

Exercise Aegis 2026

Overview report: priority risks, gaps, commissioning opportunities and proposed action plan

Central East ICB winter planning exercise | System Coordination Centre | Draft v2, September 2026

1. Summary

Exercise Aegis 2026 tested how the Central East system would respond to winter pressure. Participants built a baseline shared risk picture and then worked through three injects: community discharge and flow failure, a mental-health and primary-care surge, and workforce exhaustion combined with industrial action. The exercise closed with calls to action and commitments from providers.

Overall assessment. The system is not short of useful services or local workarounds. What it lacks is a single operating model that is understood in the same way across the enlarged Central East footprint. The pressure participants described does not come from one shortage. It comes from the interaction of workforce fragility, inconsistent pathways, limited seven-day capacity and poor visibility of commissioned services. Together these slow discharge, push pressure back onto ambulance services and ED, and leave organisations unsure where clinical and operational risk sits. The system is weakest out of hours, at weekends and bank holidays, and at the handoffs between organisations, and participants were clear that this is no longer only a winter issue.

The biggest gains are likely to come from three things: making existing services visible and accessible; extending a small number of critical functions to seven days; and commissioning flexible bridge capacity at the interfaces between acute, community, mental-health and social care. These need to be underpinned by common escalation triggers, available senior decision-makers and a clear account of who holds risk at each point in the pathway.

Key messages

- **Flow is a single chain.** Delayed discharge, ED congestion and ambulance delays were repeatedly linked; no organisation described a solution it could deliver alone.
- **Mental-health crisis provision is the most specific, repeated gap.** Section 136 capacity, safe places for assessment, AMHP cover and MH beds came up in the baseline, Inject 1, Inject 2 and two live requests.
- **Staff cannot see what the system commissions.** A single Directory of Services exists, but participants were not consistently aware of it or of what it contains. Commissioning consistency across local-authority areas was also named a major risk.
- **Out-of-hours cover needs strengthening.** Lack of clarity over who holds clinical risk outside normal hours was recorded as a risk, alongside calls for more senior decision-makers on call and more senior clinical oversight out of hours.
- **Mutual-aid headroom is thin.** Some organisations reported no remaining capacity to offer mutual aid under workforce pressure.

- **SCC was asked to do more.** Stronger SCC links, clearer system communication, shared escalation triggers and a more effective system call were requested from the baseline onwards.

Top priorities before winter (detailed in section 7): agree shared escalation triggers and a simplified pre-escalation process; clarify out-of-hours clinical-risk ownership and senior on-call cover; confirm Section 136, safe-place and AMHP arrangements, including cross-border support; raise awareness and use of the existing Directory of Services among SCC and provider staff.. Section 6.4 sets out promising practices the system can build on, and section 8 proposes outcome measures to track whether these actions are working.

2. About the exercise and this report

Scope and structure

The exercise ran in five parts: a baseline shared risk picture (one risk and one action per organisation), Inject 1 (community discharge and flow failure), Inject 2 (mental health and primary care surge), Inject 3 (workforce exhaustion and industrial action), and a closing round of changes and commitments. A key request cards, running action log and "car park" captured cross-cutting points throughout.

3. Priority risks

Ten priority risks emerged. The four rated High were raised most often and by the widest range of organisations.

#	Risk	What participants described	Likely consequence	Where raised	Priority
R1	Capacity and flow failure across the urgent care pathway	Delayed discharge, ED congestion and ambulance delays linked as one chain; stagnation of capacity; patient harm when people are not in the right place. Named by EEAST, BHT, WHHT, HCT, SWHHCP and ELFT.	Ambulance queues, ED crowding, longer stays, patient harm and slower recovery	Baseline, Inject 1, action log	High
R2	Workforce shortage and exhaustion	Uncovered shifts, nurse and ward staffing pressure, no clear medical staffing plan in some areas, elective and urgent work competing for the same staff, weak night, weekend and bank-holiday cover. "Biggest risk: lack of capacity and staffing."	Services cannot open, extend hours or safely absorb surge; mutual aid not available	Baseline, Inject 3, action log, loose notes	High
R3	Mental-health crisis response	Insufficient Section 136 and safe-space capacity; insufficient MH beds; patients left without a timely crisis response; need for additional AMHP capacity; actively suicidal patients presenting with physical care demand.	Patients held in ED or unsuitable settings; rising clinical and safeguarding risk	Baseline, Injects 1 and 2, two live requests	High

