capacity including cross-border mutual aid; confirm out-of-hours and weekend AMHP cover	Aegis A4	Mental health commissioning with local authorities	Arrangement documented and known to the SCC
5	Ambulance Category 3 clinical safety plan shared with the SCC	Aegis A5	Ambulance services with SCC	Plan shared and referenced in the escalation framework
6	Directory of Services awareness campaign for provider and SCC staff;	Aegis A6	ICB DoS lead with SCC & comms	Provider staff know how to access the DoS
7	Establish a mutual aid capability register held by the SCC, recording offers as well as asks;	Aegis A9	SCC with providers	Register held in the SCC
8	Agree a single IPC advice route into care homes,	Aegis A10	ICB IPC lead with LAs	Single route agreed
9	Collate and monitor reporting of patients with no criteria to reside by pathway 1 to 3 from every acute provider	BAS B2.1	SCC with provider operational leads	Pathway-level NCTR visible and information used to expedite discharge blocks
10	Obtain corridor care baselines & plans	BAS B2.2	Winter lead	Baseline and plan held for every acute site
11	Obtain model discharge pathway baselines from the remaining providers	BAS B2.4	Winter Lead with provider operational leads	Baseline held for every acute provider
12	Agree a dated pre-Christmas and holiday-period occupancy reduction plan at each provider	BAS B2.5	Provider discharge governance with local authorities	Target, date and named owner agreed per provider
13	Obtain a fit testing compliance figure, target and trajectory from every provider	BAS A1.7	ICB IPC lead	Compliance return held for all 14 providers
14	Confirm a minimum FFP3 stock standard and monitoring arrangement with every provider	BAS A1.7	ICB IPC lead	Stock position confirmed; minimum levels monitored
15	Complete recruitment to the two additional Band 8a senior duty manager posts	BAS B7.2	SCC Lead	Both posts in service before winter
16	Publish the October 2026 to March 2027 on-call rota and revised on-call guidance	BAS B7.1	EPRR Lead	Rota and guidance issued by end September 2026
17	Schedule system calls weekly (inc RPH)	Provider assurance	SCC team	Membership list updated; attendance recorded

Ref	Action	Source	Owner	Completion measure
18	Publish Central East action cards & playbook for operational escalations	BAS B7.3	SCC team	Action cards issued by mid-October 2026
19	Complete EPRR and System Co-ordination Centre business impact assessments	BAS B7.4	EPRR Lead	Both completed before 1 November 2026
20	Local authorities to present webinar supporting system understanding of processes	Aegis 6.2	LA winter leads	Webinar complete and shared with staff
21	Mental Health providers to meet and share how the model discharge pathway can be managed in their setting	Aegis 6.2	Mental health winter leads	Meeting in place

PHASE 2 — to be completed by the end of November 2026

Ref	Action	Source	Owner	Completion measure
22	Consider increasing CHC and Section 117 panel frequency; agree delegated authority for escalation decisions; consider introducing a CHC decision tree and early CHC lead input; scope bridging provision	Aegis A7	ICB CHC with local authorities	Panel waits reduced; bridge option agreed
23	Agree the escalation route for children and young people aged 15 to 18 and name a representative to the system call	Aegis A8	CYP and mental health commissioning with SCC	Route documented; representative named
24	Review discharge transport options including VCSE-supported and safe family transport	Aegis A11	UEC commissioning with VCSE	Transport options list available to providers via the SCC
25	Review historical COVID-19 arrangements for anything that could be reinstated this winter	Aegis A12	All partners	Short options paper
26	Quantify urgent care demand; investigate the NHS 111 to ED gap and 08:00 to 10:00 appointment utilisation	Aegis A13	Strategic Commissioning	Data confirmed and reported
27	Define what recovery looks like, including expected recovery time by trust	Aegis A14	SCC with providers	Recovery definition agreed
28	Run a tabletop test of weekend and bank holiday discharge with senior decision-makers, local authorities and transport	Aegis A15	SCC with providers and local authorities	Test held before the Christmas bank holidays

PHASE 3 — during winter and into 2027/28 planning

Ref	Action	Source	Owner	Completion measure
29	Embed discharge and family conversations from admission; engage care homes earlier	Aegis A16	Acute and community providers	Provider assurance through winter
30	Review service hours across SDEC, UCC, frailty, same-day and five-day fast-track provision; agree pre-authorised surge variations; identify 24-hour needs	Aegis A17	Strategic Commissioning	Contract variations agreed for 2027/28
31	Cross-check exercise findings against provider winter plan assurance and hold a follow-up exercise with full representation	Aegis A18	SCC team	Gaps reflected in assurance; follow-up exercise held
32	Exercise the ICB overarching Business Continuity Plan	BAS B7.4	EPRR Lead	Exercise held in early 2027

10.2 Material risks and decisions

The risks below remain material after planned mitigation. The full winter risk register, with owners, likelihood and impact scoring, mitigations and residual risk, is held locally and will be reviewed by the Winter Assurance Group through winter, with material movement escalated to the Management Executive Team.

