

Appendix B: Board Assurance Statement summaries

This appendix holds the detailed assurance summary for each Board Assurance Statement. The narrative position for every statement is set out in the corresponding chapter of the main plan; this document carries the supporting baseline, winter response, evidence and residual risk detail behind it. Completed BAS assurance templates submitted by the statement leads are held at Appendix B. Assurance status is shown against each statement within the tables below.

ASSURED	The Board can be assured against this statement. Residual risks, where recorded, are managed within existing arrangements.
NOT ASSURED	The Board cannot currently be assured against this statement. The position and the action required are set out in the corresponding chapter of the main plan.
IN PROGRESS	The Board is awaiting requested assurance.

Section A — Governance, quality and assurance

BAS	Assurance status	Board assurance required	Central East position / action	Evidence
A1.1	Due 25/9/26	The plan has been assured by the ICB Board	Sign off due 25/9 with delegated action to Chair for final assurance and submission by 7/10	
A1.2	IN PROGRESS, EXPECTED TO BE ASSURED	QEIA assessment	QEIA assessment in progress with regular panel meeting and strong internal governance	Panel evidence
A1.3	ASSURED	Engagement of system partners	System partners have been engaged in development of the plan, with the exception of quality primary care involvement.	Place-based plans and meeting minutes
A1.4	ASSURED	Named Executive sponsor	Maria Wogan	MET minutes
A1.5	ASSURED	Winter exercise undertaken, reviewed and incorporated	Complete, see event report	Event review
A1.6	ASSURED	Governance arrangements in place	In place, see winter plan documentation	ICB governance documents
A1.7	ASSURED	Fit testing, PPE provision and IPC mitigations, including ability to scale rapidly during infectious-disease surge.	Five are fully assured eight partial and one not assured yet. Vaccination planning is the strongest element and is quantified by most providers. For Fit testing and PPE four providers state a current fit testing compliance figure, and only one states a PPE stock position - and that provider reports it as insufficient.	Provider winter plans; provider IPC returns.
A1.8	ASSURED	Health-protection governance, escalation and provider response arrangements for infectious-disease incidents and outbreaks.	Nine are fully assured, three partial and two not assured yet. Where governance is evidenced it is generally strong, with named committees, outbreak policies and board reporting routes. The gap is concentrated rather than general: two providers have nothing, and three describe outbreak response without naming the governance that oversees it.	Provider winter plans; health protection escalation arrangements.

B1 — Prevention and vulnerable cohorts

BAS	Assurance status	Area	Current position / baseline	Winter response	Assurance / evidence	Residual risk
B1.1	ASSURED	Priority vaccination programmes (flu, COVID, RSV),	Uptake exceeded the 75% national ambition in 2025/26 for adults 65+ and care home residents. Lower uptake in Luton and Peterborough, and among traveller, homeless, inclusion health and rural communities. Healthcare worker uptake below ambition in parts of the system.	Coordinated flu, COVID-19 and RSV programme across three areas. Delivery from 1 Sept 2026 (children, pregnant women) and 1 Oct 2026 (all other eligible cohorts). Place Vaccination Hubs maintained, standing vaccination item at each Place NPCCS. Targeted outreach and trusted communications for underserved groups.	Weekly uptake monitoring; Central East Vaccination Programme Board and QUM governance reporting.	Healthcare worker uptake; persistent inequality in Luton, Peterborough, traveller/homeless/inc lusion health and rural communities; public confidence; variation in operational capacity between Places.
B1.2	ASSURED	Risk stratification and targeted support	Risk stratification via GP clinical systems and population health intelligence. eFI and local frailty registers. DELPHI tool used in Hertfordshire, extending across C&P and BLMK. Neighbourhood multidisciplinary teams. Healthier Together website commissioned in one area.	Anticipatory and personalised care planning; long-term condition reviews; medicines optimisation; care home support via EHCH PCN DES; vaccination; UCR and virtual wards; Pharmacy First; neighbourhood MDT review of highest-risk patients. COVID-19 treatments via HUC/MKUC and general practice; influenza antivirals via general practice and OOH. Healthier Together response for children and families.	GP contractual reporting; ePACT2, OpenPrescribing and Eclipse intelligence; commissioned pathway activity and access data. Website data tracking	Consistency of neighbourhood MDT coverage across the new footprint while the Neighbourhood Health Model develops; DELPHI roll-out timing outside Hertfordshire.