#	Risk	What participants described	Likely consequence	Where raised	Priority
R4	Community, social care and care-home capacity	Care packages, transfer capacity and community resources slow to mobilise; care homes may decline admissions without GP or clinical cover; LA unfilled posts and care-market fragility; people who miss CHC criteria but have substantial needs fall between services.	Discharge delays and over-reliance on acute beds	Injects 1 and 3	High
R5	Out-of-hours clinical risk and decision-making	Lack of clarity over who holds clinical risk outside normal hours; not enough senior decision-makers on call; staffing and beds weakest at weekends and overnight.	Decisions delayed overnight and at weekends; demand builds up for the next weekday	Injects 1 and 2	Medium-high
R6	Children and young people aged 15 to 18	No consistent all-age response; system response for children unclear and lacking representation; safeguarding needs for young people.	Young people held in unsuitable settings; heightened safeguarding risk	Injects 1 and 2	Medium-high
R7	Infection outbreaks closing beds	Ward closures from influenza, norovirus and COVID directly affecting flow; inconsistent IPC advice and routes into care homes.	Sudden loss of beds and care-home admissions; flow deteriorates further	Inject 1, loose notes	Medium-high
R8	Ambulance unmet demand escalating in acuity	Category 3 unmet demand may become Category 2. Participants asked for a clinical-safety plan that is short and usable.	Patients deteriorate while waiting in the community	Inject 1, loose notes	Medium-high
R9	Transport	Insufficient or unsuitable transport to move people to the right place, including for discharge.	Discharges delayed or cancelled on the day	Inject 1, loose notes	Medium
R10	Safeguarding and lone working	Safeguarding demand rising alongside MH pressure; lone-working risks for staff.	Harm to vulnerable patients and to staff	Injects 1 and 2	Medium

4. Priority gaps

The gaps below are the system weaknesses that sit behind the risks. Several were described as structural rather than seasonal.

#	Gap	Detail from the exercise	Risks affected
G1	Awareness of commissioned services	A single DoS exists, but participants believed there was no consistent directory and did not always know what it contains. The gap is awareness and use.	R1, R3, R4
G2	Commissioning consistency	Provision and pathways vary by area, making consensus hard. Commissioning consistency named a major risk. Discussion of using the larger footprint to advantage.	R1, R3, R4

#	Gap	Detail from the exercise	Risks affected
G3	Seven-day and 24-hour provision	Core contracts may not give access at the times required; UTC access limitations; frailty and same-day services should run longer, potentially 24/7; one UCC described as eight beds with limited hours; only five-day provision noted for community assessment against a seven-day fast-track requirement.	R1, R5
G4	Shared escalation framework	No shared escalation triggers or framework for system asks; no simplified process to manage pressure before escalation, ideally activated in advance; inconsistent communication; request to review system-call frequency.	All
G5	Slow decision processes	Lengthy panel and approval processes (CHC, Section 117); policy and approval processes prevent rapid changes in practice; request for CHC leads and a decision tree earlier in the pathway.	R1, R4
G6	Data and intelligence	Urgent-care demand recognised but not always quantifiable; ICB data availability and weak links from some providers with SCC; primary care may not see wider system pressure. Car-park notes: 111 "60 per cent gap for ED" and low appointment utilisation between 08:00 and 10:00.	R1, R5
G7	Representation and partnership	Primary care, VCSE and hospice absent from part of the exercise; children's system response unrepresented; request to treat LA and care-home providers as system partners, not only suppliers.	R4, R6
G8	Early family engagement	Families not always involved early enough in discharge and alternatives to admission; conversations should start at the point of admission.	R1, R4
G9	Policy and legal cover for risk-sharing	Need agreed policy and legal arrangements so staff can hold clinical risk safely and carry out delegated healthcare tasks, with the right equipment.	R2, R4, R5
G10	Money and resource allocation	Money, staff, transport and communication not consistently allocated to the right place; fixed prices and financial limits may restrict appropriate provision; clinical-safety plan and finance.	R1, R2, R4

5. Commissioning opportunities

These opportunities come directly from gaps and suggestions recorded in the exercise. Suggested leads are proposals for the SCC team to confirm with commissioning colleagues. Some are deliverable this winter; others are longer-term and should feed into 2027/28 commissioning intentions.