Ref	Risk	Principal mitigation
R1	Sustained UEC demand above planned capacity	Demand and capacity analysis under way (B3.1 not assured); surge and extreme surge arrangements tested at Exercise Aegis
R2	Workforce capacity and resilience	Workforce resilience and mutual aid register
R3	Seasonal infection, IPC and respiratory illness	Vaccination (flu, COVID, RSV), IPC and health protection
R4	High occupancy and delayed discharge	Flow and discharge arrangements
R5	Community, social-care and care-home capacity	Joint commissioning and escalation
R6	Ambulance demand and handover delay	Alternative pathways and handover plan
R7	Mental health crisis capacity	All-age crisis and escalation arrangements
R8	Severe weather and business disruption	EPRR and business continuity arrangements
R9	Variation in frailty capacity between places	Commissioned frailty capacity mapped by Place
R10	Corridor and non-designated care	Provider resubmissions requested; corridor care reported through SHREWD and reviewed at the Winter Assurance Group
R11	Discharge transport capacity and reliability	NEPTS service specification and performance review
R12	Discharge medicines and prescribing delay	Discharge Medicines Service referral routes to be confirmed; electronic prescribing at discharge trialled

10.3 What success looks like

The measures below show whether we have made a difference for our residents. Baselines marked for confirmation are to be agreed by the Winter Assurance Group before 1 November 2026, in line with the next step recorded in the Exercise Aegis report. The position against each measure will be reviewed in April 2027 as part of the winter debrief and will inform 2027/28 planning.

Outcome measure	Baseline	Winter 2026/27 target	Source	Reported to
Four-hour emergency access standard	[Baseline to confirm]	Delivery of the agreed 2026/27 trajectory through winter, with no December or January trough below the 2025/26 position	SHREWD; provider SITREPs	Winter Assurance Group, weekly
Category 2 ambulance response time	00:34:16 (East of England 25/26 Cat 2 Mean)	00:31:43 (NHSE Plan East of England 26/7 Cat 2 Mean)	Ambulance service reporting	Winter Assurance Group, weekly
Ambulance handovers over 45 minutes	[Baseline to confirm]	No handover exceeding the 45-minute maximum; 15-minute handover delivered as the aim	SHREWD; ambulance handover data	SCC daily; WAG weekly
Corridor care elimination	Listed by provider	Reduction of usage of corridor care / elimination of corridor care	Provider SITREPs	SCC daily; WAG weekly
Patients with no criteria to reside, by pathway 1 to 3	[Baseline to confirm]	Pathway-level reporting from every acute provider from 1 November 2026, with the NCTR cohort reduced against the pre-winter baseline	SHREWD; discharge SITREP	SCC daily; WAG weekly
Section 136 waits, mental health waits in ED including under-18s	[Baseline to confirm]	No patient held in an unsuitable setting for want of a place of safety	Mental health provider returns; local authorities; acute ED data	WAG monthly

Outcome measure	Baseline	Winter 2026/27 target	Source	Reported to
Staff influenza vaccination uptake, frontline workers	[Baseline to confirm]	Every provider to improve on its 2025/26 position	RAVS and ESR; provider returns	Vaccination Programme Board, weekly
Vaccination (flu, COVID, RSV) uptake, adults aged 65 and over and care home residents	75.93% and 75.40% (Autumn/Winter 2025)	Maintain above the 75% national ambition, with a stretch ambition of 80% and 85% respectively, and reduced variation between Places	Weekly uptake reporting	Vaccination Programme Board, weekly
Increased response to mutual aid and live requests raised through the SCC	Not currently measured	Measurement established from 1 November 2026, with every request closed and the outcome recorded	SCC Tracking Log	WAG monthly

WHAT THIS MEANS FOR OUR POPULATION

A woman of 78 in Luton had her flu vaccination in October, and did not need admission for flu this winter.

A man in mental health crisis accessed a place of safety rather than a night in an emergency department, because the Section 136 suite had capacity.

A frail woman in Fenland went home on a Saturday, not the following Tuesday, because the decision did not have to wait for a weekday.

A child with bronchiolitis was seen and sent home the same day, through a paediatric pathway that held up when the respiratory peak came.

None of these appear in a performance report. Every measure at 10.3 is a proxy for them: a handover time is an ambulance released to the next patient, a no-criteria-to-reside figure represents people waiting in a bed they no longer need, a vaccination percentage may be admissions that never happened. A successful winter is largely measured in what did not occur. The test the Board should apply in April is not whether all the actions in this chapter were completed, but whether winter was safer for the people we serve.

DRAFT