B2 — Flow, occupancy and discharge

BAS	Assurance status	Requirement	Current position / gap	Winter response	Evidence / measure	Residual risk
B2.1	ASSURED	Seven-day flow, bed occupancy, discharge and executive oversight	Seven-day flow and discharge arrangements are described by all assessed providers but evidenced as operating by few. Operational escalation systems are strong.	Daily SCC oversight through SHREWD and OPEL.	Appendix D; SHREWD OPEL and NMCTR reporting; feedback log.	Described but not demonstrated in operation.
B2.2	AWAITING PROVIDER RESUBMISSIONS FOLLOWING ADVICE, EXPECTING TO ASSURE	Corridor care elimination, safety thresholds and system mitigation	Two hospitals not utilizing, 2 with plans for reduction, awaiting others.	Feedback on absent baselines, safety thresholds and Board oversight. Corridor care reported through SHREWD and reviewed at the Winter Assurance Group.	Provider plans; SHREWD; provider IPR extracts.	Cases where no baseline or safety threshold exists.
B2.3	ASSURED	Joint discharge planning with local authorities and social care	Provider returns vary but holistic assessment of neighbourhood arrangements is strong, with effective TOC hubs in Herts and C&P and integrated care hubs in BLMK and established working arrangements for escalation.	Named local authority participation to be confirmed at each Place through the routes at 2.3, including holiday-period arrangements.	Provider plans; Place partnership validation; D2A commissioning records.	MEDIUM.
B2.4	AWAITING PROVIDER RESUBMISSIONS FOLLOWING ADVICE, EXPECTING TO ASSURE	Baseline against the model discharge pathway and improvement actions	Baseline completed by two providers, awaiting others.	Baseline against model discharge pathway requested from remaining providers.	Provider self-assessments.	Cross-partner improvement actions not present system-wide.
B2.5	AWAITING PROVIDER RESUBMISSIONS FOLLOWING ADVICE, EXPECTING TO ASSURE	Pre-Christmas and holiday-period occupancy reduction	One provider has a dated, agreed programme and as second has planned decompression events, awaiting others.	Occupancy reduction to be agreed at each Place with a target, dates and named owner. West Hertfordshire model offered across Central East as system learning.	Provider plans; Place discharge governance; Christmas and New Year command plan.	Not yet planned across most of the system.

B3 — Demand, Capacity & Surge Management

BAS	Assurance status	Requirement	Current position / gap	Winter response	Evidence / metric	Residual risk
B3.1	PENDING	The plan to be built on whole system demand and capacity modelling, tested surge and extreme surge responses	Work is still in progress to provide demand and capacity modelling. Once complete, this modelling will provide further assurance around commissioned activity and any additional activity that might be required.	The ICB are reviewing five years of historic data to compare winter and non-winter demand, against commissioned activity and apply scenario testing to assess against a worse-than-usual winter.	Data modelling appendix,	TBD following receipt of data
B3.2	ASSURED	Workforce, NHS 111 & mutual aid arrangements are sufficient	Workforce plans are strong in acute trusts with key gaps being lack of clear funding and staffing across community and mental health providers. NHS 111 providers confirm contingency and surge arrangements, and mutual aid is available, though variable.	Create mutual aid directory (all partners). Receive additional provider information regards workforce resilience	Provider plans	Unforeseen staffing issues above planned capacity.
B3.3	ASSURED	Bed escalation capacity arrangements agreed and tested	Acute bed escalation is generally documented, but three community providers note no escalation capacity. The system has the same commissioned capacity that supported winter last year which relies on the model discharge pathway, maximising existing commissioned pathways and supporting shorter patient lengths of stay.	Document bed capacity. Agree shared escalation triggers and a simplified pre-escalation process (Aegis A1). Confirm the escalation offer and activation trigger for each provider at system OPEL 4.	Contracted beds, escalation policy	Following modelling, identify deficits to mitigate