#	Opportunity	Why (from the exercise)	Suggested lead	Horizon
C1	Promote the existing Directory of Services to SCC and provider staff, and confirm it holds current entries and referral routes for the services raised in the exercise	G1; ICB and BLMK asked for clarity on commissioned services	ICB DoS lead with SCC	Pre-winter
C2	Section 136 and place-of-safety capacity, including a cross-border arrangement with neighbouring ICBs	R3; raised by Herts, BLMK and C and P; C and P live request on two cards	MH commissioning	Pre-winter

#	Opportunity	Why (from the exercise)	Suggested lead	Horizon
C3	Out-of-hours and weekend AMHP capacity to review ED waits proactively	R3; HPFT live request, directed to HCC	MH commissioning with local authorities	Pre-winter
C4	All-age mental-health crisis pathway, closing the 15 to 18 gap	R6; raised in Injects 1 and 2	MH and CYP commissioning	Winter and beyond
C5	Bridge provision for people between standard social care and CHC, through a jointly funded specification with local authorities	R4; recorded as a direct suggestion in Inject 3	ICB CHC with local authorities	Winter
C6	Pathway 2 care support and bridging capacity into people's own homes	R4; CLCH live request to Hertfordshire County Council	ICB and LA joint commissioning	Pre-winter
C7	Additional same-day urgent-care capacity to support primary care, plus primary-care step-up in the home	R1; SWHHCP live request; Inject 2 suggestion	ICB primary care and UEC	Winter
C8	Extended hours for SDEC, UCC, frailty and same-day services; identify where 24-hour provision is needed	G3; raised in Inject 2 and loose notes	UEC commissioning	Review now, commission 2027/28
C9	Seven-day fast-track provision where only five-day exists	G3; CPFT/CPA noted as five-day only	Community commissioning	Winter
C10	Care-home capability: clinical oversight, GP cover, technology, IPC input, delegated healthcare training	R4, R7; Inject 3 suggestion	ICB care-home and IPC leads	Winter and beyond
C11	VCSE-supported discharge transport	R9; raised in Inject 1 and loose notes	UEC commissioning with VCSE	Pre-winter
C12	Contract review for access hours and consistency across local-authority areas, including pre-authorised variation mechanisms so services can flex during surge without renegotiation	G2, G3, G10; "Review core contracts and gaps in services"	ICB contracting	Variations pre-winter; review 2027/28
C13	Delegated authority for rapid CHC, Section 117 and funding decisions during escalation, supported by standard decision trees	G5; lengthy panels and approval processes in Injects 2 and 3	ICB CHC and finance with local authorities	Pre-winter

6. Provider actions and suggestions

6.1 By organisation

The table combines each organisation's baseline risk and action, per-provider notes from Inject 2, and live requests. The final column suggests what the SCC team may want to follow up.