B4 — Primary care, NHS 111 and admission avoidance

BAS	Assurance status	Requirement	Current position / gap	Winter response	Evidence / metric	Residual risk
B4.1	ASSURED	GP demand has been assessed and sufficient capacity has been commissioned, including surge capacity, escalation and out-of-hours general practice	Demand assessed using historic activity, GPAD seasonal trends and local intelligence. Capacity reviewed through GMS, PMS and APMS contracts, PCN Enhanced Access and commissioned OOH. Where capacity gaps are identified, the ICB has a commissioning plan to mitigate these with evidence-based interventions such as respiratory and COPD hubs, triggered on an 'as needs' basis.	Enhanced access across all PCNs; NHS 111 direct booking into practices and enhanced access; urgent and emergency care hubs; escalation via Place and SCC; primary care assurance meetings; daily intelligence sharing during escalation; OOH covering evenings, weekends and bank holidays. Additional evidence-based interventions being costed and considered.	GPAD; GP Access Improvement Dashboard; GP hub activity; NHS 111 booking data; OOH contracts; winter escalation SOPs.	Resilience delivered from existing commissioned capacity, surges would trigger additional interventions.
B4.2	ASSURED	Contractual access, online consultation, urgent same-day appointments and NHS 111 direct booking	Compliance maintained through routine contractual assurance and delivery against the Primary Care Action Plan.	Monitoring of core opening hours, Online Consultation requirements, clinically urgent same-day appointments, NHS 111 direct booking at minimum one appointment per 3,000 registered population, contractual reporting, practice visits where needed and contractual performance management.	National and local primary care dashboards; Online Consultation compliance; NHS 111 booking reports; CPQAF and quality oversight; Primary Care Commissioning Sub-Committee performance reports.	Escalation where practices fall below expected standards; managed through existing contractual routes.
B4.3	ASSURED	PCN enhanced access and release of unused on-the-day slots to NHS 111	All PCNs provide Enhanced Access in line with PCN DES requirements; some sub-contract through GP federations and alliances.	Continued work with PCNs to maximise utilisation and improve access across neighbourhoods; unused on-the-day slots made available to NHS 111.	Evening and weekend appointment delivery; appointment utilisation; NHS 111 direct booking and access to enhanced access appointments; provider contractual returns.	Variation in utilisation between PCNs; managed through routine contractual assurance.
B4.4	ASSURED	Unscheduled / urgent dental care monitoring	Mandated urgent dental appointment allocation monitored routinely with providers. Dental oversight dashboard in development.	Performance reviewed against commissioned urgent care capacity, utilisation, provider delivery, contractual compliance and access. Recovery actions agreed where under-delivery is identified. Continuing work to integrate dentistry into neighbourhood models.	Commissioned urgent dental capacity and utilisation reporting; contract monitoring; dental oversight dashboard once live.	Dashboard not completed in a timely manner. Dependent on digital support and providers.
B4.5	ASSURED	Community pharmacy	Population need assessed and pharmacy access commissioned or	Commissioning for reliable Discharge Medicines Service referral across providers	MYS and DMS data; provider referral reports; Pharmacy	Data to support demand and activity

BAS	Assurance status	Requirement	Current position / gap	Winter response	Evidence / metric	Residual risk
		demand/capacity, OOH provision, Pharmacy First and DMS	influenced across the footprint. Pharmacy First activity, referral completion, outcomes and OOH coverage monitored. Provider plan review found no reference to the Discharge Medicines Service, to electronic prescribing at discharge, or to FP10 use, in any of the fifteen documents submitted by providers. Confirmation of a working referral route is therefore a winter action for every acute provider.	with monitoring of referral, acceptance and completion. Resilient, equitable access to anticipatory and urgent palliative medicines including out of hours, with access risks mapped and gaps addressed through commissioning action.	First activity; contract and pathway specifications; access mapping.	assessment. Geographical, temporal and equality-related gaps in palliative medicines access.
B4.6	ASSURED	Accurate and regularly reviewed NHS 111 Directory of Services profiles	Directory of Services is accurate, up to date and regularly reviewed, with robust governance ensuring service information remains current and clinically safe.	Work with acute and community service managers to keep UEC DoS profiling current and notify the 111 UEC DoS team of emergency changes promptly. Services commissioned through winter planning added to the DoS as they become available. Cross-cover within the team to mitigate capacity gaps. Winter exercise action to improve communications to providers about the use of DoS.	DoS profile review records; governance sign-off through the Clinical Advisory and Population Risk Directorate.	Reduced 111 call handler or clinician capacity at HUC would increase ED attendance and waiting times, and increase pressure on the service.
B4.7	ASSURED	Public communications on in-hours and out-of-hours provision	Clear plans to ensure public communications about services with additional plans for vaccination and operational escalation.	Medicines-related self-care and appropriate-use communications are covered in the Medicines and Prescribing Winter Assurance Map. Comms plan utilizing national materials and working in conjunction with providers. Targeted vaccination campaign and information about service availability.	Communications plan and evaluation; website analytics; NHS 111 and pharmacy intelligence; equality analysis.	Dependencies on provider messaging.