Organisation (as recorded)	In-Exercise Risks raised	Actions offered or asks made	Suggested follow-up
Ambulance	Capacity and flow; Category 3 unmet demand becoming Category 2	No clear action recorded at baseline	Confirm action; request short Cat 3 clinical-safety plan
NHSE	Patient-safety concern	Safety checks	Clarify what safety checks are expected and how SCC reports them
MK	Specialty flow		Confirm risk and action with MK
BHT	Unexpected demand, workforce pressure, delayed discharge	Bank exercise and winter planning; review elective activity; prepare pathways and staffing	Link elective review to agreed escalation triggers
ELFT	ED overcrowding and patient safety	Deploy staff; review activity and delays; link with SCC	Confirm organisation; agree SCC link contact
ENHT	Not recorded at baseline	Owner of action log entry: "pull to safety" and "pull to discharge" with FCP	Confirm what the action involves and its status
WHHT	Congested ED, delays and safety risk	Capacity mapping; review staffing; senior decision-makers. "Get the word out" at 10:37: OPEL 4 and FCP message to HCPs and ICB via WhatsApp and SCC Teams	Confirm message; check WhatsApp use for system messaging against IG policy
HCT	Insufficient capacity	Review patients and speed discharge	Capture in discharge actions
HPFT	Insufficient MH beds; need for AMHP capacity	Redeploy clinicians; rapid review of patients. Live request at 10:50 to HCC for OOH and weekend AMHP capacity	Track AMHP request to outcome
SWHHCP	Urgent-care system flow	Rapid calls and escalation	Include in escalation framework design
CLCH	Support staff and bed availability	Live request at 10:46 to Herts CC for Pathway 2 care support	Confirm baseline action; track P2 request
C and P	Right care, right person; Section 136	Offered UEC hub as safe place for staff (Sawston) asked for staff and equipment space in Ely (Gemini?). Live request at 12:20 for S136 support from historic ICB neighbours	Broker cross-border S136 conversation
Herts	Urgent physical care demand; actively suicidal patients; S136 space; safeguarding demand	None recorded	Feed into S136 and safeguarding actions
BLMK	Variable pathways; limited service visibility; insufficient S136 space; year-round demand	None recorded	Include in DoS awareness work (C1)
Granta/UEC Hub	Not recorded	Asked for CPFT to become an approved referrer into ICT	Follow up with CPFT
SWHHCP	Not recorded	Live request at 13:50 to ICB/HUC to stand up same-day urgent capacity for primary care	Confirm requester and route

Organisation (as recorded)	In-Exercise Risks raised	Actions offered or asks made	Suggested follow-up
ICB	Data availability; weak SCC links with some organisations	Improve links, communication and pathways; clarify commissioned services, directory, panels and Central East coordination	Own DoS awareness and escalation actions
Primary care	Not represented for part of exercise	Role in same-day urgent care, shared risk, referrals, communications and pressure awareness	Invite to system call and future exercises

6.2 Cross-system suggestions

Beyond individual organisations, participants made a consistent set of suggestions, grouped here by theme.

Flow and discharge. Use SDEC, UCC, frailty and community services more extensively, including weekends and overnight. Review patients proactively and accelerate discharge. Use rapid calls and panels to unblock discharge and CHC decisions, and increase panel frequency. Start discharge and family conversations at admission, and mobilise face-to-face urgent-discharge support.

Escalation and coordination. Adopt provider-driven action supported by NHS and ICB coordination and monitoring. Agree shared escalation triggers and a framework for system asks, with a simplified process that can be activated in advance. Review system-call frequency and effectiveness, and clarify how primary care, local authorities and partners contribute during escalation. Review historical COVID processes for arrangements that could be reinstated, and define what recovery looks like, including how long each trust may take.

Workforce. Protect critical services and consider reducing or pausing elective activity where necessary. Move staff flexibly using bank, agency and mutual aid. Develop transferable and delegated healthcare teams with training and equipment. Run a system-wide campaign asking retired nurses and other registered professionals to return. Plan bank-holiday contingency and fill uncovered shifts.

Partnership. Treat local authorities and care homes as system partners. Use LA brokerage and directors of commissioning to coordinate the care market. Hold a joint briefing on statutory responsibilities (offer from some councils). Involve families and care homes earlier.

Protect, change, stop (Inject 2). Protect mental-health and primary-care provision. Change winter planning where gaps have been identified, review core contracts and address UTC access. Stop inconsistent communication.

6.3 Live requests raised during the exercise

These requests were made in the closing round. None has a recorded outcome, so all seven should be treated as open

Type	From (time)	Request or message	Directed to	Suggested next step
Phone a friend	C and P (12:20)	Section 136 provision and a safe space to assess MH patients.	Historic ICB neighbours	SCC to broker cross-border discussion
Phone a friend	HPFT (10:50)	Additional AMHP capacity to review ED waits proactively out of hours and at weekends	HCC	Confirm with HCC; link to C3
Phone a friend	CLCH community (10:46)	Care support to enable Pathway 2 discharge	Hertfordshire County Council	Confirm with Herts CC; link to C6
Phone a friend	SWHHCP (13:50)	Stand up additional same-day urgent capacity to support primary care	ICB / HUC	Confirm requester; link to C7
Phone a friend	UEC Hub	Become an approved referrer into ICT	CPFT	Follow up with CPFT
Get the word out	System workforce	Ask retired nurses and nurses not on a bank to return. Message: "Come and help". Audience: registered nurses and HCPs	Wider public via system comms	Brief ICB comms; link to A11
Get the word out	WHHT (10:37)	OPEL 4 and FCP enacted	HCPs and ICB via WhatsApp and SCC Teams	Confirm wording; check channel against IG policy

6.4 Promising practices

The practices below come from what organisations said they would do at baseline and in response to the injects. They were not tested in real pressure, so they are best treated as promising rather than proven. Action A1 includes confirming with each organisation whether they worked in practice.

Practice	What organisations said they would do	Source	How SCC could use it
Bringing senior decisions forward	Bring in senior decision-makers; use rapid calls and escalation; use rapid calls and panels to unblock discharge and CHC decisions	WHHT, HCP, Inject 1	Build senior decision-maker availability into the escalation framework (A3, A5)
Reviewing patients before pressure peaks	Rapid review of patients to speed discharge; out-of-hours AMHP review of ED waits before delays build	HPFT, HCT	Make proactive review a standard trigger action (A3); link to AMHP arrangements (A6)
Preparing before escalation	Bank exercise and winter planning; prepared pathways and staffing; capacity mapping; a pressure process that can be activated in advance	BHT, WHHT, participants	Use as the basis for the simplified pre-escalation process (A3)
Flexing the workforce	Redeploy clinicians; deploy staff; review elective activity to protect urgent care; transferable and delegated care teams; returner campaign	HPFT, ELFT, BHT, Inject 3	Feed into the mutual-aid capability register (A11)
Offering as well as asking	Offered a UEC hub or safe place while asking for Section 136 support; offered to become an approved referrer into ICT	C and P, UEC Hub	Record offers as well as asks in the mutual-aid register (A11)

Practice	What organisations said they would do	Source	How SCC could use it
Starting discharge at admission	Family and care-home conversations from admission; VCSE or family transport where safe; "pull to safety, pull to discharge"	Participants, ENHT	Share through provider assurance (A18) and transport mapping (A13)
Making specific, targeted asks	Requests named the recipient, the time and the exact need, for example HPFT to HCC for out-of-hours AMHP cover and CLCH to Herts CC for Pathway 2	HPFT, CLCH, C and P, SWHHC	Adopt as the standard format for mutual-aid requests into SCC (A3)

7. Proposed action plan

The plan is organised into three phases against a winter start in November: **Phase 1** by end of October 2026 (pre-winter essentials), **Phase 2** by end of November 2026, and **Phase 3** during winter through to March 2027 and into 2027/28 planning. Owners are suggested and should be confirmed. Actions marked with an asterisk (*) are within the SCC team's direct control.

Ref	Action	Addresses	Suggested owner	Timescale	Measure of completion
A1	Draft shared escalation triggers, a framework for system asks, and a simplified pre-escalation process that can be activated in advance; align with OPEL and SHREWD	G4, R1	SCC with UEC leads and providers	Phase 1 (PDSA)	Framework agreed and tested on a system call
A2	Review system-call frequency, membership and terms of reference; include primary care, local authorities, VCSE and hospice	G4, G7	SCC team	Phase 1	Revised terms of reference in use
A3	Agree who holds clinical risk out of hours and publish senior decision-maker on-call arrangements, including policy and legal cover for risk-sharing	R5, G9	ICB medical and nursing directors	Phase 1	Out-of-hours risk-ownership statement issued
A4	Confirm Section 136 and safe-place capacity, including cross-border mutual-aid arrangement; confirm OOH and weekend AMHP cover	R3, C2, C3	MH commissioning, local authorities	Phase 1	Arrangement documented and known to SCC
A5	Ambulance to share a short, usable Category 3 clinical-safety plan and share with SCC	R8	Ambulance service with SCC	Phase 1	Plan shared and referenced in escalation framework
A6	Run a DoS awareness push for provider staff (briefings, system-call reminder, links in escalation materials), and confirm entries are current for services raised in the exercise	G1, C1	ICB DoS lead with SCC	Phase 1 to 2	Provider staff know how to access the DoS; entries confirmed
A7	Increase CHC and Section 117 panel frequency; agree delegated authority for escalation decisions; introduce CHC decision tree and early CHC lead input; scope bridge provision	G5, R4, C5, C13	ICB CHC with local authorities	Phase 2	Panel waits reduced; bridge option agreed