B5 — Community health capacity

BAS	Assurance status	Requirement	Current position / gap	Winter response	Evidence / metric	Residual risk
B5.1	ASSURED	Sufficient urgent community capacity commissioned, monitored and used effectively for admission avoidance and discharge, with access to senior clinical decision-making through SPOAs at least 12 hours a day, 7 days a week.	UCR, virtual wards, Hospital at Home and community diagnostics live and fully operational across all Places. Bedfordshire coordinated through EoE Community Health Services with single activity reporting; MK monitored daily through service safety huddles. CDCs operated by provider trusts under NHSE-approved 2026/27 plans including seasonal demand. Understanding of community bed and Pathway 1 capacity incomplete outside Cambridgeshire and Peterborough. SPOA senior clinical cover against the 12/7 requirement is confirmed by all community and mental health providers.	Establish ICB data flows and a designated oversight function; right-size capacity alongside Home First; progress Pathway 1 workforce recruitment with CPFT and both local authorities. Winter opportunities schedule submitted to MET and ICB working has been established.	Weekly escalation meetings; daily safety huddles and system bed calls; OPEL and SHREWD intelligence; provider and local authority recruitment reporting; P1 demand, capacity and backlog oversight; SPOA operating procedures.	Confidence in deliverability high if data flows and oversight function established at pace.

B6 — Whole-system response

BAS	Assurance status	Requirement	Current position / gap	Winter response	Evidence / metric	Residual risk
B6.1	ASSURED	The whole system optimises out-of-hospital capacity and admission-avoidance pathways.	Urgent Care Coordination Hubs operating in all three Places, supported by UCR, virtual wards, Hospital at Home, Pharmacy First, NHS 111 and OOH general practice, with referral through the Hub, SPOA and NHS 111 supported by DoS profiling. Admission avoidance delivered through anticipatory care planning, neighbourhood MDT review, frailty and care home support, antiviral and COVID-19 treatment pathways and medicines optimisation. Home First and Pathway 1 include the Bedford Hospital Home First Transformation Pilot. Utilisation not yet fully visible to the ICB.	Establish clearer ICB oversight responsibility for UCCHs to ensure all out-of-hospital admission avoidance services are fully utilised. Bedford pilot extended to October 2026 with full evaluation to determine impact and long-term sustainability. Escalation via OPEL and system calls convened during significant pressure including OPEL 4.	UCCH activity and referral data; OPEL escalation records; pilot evaluation report; Place discharge governance.	Capacity not quantified system-wide; ICB understanding of discharge support mechanisms and pathways incomplete in some Places. Commissioned frailty capacity varies materially between Places (see 4.2).