Ref	Action	Addresses	Suggested owner	Timescale	Measure of completion
A8	Agree CYP 15 to 18 escalation route and representation on the system call	R6, C4	CYP and MH commissioning, SCC	Phase 2	Route documented; CYP representative named
A9	Launch return-to-practice communications campaign; create a mutual-aid capability register; agree bank-holiday contingency	R2	ICB workforce and communications; SCC for register	Phase 1 to 2	Campaign live; register in SCC
A10	Agree consistent IPC advice route into care homes and ward-closure reporting into SCC	R7, C10	ICB IPC lead	Phase 1	Single IPC route agreed; closures visible to SCC
A11	Map discharge transport options, including VCSE-supported transport and safe use of family transport	R9, C11	UEC commissioning with VCSE	Phase 2	Transport options list available to providers via SCC
A12	Review historical COVID arrangements for anything that could be reinstated this winter	G4	All	Phase 2	Short options paper
A13	Quantify urgent-care demand; investigate the 111 ED gap and 08:00 to 10:00 appointment utilisation	G6	Strat Commissioning	Phase 2	Data confirmed and reported
A14	Define what recovery looks like, including expected recovery time by trust	R1	SCC with providers	Phase 2	Recovery definition agreed
A15	Run a tabletop test of weekend and bank-holiday discharge, including senior decision-makers, local authorities and transport	R4, R5, R9	SCC with providers and local authorities	Phase 2	Test held before Christmas bank holidays; lessons fed into escalation framework
A16	Embed discharge and family conversations from admission; engage care homes earlier	G8	Acute and community providers	Phase 3	Provider assurance through winter
A17	Review service hours (SDEC, UCC, frailty, same-day, five-day fast-track) and core contracts; agree pre-authorised surge variations; identify 24-hour needs	G2, G3, C8, C9, C12	Strategic commissioning, contracting	Variations Phase 2; review Phase 3	Variations agreed; recommendations into 2027/28 intentions
A18	Cross-check exercise findings against provider winter plan assurance; hold a follow-up exercise with full representation	All	SCC team	Phase 3	Gaps reflected in assurance; follow-up held
A19	Local authorities to present webinar supporting system understanding of processes		LA winter leads	Phase 1	Webinar complete and shared with staff
A20	Mental Health providers to meet and share how the model discharge pathway can be managed in their setting		Mental health winter leads	Phase 1	Meeting in place

8. Assurance measures

The completion measures in section 7 show whether actions have been delivered. The measures below show whether they are making a difference.

Outcome measure	Risks	Related actions	Suggested source (to confirm)
Ambulance handover delays and conveyance to alternative pathways	R1	A3, A13	SHREWD; ambulance handover data
Category 3 unmet demand and waits	R8	A7	Ambulance service reporting
ED crowding, length of stay and patients with no criteria to reside	R1, R4	A3, A9, A18	SHREWD; SITREPs; discharge SITREP
Discharge pathway capacity (including Pathway 2), acceptance rates and time to discharge	R1, R4	A9, A13, A17	Community provider and local-authority data
Section 136 waits, AMHP response times and mental-health waits in ED, including under-18s	R3, R6	A6, A10	MH provider returns; local authorities; acute ED data
Uncovered shifts, service closures and out-of-hours availability	R2, R5	A5, A11	Provider SITREPs and OPEL returns; workforce data
CHC and Section 117 panel turnaround and delayed funding decisions	R4	A9	ICB CHC team
Ward and care-home outbreaks, closures and declined care-home admissions	R4, R7	A12	IPC and outbreak reporting; SITREPs
Time to respond to mutual aid and live requests raised through SCC	R2, R3	A2, A3, A11	SCC contact log

Next step for the SCC team: agree owners and dates for A1 to A7 at the next team meeting, as these need to be in place before winter pressure builds, and agree baselines for the section 8 measures.