B7 — Leadership, operational grip and resilience

BAS	Assurance status	Requirement	Current position / gap	Winter response	Evidence / metric	Residual risk
B7.1	ASSURED	Tested on-call arrangements provide access to medical and nursing leadership.	ICB 24/7 on-call with a minimum of two Tactical Commanders and one Strategic Commander available at all times, providing resilience against concurrent incidents. Clinical and quality escalation out of hours provided by the escalating trust on-call clinical lead, lead nurse or medical director.	October 2026 to March 2027 rota and revised on-call guidance issued by end September 2026. Central East action cards for operational escalations due mid-October 2026. Publication of an out-of-hours clinical risk ownership statement (Exercise Aegis action A3).	ICB On Call Guidelines; incident debriefs; communications test records.	Exercise Aegis recorded that clarity over who holds clinical risk out of hours requires strengthening; action in train before winter.
B7.2	ASSURED	The system coordination model is appropriately skilled and resourced.	Senior duty manager establishment increased from 4.0 to 6.0 WTE Band 8a following approval of the business plan. At 4.0 WTE the rota required 728 shifts a year against a shortfall of 71 after leave and bank holidays, rising to c.104 with sickness; at 6.0 WTE the rota is deliverable in full.	Expedited recruitment to both additional posts ahead of winter. Extreme surge cadre of ICB staff identified, briefed and issued with action cards for activation at 7 or more acute sites at OPEL 4.	Job descriptions and rota; MET business case decision; SCC staffing model at 9.2.	LOW-MEDIUM, reduced from HIGH. Residual risk is recruitment timescale: benefit realised only once both posts are in service.
B7.3	ASSURED	Command, control and OPEL/EPRR escalation arrangements are tested.	OPEL monitored through SHREWD throughout the SCC operating day; established escalation processes with providers; Surge and Escalation SOP exercised at Exercise Aegis on 8 September 2026 for mobilisation this winter.	Agreement of shared escalation triggers and a simplified pre-escalation process aligned to OPEL and SHREWD (Exercise Aegis action A1). Provider Critical Incident declaration annex published by end September 2026.	SHREWD OPEL records; Surge and Escalation SOP; Exercise Aegis report and action plan.	Exercise Aegis identified the absence of shared escalation triggers as a system gap; action in train before winter.
B7.4	ASSURED	Mutual aid, business continuity, severe weather and industrial action contingencies have been reviewed.	Mutual aid incorporated within the ICB Incident Response Plan and the NHSE East of England Mutual Aid Framework, tested through live incident response and at Exercise Aegis. Adverse Weather Plan enacted during the summer 2026 heat events with learning embedded. SOP in place for industrial action. Overarching Business Continuity Plan in place but not yet exercised.	BCP exercising scheduled early 2027. EPRR and SCC business impact assessments prioritised for completion before 1 November 2026, remainder on a 12-month plan. Mutual aid capability register held by the SCC (Exercise Aegis action A9).	Incident Response Plan and annexes via EPRR Vault; Mutual Aid Framework; Adverse Weather Plan; debrief records.	Exercise Aegis recorded thin mutual aid headroom, with some organisations reporting no remaining capacity under workforce pressure. Team and directorate BIAs incomplete.
B7.5	ASSURED	Staff welfare is supported.	Confidential Employee Assistance Programme available 24/7, Occupational Health service, trained Wellbeing Champions and accredited Mental Health First Aiders, year-round wellbeing programme, and flexible and agile working where operationally feasible.	Wellbeing conversations reinforced during periods of increased demand through regular one-to-ones and annual appraisal. SCC rota managed to protect recovery time.	Staff survey feedback; sickness absence data; workforce indicators; People and Culture team review.	No capacity gap identified; high confidence. Fatigue risk in the SCC is the principal known welfare concern and is addressed through the establishment increase at B7.2.

B8 — System Co-ordination Centre

BAS	Assurance status	Requirement	Current position / gap	Winter response	Evidence / metric	Residual risk
B8.1	ASSURED	The SCC proactively resolves operational pressures in hours.	OPEL monitored through SHREWD throughout the operating day; provider meetings identify local pressures and required system support; informal channels maintained alongside formal escalation. Where pressure is unresolved the SCC convenes system partners, brokers mutual aid and coordinates resource flexing.	Surge and Escalation SOP mobilised for winter; daily close-of-play reporting; clinical and patient-safety escalation validated with the escalating provider and ICB command engaged as required.	SHREWD OPEL records; SCC escalation and contact log; Incident Response Plan and Mutual Aid Framework.	Exercise Aegis recorded requests for stronger SCC links, clearer system communication and a more effective system call; system call terms of reference under review (action A2).
B8.2	ASSURED	The SCC operates 08:00-18:00 seven days a week and can extend during extreme pressure.	Fully staffed across the entire Central East footprint with minimum daily cover of two duty managers and two administrators. Start and end times flexed to extend coverage. At 6.0 WTE extended hours are sustainable through a prolonged escalation rather than for short periods only.	Drafted rota for the remainder of 2026/27; extreme surge cadre activated at 7 or more acute sites at OPEL 4; ICB 24/7 on-call provides out-of-hours oversight.	SCC rota; SCC staffing model at 9.2; ICB On Call Guidelines.	Extension depends on completion of recruitment to the two additional Band 8a posts.
B8.3	ASSURED	Proactive engagement with NHS England regional teams is maintained.	Duty manager attendance at regional tactical calls; SHREWD reporting; daily close-of-play reports; scheduled monthly meeting; open channel for real-time intelligence on ambulance delays and emerging pressure.	Call cadence increased during sustained pressure with ad-hoc escalation available. A regional representative has accepted an invitation to join the Winter Assurance Group.	Regional call attendance records; close-of-play reports; Winter Assurance Group membership.	None recorded.